

PARAMOUNT INSURANCE COMPANY

HMO INDIVIDUAL Health Insurance

**MEMBER HANDBOOK
AND
EVIDENCE OF COVERAGE**

NOTICE CONCERNING COORDINATION OF BENEFITS (COB):

IF YOU OR YOUR FAMILY MEMBERS ARE COVERED BY MORE THAN ONE HEALTH CARE PLAN, YOU MAY NOT BE ABLE TO COLLECT BENEFITS FROM BOTH PLANS. EACH PLAN MAY REQUIRE YOU TO FOLLOW ITS RULES OR USE SPECIFIC DOCTORS AND HOSPITALS, AND IT MAY BE IMPOSSIBLE TO COMPLY WITH BOTH PLANS AT THE SAME TIME. READ ALL OF THE RULES VERY CAREFULLY, INCLUDING THE COORDINATION OF BENEFITS SECTION, AND COMPARE THEM WITH THE RULES OF ANY OTHER PLAN THAT COVERS YOU OR YOUR FAMILY.

This policy is not a Medicare supplement policy. If you are eligible for Medicare, review the "Guide to Health Insurance for People with Medicare" available from Paramount.



Our mission
is to improve
your health and
well-being.

Your health. Our mission.

Paramount Insurance Company is an affiliate of ProMedica a locally owned, nonprofit healthcare organization serving northwest Ohio and southeast Michigan.

English ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-462-3589 (TTY: 1-888-740-5670).

Albanian: KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-800-462-3589 (TTY: 1-888-740-5670).

Arabic:

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-462-3589 (رقم هاتف الصم والبكم: 1-888-740-5670).

Bantu: ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu.

Woterefona 1-800-462-3589 (TTY: 1-888-740-5670).

Bengali: লক্ষ্য করুন: যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ

আছে। ফোন করুন ১-৮০০-৪৬২-৩৫৮৯ (TTY: ১-৮৮৮-৭৪০-৫৬৭০)।

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-462-3589 (TTY : 1-888-740-5670)。

Cushite: XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-462-3589 (TTY: 1-888-740-5670).

Dutch: AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 1-800-462-3589 (TTY: 1-888-740-5670).

French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-462-3589 (ATS : 1-888-740-5670).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-462-3589 (TTY: 1-888-740-5670).

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-462-3589 (TTY: 1-888-740-5670).

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-462-3589 (TTY:1-888-740-5670) まで、お電話にてご連絡ください。

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-462-3589 (TTY: 1-888-740-5670) 번으로 전화해 주십시오.

Nepali: ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-800-462-3589 (टिटिवाइ: 1-888-740-5670) ।

Wann du Deutsch (Pennsylvania German / Dutch) schwetzsch, kannst du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-462-3589 (TTY: 1-888-740-5670).

Notice of Nondiscrimination and Accessibility: Discrimination is Against the Law

Paramount Insurance Company complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Paramount Insurance Company does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Paramount Insurance Company provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact Member Services at 1-800-462-3589.

If you believe that Paramount Insurance Company 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. You can file a grievance in person or by mail, fax, or email.

Member Services
1901 Indian Wood Circle, Maumee OH 43537
Phone: 419-887-2525
Toll Free: 1-800-462-3589
TTY: 1-888-740-5670
Fax: 419-887-2047
Email: Paramount.MemberServices@ProMedica.org.

If you need help filing a grievance, Member Services 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>.

PARAMOUNT INSURANCE COMPANY
P. O. Box 928
Toledo, Ohio 43697-0928
419-887-2500
Member Services: 419-887-2525

EVIDENCE OF COVERAGE SPECIFICATIONS

RATE PERIOD: 01-01-2022 THRU 12-31-2022
PREPAYMENT DUE: BY THE END OF EACH MONTH PRIOR TO COVERAGE.

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	PARAMOUNT Summary of Benefits	Attachment A

I. WELCOME TO PARAMOUNT

Welcome to Paramount Insurance Company (Paramount), a health maintenance organization (HMO) licensed in Ohio. We are pleased that you have selected our Health Plan. Paramount Members are entitled to a wide range of health care services. The information contained in this Handbook will help you become familiar with the Health Plan. This will enable you to use your benefits most effectively.

The Primary Care Provider selected or assigned when you joined Paramount will assist you as you seek medical care. **EXCEPT FOR EMERGENCY MEDICAL CONDITIONS and OB/GYN CARE, ALWAYS REMEMBER TO CONTACT YOUR PRIMARY CARE PROVIDER FIRST IF YOU NEED MEDICAL CARE.**

This Member Handbook and Evidence of Coverage contain detailed information regarding eligibility, procedures and benefits. Please take a few minutes to read it.

Paramount offers the following options in the individual market on and off the Marketplace. The plans that are available to you are dependent upon the county in which you reside.

- Bronze
- Silver
- Gold

If you have any questions, or if you require assistance, please feel free to call:

Member Service Department
(419) 887-2525
Toll-Free 1-800-462-3589
TTY (419) 887-2526
TTY Toll-Free 1-888-740-5670
Monday through Friday
8:00 A.M. to 5:00 P.M.

SURPRISE BILLING

An individual enrolled with a health plan may unexpectedly receive care from a non-participating provider.

For example, a non-participating provider may provide Emergency Services or certain Diagnostic Services at an in-network hospital. The enrolled individual may then be presented with a bill for those services based on the provider's non-participating status. Without a prior authorization, the amount due is now owed by the enrolled individual.

Such a bill is commonly known as a surprise bill. If those services had been performed by a provider participating with the health plan, the services may have been covered or covered at a lower cost to the individual pursuant to that plan.

Both the Ohio Revised Code (ORC 3902.50 to 3902.54) and the federal "No Surprises Act" (Public Law 116-260) establish patient protections against non-participating providers' surprise bills for Emergency Services or, in certain circumstances, for covered services rendered at in-network facilities by non-participating providers. Paramount will comply with state and federal surprise billing requirements as they apply to health plans, including those which relate to the processing of claims out-of-network providers.

Specifically, a provider shall not bill a Paramount Member for the difference between Paramount's reimbursement and the provider's charge for the below services:

- Unanticipated out-of-network care provided at an in-network facility in Ohio;
- Emergency services provided at an out-of-network emergency facility in Ohio;
- Emergency services provided by an out-of-network ambulance in Ohio; and
- In the case of clinical laboratory services provided in Ohio if:
 - The services are provided to a covered person at an in-network facility; and
 - The services would be covered if provided by an in-network provider.

If you experience any of the above circumstances as a Paramount Member, the bill you have received may violate state and federal law. Please contact the Non-Participating Provider listed on the bill to ask that he or she contact Provider Inquiry at Paramount to discuss the services you received and the resulting bill. Paramount Provider Inquiry may be reached by phone at (419) 887-2564 (toll-free at 1-888-891-2564), or by fax at (419) 887-2014.

II. YOUR MEMBERSHIP CARD

Every Paramount Member receives a Paramount identification card with his or her name. The name of that person's Primary Care Provider (PCP) is on the card.

If your card is lost or stolen or any information is incorrect, call Member Services immediately. A new card will be mailed to you promptly.

Please check to see that the information printed on the front of your I.D. card is correct. If there are any errors, call:

**Member Services Department
(419) 887-2525
Toll-Free 1-800-462-3589
TTY (419) 887-2526
TTY Toll-Free 1-888-740-5670**

Be sure to familiarize yourself and your family with the instructions on the back of the card.

III. YOUR PRIMARY CARE PROVIDER (PCP)

When you enrolled in Paramount, you selected or were assigned a Primary Care Provider (PCP) for yourself, and for each Member of your family. Your PCP will coordinate your medical care with other Participating Providers in the Paramount network. Female Members may receive OB/GYN care from a participating obstetrics/gynecology specialist without an out-of-plan Prior Authorization from the Primary Care Provider. See **Prior Authorizations** in this handbook for more information.

Your PCP is the doctor who will handle your medical care through your Paramount plan. Paramount requires the designation of a Primary Care Provider (PCP) for each Member. You have the right to designate any PCP who participates in the Paramount network as a PCP and who is available to accept you or your family members. PCPs are family practitioners, internists and pediatricians participating in the Paramount network. For children, you may designate a pediatrician as the PCP. Each family member can have a different PCP. For information on how to select or change a PCP, and a list of the Participating PCPs, contact Paramount Member Services at (419) 887-2525 or toll-free 1-800-462-3589. A directory of Participating Providers is also available at: www.paramountinsurancecompany.com.

If you have chosen a doctor you have not seen before, make an appointment and get to know the doctor and staff. The more comfortable you are with your doctor - and the better your doctor knows you - the more effective your health care can be.

For doctor appointments, call your PCP's office.

Paramount maintains specific access standards to make sure you get the care you need on a timely basis. Access refers to both telephone access and the ability to schedule appointments. If you are having difficulty scheduling an appointment or reaching a provider's office, please contact the Member Service Department. They will assist you.

Please call as far in advance as possible for an appointment. Use the following table as a guide for the lead-time you should allow.

Access Standards for Medical Health Care Services
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Type of Care Required	Expected Access Standards
Routine assessments, physicals or new visits	30 days
Routine follow-up visits (for recurring problems related to chronic ailments like high blood pressure, asthma, diabetes, etc.)	14 days
Symptomatic, non-urgent (cold, sore throat, rash, muscle pain, headache)	2 - 4 days
Urgent medical problems (unexpected illnesses or injuries requiring prompt attention soon after they appear; Urgent Medical Conditions are not permanently disabling or life-threatening; an example would be a persistent high fever)	1 – 2 days
Emergency Medical Conditions (such as heart attack, stroke, poisoning, loss of consciousness, inability to breathe, uncontrolled bleeding and convulsions)	Immediately call 911 or seek medical treatment. Afterward, call your PCP for follow-up care.

Access Standards for Behavioral Health Care Services	
Type of Care Required	Expected Access Standards
Emergency care, immediate threat to self or others (acutely suicidal or homicidal)	Immediately call 911 or seek medical treatment. Then call your PCP for follow-up care
Urgent Care, may not be life-threatening, but requires urgent attention (complex or dual problems)	1 – 2 days
Routine Care/ Office Visit for new problems upon request of the Member or provider	14 days
Routine Care/ Office Follow-Up Visits	30 days

If you are unable to keep an appointment, call your Physician as soon as possible so the time can be made available for other patients. Paramount will not cover claims associated with missed appointments.

Paramount offers a wellness incentive to members who visit their Primary Care Provider for an annual Wellness Visit and receive an influenza vaccine during a calendar year. This incentive is automatically available to all members upon enrollment and will remain available as long as coverage remains active. Shortly after Paramount receives claims for your Wellness Visit and influenza vaccine, you will receive your incentive in the mail. Upon termination of coverage, wellness incentive benefits are no longer available. For questions regarding this incentive, you may call Member Services at 419-887-2525 or Toll-Free at 1-800-462-3589.

After Hours Care

Your Primary Care Provider can be reached 24 hours a day, seven (7) days a week. If you need medical advice after hours, on weekends or holidays, call your doctor's office number. The answering service will take your call. Leave a message for the doctor to return your call.

When your doctor, the doctor who is covering for your Primary Care Provider or a nurse calls you, explain the problem clearly. They will advise you on what to do.

When your doctor recommends a treatment or test, in most cases it will be covered. However, some treatments may not be covered or are covered only when authorized in advance by Paramount. Your doctor may be working with several Paramount plans; the service your doctor recommends for you may be covered under some similar plans, but not under your particular plan. If you received services that are not covered under your benefit plan, you are responsible for full payment to the provider of those services.

If you are not sure, the best thing to do is ask Paramount Member Services. Don't be afraid to call.

IF YOU HAVE A QUESTION about whether a service is covered, you can find out by calling Member Services.

If another doctor is covering for your Primary Care Provider during off-hours or vacation, you do not need Paramount Prior Authorization before you see that doctor. But be sure to tell the doctor you are a Member of Paramount.

You may change your Primary Care Provider. You must notify Paramount first, before you see any new Primary Care Provider. Call the Member Services Department or email through the Paramount web site at: www.paramountinsurancecompany.com. The change can be made effective the day you call. You will receive a new identification card with your new physician's name. If you need to see the doctor before your card arrives, your doctor can call Member Services to check your membership.

What to Consider When Selecting or being referred to a Physician or Hospital/Facility

If you need specific information about the qualifications of any participating physicians, you may call the Academy of Medicine, the Member Services Department or you may use the on-line provider directory available through our web site at www.paramountinsurancecompany.com with links to the Ohio State Medical Association.

The following qualifications are important to consider in selecting a Primary Care Provider or referred to a specialist:

- Professional education – medical school/residency training,
- Current Board Certification status,
- Number of years in practice and
- Languages spoken
- Is the physician a Participating Provider

The following qualifications are important when selecting a hospital/facility:

- The Joint Commission status (Paramount Participating Hospitals are required to have Joint Commission accreditation)
- Hospital experience/volume in performing certain procedures.
- Consumer satisfaction and comparable measures of quality on hospitals and outpatient surgical facilities.
- Is the hospital/facility a Participating Provider

If you need a current directory, you may request one by calling the Member Services Department or

you may use the on-line provider directory available through our web site at www.paramountinsurancecompany.com.

Obstetrical/Gynecological Care

You do not need a Prior Authorization from Paramount or from any other person (including your PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in the Paramount network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining Prior Authorization for certain services or following a pre-approved treatment plan. See **Prior Authorizations** in this handbook for more information. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Paramount Member Services at (419) 887-2525 or toll-free 1-800-462-3589. A directory of Participating Providers is also available at: www.paramountinsurancecompany.com.

If you need more specialized OB/GYN care, the gynecologist may recommend another Participating Specialist.

IV. SPECIALIST CARE

Most of your health care needs can and should be handled by your Primary Care Provider. If your Primary Care Provider believes you need to see a specialist - a cardiologist, orthopedist or others - your Primary Care Provider will recommend a Participating Specialist. Or you may choose the Participating Specialist you wish to see from those listed in the *Participating Physicians and Facilities* directory (also available on the website) and make an appointment. You will be held financially responsible if your selected Specialist (and/or hospital/facility where services are rendered) is non-Participating and an out-of-plan Prior Authorization was not obtained. See **Prior Authorizations** in this handbook for more information.

Enrolled Members of Paramount who are already seeing a specialist should verify that the specialist is participating with Paramount.

IF YOU HAVE A QUESTION about whether a service, facility or provider is covered and is participating, you can find out by calling Member Services.

Prior Authorizations

Prior Authorization is required for certain procedures or services. It is the responsibility of the Participating Provider to obtain Prior Authorization from Paramount in advance of these procedures or services. However, it is the Member's responsibility to make sure procedures and services are provided by a Participating Provider or that an out-of-plan Prior Authorization is obtained.

Participating Providers are listed in your Directory of Participating Physicians and Facilities or at the Paramount website www.paramountinsurancecompany.com.

If a medically necessary covered service or procedure is not available from any Participating Providers, Paramount will make arrangements for an "out-of-plan Prior Authorization". Your Primary Care Provider must request an "out of plan Prior Authorization" in advance. **Consultations with Participating Specialists** will be required before an "out-of-plan Prior Authorization" can be considered. If Paramount approves the "out-of-plan Prior Authorization", written confirmation will be sent to you, your PCP and the non-participating provider. All eligible authorized services will be covered at no greater cost to you than if you had obtained the service or procedure from a Participating Provider. It is your responsibility to confirm your selected Specialist (and/or hospital/facility where services are rendered) is Participating or

an out-of-plan Prior Authorization was obtained if your Specialist is non-participating. Otherwise, you will be held financially responsible.

If you **do not obtain Pre-Authorization** and the services are Medically Necessary, any benefit payment for a **facility fee (including inpatient services under Section XI)** will be reduced by \$500 of the Allowable Amount. The services are then subject to the applicable Deductible, Copayment and/or Coinsurance. Financial penalties for failure to obtain Pre-Authorization for care received In-Network will count toward your Out-of-Pocket Maximum. Financial penalties for care received Out-of-Network will not count toward your Out-of-Pocket Maximum.

Utilization Management

Participating physicians and providers have direct access to Paramount's Utilization Management Department to authorize specific procedures and certain other services based on Medical Necessity. If you experience an Emergency Medical Condition after normal office hours, you should call 911, an ambulance or rescue squad or go to the nearest medical facility. You may also call the Member Services number on the back of your I.D. Card at (419) 887-2525 or Toll-Free 1-800-462-3589 24 hours/7 days per week for information as to where and how health care services may be obtained. You do not need to obtain prior approval from your PCP or Paramount. Afterward, you should notify your Primary Care Provider that you were treated.

Utilization management decisions are not subject to incentives to restrict or deny care and services. In fact, Paramount monitors under-utilization of important preventive services, health screening services (immunizations, pap tests, etc.), medications and other services to care for chronic conditions, such as asthma and diabetes. Paramount will send reminder cards to the Member and physician if a claims review suggests that important services were missed.

If you need to discuss the status of a Prior Authorization, you should contact your Primary Care Provider. You may also call the Member Services Department at (419) 887-2525 or toll-free 1-800-462-3589.

Initial Determinations

When Prior Authorization is required in the case of a non-urgent non-electronic claim, Paramount will make a decision within two (2) business days from obtaining all the necessary information about the admission, or procedure that requires Prior Authorization. Paramount will advise the provider of the decision within three (3) working days after making the decision.

In the case of an urgent non-electronic claim, Paramount will make a decision as soon as possible, but not later than 48 hours after receipt of the claim. If insufficient information is received, Paramount will notify the claimant not later than 24 hours after receipt, of the specific information needed. The member will be afforded not less than 48 hours to provide the specified information. Paramount will provide a decision no later than 48 hours after the earlier of:

- a) Paramount's receipt of the specified information
- b) The end of the period afforded the member to provide the specified information.

Paramount will accept provider requests (with all information necessary to support the Prior Authorization request) when received electronically. Paramount's response will be sent within forty-eight hours for urgent care services, or within ten calendar days for non-urgent care services. These timeframe requirements do not apply to Emergency Services. For electronically received determinations, urgent care services means medical care or other service for a condition where application of the timeframe for making routine or non-life threatening care determinations is either of the following:

- (a) Could seriously jeopardize the life, health, or safety of the patient or others due to the patient's psychological state;

(b) In the opinion of a practitioner with knowledge of the patient's medical or behavioral condition, would subject the patient to adverse health consequences without the care or treatment that is the subject of the request.

If the Prior Authorization electronic request is incomplete, Paramount will indicate the specific additional information that is required to process the request within 24 hours of receipt of the request. The health care provider must provide a receipt to Paramount acknowledging the request.

Paramount's response will indicate whether the request is approved or denied. If the Prior Authorization is denied, Paramount will provide the specific reason for the denial. You have the right to appeal through the appeals process outlined in Section XVII, **Internal Claims and Appeals Procedures and External Review** of this Handbook.

Retroactive Denials

If Paramount authorizes a proposed admission, treatment, or health care service by a Participating Provider based upon the complete and accurate submission of all necessary information Paramount will not retroactively deny this authorization if the Participating Provider renders the care in good faith and pursuant to the authorization and all of the terms and conditions of the provider's contract with Paramount.

Concurrent Reviews

For concurrent reviews, which are requests to extend coverage that was previously approved for a specified length of time, Paramount will make a decision within twenty-four (24) hours after receipt of request. Paramount will advise the provider by telephone or electronically within twenty-four (24) hours after making the decision.

If Paramount reduces or terminates a course of treatment (other than by plan amendment or termination) before the end of such period of time or number of treatments, this constitutes an Adverse Benefit Determination. Paramount will notify the Member (in cases where the Member will have financial liability) and requesting provider in writing or electronically within twenty-four (24) hours after making the decision.

Any request that involves both urgent care and the extension of a course of treatment previously approved by Paramount must be decided as soon as possible, and notification must be provided within 24 hours after receipt of the claim, provided the request is made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

Any non-urgent request to extend a course of treatment previously approved by Paramount, the request may be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim, e.g., as a *pre-service claim* or a *post-service claim*.

If requests are not made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments, the request must be treated as a *claim involving urgent care* and decided in accordance with the urgent care claim timeframes, e.g., as soon as possible, taking into account the medical emergencies, but not later than 48 hours after receipt.

You have the right to appeal through the appeals process outlined in Section XVII, **Internal Claims and Appeals Procedures and External Review** of this Handbook.

Retrospective Reviews

A retrospective review is a request for Paramount to evaluate whether a health care service that a Member has already received was Medically Necessary. For all retrospective reviews, Paramount will make a decision within thirty (30) business days after receiving all necessary information. Paramount will notify the provider and the Member of its decision in writing. If Paramount makes an Adverse Benefit Determination, Paramount will notify the provider and the Member of its decision in writing five (5) business days after receiving the request.

Additionally, in the event that a claim is submitted for a service for which Prior Authorization was required but not obtained, Paramount will permit a retrospective review of such a claim if the service in question meets all of the following:

- The service is directly related to another service for which prior approval has already been obtained and that has already been performed.
- The new service was not known to be needed at the time the original prior authorized service was performed.
- The need for the new service was revealed at the time the original authorized service was performed.

If the claim meets all three conditions, Paramount will review the claim for coverage and medical necessity once the written request and all necessary information are received. Paramount will not deny a claim for such a new service based solely on the fact that a Prior Authorization approval was not received for the new service in question. Paramount will make a decision regarding the claim within thirty (30) business days after receiving all necessary information. Paramount will notify the provider and the Member in writing. If Paramount makes an Adverse Benefit Determination, Paramount will notify the provider and the Member in writing within five (5) business days from making the decision.

Adverse Determinations and Requests for Reconsideration

Paramount's written notification will include the principal reasons for the decision and instructions for requesting a written statement of the clinical rationale used to make the decision. Paramount will provide a written statement of the clinical rationale to any person making the request and following the instructions.

When an Adverse Benefit Determination has been made in response to an initial determination or concurrent review request, the provider may, in writing and on the enrollee's behalf, request that Paramount reconsider the Adverse Benefit Determination. No reconsideration may occur without the prior consent of the enrollee. Paramount will reconsider the Adverse Benefit Determination within three (3) business days after Paramount's receipt of the written request. The reconsideration shall be conducted between the provider or facility rendering the service and the reviewer who made the Adverse Benefit Determination, unless that reviewer is unavailable. If that reviewer cannot be available within three business days, the reviewer may designate another reviewer. If the reconsideration does not resolve the difference of opinion, you or your provider acting with your prior consent may request an internal review through the appeals process outlined in Section XVII, Internal Claims and Appeals Procedures and External Review of this Handbook.

Obtaining Necessary Information

If a provider or Member will not release the necessary information needed to make a decision, Paramount may deny request.

V. CHANGE IN PROVIDER STATUS

Paramount will notify affected enrollees of the termination of a contract for the provision of health care services between Paramount and a provider or facility by mail within fifteen (15) business days of Paramount receiving notification of the termination. Notice will be given to members who have received health care services or if the insured has selected the physician as their primary care physician within the previous twelve months from the provider or facility.

Additionally, if a member has received health care services within the last twelve months, Paramount will pay, in accordance with this handbook, all covered health care services rendered to a member by the Primary Care Provider or hospital between the date of the termination of the contract and five days after the notification of the termination is mailed to member's last known address.

In cases where the provider is terminated without cause, Paramount will allow an enrollee in an Active Course of Treatment to continue treatment until it is complete or for 90 days, whichever is shorter. Decisions with respect to requests for continuing care coverage are subject to internal and external appeal.

VI. URGENT CARE AND EMERGENCY SERVICES

URGENT CARE SERVICES means Covered Services provided for an Urgent Medical Condition. An Urgent Medical Condition is an **unforeseen condition of a kind that usually requires medical attention without delay but that does not pose a threat to life, limb or permanent health of the injured or ill person**. Urgent Medical Conditions include but are not limited to:

- Colds and cough, sore throat, flu
- Earache
- Persistent high fever
- Minor cuts where bleeding is controlled
- Sprains
- Sunburn or minor burn
- Skin rash

Urgent Medical Conditions should be treated by your Primary Care Provider (PCP) or, in the event your PCP is not available, in a participating urgent care facility. You should not go to a hospital emergency room for Urgent Medical Conditions. Services received in a hospital emergency room for an Urgent Medical Condition without prior direction from your PCP, a participating Paramount physician or Paramount are not covered

What to do:

During office hours: Call your Primary Care Provider's office as soon as symptoms persist or worsen. In most cases, your PCP will be able to treat you the same day or the next day. If the office cannot schedule you within a reasonable time, you may seek treatment at a **participating** urgent care facility or physician's office. The service will be subject to an urgent care facility or office visit Coinsurance. Your Coinsurance may be found in your Summary of Benefits.

Participating Providers are listed in your Directory of Participating Physicians and Facilities or the Paramount web site at www.paramountinsurancecompany.com.

After office hours: Call the telephone number of your Primary Care Provider and ask the answering service to have your doctor call you back. When the doctor or a nurse calls back, explain your condition and the doctor or nurse will give you instructions.

Outside the Service Area: Call your Primary Care Provider first and explain your condition. If you cannot call your PCP, go to the nearest urgent care or walk-in clinic. The service will be subject to a Coinsurance. Your Coinsurance may be found in your Summary of Benefits.

Follow-up care within the Service Area: Your Primary Care Provider will coordinate what care you need after your Urgent Care Services.

Follow-up care outside the Service Area: Follow-up services outside the Paramount Service Area will not be covered unless authorized by your Primary Care Provider and Paramount in advance.

ANY TIME AN URGENT CARE PHYSICIAN RECOMMENDS ADDITIONAL CARE, such as a return visit, seeing a specialist, additional testing or X-rays, etc., call Member Services BEFORE you get the services. Member Services can tell you if the service will be covered, or if you need to contact your Primary Care Provider.

Emergency Services

If you are experiencing an emergency, call 9-1-1 or go to the nearest hospital. Services which Paramount determines to meet the definition of Emergency Services will be covered, whether the care is rendered by a Network Provider or Non-Network Provider. Emergency Services rendered by a Non-Network Provider will be covered as network services, however the Member will be responsible for any applicable Coinsurance, Copayment or Deductible.

Hospitals are open to treat an emergency 24 hours a day, 7 days a week. **Follow-up care is not considered an Emergency Service.** Benefits are provided for treatment of Emergency Medical Conditions and emergency screening and Stabilization services without Prior Authorization for conditions that reasonably appear to a prudent layperson to constitute an Emergency Medical Condition based upon the patient's presenting symptoms and conditions. Benefits for Emergency Services include but are not limited to facility costs and physician services, and supplies and prescription drugs charged by that facility. Whenever you are admitted as an Inpatient directly from a hospital emergency room, the emergency room services Copayment/Coinsurance for that emergency room visit will be waived.

Emergency Medical Condition means a medical condition that manifests itself by such acute symptoms of sufficient severity, including severe pain that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:

1. Placing the health of the individual or, with respect to a pregnant woman, the health of the woman and her unborn Child, in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

An Emergency Medical Condition also includes a behavioral health emergency where the Member is acutely suicidal or homicidal.

Emergency Services means the following:

1. A medical screening examination, as required by federal law, that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department, to evaluate an Emergency Medical Condition;
2. Such further medical examination and treatment that are required by federal law to *Stabilize* an Emergency Medical Condition and are within the capabilities of the staff and facilities available at the hospital, including any trauma and the burn center of the hospital.

Stabilize/Stabilized means the provision of such medical treatment as may be necessary to assure,

within reasonable medical probability that no material deterioration of an individual's medical condition is likely to result from or occur during a transfer, if the medical condition could result in any of the following:

1. Placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn Child, in serious jeopardy;
2. Serious impairment to bodily functions;
3. Serious dysfunction of any bodily organ or part. In the case of a woman having contractions, "Stabilize" means such medical treatment as may be necessary to deliver, including the placenta.

The determination as to whether or not an **Emergency Medical Condition** exists in accordance with the definition stated in this section rests with Paramount.

What to do:

Inside the Service Area: In the event of an **Emergency Medical Condition**, call 911, an ambulance or rescue squad or go directly to the nearest medical facility. In the event you are unsure about whether a condition is an **Emergency Medical Condition**, you may contact your Primary Care Provider for instructions. Medical care is available through Paramount Physicians seven (7) days a week, 24 hours a day. Paramount will cover Emergency Services from non-Participating Providers inside the Service Area for Emergency Medical Conditions meeting the definition in Section XXII of this handbook. Members are not responsible for a balance bill from non-Participating Providers for services for Emergency Medical Conditions when treated or transported by non-Participating Providers. Please contact Paramount's Member Services Department if you receive a balance bill for services for Emergency Medical Conditions when treated or transported by non-Participating Providers.

Afterward, you should contact your Primary Care Provider for advice on follow-up care.

Outside the Service Area: Call 911, an ambulance or rescue squad or go to the nearest emergency facility for treatment. Show your Paramount card. In some cases, the provider may require you to make payment and seek reimbursement from Paramount. Paramount will cover Emergency Services from non-Participating Providers outside the Service Area for Emergency Medical Conditions meeting the definition in Section XXII of this handbook. Members are not responsible for a balance bill from non-Participating Providers for services for Emergency Medical Conditions when treated or transported by non-Participating Providers. Please contact Paramount's Member Services Department if you receive a balance bill for services for Emergency Medical Conditions when treated or transported by non-Participating Providers.

Follow-up care within the Service Area: your Primary Care Provider must arrange follow-up medical care with Participating Providers.

Follow-up care outside the Service Area: Only initial care for an **Emergency Medical Condition** is covered. Any follow-up care outside the Service Area is not covered unless authorized by your Primary Care Provider and Paramount BEFORE the care begins.

If you are admitted to a hospital outside the Paramount Service Area, you or your authorized representative must call Paramount within 24 hours or as soon as reasonably possible, or the services may not be covered. Follow-up care must be coordinated through your Primary Care Provider.

The Paramount Service Area

The Paramount Service Area includes Defiance, Erie, Fulton, Henry, Huron, Lucas, Ottawa, Sandusky, Seneca, Williams, Wood and Wyandot counties in Ohio.

VII. HOSPITAL ADMISSIONS

Your Primary Care Provider or Participating Specialist will make the arrangements when you need hospital care. Paramount Participating Hospitals are listed in your *Participating Physicians and Facilities* directory or the Paramount web site at www.paramountinsurancecompany.com. Present your I.D. card when you are admitted.

If you are in the hospital when this plan becomes effective, your Paramount coverage will begin on your Effective Date. (The plan you had when you were admitted should cover your hospital stay up to your Effective Date with this plan.)

An emergency admission to a Non-Participating Hospital must be called in to Paramount within 24 hours (or as soon as reasonably possible) or your hospital care may not be covered. If and when your medical condition allows, your Primary Care Provider and Paramount may arrange for you to be transferred to a Participating Hospital.

VIII. DEDUCTIBLE, COPAYMENTS (COPAYS)/COINSURANCE AND OUT-OF-POCKET MAXIMUM

Your share in the cost of Covered Services may include a Deductible, Copayment, and Coinsurance as shown in the Summary of Benefits.

Embedded Deductible. The amount You and Your Dependents must pay for Covered Services within a calendar year, before any benefits will be paid by the Plan. The single Deductible is the amount each covered person must pay. The family Deductible is the total amount any **two** or more covered family members must pay. The deductible amount of one family member will not exceed that of an individual annual deductible maximum amount. If your plan is a High Deductible Health Plan (HDHP), all Covered Services except for Preventive Health Services are subject to the Deductible. An Embedded Deductible plan cannot be used as a High Deductible Health Plan (HDHP) with a Health Savings Account (HSA) if either the deductible for the family as a whole or the deductible for an individual family member is less than the minimum annual deductible for family coverage. See Section XXII, Definitions, in this handbook for more information regarding an HDHP and HSA.

See your Summary of Benefits for Deductible amount under your Plan.

Paramount members pay Copayments (copays) or Coinsurance for certain Covered Services such as: office visits and services, inpatient services (services you receive while a patient in a hospital or other medical facility), outpatient medical services, Emergency Services, laboratory and radiology services. See your Summary of Benefits for Copayments/Coinsurance due for specific Covered Services. Copayments are payable at the time you receive services and do not apply toward your Deductible.

If You are required to pay for a health care service out-of-pocket, the amount You are required to pay shall not exceed the amount the applicable reimbursement rates negotiated with the provider or pharmacy. This provision does not preclude a person from reaching an agreement with a health care provider or pharmacy on terms that are more favorable to the person than negotiated reimbursement rates that otherwise would apply as long as the claim submitted reflects the alternative amount negotiated.

The **Embedded Out-of-Pocket Maximum** is the maximum amount of Deductible, Copayments and Coinsurance including Prescription Drugs you pay every Calendar Year. Once the Out-of-Pocket Maximum is met, there will be no additional Copayments and Coinsurance. The Out-of-Pocket Maximum is stated in your Summary of Benefits. The single Out-of-Pocket Maximum is the amount each Member must pay, and the family Out-of-Pocket Maximum is the total amount any **two** or more covered family members must pay. The Out-of-Pocket Maximum amount of one family member will not exceed that of the single maximum amount.

If you **do not obtain Pre-Authorization** and the services are Medically Necessary, any benefit payment for a **facility fee (including inpatient services under Section XI)** will be reduced by \$500 of the Allowable Amount. The services are then subject to the applicable Deductible, Copayment and/or Coinsurance. Financial penalties for failure to obtain Pre-Authorization for care received In-Network will count toward your Out-of-Pocket Maximum. Financial penalties for care received Out-of-Network will not count toward your Out-of-Pocket Maximum.

IX. PROVIDER REIMBURSEMENT

You should always show your Paramount I.D. card to all providers. You are responsible for paying any office visit Copayments at the time you receive services.

If you have received services from a non-Participating Provider, it is your responsibility to submit a claim for consideration. You must obtain a standard claim form from the provider and send the claim to Paramount at the address below *within 120 days from the date of the service*. Be sure to include your Paramount ID number and a brief explanation of the circumstances related to the service.

Paramount Insurance Company
P.O. Box 928
Toledo, Oh 43697-0928

Paramount will send reimbursement directly to Participating Providers for Covered Services. In most cases, reimbursement for Covered Services will be sent directly to a non-Participating Provider, but instead may be paid directly to you. Claims are processed within 30 days from receipt of a fully completed claim. If any claim is denied, Paramount will send you an "Explanation of Benefits" with the reason for the denial. If you receive a denial on a claim and need further explanation or wish to appeal the denial, you may call the Member Services Department for assistance. The appeal process is also described in Section XVII of this Handbook.

Non-Covered Services If you receive services that are not covered under your benefit plan, you are responsible for full payment to the provider of those services.

X. MEMBERS' RIGHTS AND RESPONSIBILITIES

Members' Rights

As a Member of Paramount, you have certain rights you can expect from Paramount and Paramount providers. You have the right to:

1. Receive information about Paramount, its services, providers and your rights and responsibilities.
2. Participate with your physicians in decision-making regarding your health care.
3. A candid discussion of appropriate or Medically Necessary treatment options for the conditions regardless of cost or benefit coverage.
4. Voice complaints or appeals about the Health Plan or care provided.
5. Be treated with respect, recognition of your dignity and the need for privacy.
6. Make recommendations regarding Paramount's Member rights and responsibilities policies.

Members' Responsibilities

As a Member of Paramount, you have certain responsibilities that Paramount and Paramount providers can expect from you. You have the responsibility to:

1. Provide to the extent possible information that Paramount and the Participating Providers need to care for you. Help your PCP fill out current medical records by providing current prescriptions and your previous medical records.
2. Engage in a healthy lifestyle, become involved in your health care and follow the plans and instructions for the care that you have agreed on with your PCP or specialists.
3. Understand your health problems and participate in developing mutually agreed-upon treatment and goals to the degree possible.
4. Notify Paramount if you suspect healthcare fraud, waste or abuse against the company by using the following resources:
 - Contact Paramount's Member Services Department for a confidential discussion at 419-887-2525 or toll free at 1-800-462-3589
 - TTY Services for the hearing-impaired are available at 1-888-740-5670 or 419-887-2526
 - You can contact the ProMedica Health System Compliance Hotline at 1-800-807-2693
 - Writing a letter to Paramount mailing address:
Paramount Health Care
attn: Paramount Compliance Fraud, Waste, and Abuse
1901 Indian Wood Circle
Maumee, OH 43537
 - Email Address: paramount.memberservices@promedica.org
 - Confidential fax number: 419-887-2037

For more information, please visit Paramount's website at <https://www.paramounthealthcare.com/fraud-waste-and-abuse/>

XI. COVERED SERVICES

This section describes the Covered Services available under your Health Plan benefits when provided and billed by Participating Providers. To receive maximum benefits for Covered Services, care must be received from a Primary Care Provider (PCP), Participating Specialist or another Participating Provider, except for Emergency Services. Services which are not received from a Participating Provider or approved with an out-of-plan Prior Authorization will be considered a non-covered service. The amount payable for Covered Services varies depending on the type of Participating Provider providing care.

All Covered Services and benefits are subject to the conditions, exclusions, limitations, terms and provisions of this Handbook, including any attachments, riders and endorsements. Covered Services must be Medically Necessary and not Experimental/Investigative. The fact that a provider may prescribe, order, recommend or approve a service, treatment or supply does not make it Medically Necessary or a Covered Service and does not guarantee payment. To receive maximum benefits for Covered Services, you must follow the terms of the Handbook, including receipt of care from a Participating Provider, and ensuring your Participating Provider has obtained any required Prior Authorizations. Our payment for Covered Services will be limited by any applicable Coinsurance, Copayment, Deductible, or Calendar Year Limit/Maximum in this Handbook.

See the Summary of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information

Ambulance Services

Ambulance Services are transportation by a vehicle (including ground, water, fixed wing and rotary wing air transportation) designed, equipped and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals:

- From your home, scene of accident or medical emergency to a Hospital;
- Between Hospitals;
- Between a Hospital and Skilled Nursing Facility; or
- From a Hospital or Skilled Nursing Facility to your home.

Treatment of a sickness or injury by medical professionals from an Ambulance Service when you are not transported will be covered if Medically Necessary. Other vehicles which do not meet this definition, including but not limited to ambulances, are not Covered Services.

Ambulance services are a Covered Service only when Medically Necessary, except:

- When ordered by an employer, school, fire or public safety official and the Member is not in a position to refuse; or
- When a Member is required by Paramount to move from a Non-Participating Provider to a Participating Provider.

Ambulance trips must be made to the closest local facility that can give Covered Services appropriate for your condition. If none of these facilities are in your local area, you are covered for trips to the closest facility outside your local area.

Paramount will cover Emergency Services from non-Participating Providers for Emergency Medical Conditions meeting the definition in Section XXII of this handbook. Members are not responsible for a balance bill from non-Participating Providers for services for Emergency Medical Conditions when treated or transported by non-Participating Providers. Please contact Paramount's Member Services Department if you receive a balance bill for services for Emergency Medical Conditions when treated or transported by non-Participating Providers.

Ambulance usage is not covered when another type of transportation can be used without endangering the Member's health. Any ambulance usage for the convenience of the Member, family or Physician is not a Covered Service.

Non Covered Services for Ambulance include but are not limited to, trips to:

- a Physician's office or clinic;
- a morgue or funeral home.

Acute Care at Home

Acute Care at Home provides Members with specific qualifying conditions the option to receive certain Medically Necessary Covered Services and to recuperate in the Member's residence. For the approved duration of the Acute Care at Home benefit (the "episode"), the Member's care is overseen by a provider and is managed by one collaborative care team utilizing both in-person, at-home clinical encounters, and telemonitoring and remote biometric monitoring technology. Physician referral and Prior Authorization are required.

This benefit will be available for Members with one or more of the following qualifying conditions:

pneumonia, chronic obstructive pulmonary disease exacerbation, congestive heart failure exacerbation, urinary tract infection, and cellulitis. The Member must meet medical criteria, including cognitive function criteria, as well as social screening criteria, to be cared for safely in the home environment.

For the following services, if delivered by and billed under the Acute Care at Home benefit, Members will be responsible only for the Inpatient Hospital Copays, Coinsurance, and/or Deductible listed on their Schedule of Benefits. Unless otherwise noted below, any limitations or exclusions to Covered Services as described in this Certificate apply to those Covered Services when delivered by the Acute Care at Home benefit.

- Professional services from a provider as per the Inpatient Services benefit, including both visits performed in-person and remotely; excluding surgery, the administration of general anesthesia, and newborn exams.
- Ancillary services as per the Inpatient Services benefit, including prescribed medical drugs and pharmacy services, medical and surgical dressings and supplies, diagnostic services, and therapy services; excluding operating rooms and equipment and anesthesia, and therapy services and diagnostic services not Medically Necessary for management of the qualifying condition.
- General nursing services per the Inpatient Services benefits, including encounters performed in-person and remotely.
- Meals, as would ordinarily be provided under the Inpatient Services benefit.
- Home health aide services as per the Home Care Services benefit.
- For the duration of the episode, rental of durable medical equipment (as defined in this Certificate), including oxygen therapy, that is Medically Necessary to treat the Member's condition in the home environment. Includes items used by individuals but which are reusable and expected to be available, such as ice bags, bedrails, canes, crutches, walkers, wheelchairs, and traction equipment; excludes any durable medical equipment unrelated to or not Medically Necessary for the delivery of services under the Acute Care at Home benefit.
- Home infusion therapy, including related nursing services, infusion durable medical equipment, and pharmaceutical services which are delivered and administered intravenously in the Member's residence during the episode. Includes but is not limited to: injections (intra-muscular, subcutaneous, continuous subcutaneous), total parenteral nutrition, enteral nutrition therapy, antibiotic therapy, pain management and chemotherapy. Excludes home infusion therapy not related to or Medically Necessary for management of the qualifying condition.
- Ambulance Services, as Medically Necessary, immediately before, during, and/or immediately after the episode.

The following services are also available under the Acute Care at Home Benefit:

- Real-time patient monitoring and alerts.
- Translation and interpreter services.
- Use of a personal emergency response system (PERS), also known as a medical emergency response system.

For any Covered Service not listed above that is rendered during the episode, and for any Covered Service not delivered by and billed under the Acute Care at Home benefit, the Member will be responsible for applicable Copays, Coinsurance, and/or Deductible as listed for that Covered Service on the Schedule of Benefits.

Exclusions:

- Services provided by registered nurses and other health workers who are not acting as employees of, or under approved arrangements with, the contracted Acute Care at Home provider.
- Prescription Drug Benefits expect those delivered by and billed under the Acute Care at Home benefit.
- Any services rendered prior to, or after the conclusion of, the approved duration of the episode.

Behavioral Health Services (Mental Illness/Substance Abuse)

Behavioral Health Services (Mental Illness/Substance Abuse Services) are covered for care of mental health and substance use disorders. Coverage includes inpatient and outpatient care, emergency care and prescription drugs subject to the same Deductible, Copayments and/or Coinsurance, plan standards and medical management processes to which those Covered Services would be subject if delivered as medical/surgical benefits. This includes intermediate levels of care such as residential treatment, partial hospitalization and intensive outpatient services. Outpatient office visits are subject to the Primary Care Physician Copayment/Coinsurance.

NOTE: Paramount will contact a Member by mail when the Member fills a prescription for certain opioid medications if that Member has not filled a similar prescription in the previous six months. This letter is developed in coordination with Paramount's Pharmacy Benefit Manager to describe the risks and benefits of opioid use and educates the Member on how to dispose of unused opioids safely. This communication is intended to help prevent the development of opioid dependency by our Members. For additional information on opioid education, you may call Member Services at the number on the back of your identification card.

To identify Members who may be dependent on opioids and to intervene appropriately when a Member's opioid use may require care coordination, Paramount's case management clinical team regularly reviews pharmacy and claims data against other criteria associated with high-risk opioid use. Case management clinical team members may contact a Member identified through this effort by telephone to offer case management services which include referral to appropriate providers and community resources, education regarding medical and behavioral health conditions and coordination of care between providers. The care management team is a multi-disciplinary group of clinical case managers, pharmacists, physicians, social workers and other behavioral health professionals, who can interact with Participating Providers and pharmacists to help them treat opioid-use disorder more effectively.

Participating Providers will treat opioid-use disorder with a monitored drug and therapy protocol called medication assisted treatment. To facilitate prompt treatment of opioid-use disorder, most medication assisted treatment does not require Prior Authorization. Paramount's limits on medication assisted treatment are related only to quantity or duration or to potentially disqualifying conditions.

Prior Authorization for services related to treatment of opioid-use disorder will be expedited.

Non-Covered Services (please also see Section XII Non Covered Services/Exclusions of this Handbook)

Custodial or Domiciliary Care

- Supervised living or halfway houses.
- Room and board charges unless the treatment provided meets our Medical Necessity criteria for Inpatient admission
- Services or care provided or billed by a school, halfway house, custodial care center for the developmentally disabled, or outward bound programs, even if psychotherapy is included.

NOTE: The benefit plan is intended to comply with the federal Mental Health Parity and Addictions Equity

Act.

Clinical Trials

Coverage is provided to a qualified individual (as defined under PHS Act section 2709(b)) for routine patient care rendered as part of a clinical trial if the services are otherwise covered services under this handbook. A qualified individual is generally a participant or beneficiary who is eligible to participate in an approved clinical trial according to the trial protocol with respect to the treatment of cancer or another life-threatening disease or condition; and either: (1) the referring health care professional is a Participating Provider and has concluded that the individual's participation in such trial would be appropriate; or (2) the participant or beneficiary provides medical and scientific information establishing that the individual's participation in such trial would be appropriate. Paramount:

(1) may not deny the qualified individual participation in an approved clinical trial with respect to the treatment of cancer or another Life-Threatening Disease or Condition;

(2) may not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial; and

(3) may not discriminate against the individual on the basis of the individual's participation in the trial.

For clinical trials, Life-Threatening Disease or Condition means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

In Ohio for cancer clinical trials the following applies:

- 1) Coverage is not limited to a "qualified individual" as defined in federal law.
- 2) The participant is not required to have a referral from a participating health professional or provide medical and scientific information establishing the appropriateness of participation.

Dental Services

Related to Accidental Injury - Outpatient Services, Physician Home Visits and Office Services, emergency care and Urgent Care Services for dental work and oral surgery are covered if they are for the initial repair of an injury to the jaw, sound natural teeth, mouth or face which are required as a result of an accident and are not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment without adversely affecting the patient's condition. Injury as a result of chewing or biting is not considered an accidental injury. "Initial" dental work to repair injuries due to an accident means performed within 12 months from the injury, or as reasonably soon thereafter as possible and includes all examinations and treatment to complete the repair. For a Child requiring facial reconstruction due to dental related injury, there may be several years between the accident and the final repair. See the Summary of Benefits for Benefit Limitation information. The benefit limit will not apply to outpatient facility charges, anesthesia billed by a provider other than the physician performing the service, or to covered services required by law.

Covered Services for accidental dental include, but are not limited to:

- oral examinations;
- x-rays;
- tests and laboratory examinations;
- restorations;
- prosthetic services;
- oral surgery;

- mandibular/maxillary reconstruction;
- anesthesia;

Other Dental Services

The only other dental expenses that are Covered Services are facility charges for Outpatient Services. Benefits are payable for the removal of teeth or for other dental processes only if the patient's medical condition or the dental procedure requires a Hospital setting to ensure the safety of the patient.

Dental x rays, supplies & appliances and all associated expenses, including hospitalization and anesthesia for transplant preparation, initiation of immunosuppressives, and direct treatment of cancer or cleft palate are covered services.

Diabetic Equipment, Education and Supplies

Diabetes Self-Management Training for an individual with insulin dependent diabetes, non-insulin dependent diabetes, or elevated blood glucose levels induced by pregnancy or another medical condition when:

- Medically Necessary;
- Ordered in writing by a Physician or a podiatrist; and
- Provided by a Health Care Professional who is licensed, registered, or certified under state law.

For the purposes of this provision, a "Health Care Professional" means the Physician or podiatrist ordering the training or a provider who has obtained certification in diabetes education by the American Diabetes Association.

Covered Services also include all Physician prescribed Medically Necessary equipment and supplies used for the management and treatment of diabetes. See "Medical Supplies, Durable Medical equipment and Appliances" and "Preventive Health Services" "Physician Home Visits and Office services".

Diagnostic Services

Diagnostic services are tests or procedures performed when you have specific symptoms, to detect or monitor your condition. Coverage for Diagnostic Services, including when provided as part of Physician Home Visits and Office Services, Inpatient Services, Outpatient Services, Home Care Services, and Hospice Services includes but is not limited to:

- X-ray and other radiology services, including mammograms for any person diagnosed with breast disease
- Magnetic Resonance Angiography (MRA)
- Magnetic Resonance Imaging (MRI)
- CAT scans
- Laboratory and pathology services
- Cardiographic, encephalographic, and radioisotope tests
- Nuclear cardiology imaging studies
- Ultrasound services
- Allergy tests
- Electrocardiograms (EKG)
- Electromyograms (EMG) except that surface EMG's are not Covered Services
- Echocardiograms
- Bone density studies
- Positron emission tomography (PET scanning)
- Diagnostic Tests as an evaluation to determine the need for a Covered Transplant Procedure

- Echographies
- Doppler studies
- Brainstem evoked potentials (BAER)
- Somatosensory evoked potentials (SSEP)
- Visual evoked potentials (VEP)
- Nerve conduction studies
- Muscle testing
- Electrocardiograms

Central supply (IV tubing) or pharmacy (dye) necessary to perform tests are covered as part of the test, whether performed in a Hospital or Physician's office.

When Diagnostic radiology is performed in a Participating Physician's Office, no Copayment is required.

Emergency Services

Covered for Emergency Services for Emergency Medical Conditions as described in **Section VI. URGENT CARE AND EMERGENCY SERVICES** of this Handbook. Benefits for Emergency Services include but are not limited to facility costs and physician services, and supplies and prescription drugs charged by that facility. The facility (hospital) charge will be subject to the appropriate Copayment/Coinsurance. If there is a Copayment it will be waived if the Member is admitted as a hospital inpatient. All other physician and professional services charges will be subject to the appropriate Coinsurance as described in the Covered Services section of your Summary of Benefits.

Care and treatment provided once you are Stabilized is no longer considered emergency care. Continuation of care from a non-Participating Provider beyond that needed to evaluate or Stabilize your condition in an emergency will be covered if we authorize the continuation of care and it is Medically Necessary.

Urgent Care Center Services

Covered ONLY for initial treatment of an Urgent Medical Condition in a participating urgent care facility or physician office. Follow-up treatment in or outside the Paramount Service Area must be authorized in advance by the Primary Care Provider in order to be covered.

Not covered:

Services received in a hospital emergency room for an Urgent Medical Condition without prior direction from your PCP, a participating Paramount physician or Paramount.

Home Care Services

Covered Services are those performed by a Home Health Care Agency or other provider in your residence. Home Health Care includes professional, technical, health aide services, supplies, and medical equipment. The Member must be confined to the home for medical reasons, and be physically unable to obtain needed medical services on an Outpatient basis.

Covered Services include but are not limited to:

- Intermittent Skilled Nursing Services (by an R.N. or L.P.N.)
- Medical/Social Services
- Diagnostic Services
- Nutritional Guidance
- Home Health Aide Services. The Member must be receiving skilled nursing or therapy. Services

must be furnished by appropriately trained personnel employed by the Home Health Care provider. Other organizations may provide services only when approved by Paramount, and their duties must be assigned and supervised by a professional nurse on the staff of the Home Health Care provider.

- Therapy Services (except for Manipulation Therapy which will not be covered when rendered in the home). Home Care Visit limits specified in the Summary of Benefits for Home Care Services apply when Therapy Services are rendered in the home.
- Medical/Surgical Supplies
- Durable Medical Equipment
- Prescription Drugs (only if provided and billed by a Home Health Care Agency)
- Private Duty Nursing is covered only when provided through the Home Care Services benefit. There is no visit limit and private duty nursing visits are not combined with the home health care visits which are limited to 100 visits per Benefit Period.

Non Covered Services include but are not limited to:

- Food, housing, homemaker services and home delivered meals
- Home or Outpatient hemodialysis services (these are covered under Therapy Services)
- Physician charges
- Helpful environmental materials (hand rails, ramps, telephones, air conditioners, and similar services, appliances and devices.)
- Services provided by registered nurses and other health workers who are not acting as employees or under approved arrangements with a contracting Home Health Care provider.
- Services provided by a member of the patient's immediate family.
- Services provided by volunteer ambulance associations for which patient is not obligated to pay, visiting teachers, vocational guidance and other counselors, and services related to outside, occupational and social activities.

Home infusion therapy

Benefits for home infusion therapy include a combination of nursing, durable medical equipment and pharmaceutical services which are delivered and administered intravenously in the home. Home IV therapy includes but is not limited to: injections (intra-muscular, subcutaneous, continuous subcutaneous), Total Parenteral Nutrition (TPN), Enteral nutrition therapy, Antibiotic therapy, pain management and chemotherapy.

Hospice Services

Hospice care may be provided in the home or at a Hospice facility where medical, social and psychological services are given to help treat patients with a terminal illness. Hospice Services include routine home care, continuous home care, Inpatient Hospice and Inpatient respite. To be eligible for Hospice benefits, the patient must have a life expectancy of six months or less, as confirmed by the attending Physician.

Covered Services will continue if the Member lives longer than six months. When approved by your Physician, Covered Services include the following:

- Skilled Nursing Services (by an R.N. or L.P.N.).
- Diagnostic Services.
- Physical, speech and inhalation therapies if part of a treatment plan.
- Medical supplies, equipment and appliances (benefits will not be covered for equipment when the Member is in a Facility that should provide such equipment).
- Counseling services.
- Inpatient confinement at a Hospice.

- Prescription Drugs given by the Hospice.
- Home health aide.

Non Covered Services include but are not limited to:

- Services provided by volunteers.
- Housekeeping services.

Infertility Services

Covered for the medically necessary diagnosis and exploratory procedures to determine infertility including surgical procedures to correct the medically diagnosed disease or condition of the reproductive organs including but not limited to endometriosis, collapsed/clogged fallopian tubes, or testicular failure.

Non Covered Services include but are not limited to procedures not essential for the protection of a Member's health.

Inpatient Services

Inpatient Services include:

- Charges from a Hospital, Skilled Nursing Facility (SNF) or other provider for room, board and general nursing services.
- Ancillary (related) services.
- Professional services from a Physician while an Inpatient.
- **Room, Board, and General Nursing Services**
 - A room with two or more beds.
 - A private room. The private room allowance is the Hospital's average semi-private room rate unless it is Medically Necessary that you use a private room for isolation and no isolation facilities are available.
 - A room in a special care unit approved by Paramount. The unit must have facilities, equipment and supportive services for intensive care of critically ill patients.
- **Ancillary (Related) Services**
 - Operating, delivery and treatment rooms and equipment.
 - Prescribed Drugs.
 - Anesthesia, anesthesia supplies and services given by an employee of the Hospital or other provider.
 - Medical and surgical dressings, supplies, casts and splints.
 - Diagnostic Services.
 - Therapy Services.
- **Professional Services**
 - **Medical care** visits limited to one visit per day by any one Physician.
 - **Intensive medical care** for constant attendance and treatment when your condition requires it for a prolonged time.

- **Concurrent care** for a medical condition by a Physician who is not your surgeon while you are in the Hospital for Surgery. Care by two or more Physicians during one Hospital stay when the nature or severity of your condition requires the skills of separate Physicians.
- **Consultation** which is a personal bedside examination by another Physician when requested by your Physician. Staff consultations required by Hospital rules; consultations requested by the patient; routine radiological or cardiographic consultations; telephone consultations; EKG transmittal via phone are excluded.
- **Surgery and the administration of general anesthesia.**
- **Newborn exam.** A Physician other than the Physician who performed the obstetrical delivery must do the examination.

Maternity Services (Delivery and Prenatal/Postnatal Services)

Maternity services include Inpatient Services, Outpatient Services and Physician Home Visits and Office Services. These services are used for normal or complicated pregnancy, miscarriage, therapeutic abortion (abortion recommended by a provider), and ordinary routine nursery care for a healthy newborn. Abortion means the ending of a pregnancy before the birth of the infant. Miscarriage is a spontaneous abortion (occurs naturally and suddenly). A therapeutic abortion is one performed to save the life or health of the mother, or as a result of incest or rape.

Each type of Covered Service performed as a maternity delivery service, including but not limited to the inpatient hospital stay, physician services, and ancillary services, is subject to any applicable Member's cost share as listed on the Schedule of Benefits for that respective type of Covered Service.

NOTE: If a newborn Child is required to stay as an Inpatient past the mother's discharge date, the services for the newborn Child will then be considered a separate admission from the Maternity and an ordinary routine nursery admission, and will be subject to a separate Inpatient Coinsurance.

Coverage for the Inpatient postpartum stay for you and your newborn Child in a Hospital will be, at a minimum, 48 hours for a vaginal delivery and 96 hours for a cesarean section. Coverage will be for the length of stay recommended by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists in their Guidelines for Prenatal Care.

Coverage for a length of stay shorter than the minimum period mentioned above may be permitted if your attending Physician or certified nurse-midwife working in collaboration with a Physician determines further Inpatient postpartum care is not necessary for you or your newborn Child, provided the following are met and the mother concurs:

- In the opinion of your attending Physician, the newborn Child meets the criteria for medical stability in the Guidelines for Perinatal Care prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists that determine the appropriate length of stay based upon evaluation of:
 1. the antepartum, intrapartum, and postpartum course of the mother and infant;
 2. the gestational stage, birth weight, and clinical condition of the infant;
 3. the demonstrated ability of the mother to care for the infant after discharge; and
 4. the availability of postdischarge follow-up to verify the condition of the infant after discharge.

Pre-Natal/Post-Natal services, as listed on the Schedule of Benefits, are covered separately from maternity delivery services.

Covered pre-natal services include obstetrical Physician Home Visits and Office Services for the initial pre-natal care visit to diagnose the pregnancy, the initial pre-natal examination, and subsequent, Medically Necessary routine pre-natal visits. The coverage shall apply to a home health care visit only if the health care professional who conducts the visit is knowledgeable and experienced in maternity care.

Covered pre-natal services also include covered screening, and diagnostic laboratory and radiological services.

Covered post-natal services include Medically Necessary, Physician-directed obstetrical care following delivery and discharge from delivery services by an advanced practice registered nurse. Services covered as follow-up care include physical assessment of the mother and newborn, parent education, assistance and training in breast or bottle feeding, assessment of the home support system, performance of any Medically Necessary and appropriate clinical tests, and any other services that are consistent with the follow-up care recommended in the protocols and guidelines developed by national organizations that represent pediatric, obstetric, and nursing professionals. The coverage applies to services provided in a medical setting or through home health care visits. The coverage shall apply to a home health care visit only if the provider who conducts the visit is knowledgeable and experienced in maternity and newborn care. The initial post-delivery care visit is performed no later than 72 hours following you and your newborn Child's discharge from the Hospital. Coverage for this visit includes, but is not limited to:

1. parent education;
2. assistance and training in breast or bottle feeding; and
3. performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care for you or your newborn Child, including the collection of an adequate sample for the hereditary and metabolic newborn screening.

Medical Supplies, Durable Medical Equipment, and Appliances

The supplies, equipment and appliances described below are Covered Services under this benefit. If the supplies, equipment and appliances include comfort, luxury, or convenience items or features which exceed what is Medically Necessary in your situation or needed to treat your condition, reimbursement will be based on the Maximum Allowable Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowable Amount for the standard item which is a Covered Service is your responsibility. For example, the reimbursement for a motorized wheelchair will be limited to the reimbursement for a standard wheelchair, when a standard wheelchair adequately accommodates your condition.

Repair, adjustment and replacement of purchased equipment, supplies or appliances as set forth below may be covered, as approved by Paramount. The repair, adjustment or replacement of the purchased equipment, supply or appliance is covered if:

- The equipment, supply or appliance is a Covered Service;
- The continued use of the item is Medically Necessary;
- There is reasonable justification for the repair, adjustment, or replacement (warranty expiration is not reasonable justification).

In addition, replacement of purchased equipment, supplies or appliance may be covered if:

1. The equipment, supply or appliance is worn out or no longer functions.
2. Repair is not possible or would equal or exceed the cost of replacement. An assessment by a rehabilitation equipment specialist or vendor should be done to estimate the cost of repair.
3. Individual's needs have changed and the current equipment is no longer usable due to weight gain, rapid growth, or deterioration of function, etc.
4. The equipment, supply or appliance is damaged and cannot be repaired.

Benefits for repairs and replacement do not include the following:

- Repair and replacement due to misuse, malicious breakage or gross neglect.
- Replacement of lost or stolen items.

We may establish reasonable quantity limits for certain supplies, equipment or appliance described below.

Covered Services may include, but are not limited to:

- **Medical and surgical supplies**

Covered Services provided under medical benefits may include, but are not limited to:

1. Allergy serum extracts
2. Chem strips, Glucometer, Lancets
3. Clinitest
4. Needles/syringes
5. Ostomy bags and supplies except charges such as those made by a Pharmacy for purposes of a fitting are not Covered Services.
6. Contraceptive devices including diaphragms, intra uterine devices (IUDs), and implants. These may also be covered under prescription benefits depending on where the service is performed or the item is obtained.

Non Covered Services include but are not limited to:

1. Adhesive tape, band aids, cotton tipped applicators
2. Arch supports
3. Doughnut cushions
4. Hot packs, ice bags
5. Vitamins
6. Medijectors

Covered Services do not include items usually stocked in the home for general use like Band Aids, thermometers and petroleum jelly. If you have any questions regarding whether a specific medical or surgical supply is covered call the Member Services number on the back of your Identification Card.

- **Durable medical equipment** - The rental (or, at our option, the purchase) of durable medical equipment prescribed by a Physician or other provider. Durable medical equipment is equipment which can withstand repeated use; i.e., could normally be rented, and used by successive patients; is primarily and customarily used to serve a medical purpose; is not useful to a person in the absence of illness or injury; and is appropriate for use in a patient's home. Examples include but are not limited to wheelchairs, crutches, hospital beds, and oxygen equipment. Rental costs must not be more than the purchase price. Health Plan will not pay for rental for a longer period of time than it would cost to purchase equipment. The cost for delivering and installing the equipment are Covered Services. Payment for related supplies is a Covered Service only when the equipment is a rental, and medically fitting supplies are included in the rental; or the equipment is owned by the Member; medically fitting supplies may be paid separately. Equipment should be purchased when it costs more to rent it than to buy it. Repair of medical equipment is covered.

Covered Services may include, but are not limited to:

1. Hemodialysis equipment
2. Crutches and replacement of pads and tips
3. Pressure machines
4. Infusion pump for IV fluids and medicine
5. Glucometer
6. Tracheotomy tube
7. Cardiac, neonatal and sleep apnea monitors

8. Augmentive communication devices are covered when we approve based on medical necessity.

Non-covered items may include but are not limited to:

1. Air conditioners
2. Ice bags/coldpack pump
3. Raised toilet seats
4. Rental of equipment if the Member is in a Facility that is expected to provide such equipment
5. Translift chairs
6. Treadmill exerciser
7. Tub chair used in shower.

If you have any questions regarding whether a specific durable medical equipment is covered call the Member Services number on the back of your Identification Card.

- **Prosthetics** – Artificial substitutes for body parts and tissues and materials inserted into tissue for functional or therapeutic purposes. Covered Services include purchase, fitting, needed adjustment, repairs, and replacements of prosthetic devices and supplies that:

1. Replace all or part of a missing body part and its adjoining tissues; or
2. Replace all or part of the function of a permanently useless or malfunctioning body part.

Prosthetic devices should be purchased not rented, and must be Medically Necessary. Applicable taxes, shipping and handling are also covered.

Covered Services may include, but are not limited to:

1. Aids and supports for defective parts of the body including but not limited to internal heart valves, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograft vascular replacements, fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction.
2. Left Ventricular Artificial Devices (LVAD) (only when used as a bridge to a heart transplant).
3. Breast prosthesis whether internal or external, following a mastectomy, and four surgical bras per Calendar Year, as required by the Women's Health and Cancer Rights Act. Maximums for Prosthetic devices, if any, do not apply.
4. Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc.
5. Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or glasses are often prescribed following lens implantation and are Covered Services. (If cataract extraction is performed, intraocular lenses are usually inserted during the same operative session). Eyeglasses (for example bifocals) including frames or contact lenses are covered when they replace the function of the human lens for conditions caused by cataract surgery or injury; the first pair of contact lenses or eyeglasses are covered. The donor lens inserted at the time of surgery are not considered contact lenses, and are not considered the first lens following surgery. If the injury is to one eye or if cataracts are removed from only one eye and the Member selects eyeglasses and frames, then reimbursement for both lenses and frames will be covered.
6. Cochlear implant.
7. Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
8. Restoration prosthesis (composite facial prosthesis)
9. Wigs (the first one following cancer treatment, not to exceed one per Calendar Year).

Non-covered Prosthetic appliances include but are not limited to:

1. Dentures, replacing teeth or structures directly supporting teeth.
2. Dental appliances.
3. Such non-rigid appliances as elastic stockings, garter belts, arch supports and corsets.
4. Artificial heart implants.
5. Wigs (except as described above following cancer treatment).
6. Penile prosthesis in men suffering impotency resulting from disease or injury.

If you have any questions regarding whether a specific prosthetic is covered call the Member Services number on the back of your Identification Card.

- **Orthotic devices** - Covered Services are the initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part. The cost of casting, molding, fittings, and adjustments are included. Applicable tax, shipping, postage and handling charges are also covered. The casting is covered when an orthotic appliance is billed with it, but not if billed separately.

Covered orthotic devices may include, but are not limited to, the following:

1. Cervical collars.
2. Ankle foot orthosis.
3. Corsets (back and special surgical).
4. Splints (extremity).
5. Trusses and supports.
6. Slings.
7. Wristlets.
8. Built-up shoe.
9. Custom made shoe inserts.

Orthotic appliances may be replaced once per year per Member when Medically Necessary in the Member's situation. However, additional replacements will be allowed for Members under age 18 due to rapid growth, or for any Member when an appliance is damaged and cannot be repaired.

Non-Covered Services include but are not limited to:

1. Orthopedic shoes (except therapeutic shoes for diabetics).
2. Foot support devices, such as arch supports and corrective shoes, unless they are an integral part of a leg brace.
3. Standard elastic stockings, garter belts, and other supplies not specially made and fitted (except as specified under Medical Supplies).
4. Garter belts or similar devices.

If you have any questions regarding whether a specific orthotic is covered call the Member Services number on the back of your Identification Card.

Outpatient Services

Outpatient Services include both facility, ancillary, facility use, and professional charges when given as an Outpatient at a Hospital, Alternative Care Facility, Retail Health Clinic, or other provider as determined by the Health Plan. These facilities may include a non-Hospital site providing Diagnostic and therapy services, surgery, or rehabilitation, or other provider facility as determined by Paramount.

Professional charges only include services billed by a Physician or other professional.

When Diagnostic Services or Other Therapy Services (chemotherapy, radiation, dialysis, inhalation, or cardiac rehabilitation) is the only Outpatient Services charge, no Copayment is required if received as part of an Outpatient surgery. Any Coinsurance will still apply to these services.

For Emergency Medical Conditions refer to the **Urgent Care and Emergency Services** Section VI of this Handbook.

Physician Home Visits and Office Services

Covered Services include care provided by a Physician in their office or your home. Refer to the sections titled "Preventive Health Services", "Maternity Services", "Home Care Services" and "Behavioral Health" Services for services covered by the Health Plan. For emergency care refer to the Urgent Care and Emergency Services Section VI of this Handbook.

Office visits for medical care and consultations to examine, diagnose, and treat an illness or injury performed in the Physician's office. Office visits also include allergy testing, injections and serum. When allergy serum is the only charge from a Physician's office, no Copayment is required. Coinsurance is not waived. Please reference exclusion 8(e) for additional information.

Home Visits for medical care and consultations to examine, diagnose, and treat an illness or injury performed in your home.

Diagnostic Services when required to diagnose or monitor a symptom, disease or condition.

Surgery and Surgical Services (including anesthesia and supplies). The surgical fee includes normal post-operative care.

Therapy Services for physical medicine therapies and other therapy services when given in the office of a Physician or other professional provider.

Telemedicine Services. Covered Services include a medical consultation through synchronous or asynchronous information and communication technology by a Health Care Professional. This plan will cover Telemedicine Services on the same basis and to the same extent that the plan provides coverage for in-person health care services. Please reference exclusion 8(e) for additional information.

For the purpose of this provision, "Health Care Professional" means any of the following: a physician licensed to practice medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery; a licensed physician assistant; an advanced practice registered nurse.

ProMedica OnDemand Visit: ProMedica OnDemand allows you and your Dependents to have a live video visit via webpage or mobile device with a board-certified Provider 24 hours a day, 7 days a week, and 365 days a year. This service is ideal for conditions such as allergies, cold and flu, pinkeye, and rash. Refer to your Summary of Benefits for an explanation of how this benefit is covered. To sign up or download the mobile device application, please visit <https://www.promedica.org/Pages/medical-services/ondemand/default.aspx> .

Preventive Health Services (More information available in **DEFINITIONS** section of this handbook.

Preventive Health Services include, Outpatient services and Office Services. Screenings and other services are covered as preventive for adults and children with no current symptoms or prior history of a

medical condition associated with that screening or service.

Members who have current symptoms or have been diagnosed with a medical condition are not considered to require preventive care for that condition but instead benefits will be considered under the Diagnostic Services benefit.

Preventive Health Services in this section shall meet requirements as determined by federal and state law. Preventive Health Services are covered by this Handbook with no Deductible, Copayments or Coinsurance from the Member when provided by a Participating Provider. That means we pay 100% of the Maximum Allowed Amount. These services fall under four broad categories as shown below:

1. Services with an “A” or “B” rating from the United States Preventive Services Task Force. Examples of these services are screenings for:
 - a. Breast cancer mammography screenings every 1 to 2 years for women over 40;
 - b. Cervical cancer;
 - c. Colorectal cancer;
 - d. High Blood Pressure;
 - e. Type 2 Diabetes Mellitus;
 - f. Cholesterol;
 - g. Child and Adult Obesity;
 - h. Tobacco Cessation Programs, see below for coverage.
2. Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
3. Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
4. Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including:
 - a. All FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity. Prescription coverage includes at least one product for each of the following contraceptive methods: Barrier (diaphragm), implanted devices (IUD), Hormonal (generic orals), and emergency Contraception. (Refer to the Standard and Expedited Review for Prior Authorizations, Step Therapy Exceptions, and Non-formulary Exceptions in the prescription drug section for more details.)
 - b. Breastfeeding support, supplies, and counseling. Benefits for breast pumps are limited to one pump per benefit period.

You may call Member Services using the number on your ID card for additional information about these services. (or view the federal government’s web sites, <http://www.healthcare.gov/center/regulations/prevention.html>; or <http://www.ahrq.gov/clinic/uspstfix.htm>; <http://www.cdc.gov/vaccines/recs/acip/>.)

You will be notified, at least sixty (60) days in advance, if any item or service is removed from the list of eligible services. Eligible services will be updated annually to include any new recommendations or guidelines.

Paramount may use reasonable medical management techniques to control costs and promote efficient delivery of care. This may include the exclusion of brand name medications when a generic equivalent is available. If your physician determines a specific non-formulary preventive medication or device is medically necessary, it can be requested through the non-formulary exceptions process and will be provided at no cost share. Refer to the Standard and Expedited Review for Prior Authorizations, Step Therapy Exceptions, and Non-formulary Exceptions in the prescription drug section for more details.

In addition to the services with an “A” or “B” rating from the United States Preventive Services Task Force, Paramount also covers the following services:

- In addition to the breast cancer mammography screening Federal mandate, routine screening mammograms are covered:
 - If a woman is at least thirty-five years of age but under forty years of age, one screening mammography.
 - If a woman is at least forty years of age but under fifty years of age, either of the following:
 - a) One screening mammography every two years;
 - b) If a licensed physician has determined that the woman has risk factors to breast cancer, one screening mammography every year.
 - If a woman is at least fifty years of age but under sixty-five years of age, one screening mammography every year.
 - The maximum cost share a Member between the ages of 35 and 40 will be responsible for will not exceed one hundred thirty percent (130%) of the Medicare reimbursement amount, and the provider cannot balance bill for the amount exceeding one hundred thirty percent (130%). For a mammography screening under the age of 35 you will be responsible for cost sharing.
- Routine hearing screenings
- Routine children’s vision screenings

For those who use tobacco products, at least two tobacco cessation attempts per year. For this purpose, covering a cessation attempt includes coverage for:

1. Four tobacco cessation counseling sessions of at least 10 minutes each (including telephone counseling, group counseling and individual counseling) without Prior Authorization; and
2. All Food and Drug Administration (FDA) approved tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a health care provider without Prior Authorization.
3. Tobacco Cessation Programs are offered to plan members over the age of twenty-one (21) at in-plan hospitals or ancillary providers and are covered as a preventive service.
4. Call the Member Services Department for complete details on enrolling in a program. See also Preventive Health Services for additional information.

Premium Rates for Tobacco Users

A tobacco user is someone who is age 21 or older who has regularly used tobacco (smoking or chewing) at least four or more times per week in the past six months. Religious or ceremonial uses of tobacco, for example, by American Indians and Alaskan Natives are specifically exempt.

Your plan has different premium rates for tobacco users and non-tobacco users. If you are a tobacco user, by participating in a Tobacco Cessation Program, you can have your premium rates reduced to the non-tobacco user rate. You may decide at any time during your coverage period to participate.

How the premium rate reduction works

If you are a tobacco user paying the tobacco user rate and enroll in a program, your premium rate will be adjusted to the non-tobacco user rate. If you are a tobacco user and you do not participate in a program, your premium rate will remain at the tobacco-user premium rate.

To have the tobacco-user rate adjusted you will be required to submit a signed attestation to Paramount certifying your enrollment in a tobacco cessation program. You can obtain a copy of the attestation form by contacting Paramount or visiting our website.

Surgical Services

Coverage for Surgical Services when provided as part of Physician Home Visits and Office Services, Inpatient Services or Outpatient Services include but are not limited to:

- Performance of accepted operative and other invasive procedures;
- The correction of fractures and dislocations;
- Anesthesia and surgical assistance when Medically Necessary;
- Usual and related pre-operative and post-operative care;
- Other procedures as approved by Paramount.
- Operative and cutting procedures;
- Endoscopic examinations, such as arthroscopy, bronchoscopy, colonoscopy, laparoscopy;
- Other invasive procedures such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine.

The surgical fee includes normal post-operative care. We may combine the reimbursement when more than one surgery is performed during the same operative session. Contact Paramount for more information.

Reconstructive Services

Benefits include reconstructive surgery to correct significant deformities caused by congenital or developmental abnormalities, illness, injury or an earlier treatment in order to create a more normal appearance. Benefits include surgery performed to restore symmetry after a mastectomy. Reconstructive services needed as a result of an earlier treatment are covered only if the first treatment would have been a Covered Service under this Plan.

Note: Coverage for reconstructive services does not apply to orthognathic surgery. See the “Surgical Services” section above for that benefit.

Mastectomy Notice

A Member who is receiving benefits for a covered mastectomy or for follow-up care in connection with a covered mastectomy, and who elects breast reconstruction, will also receive coverage for:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the patient and the patient’s attending Physician and will be subject to the same annual Deductible, Coinsurance, Copayment provisions otherwise applicable under the Health Plan.

Sterilization

Sterilization benefits for men and women include sterilization services and services to reverse a non-elective sterilization that resulted from an illness or injury. Reversals of elective sterilizations are not covered. Sterilizations for women are covered under the "Preventive Health Services".

Temporomandibular or Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder

Benefits are provided for medical treatment of temporomandibular (joint connecting the lower jaw to the temporal bone at the side of the head) and craniomandibular (head and neck muscle) disorders.

Treatment is covered if provided within our guidelines and with Prior Authorization.

Therapy Services

When Therapy Services are given as part of Physician Home Visits and Office Services, Inpatient Services, Outpatient Services, or Home Care Services, coverage for these Therapy Services is limited to the following:

Physical Medicine Therapy Services

The expectation must exist that the therapy will result in a practical improvement in the level of functioning within a reasonable period of time.

- **Physical therapy** including treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles and devices. Such therapy is given to relieve pain, restore function, and to prevent disability following illness, injury, or loss of a body part. Non Covered Services include but are not limited to: maintenance therapy to delay or minimize muscular deterioration in patients suffering from a chronic disease or illness; repetitive exercise to improve movement, maintain strength and increase endurance (including assistance with walking for weak or unstable patients); range of motion and passive exercises that are not related to restoration of a specific loss of function, but are for maintaining a range of motion in paralyzed extremities; general exercise programs; diathermy, ultrasound and heat treatments for pulmonary conditions; diapulse; work hardening.
- **Speech therapy** for the correction of a speech impairment.
- **Occupational therapy** for the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the person's particular occupational role. Occupational therapy does not include diversional, recreational, vocational therapies (e.g. hobbies, arts and crafts). Non Covered Services include but are not limited to: supplies (looms, ceramic tiles, leather, utensils); therapy to improve or restore functions that could be expected to improve as the patient resumes normal activities again; general exercises to promote overall fitness and flexibility; therapy to improve motivation; suction therapy for newborns (feeding machines); soft tissue mobilization (visceral manipulation or visceral soft tissue manipulation), augmented soft tissue mobilization, myofascial; adaptations to the home such as rampways, door widening, automobile adaptors, kitchen adaptation and other types of similar equipment.
- **Manipulation Therapy** includes Osteopathic/Chiropractic Manipulation Therapy used for treating problems associated with bones, joints and the back. The two therapies are similar, but chiropractic therapy focuses on the joints of the spine and the nervous system, while osteopathic

therapy includes equal emphasis on the joints and surrounding muscles, tendons and ligaments. Manipulations whether performed and billed as the only procedure or manipulations performed in conjunction with an exam and billed as an office visit will be counted toward any maximum for Manipulation Therapy services as specified in the Summary of Benefits. Manipulation Therapy services rendered in the home as part of Home Care Services are not covered.

Other Therapy Services

- **Cardiac rehabilitation** to restore an individual's functional status after a cardiac event. It is a program of medical evaluation, education, supervised exercise training, and psychosocial support. Home programs, on-going conditioning and maintenance are not covered.
- **Chemotherapy** for the treatment of a disease by chemical or biological antineoplastic agents, including the cost of such agents.
- **Dialysis treatments** of an acute or chronic kidney ailment which may include the supportive use of an artificial kidney machine.
- **Radiation therapy** for the treatment of disease by X-ray, radium, or radioactive isotopes. Includes treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources); materials and supplies used in therapy; treatment planning.
- **Inhalation therapy** for the treatment of a condition by the administration of medicines, water vapors, gases, or anesthetics by inhalation. Covered Services include but are not limited to, introduction of dry or moist gases into the lungs; nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication; continuous positive airway pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.
- **Pulmonary rehabilitation** to restore an individual's functional status after an illness or injury. Covered Services include but are not limited to Outpatient short-term respiratory services for conditions which are expected to show significant improvement through short-term therapy. Also covered is inhalation therapy administered in Physician's office including but are not limited to breathing exercise, exercise not elsewhere classified, and other counseling. Pulmonary rehabilitation in the acute Inpatient rehabilitation setting is not a Covered Service.

Physical Medicine and Rehabilitation Services

A structured therapeutic program of an intensity that requires a multidisciplinary coordinated team approach to upgrade the patient's ability to function as independently as possible; including skilled rehabilitative nursing care, physical therapy, occupational therapy, speech therapy, services of a social worker or psychologist, and habilitative services. The goal is to obtain practical improvement in a reasonable length of time in the appropriate setting.

Physical medicine and rehabilitation involves several types of therapy, not just physical therapy, and a coordinated team approach. The variety and intensity of treatments required is the major differentiation from an admission primarily for physical therapy.

Non-Covered Services for physical medicine and rehabilitation

Include, but are not limited to:

- admission to a Hospital mainly for physical therapy;
- long-term rehabilitation in an Inpatient setting.

Day Rehabilitation Program services provided through a Day Hospital for physical medicine and rehabilitation are Covered Services. A Day Rehabilitation Program is for those patients who do not require Inpatient care but still require a rehabilitation therapy program four to eight hours a day, 2 or more days a week at a Day Hospital. Day rehabilitation program services may consist of Physical

Therapy, Occupational Therapy, Speech Therapy, nursing services, and neuro psychological services. A minimum of two Therapy Services must be provided for this program to be a Covered Service.

Habilitative Services

Habilitative services cover health care services and devices that help a person keep, learn, or improve skills and functioning for daily living. This includes but is not limited to **habilitative** services to children (ages 0 - 21) with a medical diagnosis of autism spectrum disorder, which at a minimum includes:

1. Out-Patient Physical Rehabilitation services including:
 - a. Speech and Language therapy and/or Occupational therapy, performed by a licensed therapist 20 visits per year of each service; and
 - b. Clinical Therapeutic intervention defined as therapies supported by empirical evidence, which include but are not limited to Applied Behavioral Analysis, provided by or under the supervision of a professional who is licensed, certified, or registered by an appropriate agency of this state to perform the services in accordance with a treatment plan, 20 hours per week;
2. Mental/Behavioral Health Outpatient Services performed by a licensed Psychologist, Psychiatrist, or Physician to provide consultation, assessment, development and oversight of treatment plans.

Each type of Covered Service performed as a habilitative service, including but not limited to the types of services listed in this section, is subject to applicable Member's cost share as listed on the Schedule of Benefits for that respective type of Covered Service.

Vision Services

Benefits are available for medical and surgical treatment of injuries and/or diseases affecting the eye.

Childhood vision screenings are covered under the "Preventive Health" benefit. Benefits for other Covered Services are based on the setting in which services are received.

Benefits are not available to Members **age 19 and up** for glasses and contact lenses except as described in "Prosthetics" benefit.

IMPORTANT: If you opt to receive vision care services or vision care materials that are not covered benefits under this plan, a participating vision care provider may charge you his or her normal fee for such services or materials. Prior to providing you with vision care services or vision care materials that are not covered benefits, the vision care provider will provide you with an estimated cost for each service or material upon your request.

Additional Covered Services for all Members include:

- Determination of refraction,
- Routine Ophthalmological examination including refraction for new and established patients, and
- A visual functional screening for visual acuity.

Pediatric Vision

Covered Services discussed below are covered in full for any Member or dependent to the end of the month they turn age 19:

- One routine eye examination, including dilation if professionally indicated, each year.

- One pair of prescription eyeglass lenses each year including glass or plastic lenses, all lens powers (Single Vision, Bifocal, Trifocal, and Lenticular), fashion and gradient tinting, ultraviolet protective coating, oversized and glass-grey #3 prescription sunglass lenses.
- One frame each year.
- In lieu of eyeglasses, one pair of contact lenses each year including evaluation, fitting and follow up care.
- Low vision services, including one comprehensive low vision evaluation every 5 years, 4 follow-up visits in any 5 year period, and prescribed optical devices, such as high-power spectacles, magnifiers and telescopes.
- Optional Lenses and Treatments:
 - Polycarbonate Lenses (if not child, monocular or prescription >+/-6.00 diopters)
 - Blended Segment Lenses
 - Intermediate Vision Lenses
 - Standard Progressives
 - Premium Progressives (Varilux®, etc.)
 - Photochromic Glass Lenses
 - Plastic Photosensitive Lenses (Transitions®)
 - Polarized Lenses
 - Standard Anti-Reflective (AR) Coating
 - Premium AR Coating
 - Ultra AR Coating
 - Hi-Index Lenses

Medically Necessary Contact Lenses: Contact lenses may be determined to be medically necessary and appropriate in the treatment of patients affected by certain conditions. In general, contact lenses may be medically necessary and appropriate when the use of contact lenses, in lieu of eyeglasses, will result in significantly better visual and/or improved binocular function, including avoidance of diplopia or suppression. Contact lenses may be determined to be medically necessary in the treatment of the following conditions:

Keratoconus, Pathological Myopia, Aphakia, Anisometropia, Aniseikonia, Aniridia, Corneal Disorders, Post-traumatic Disorders, Irregular Astigmatism.

Medically necessary contact lenses are dispensed in lieu of other eyewear. Participating Providers will obtain the necessary Prior Authorization for these services.

Transplants

The human organ and tissue transplant (bone marrow/stem cell) services benefits or requirements described below do not apply to the following:

- Cornea and kidney transplants; and
- Any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. Please note that the initial evaluation and any necessary additional testing to determine your eligibility as a candidate for transplant by your provider and the harvest and storage of bone marrow / stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

The above services are covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the service is performed subject to Member cost shares.

Each type of Covered Service performed as a transplant service, including but not limited to Diagnostic Services, Inpatient Services, Outpatient Services, Surgery Services, and Therapy Services, is subject to any applicable Member's cost share as listed on the Schedule of Benefits for that respective type of Covered Service. All covered transplant services or benefits listed below that are not covered under another type of Covered Service are subject to the Human Organ and Tissue Transplant Service Member's cost share as listed on the Schedule of Benefits.

Covered Transplant Procedure

Any Medically Necessary human organ and stem cell / bone marrow transplants and transfusions as determined by Paramount including necessary acquisition procedures, harvest and storage, and including Medically Necessary preparatory myeloablative therapy.

Transplant Benefit Period

Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate / global time period. The number of days will vary depending on the type of transplant received and the Network Transplant provider agreement. Contact the Case Manager for specific Network Transplant provider information for services received at or coordinated by a Network Transplant provider Facility or starts one day prior to a Covered Transplant Procedure and continues to the date of discharge at a Non-Network Transplant provider Facility.

Transportation and Lodging

The Plan will provide assistance with reasonable and necessary travel expenses as determined by Paramount when you obtain prior approval and are required to travel more than 75 miles from your residence to reach the facility where your Covered Transplant Procedure will be performed. Our assistance with travel expenses includes transportation to and from the facility and lodging for the patient and one companion. If the Member receiving treatment is a minor, then reasonable and necessary expenses for transportation and lodging may be allowed for two companions. The Member must submit itemized receipts for transportation and lodging expenses in a form satisfactory to Paramount when claims are filed.

Contact us for detailed information.

For lodging and ground transportation benefits, We will provide a maximum benefit up to a \$10,000 benefit limit.

Non-Covered Services for transportation and lodging include, but are not limited to:

- Child care,
- Mileage within the medical transplant facility city,
- Rental cars, buses, taxis, or shuttle service, except as specifically approved by Paramount,
- Frequent Flyer miles,
- Coupons, Vouchers, or Travel tickets,
- Prepayments or deposits,
- Services for a condition that is not directly related, or a direct result, of the transplant,
- Telephone calls,
- Laundry,
- Postage,
- Entertainment,
- Interim visits to a medical care facility while waiting for the actual transplant procedure,

- Travel expenses for donor companion/caregiver,
- Return visits for the donor for a treatment of a condition found during the evaluation.

Unrelated Donor Search

The Plan will cover searches for bone marrow/stem cell transplants for a covered transplant procedure as approved by the Plan up to a \$30,000 per transplant limit.

Live Donor Health Services

The Plan will cover Medically Necessary charges for the procurement of an organ from a live donor including complications from the donor procedure for up to six weeks from the date of procurement. Donor benefits are limited to benefits not available to the donor from any other source.

Prescription Drug Benefits

See the Summary of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Pharmacy and Therapeutics (P&T) Working Group

The Plan has a P&T Working Group, a committee consisting of health care professionals, including but not limited to local pharmacists and physicians. The purpose of this committee is to assist in determining clinical appropriateness of drugs; determining the tier assignments of drugs; and advising on programs to help improve care. Such programs include, but are not limited to, drug utilization programs, Prior Authorization criteria, therapeutic conversion programs, cross-branded initiatives, drug profiling initiatives, etc.

Paramount's P&T reviews and approves Paramount's Formulary annually. However, formulary management may be delegated to the Pharmacy Benefit Manager (PBM). When formulary management is delegated, the initial formulary is approved by Paramount's P&T, but ongoing formulary changes throughout the year are reviewed and approved by the PBM's P&T committee or other clinical working group that handles the delegated function of formulary management.

Pharmacy Benefits Manager

The pharmacy benefits available to you under this Handbook are administered by Our Pharmacy Benefits Manager (PBM). The PBM is a company with which the Plan contracts to administer your pharmacy benefits. The PBM has a nationwide network of retail pharmacies, and a Mail Service pharmacy.

The services the PBM provides include, among others, managing a network of retail pharmacies, operating a Mail Service pharmacy, and prescription drug claims processing. The PBM, in consultation with Paramount, also provides services to promote and enforce the appropriate use of pharmacy benefits. These services can include reviews for possible excessive use; recognized and recommended dosage regimens; Drug interaction screenings.

Covered Prescription Drug Benefits

A valid prescription is required to obtain all prescription drug benefits. Prescription Drugs, unless otherwise stated, must be Medically Necessary and not Experimental/Investigative, in order to be Covered Services. For certain Prescription Drugs, the prescribing Physician may be asked to provide additional information before the Health Plan can determine Medical Necessity. The Health Plan can establish quantity and/or age limits for specific Prescription Drugs which the PBM will administer.

Covered Services will be limited based on Medical Necessity, quantity and/or age limits established by the Health Plan, or utilization guidelines.

- FDA approved Prescription Legend Drugs.
- FDA approved Specialty Drugs.
- Injectable insulin and syringes used for administration of insulin.
- Contraceptive devices, oral immunizations, and biologicals, although they are legend drugs may be payable as medical supplies based on where the service is performed or the item is obtained. If such items are over-the-counter drugs, devices or products, they are not Covered Services unless prescribed by a physician and covered as a preventive service, as required by federal and state law.
- Off label use of FDA approved drugs as defined in ORC 1751.66. Paramount shall not limit or exclude coverage for any drug approved by the United States food and drug administration on the basis that the drug has not been approved by the United States food and drug administration for the treatment of the particular indication for which the drug has been prescribed, provided the drug has been recognized as safe and effective for treatment of that indication in one or more of the standard medical reference compendia adopted by the United States department of health and human services.

Non Covered Prescription Drug Benefits (please also see Section XII Non Covered Services/ exclusions of this Handbook):

The following exclusions apply:

1. Unless otherwise specified in your summary of benefits, durable medical equipment, therapeutic devices, support garments; and other supplies or substances which may be obtained without a prescription;
2. Prescription Drugs or Refills in excess of either the quantity or days supply indicated on the prescription. For any prescription that is filled before the designated days supply on the previous fill has been exhausted, the member will be responsible for full cost of the prescription.
3. Dietary supplements and some prescription vitamins (other than prenatal vitamins or those mandated by PPACA guidelines);
4. Prescription Drugs used for cosmetic purposes such as: drugs used to decrease wrinkles, drugs to promote hair growth, and drugs to control perspiration;
5. Drugs for weight loss including diet pills and appetite suppressants;
6. Drugs that do not require a prescription for dispensing known as "Over-the-Counter" drugs unless approved by the Plan;
7. Any prescription products that are not FDA approved medications or are labeled as experimental or investigational. This includes prescription devices;
8. Prescription Drugs used to enhance athletic or sexual performance;
9. Compounded medications are not covered when a similarly equivalent product is available commercially, when the active ingredients do not require a Prescription, or there is insufficient evidence to prove the specific formulation is safe and effective. The Plan will not pay any preparation fee for compounded medications;
10. Any claim for Prescription Drug(s) submitted to the Plan or the PBM for reimbursement **more than one (1) year** from the date the Prescription Drug was dispensed will not be eligible for reimbursement;
11. Prescription Drugs for which the cost is recoverable under any workers' compensation or occupations disease law or any federal or state agency or any drug for which no or substantially discounted charge is made;
12. Prescription Drugs that are prescribed, dispensed or intended for use during a hospital inpatient or skilled nursing facility stay;
13. Non-Formulary Prescription Drugs unless determined to be medically necessary through the Non-formulary Exceptions process;
14. Prescription Drugs obtained from Non-Network Pharmacies.

15. Growth hormones for growth and development unless medically necessary and covered according to your summary of benefits;
16. Any drugs or devices used for treatment of male/female sexual dysfunction including but not limited to erectile dysfunction, delayed ejaculation, anorgasmia and decreased libido;
17. Fertility drugs unless otherwise stated in your summary of benefits.

How to Obtain Prescription Drug Benefits

Network Pharmacy – Present your written Prescription Order from your Physician, and your Identification Card to the pharmacist at a Network Pharmacy. The Pharmacy will file your claim for you. You will be charged at the point of purchase for applicable Deductible and/or Copayment/Coinsurance amounts. If you do not present your Identification Card, you will have to pay the full retail price of the prescription. If you do pay the full charge, ask your pharmacist for an itemized receipt and submit it to Paramount with a written request for refund. Prior Authorizations and limitations to coverage will still apply prior to refunds.

CVS Mail Order Pharmacy – Refer to your Summary of Benefits for Mail Service coverage. If you have Mail Service coverage, you will need to complete a patient profile with the appropriate pharmacy. You may mail written prescriptions from your Physician, or have your Physician fax the prescription to the Mail Service. You will need to pay the applicable Deductible, Coinsurance and/or Copayment amounts to the Mail Service when you request a prescription or refill. Not all drugs are covered through the Mail Service pharmacy. Some drugs, such as controlled substances or specialty medications, are limited by the Plan. For information about limitations and availability of coverage, you may contact Member Services at the phone number printed on the back of your card.

CVS Maintenance Choice (90-day) Pharmacy Program - The Maintenance Choice program is for prescription drugs taken continuously to manage chronic or long-term conditions, such as high blood pressure, asthma, diabetes, or high cholesterol. After two 30-day fills of a prescription medication that is on the CVS Maintenance Choice list, the prescription must be filled for a 90-day supply at either CVS Caremark mail order or a CVS retail store. Members may obtain a list of the CVS Maintenance Choice medications by calling the Member Services telephone number on the back of their Identification Card, or by reviewing the list on the internet at www.paramountinsurancecompany.com.

Specialty Pharmacy Network

Paramount's Specialty Pharmacy Network is available to Members who use Specialty Drugs. Members may obtain a printed list of the Specialty Network Pharmacies and covered Specialty Drugs, by calling the Member Services telephone number on the back of their Identification Card, or may review an electronic copy of the lists on the internet at www.paramountinsurancecompany.com.

Days Supply

The number of days supply of a Drug which you receive can be limited based upon the type of pharmacy and specific medication. The days supply limit applicable to Prescription Drug coverage is shown in the Summary of Benefits.

Payment of Benefits

The amount of benefits paid by Paramount is based upon the type of pharmacy from which you receive the Covered Services. It is also based upon which Tier we have classified the Prescription Drug or Specialty Drug, days supply, covered Additional Benefits and Programs, and Special Promotions.

The amounts for which you are responsible and the applicable number of days supply are shown in the Summary of Benefits. Your Copayment(s), Coinsurance and/or Deductible amounts will not be reduced by any discounts, rebates or other funds received by the PBM and/or the Health Plan from Drug manufacturers or similar vendors.

No payment will be made by Paramount for any Covered Service unless the negotiated rate exceeds any applicable Deductible and/or Copayment/Coinsurance for which you are responsible.

Deductible/Coinsurance/Copayment

Each Prescription Order may be subject to a Deductible and Coinsurance/Copayment. The Coinsurance/Copayment may be dependent on the Covered Drug's Formulary placement and days supply of medication. If the Prescription Order includes more than one covered Drug, a separate Coinsurance/Copayment will apply to each covered Drug. Your Prescription Drug Coinsurance/Copayment will be the lesser of your Copayment/Coinsurance amount or the cost of the Drug. Please see the Summary of Benefits for any applicable Deductible and Coinsurance/Copayment.

Formulary

A Formulary is a list of drugs that are covered by the Plan under a member's prescription drug benefits. Members can obtain a copy of the Plan's Formulary by calling the Member Services telephone number on the back of their ID card, or by reviewing an electronic copy on the internet at www.paramountinsurancecompany.com. The Formulary list is subject to periodic review and amendment. Inclusion of a Drug or related item on the covered Prescription Drug list is not a guarantee of coverage.

Tier and Formulary Assignment Process

Your Copayment/Coinsurance amount varies based on how the Prescription Drug, including covered Specialty Drugs, has been classified by the Plan's Formulary and the type of Copayment/Coinsurance tier structure per the Summary of Benefits.

The determination of tiers and formulary assignment is made by a P&T Committee based upon clinical information, treatment options, and Drug costs relative to other Drugs used to treat the same or similar condition.

We retain the right at our discretion to determine coverage for dosage formulations in terms of covered dosage administration methods (for example, by mouth, injections, topical, or inhaled) and may cover one form of administration and exclusion or place other forms of administration in another tier.

6-Tier Copayment

Refer to the Summary of Benefits for exceptions that apply to drugs subject to Additional Benefits and Programs.

- **Tier 1** - Preferred Generic Prescription Drugs have the lowest Coinsurance or Copayment.
- **Tier 2** - Non-Preferred Generic Prescription Drugs will have a higher Coinsurance or Copayment than those in Tier 1.
- **Tier 3** - Preferred Brand Prescription Drugs will have a higher Coinsurance or Copayment than those in Tier 2.

- **Tier 4** - Non-Preferred Brand Prescription Drugs will have a higher Coinsurance or Copayment than those in Tier 3.
- **Tier 5** - Preferred Specialty and Injectable Prescription Drugs will have a higher Coinsurance or Copayment than those in Tier 4.
- **Tier 6** - Non-Preferred Specialty Prescription Drugs will have the highest Coinsurance or Copayment.

DAW Status

Dispense As Written (DAW) is a designation that you may request at the pharmacy or that your prescriber may make on your prescription. DAW requires the pharmacy to dispense the exact product that was written by the prescriber and no substitutions may be made. Refer to your Summary of Benefits for an explanation of how these drugs are covered.

Prior Authorization

Prior Authorization will be required for certain Prescription Drugs, or for the prescribed quantity of a particular Drug. Prior Authorization helps promote appropriate use of medications and enforcement of guidelines for Prescription Drug benefit coverage. At the time you fill a prescription, the Network pharmacist is informed of the Prior Authorization requirement through the pharmacy's computer system. The PBM uses pre-approved edits with criteria developed by a Pharmacy and Therapeutics (P&T) Committee, which is reviewed and adopted by Paramount. Prescribers or pharmacies should contact Paramount with information to determine whether Prior Authorization should be granted. We communicate the results of the decision to your provider.

Prior Authorization is required for coverage of an opioid analgesic prescription for chronic pain. Prior Authorization is not required for coverage of an opioid analgesic prescribed for chronic pain, when the drug is prescribed under one of the following circumstances: (a) To an individual who is a hospice patient in a hospice care program; (b) To an individual who has been diagnosed with a terminal condition but is not a hospice patient in a hospice care program; (c) To an individual who has cancer or another condition associated with the individual's cancer or history of cancer.

Paramount will contact a Member by mail when the Member fills a prescription for certain opioid medications if that Member has not filled a similar prescription in the previous six months. This letter is developed in coordination with Paramount's Pharmacy Benefit Manager to describe the risks and benefits of opioid use and educates the Member on how to dispose of unused opioids safely. This communication is intended to help prevent the development of opioid dependency by our Members. For additional information on opioid education, you may call Member Services at the number on the back of your identification card.

To identify Members who may be dependent on opioids and to intervene appropriately when a Member's opioid use may require care coordination, Paramount's case management clinical team regularly reviews pharmacy and claims data against other criteria associated with high-risk opioid use. Case management clinical team members may contact a Member identified through this effort by telephone to offer case management services which include referral to appropriate providers and community resources, education regarding medical and behavioral health conditions and coordination of care between providers. The care management team is a multi-disciplinary group of clinical case managers, pharmacists, physicians, social workers and other behavioral health professionals, who can interact with Participating Providers and pharmacists to help them treat opioid-use disorder more effectively.

Participating Providers will treat opioid-use disorder with a monitored drug and therapy protocol called medication assisted treatment. To facilitate prompt treatment of opioid-use disorder, most medication

assisted treatment does not require Prior Authorization. Paramount's limits on medication assisted treatment are related only to quantity or duration or to potentially disqualifying conditions.

Prior Authorization for Prescription Drugs for treatment of opioid-use disorder will be expedited.

For a list of the current Drugs requiring Prior Authorization, please contact the Member Services telephone number on the back of your ID card or review the medication formulary on Paramount's website. This list is subject to periodic review and amendment. Inclusion of a Drug or related item on the list is not a guarantee of coverage under your Handbook. Refer to the Covered Prescription Drug benefit sections in this Handbook for information on coverage, limitations and exclusions. Your provider or Network Pharmacist may check with Paramount to verify covered Prescription Drugs, any quantity and/or age limits, or applicable Brand or Generic Drugs recognized under the Health Plan.

Refer to the Standard and Expedited Review for Prior Authorizations, Step Therapy Exceptions, and Non-formulary Exceptions for details of the process.

A rejected claim at the pharmacy does not constitute coverage denial. If a claim rejects at the pharmacy, you can initiate the prior authorization process by asking the pharmacist to initiate the prior authorization process electronically or by asking your provider to submit a prior authorization request to Paramount. If you pay for the prescription prior to review, Paramount will conduct a retrospective review to determine if the prescribed medication was Medically Necessary. Coverage will be approved if the following are determined to be true:

- a. The patient was eligible under the plan at the time of dispensing;
- b. The medication is covered under the plan;
- c. The medication meets the standards for medical necessity and prior authorization criteria.

A request for coverage will not be denied based solely on the fact that a prior authorization was not obtained prior to dispensing. If you paid for the prescription and the review results in determining the above criteria are met for coverage, You can request the pharmacy reverse and reprocess the claim to be reimbursed or submit a receipt to Paramount for paper claim reimbursement. Reimbursed amount will be the difference between the total amount paid at the time of dispensing and any member cost share owed according to member benefits.

You are responsible for all charges for prescriptions Paramount determines are not Medically Necessary. The member or an authorized representative will have the right to submit an appeal if the prior authorization request is denied. Please see Internal Claims and Appeals Procedures and External Review section of this certificate.

Step Therapy

Step therapy is a protocol that requires a Member to use other medication(s) before a certain prescribed medication is authorized. Paramount monitors some Prescription Drugs to control utilization, to ensure that appropriate prescribing guidelines are followed, and to help Members access high quality yet cost effective Prescription Drugs. If a Physician decides that the prescribed medication is medically necessary a Step Therapy exception request can be submitted. Refer to the Standard and Expedited Review for Prior Authorizations, Step Therapy Exceptions, and Non-formulary Exceptions for details of the process.

Quantity Limits

Quantity limits are limits on the amount of a drug that may be covered for reasons of safety and/or dose optimization. Quantity limits may apply when medical literature, clinical best practice and/or the FDA has established a maximum dosage as a safe limit. Quantities that exceed these safe limits are not a covered benefit. Dose optimization is limits on the quantity of a certain dose of medication in order to promote

using the recommended quantity of drug per dosages available.

Specialty Drug Program

Specialty Drugs are reviewed and designated through the Plan's P&T Committee. They will have the highest Coinsurance or Copayment and will contain Specialty and Injectable medications. Characteristics of Specialty Drugs are:

- Generally high-cost drugs prescribed for rare or complex, ongoing medical conditions.
- May be injectable, infused, oral, or inhaled drugs which typically are not stocked at traditional pharmacies due to unique storage, shipment, or dispensing requirements.
- Often they require close supervision and monitoring by a physician or another trained healthcare professional.

Members may obtain a list of the Specialty Network Pharmacies, and covered Specialty Drugs, by calling the Member Services telephone number on the back of their Identification Card, or by reviewing the lists on the internet at www.paramountinsurancecompany.com.

Oral Chemotherapy

This plan shall not provide coverage or impose cost sharing for a prescribed, orally administered cancer medication on a less favorable basis than the coverage it provides or cost sharing it imposes for intravenously administered or injected cancer medications.

Standard & Expedited Review Process for Prior Authorizations, Step Therapy Exceptions and Non-formulary Exceptions

A member or physician can request and gain access to clinically appropriate drugs that are not on the formulary, are subject to a Step Therapy Protocol or are subject to Prior Authorization. A rejected claim at the pharmacy does not constitute coverage denial. If a claim rejects at the pharmacy, you can initiate a coverage exception request in the same manner as a prior authorization request and Paramount will review for medical necessity. Refer to the Prior Authorization for Prescription Drug section for details. However, if your physician recommends a particular contraceptive service or FDA approved contraceptive item based on medical necessity, Paramount will defer to the determination of the physician and cover that particular service or item without cost sharing.

A standard Prior Authorization or exception request can be submitted in non-exigent circumstances and receive a decision within 72 hours of a request. For expedited requests based on Exigent Circumstances determination and notification will be provided no later than 24 hours following receipt of the request. If a medication is approved, it will be approved for a 12 month duration or until your benefit eligibility changes. Non-chronic medications, controlled substances, medications with a typical treatment duration of less than a year, or medications that require safety and efficacy monitoring may initially be given a shorter duration of approval. Medications that are approved through the Prior Authorization or exception request process will be treated as an Essential Health Benefit with member's cost share applying to the Out-of-Pocket Maximum. If the request for coverage is denied, you have the right to appeal through the appeals process outlined in Section XVII, **Internal Claims and Appeals Procedures and External Review** of this Handbook. For more information or assistance, contact the Paramount Member Services Department.

Member Services Department
(419) 887-2525
Toll-Free 1-800-462-3589
TTY (419) 887-2526

See Section XXII Definitions for additional information on Exigent Circumstances.

Special Promotions

From time to time we initiate various programs to encourage the use of more cost-effective or clinically-effective Prescription Drugs including, but not limited to, Generic Drugs, Mail Service Drugs, over the counter or preferred products. Such programs can involve reducing or waiving Copayments or Coinsurance for certain Drugs or preferred products for a limited period of time.

XII. NON COVERED SERVICES/EXCLUSIONS

The following section indicates items which are excluded from benefit consideration, and are not considered Covered Services. Excluded items will not be covered even if the service, supply, or equipment would otherwise be considered Medically Necessary. Basic health care services will not be excluded because they were the result of a complication from a non-covered service. This information is provided as an aid to identify certain common items which may be misconstrued as Covered Services.

We do not provide benefits for procedures, equipment, services, supplies or charges:

1. Which we determine are not Medically Necessary or do not meet our medical policy, clinical coverage guidelines, or benefit policy guidelines. See **Internal Claims and Appeals Procedures and External Review** section of this handbook.
2. Received from an individual or entity that is not a Participating Provider, as defined in this Handbook, or recognized by Paramount. If a Medically Necessary Covered Service is not available from any Participating Providers, Paramount will make arrangements for an “out of plan” Prior Authorization. Please refer to the Prior Authorization section for additional information.
3. Which are Experimental/Investigative or related to such, whether incurred prior to, in connection with, or subsequent to the Experimental/Investigative service or supply, as determined by Paramount. The fact that a service is the only available treatment for a condition will not make it eligible for coverage if we deem it to be Experimental/Investigative. See the **Internal Claims and Appeals Procedures and External Review** and **Experimental/Investigative Services Exclusion** sections of this handbook.
4. For any condition, disease, defect, ailment, or injury arising out of and in the course of employment if benefits are available under any Workers’ Compensation Act or other similar law. If Workers’ Compensation Act benefits are not available to you, then this Exclusion does not apply. This exclusion applies if you receive the benefits in whole or in part. This exclusion also applies whether or not you claim the benefits or compensation. It also applies whether or not you recover from any third party.
5. To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
6. For court ordered testing or care unless Medically Necessary.
7. For which you have no legal obligation to pay in the absence of this or like coverage.
8. For the following:
 - a. Surcharges for furnishing and/or receiving medical records and reports.
 - b. Charges for doing research with providers not directly responsible for your care.
 - c. Charges that are not documented in provider records.
 - d. Charges from an outside laboratory or shop for services in connection with an order involving devices (e.g., prosthetics, orthotics) which are manufactured by that laboratory or shop, but which are designed to be fitted and adjusted by the attending Physician.

- e. For membership, administrative, or access fees charged by Physicians or other providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results.
9. Received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group.
10. Prescribed, ordered or referred by or received from a member of your immediate family, including your spouse, Child, brother, sister, parent, in-law, or self.
11. For completion of claim forms or charges for medical records or reports unless otherwise required by law.
12. For missed or canceled appointments.
13. For mileage, lodging and meals costs, and other Member travel related expenses, except as authorized by Paramount or specifically stated as a Covered Service.
14. For which benefits are payable under Medicare Parts B and/or D when Medicare is primary. If Medicare is not primary, this exclusion does not apply if a person is or could have been covered under another plan, except with respect to Part B of Medicare. For the purposes of the calculation of benefits, if the Member has not enrolled in Medicare Part B, we will calculate benefits as if they had enrolled.
15. Charges in excess of Our Maximum Allowable Amounts.
16. Incurred prior to your Effective Date.
17. Incurred after the termination date of this coverage except as specified elsewhere in this Handbook.
18. For any procedures, services, equipment or supplies provided in connection with cosmetic services. Cosmetic services are primarily intended to preserve, change or improve your appearance or are furnished for psychiatric or psychological reasons. No benefits are available for surgery or treatments to change the texture or appearance of your skin or to change the size, shape or appearance of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts). This exclusion does not apply to conditions including but not limited to: myocardial infarction; pulmonary embolism; thrombophlebitis; and exacerbation of co-morbid conditions. Medically necessary services due to complications of a non-covered procedure are covered.
19. For maintenance therapy, which is treatment given when no additional progress is apparent or expected to occur. Maintenance therapy includes treatment that preserves your present level of functioning and prevents loss of that functioning, but which does not result in any additional improvement.
20. For the following:
 - Custodial Care, convalescent care or rest cures.
 - Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
 - Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
 - Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, or outward bound programs, even if psychotherapy is included.
 - Wilderness camps.
21. For routine foot care (including the cutting or removal of corns and calluses); Nail trimming, cutting or debriding; Hygienic and preventive maintenance foot care, including but not limited to:
 - cleaning and soaking the feet.
 - applying skin creams in order to maintain skin tone.
 - other services that are performed when there is not a localized illness, injury or symptom involving the foot.
22. For surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.

23. Weight loss programs, whether or not they are pursued under medical or Physician supervision, unless specifically listed as covered in this Handbook. This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.
24. For bariatric surgery, regardless of the purpose it is proposed or performed. This includes but is not limited to Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgical procedures that reduce stomach capacity and divert partially digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastroplasty, (surgical procedures that decrease the size of the stomach), or gastric banding procedures.
25. For marital counseling.
26. For prescription, fitting, or purchase of eyeglasses or contact lenses except as otherwise specifically stated as a Covered Service. This Exclusion does not apply for initial prosthetic lenses or sclera shells following intraocular surgery, or for soft contact lenses due to a medical condition.
27. For vision orthoptic training.
28. For hearing aids or examinations to prescribe/fit them, unless otherwise specified within this Handbook.
29. For services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein.
30. For services to reverse voluntarily induced sterility.
31. Assisted reproductive technology (ART) such as artificial insemination, in vitro fertilization, embryo transplant services, GIFT, ZIFT, zygote transfer, reversal of voluntary sterilization, ovarian tissue transplant and related services, cost of donor sperm or donor egg, and services and supplies related to ART procedures.
32. For personal hygiene, environmental control, or convenience items including but not limited to:
 - Air conditioners, humidifiers, air purifiers;
 - Personal comfort and convenience items during an Inpatient stay, including but not limited to
 - daily television rental, telephone services, cots or visitor's meals;
 - Charges for non-medical self-care except as otherwise stated;
 - Purchase or rental of supplies for common household use, such as water purifiers;
 - Allergenic pillows, cervical neck pillows, special mattresses, or waterbeds;
 - Infant helmets to treat positional plagiocephaly;
 - Safety helmets for Members with neuromuscular diseases; or
 - Sports helmets.
33. Health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. This exclusion also applies to health spas.
34. For consultations other than those performed in-person, except as required by law, as authorized by Paramount, or as otherwise described in this Handbook (see, e.g., "Telemedicine Services" and "ProMedica OnDemand" in the Covered Services section).
35. For care received in an emergency room which is not emergency care, except as specified in this Handbook. This includes, but is not limited to suture removal in an emergency room.
36. For eye surgery to correct errors of refraction, such as near-sightedness, including without limitation LASIK, radial keratotomy or keratomileusis or excimer laser refractive keratectomy.
37. For self-help training and other forms of non-medical self-care, except as otherwise provided in this Handbook.
38. For examinations relating to research screenings.
39. For stand-by charges of a Physician.
40. Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes, except as required by state and federal law.

41. For Private Duty Nursing Services rendered in a Hospital or Skilled Nursing Facility; Private Duty Nursing Services are Covered Services only when provided through the Home Care Services benefit as specifically stated in the "Covered Services" section.
42. For Manipulation Therapy services rendered in the home as part of Home Care Services.
43. Unless Medically Necessary, services and supplies related to sex transformation and/or the reversal thereof, or male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This Exclusion includes sexual therapy and counseling. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, Prescription Drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related Diagnostic Testing. Evidence based and nondiscriminatory criteria will be used to determine Medical Necessity.
44. For (services or supplies related to) alternative or complementary medicine. Services in this category include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage and massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergetic synchronization technique (BEST), iridology-study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy, electromagnetic therapy, and neurofeedback.
45. For any services or supplies provided to a person not covered under the Handbook in connection with a surrogate pregnancy (including, but not limited to, the bearing of a Child by another woman for an infertile couple).
46. For surgical treatment of gynecomastia.
47. For treatment of hyperhidrosis (excessive sweating).
48. For any service for which you are responsible under the terms of this Handbook to pay a Copayment, Coinsurance or Deductible, and the Copayment, Coinsurance or Deductible is waived by a non-Participating Provider.
49. Human Growth Hormone for children born small for gestational age. It is only a Covered Service in other situations when allowed by Paramount through Prior Authorization.
50. For Drugs, devices, products, or supplies with over the counter equivalents and any Drugs, devices, products, or supplies that are therapeutically comparable to an over the counter Drug, device, product, or supply. This exclusion does not apply to over-the-counter products the Plan must cover under federal law with a prescription.
51. Sclerotherapy for the treatment of varicose veins of the lower extremities including ultrasonic guidance for needle and/or catheter placement and subsequent sequential ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy.
52. Treatment of telangiectatic dermal veins (spider veins) by any method.
53. Reconstructive services except as specifically stated in the **Covered Services** section of this Handbook, or as required by law.
54. Nutritional and/or dietary supplements, except as provided in this Handbook or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written Prescription or dispensing by a licensed Pharmacist.
55. Abortion is not covered, unless medically necessary (i.e., to save the life or protect the health of the mother).
56. Dental x rays, supplies & appliances and all associated expenses, including hospitalization and anesthesia except as required by law. The only exceptions to this are for any of the following
 - transplant preparation
 - initiation of immunosuppressives
 - direct treatment of cancer or cleft palate
 - services related to accidental injury. Please see Dental Services section.

EXPERIMENTAL/INVESTIGATIVE SERVICES EXCLUSION

Any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which we determine in Our sole discretion to be Experimental/Investigative is not covered under the Health Plan.

We will deem any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental/Investigative if we determine that one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought. The Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply:

- cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA), or other licensing or regulatory agency, and such final approval has not been granted;
- has been determined by the FDA to be contraindicated for the specific use; or
- is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function; or
- is provided pursuant to informed consent documents that describe the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental/Investigative, or otherwise indicate that the safety, toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.

Any service not deemed Experimental/Investigative based on the criteria above may still be deemed Experimental/Investigative by Paramount. In determining whether a Service is Experimental/Investigative, we will consider the information described below and assess whether:

- the scientific evidence is conclusory concerning the effect of the service on health outcomes;
- the evidence demonstrates the service improves net health outcomes of the total population for whom the service might be proposed by producing beneficial effects that outweigh any harmful effects;
- the evidence demonstrates the service has been shown to be as beneficial for the total population for whom the service might be proposed as any established alternatives; and
- evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.

The information considered or evaluated by Paramount to determine whether a Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative under the above criteria may include one or more items from the following list which is not all inclusive:

- published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or
- evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
- documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- documents of an IRB or other similar body performing substantially the same function; or
- consent document(s) and/or the written protocol(s) used by the treating Physicians, other medical professionals, or facilities or by other treating Physicians, other medical professionals or facilities studying substantially the same Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or

- medical records; or
- the opinions of consulting providers and other experts in the field.

We have the sole authority and discretion to identify and weigh all information and determine all questions pertaining to whether a Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative.

XIII. ELIGIBILITY GUIDELINES

The following persons are eligible for coverage during annual open enrollment. They must reside in the Paramount Service Area and the Subscriber must list them on the enrollment application.

Subscriber The Subscriber is the person who makes application for Individual coverage and meets eligibility requirements.

Spouse The Subscriber's legal spouse.

Dependent Children: The married or unmarried Dependent children, stepchildren, legally adopted children and children placed for adoption of the Subscriber or the Subscriber's spouse under the age of twenty-six (26) regardless of student status, and who meet the eligibility requirements. Dependent children who reside outside the Paramount Service Area and/or do not reside in the household of the parent are eligible to enroll in this plan.

Eligible Dependent children are covered through the last day of the benefit year in which they turn age twenty-six (26) or until a special enrollment period is experienced.

If a Subscriber or Subscriber's spouse has been court-ordered to maintain health care coverage on a Dependent Child, the Child is eligible to enroll without any enrollment period restrictions even if the Child resides outside the Paramount Service Area. Coverage for service rendered outside the Service Area by non-Participating Providers will be limited to Emergency Medical Conditions unless prior authorized by Paramount. If the enrolled parent fails to make application to enroll the Child, Paramount will enroll the child upon application by the other parent or upon receipt of a child support order containing provisions in compliance with 3119.29 to 3119.56 of the Ohio Revised Code. Paramount will not terminate the Child's coverage without written evidence the court order is no longer in effect or the child is or will be enrolled under comparable health care coverage through another insurer with an effective date not later than the termination date of the current coverage.

Children of Dependents (grandchildren) are not covered. If a covered Dependent Child becomes pregnant, the newborn will not be covered under the grandparents' contract. Separate coverage may be available for the mother and newborn. **Parents, grandparents, sisters or brothers of the Subscriber or Subscriber's spouse are not eligible Dependents.**

Dependents with disabilities If covered children meet the requirements of Dependents with disabilities because of physical handicap or intellectual disability (they are unable to earn their own living and rely primarily on the Subscriber for support), coverage may continue past age 26. Proof of disability must be provided to Paramount prior to or within thirty-one (31) days of the Dependent's 26th birthday or within thirty-one days of new Paramount eligibility and may be requested annually.

Newborn children A newborn Child of a Subscriber (or the Subscriber's spouse) is covered for the first thirty-one (31) days following birth. To be covered beyond the 31-day period, a completed enrollment application and any required additional premium payment must be received within the first thirty-one (31) days following the birth. If the application and appropriate payment is not received, the newborn Child will not be eligible for any benefits beyond the thirty-one days following the birth.

Adoption or placement for adoption A completed enrollment application and any required additional premium payment must be received within the first thirty-one (31) days following adoption or placement for adoption. Coverage will become effective from the date of adoptive placement. Adoptive placement means the assumption and retention by a person of a legal obligation for total or partial support of a Child in anticipation of the adoption of the Child. The Child's placement with a person terminates upon termination of the legal obligation.

The only other time you may enroll adopted children, children placed for adoption, or stepchildren is during open enrollment period, or a special enrollment period.

Marriage When a completed enrollment application is received by Paramount within thirty-one (31) days from the date of marriage, coverage of new spouses becomes effective on the date of marriage.

The only other time you may enroll your spouse is during open enrollment period, or a special enrollment period.

Divorce You must notify Paramount that you are removing your ex-Spouse and any other ineligible Dependents from the plan at the time the annulment, dissolution or divorce decree is final. Coverage will end at the end of the month in which the decree is final.

Death of a subscriber Dependents of a deceased Subscriber may be eligible for continuation coverage.

ELIGIBILITY THROUGH THE MARKETPLACE

To be eligible to enroll in this plan through the Marketplace, the Subscriber and Dependents must meet the three requirements outlined in 45 C.F.R. 155.305(a):

1. Must be a U.S. Citizen, U.S. National, or a lawfully present non-citizen;
2. Cannot be incarcerated (in prison; does not apply if you are awaiting disposition of charges); and
3. Must reside in the Paramount Service Area. (See "Dependents" for exception.)

An applicant who meets these three requirements is considered a qualified individual (QI) and is eligible for coverage through the Marketplace. A QI may only enroll through the Marketplace during the annual open enrollment period or a special enrollment period. Special enrollment periods are provided when a QI or his or her dependent experiences a qualifying event. Members of federally-recognized tribes are permitted to purchase and enroll in Marketplace coverage monthly rather than waiting for annual open enrollment or special enrollment periods. For additional information see **SPECIAL ELIGIBILITY STANDARDS AND PROCESS FOR INDIANS** of this handbook.

The Plan can be written as a Child-Only Plan for individuals who are less than 21 years of age.

During enrollment, if an individual asks for financial assistance in obtaining health care coverage, the following must be assessed:

- Medicaid eligibility
- Children's Health Insurance Program (CHIP) eligibility
- Primary tax payers' eligibility for an advance payment of premium tax credits.
- Eligibility for cost-share subsidy

ELIGIBILITY FOR COST SHARING REDUCTIONS (CSR) 45 CFR § 155.305(G)

Cost-sharing reductions decrease the overall out of pocket cost (deductibles, copayments, coinsurance and out of pocket maximum) for eligible individuals. You may be eligible for cost sharing reductions if

you enrolled on the Marketplace (see the next section for special cost sharing rules for American Indians and Alaskan Natives) and:

- You are eligible for Advance Payments of the Premium Tax Credit (APTC);
- Your household income is no more than 250 percent of the Federal Poverty Level (FPL); and
- You are enrolled in any silver plan in the individual market through Paramount.

To understand how cost sharing reductions work, we must first understand actuarial value (AV). AV is a measure of the richness or generosity of the cost sharing of a health plan. A plan with a higher AV is a richer plan which means the insurance carrier pays more and you pay less. For example, a plan with a 100% AV pays 100% of all claims while you pay nothing (after premium). If you were to purchase a plan with an 80% AV the plan would generally pay, on average, 80% of a standard population's expected medical expenses while you would pay the remaining 20%. The downside of purchasing a plan with a higher AV is that the monthly premiums are usually higher.

To help you make an apple to apple comparison of plans, each carrier is required to input the cost sharing combination into an AV calculator with a national data set provided by the Centers for Medicare and Medicaid Services. Each plan must be certified and fall within one of the following standard metal tiers (-4/+2) percentage points (other than bronze plans meeting certain conditions):

- Platinum: 90% AV
- Gold: 80% AV
- Silver: 70% AV
- Bronze: 60% AV

Individuals enrolled in silver plans, assuming everything else is equal, would expect to pay higher premiums than those enrolled in a bronze plan and smaller premiums than those enrolled in a gold or platinum plan. However, cost sharing reductions allow an individual to pay the same silver premium and receive the benefits of a higher AV (richer plan).

SPECIAL ELIGIBILITY STANDARDS AND PROCESS FOR INDIANS 45 CFR § 155.350

If you are a verified American Indian or Alaskan Native, you are permitted to purchase and enroll in Marketplace coverage monthly rather than just during annual open enrollment or special enrollment periods. You may also change your Qualified Health Plan (QHP) issuer selection a maximum of once every 30 days. Paramount will check your tribal status against available federal data sources or a roster of tribe members from an authorized representative of your federally recognized tribe, if provided. If Paramount cannot verify your status as a tribe member, you may be required to provide other proof of tribal status. Please note that if you change your plan selection, all of your plan accumulators such as Deductibles and out of pocket maximums will be reset under the new plan.

Additionally, if you are an American Indian or Alaskan Native, you may be eligible for no cost sharing (100% AV) plan; you will not pay Deductibles, Coinsurance, Copayments or out of pocket maximums. To qualify for these special cost sharing reductions:

- You must be eligible for Advance Payments of the Premium Tax Credit (APTC);

- Your household income must be no more than 300 percent of the Federal Poverty Level (FPL); and
- You must be enrolled in a plan in the individual market through Paramount.

Further, the Affordable Care Act directs a QHP issuer to eliminate cost sharing for an Indian, regardless of household income, for items or services furnished directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services, and prohibits the QHP issuer from reducing payments to any such entity for such items or services.

For more information regarding AV and cost sharing reductions, please see the Eligibility for Cost Sharing Reductions section above.

SPECIAL ENROLLMENT PERIODS

Annual open enrollment period is the time each year when people can newly enroll in a plan or change to a different plan. But certain qualifying events throughout the year can trigger a special enrollment period (SEP). A SEP may enable you to newly enroll in a plan or change to a different plan within the same level of coverage outside of annual open enrollment. If you are declining enrollment for your Dependent(s) (including your spouse) and a dependent experiences a qualifying event, you may be able to enroll your Dependent in this plan provided that you request enrollment within 60 days of a qualifying event.

Special Enrollment Period (SEP) Qualifying Event Categories

You may qualify for a SEP to enroll in or change plans outside of annual open enrollment if you experience a qualifying event in one (1) of the following categories:

- (1) Loss of qualifying health coverage** such as:
 - Loss of Minimum Essential Coverage (MEC);
 - Loss of pregnancy-related Medicaid coverage regardless of whether the pregnancy-related coverage qualifies as MEC; or
 - The expiration of a non-calendar year plan.
- (2) Change in household size** such as:
 - Marriage;
 - Birth, adoption, placement for adoption or foster care, or a court order;
 - Death of Subscriber or Dependent; or
 - Legal separation or divorce.
- (3) Change in primary place of living** such as a permanent move of Subscriber or Dependent.
- (4) Change in eligibility for financial help** such as:
 - A change in income or household size that makes the household newly eligible or ineligible for premium tax credits (PTC) or cost-sharing reduction (CSR); **(Applicable to Members enrolled through the Marketplace Only)**
 - A current employer plan is no longer considered qualifying employer coverage;
 - An individual moves out of the Medicaid coverage gap; or
 - You become newly eligible as a result of gaining a lawfully present immigration status or become a member of a federally-recognized Native American tribe or an Alaska native Claims Settlement Act Corporation Shareholder. **(Applicable to Members enrolled through the Marketplace Only)**
- (5) Enrollment or plan error (Applicable to Members enrolled through the Marketplace Only)** such as:
 - An error, misrepresentation, inaction or misconduct by the Marketplace or HHS, its instrumentalities, or other entities providing enrollment assistance;
 - A plan or benefit display error; or

- c. Proof of violation of a material provision of a QHP contract.
- (6) **Other qualifying changes** such as termination of Medicaid or Children's Health Insurance Program (CHIP) coverage and the eligibility for Employment Assistance under Medicaid or CHIP. Survivors of domestic violence or abuse or spousal abandonment may also be eligible for a qualifying event.

Qualifying events may have requirements of prior coverage, requirements for timing of application submission as well as plan selection limitations.

Special Enrollment Period Effective Dates

Regular Effective dates when a plan selection is received:

Between the first and the fifteenth day of any month, enrollee's coverage effective date is the first day of the following month; or

Between the sixteenth and the last day of any month, enrollee's coverage effective date is the first day of the second following month.

Special Effective dates:

For the following SEP categories if plan selection is made before the last day coverage ends then coverage is effective for an enrollee the first day of the month following loss of previous coverage. If plan selection is made after coverage ends, coverage is effective for an enrollee the first day of the month following plan selection.

- (1) a, b and c, and
- (4) b

For the following SEP categories coverage is effective for an enrollee on the first day of the month following plan selection.

- (2) a, c and d

For the following SEP category coverage is effective for the enrollee on the date of the event or enrollee may request an effective date of the first day of the month following the qualifying event.

- (2) b

For the following SEP categories coverage follows the Regular Effective dates noted above.

- (3), (4) a, c, and d
- For the following SEP categories coverage will be effective for the enrollee on a date appropriate to the circumstances.(5) and (6)

Nondiscrimination No one who is eligible to enroll or renew as a Subscriber, Dependent or Dependent with disabilities will be refused by Paramount based on subsidy eligibility, student status, health-status related factor, pre-existing condition, genetic testing or the results of such testing, health care needs or the exercise of rights under Paramount's internal review procedures.

XIV. TERMINATION OF COVERAGE

Termination and Non-Renewal of Coverage – Marketplace

For coverage obtained through the Marketplace, during the course of the benefit plan year, either the enrollee or the Marketplace may need to terminate an enrollee's coverage in a plan.

Similarly, at the end of the benefit plan year, coverage shall be renewed at the option of the enrollee, but the occurrence of certain events may result in non-renewal of coverage.

The following events may trigger termination or non-renewal of coverage:

- Voluntary Termination – An enrollee provides notice that the enrollee would like to terminate coverage;
- Loss of Eligibility – The enrollee is no longer eligible for coverage; ;
- Non-payment – An individual fails to pay premiums by the appropriate deadlines and the following grace periods have been exhausted:
 1. For an individual eligible to receive APTC, the 3-month grace period provided by Paramount has been exhausted; and
 2. For individuals not eligible to receive APTC, the 30 day grace period has been exhausted
- Rescission – The enrollee’s coverage is Rescinded (see **Definitions**)
- Withdrawal of Product or Decertification – The plan is withdrawn by Paramount and terminates or is decertified;
- The enrollee changes from one QHP issuer to another during an annual open enrollment period or special enrollment period; or
- The enrollee obtains other minimum essential coverage.

For the purposes of this section, reasonable notice is defined as at least fourteen days before the requested Effective Date of termination.

In the case of voluntary termination by the enrollee, the last day of coverage is –

- The termination date specified by the enrollee, if the enrollee provides reasonable notice.
- Fourteen days after the termination is requested by the enrollee, if the enrollee does not provide reasonable notice.
- On a date on or after the date on which their termination is requested by the enrollee, subject to the determination of Paramount, if Paramount agrees to effectuate termination in fewer than fourteen days, and the enrollee requests an earlier termination Effective Date.
- If the enrollee is newly eligible for Medicaid, Medicare, or CHIP, the last day of coverage is the day before the individual is determined eligible for Medicaid, Medicare or CHIP.

Retroactive termination dates requested by the enrollee, must comply with applicable state and federal law.

In the case of termination for non-payment coverage ends:

- For individuals who are eligible for the Advance Premium Tax Credit (APTC), on the last day of the first month of the three (3) month grace period.
- For all others, on the last day of the month for which premium payment was received in full.

Paramount will provide notice upon termination of coverage.

In the case of termination due to the enrollee changing from one QHP issuer to another during an annual open enrollment period or special enrollment period, the last day of coverage in an enrollee's prior QHP is the day before the Effective Date of coverage in his or her new QHP.

Termination and Non-Renewal of Coverage – Off-Marketplace

For coverage obtained not through the Marketplace, during the course of the benefit plan year, either the enrollee or Paramount may need to terminate an enrollee's coverage in a plan.

Similarly, at the end of the benefit plan year, coverage shall be renewed at the option of the enrollee, but the occurrence of certain events may result in non-renewal of coverage.

The following events may trigger termination or non-renewal of coverage:

- Voluntary Termination – An enrollee provides notice that the enrollee would like to terminate coverage;
- Loss of Eligibility – The enrollee is no longer eligible for coverage;
- Non-payment – An individual fails to pay premiums and a grace period has been exhausted;
- Fraud – The enrollee has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of coverage,
- Termination of Product – The plan is withdrawn by Paramount and terminated.

For the purposes of this section, reasonable notice is defined as at least fourteen days before the requested Effective Date of termination.

In the case of voluntary termination by the enrollee, the last day of coverage is –

- The termination date specified by the enrollee, if the enrollee provides reasonable notice.
- Fourteen days after the termination is requested by the enrollee, if the enrollee does not provide reasonable notice.
- On a date on or after the date on which their termination is requested by the enrollee, subject to the determination of Paramount, if Paramount agrees to effectuate termination in fewer than fourteen days, and the enrollee requests an earlier termination Effective Date.
- If the enrollee is newly eligible for Medicaid, Medicare, or CHIP, the last day of coverage is the day before the individual is determined eligible for Medicaid, Medicare or CHIP.

Retroactive termination dates requested by the enrollee, must comply with applicable state and federal law.

In the case of termination for non-payment coverage ends on the last day of the month for which premium payment was received in full.

Paramount will provide notice upon termination of coverage.

BENEFITS AFTER TERMINATION

If a Member is an Inpatient on the date coverage ends, the benefits of this coverage for hospital and professional services will continue for only that Member until the earliest of:

- The effective date of any new coverage,
- The date of discharge,
- The attending physician certifies that inpatient care is no longer medically indicated,
- The limit for contractual benefits has been reached.

REFUNDS

Paramount will process refunds for clerical or billing errors that are caused by Paramount. All premiums are paid before the month of coverage, and once paid, are non-refundable. The only exception to this rule is if the enrollee has elected to pay several months ahead in their premium payments. Any credit that is on an account after Paramount settles the account for the determined Effective Date of termination will be refunded to the subscriber.

XV. PAYMENT FOR COVERAGE

The prepayment rate is based on the age and gender of the contract holder and the number of covered Dependents.

Paramount requires full payment by the end of each month prior to coverage. Invoices will be sent to the current address on file approximately ten (10) days in advance of the due date.

Past due premium that is due to Paramount within the past twelve (12) months, is due prior to the effective date of coverage. Any outstanding premium that is not paid, may affect enrollment with Paramount, or any affiliated health insurance issuer.

XVI. MEMBER SERVICES

Paramount values your comments and suggestions to improve our services. It is our goal to resolve any concerns as quickly and satisfactorily as possible.

Our Member Services staff is available Monday through Friday, 8:00 A.M. to 5:00 P.M., at (419) 887-2525, or toll-free 1-800-462-3589, to answer your questions, and assist you with solving your problems. If you have an administrative complaint or a complaint unrelated to a claim, you may direct these complaints to Paramount Insurance Company Member Services Department by phone or mail to P.O. Box 928, Toledo, Ohio 43697-0928, Attention: Member Services, or email: Paramount.memberservices@promedica.org. TTY users may call 1-888-740-5670. After hours, if you need information on how to access health care services, you may call the local or toll-free Member services phone number and be connected with an after-hours information service.

If You Receive a Bill

Copays are due at time of service. For Covered Services, you may be billed for Deductibles and Coinsurance by Participating Providers. Providers may bill you for non-Covered Services. If you have any questions about any amount(s) shown on the bill or statement, please contact Member Services.

XVII. INTERNAL CLAIMS AND APPEALS PROCEDURES AND EXTERNAL REVIEW

Overview

If you need help: If you do not understand your rights or if you need assistance understanding your rights or you do not understand some or all of the information in the following provisions, you may contact

Paramount Insurance Company at the Member Services Department, P.O. Box 928, Toledo, Ohio 43697-0928, Attention: Member Services, or by telephone at, 1-800-462-3589 or email: Paramount.memberservices@promedica.org. TTY users may call 1-888-740-5670.

Internal Claims and Appeals Procedures: When a health insurance plan denies a claim for a treatment or service (a claim for plan benefits, you have already received (*post-service claim* denial) or denies your request to authorize treatment or service (*pre-service claim* denial), you, or someone you have authorized to speak on your behalf (an *authorized representative*), can request an appeal of the plan's decision. Paramount must provide for one level of internal appeal before issuing a final determination. If the plan rescinds your coverage or denies your application for coverage, you may also appeal the plan's decision. When the plan receives your appeal, it is required to review its own decision. When the plan makes a claim decision, it is required to notify you (provide notice of an *Adverse Benefit Determination*):

- The reasons for the plan's decision;
- Your right to appeal the claim decision
- Your right to request an external review; and
- The availability of a Consumer Assistance Program at The Ohio Department of Insurance.

If you do not speak English, you may be entitled to receive appeals' information in your native language upon request.

When you request an internal appeal, the plan must give you its decision as soon as possible, but no later than:

- 72 hours after receiving your request when you are appealing the denial of a claim for urgent care. (If your appeal concerns urgent care, you may be able to have the internal appeal and external reviews take place at the same time.)
- 30 days after receipt of the request for appeals of denials of non-urgent care you have not yet received.
- 30 days after receipt of the request for appeals of denials of services you have already received (post-service denials).
- No extensions of the maximum time limits are permitted unless you consent.

Continuing Coverage: The plan cannot terminate your benefits until all of the appeals have been exhausted. **However, if the plan's decision is ultimately upheld, you may be responsible for paying any outstanding claims or reimbursing the plan for claims' payments it made during the time of the appeals.**

Cost and Minimums for Appeals: There is no cost to you to file an appeal and there is no minimum amount required to be in dispute.

Defined terms: Any terms in this section appearing in *italics* are defined in the **Definitions** section of this Member Handbook.

Emergency medical services: If the plan denies a *pre-service claim* for an emergency medical service, your appeal will be handled as an urgent appeal. The plan will advise you at the time it denies the claim or authorization that you can file an expedited internal appeal. If you have filed for an expedited internal appeal, you may also file for an expedited external review (see “Simultaneous urgent claim, expedited internal review and external review”).

Your rights to file an appeal of denial of health benefits: You or your *authorized representative*, such as your *health care provider*, may file the appeal for you, in writing, either by mail or by facsimile (fax). For an urgent request, you may also file an appeal by telephone:

Paramount Insurance Company, P.O. Box 928, Toledo, Ohio 43697-0928, Attn: Member Services Department Appeals, by telephone at 1-800-462-3589 or email: PHCMbrSvcAppeals@promedica.org.

Please include in your written appeal or be prepared to tell us the following:

- Name, address and telephone number of the insured person;
- The insured’s health plan identification number;
- Name of *health care provider*, address and telephone number;
- Date the health care benefit was provided (if a *post-claim* denial appeal)
- Name, address and telephone number of an *authorized representative* (if appeal is filed by a person other than the insured); and
- A copy of the notice of *Adverse Benefit Determination*.

Rescission of coverage: If the plan rescinds your coverage, you may file an appeal according to the following procedures. The plan cannot terminate your benefits until all of the appeals have been exhausted. Since a *rescission* means that no coverage ever existed, if the plan’s decision to rescind is upheld, you will be responsible for payment of all claims for your health care services.

Time Limits for filing an internal claim or appeal: You must file the internal appeal within 180 days of the receipt of the notice of claim denial (an *Adverse Benefit Determination*). Failure to file within this time limit may result in the company’s declining to consider the appeal.

Time Limits for an External Appeal: You have 180 days to file for an *external review* after receipt of the plan’s *final Adverse Benefit Determination*.

Your Rights to a Full and fair review. The plan must allow you to review the claim file and to present evidence and testimony as part of the internal claims and appeals process.

- The plan must provide you, free of charge on request, with any new or additional evidence considered, relied upon, or generated by the plan (or at the direction of the plan) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal *Adverse Benefit Determination* is required to give you a reasonable opportunity to respond prior to that date; and
- Before the plan can issue a final internal *Adverse Benefit Determination* based on a new or additional rationale, you must be provided, free of charge, with the rationale; the rationale must be provided as soon

as possible and sufficiently in advance of the date on which the notice of final internal *Adverse Benefit Determination* is required to be provided to give you a reasonable opportunity to respond prior to that date.

- The Adverse Benefit Determination must be written in a manner understood by you, or if applicable, your *authorized representative* and must include all of the following:

The titles and qualifying credentials of the person or persons participating in the first level review process (the reviewers);

Information sufficient to identify the claim involved, including the date of service, the *health care provider*;

A statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning.

- As a general matter, the plan may deny claims at any point in the administrative process on the basis that it does not have sufficient information; such a decision, however, will allow you to advance to the next stage of the claims process.

Other Resources to help you

Department of Insurance: For questions about your rights or for assistance you may also contact the Consumer Services Division at The Ohio Department of Insurance (800) 686-1526.

Department of Labor: If this is a health plan provided through your employer or under a retiree health benefit plan through your former employer, your rights are also protected by ERISA. For information about your rights under ERISA, you may contact the **Employee Benefits Security Administration (EBSA)**, an agency of the Department of Labor, at (866) 444-3272.

Language services are available from the health benefit plan and from The Ohio Department of Insurance.

Your rights to appeal and the instructions for filing an appeal are described in the provisions following this Overview.

INTERNAL CLAIMS AND APPEALS

An appeal will be between the health care provider requesting the service in question and a clinical peer. If the appeal does not resolve the disagreement, either You or Your Authorized Representative may request an external review.

Non-urgent, Pre-service claim denial

For a non-electronic non-urgent *pre-service claim*, the plan will notify you of its decision as soon as possible but no later than 30 days after receipt of the request.

Urgent Pre-service Care claim denial

If your claim for benefits is urgent, you or your authorized representative, or your health care provider (physician) may contact us with the request, orally or in writing.

If the request received is for non-electronic *pre-service urgent care*, we will notify you of our decision as soon as possible, but no later than 72 hours after we receive your request.

Electronic Pre-service Non-urgent and Urgent Care claim denial

For electronic pre-service urgent care services, an appeal will be determined and we will notify you of our decision within forty-eight hours after receipt. Electronic pre-service appeals for non-urgent care services will be determined and we will notify you of our decision within ten calendar days of receipt.

Urgent appeal request and expedited internal review:

In the case of a *claim involving urgent care*, you or your *authorized representative* may request an expedited internal review. A request for expedited internal review may be submitted orally or in writing by you or your *authorized representative*; and all necessary information, including the plan's benefit determination on review, shall be transmitted between the plan and the claimant by telephone, facsimile, or other expeditious method.

Additionally, you, or your *authorized representative*, may simultaneously request an expedited external review if both the following apply:

(1) You have filed a request for an expedited internal review; and

(2) After a *final Adverse Benefit Determination*, if either of the following applies:

(a) Your treating physician certifies that the *Adverse Benefit Determination* involves a medical condition that could seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, if treated after the time frame of a standard external review;

(b) The *final Adverse Benefit Determination* concerns an admission, availability of care, continued stay, or health care service for which you received Emergency Services, but has not yet been discharged from a facility.

Post-service appeal of a claim denial (retrospective)

If your appeal is for a *post-service claim denial*, we will notify you of our decision as soon as possible but no later than 30 days after we have received your appeal.

EXTERNAL REVIEW

Right to External Review

Under certain circumstances, you have a right to request an external review of our adverse benefit decision by an *independent review organization* or by the superintendent of insurance, or both.

If you have filed internal claims and appeals according with the procedures of this plan, and the plan has denied or refused to change its decision, or if the plan has failed, because of its actions or its failure to act, to provide you with a *final determination* of your appeal within the time permitted, or if the plan waives, in writing, the requirement to exhaust the internal claims and appeals procedures, you may make a request for an external review of an *Adverse Benefit Determination*.

All requests for an external review must be made within 180 days of the date of the notice of the plan's *final Adverse Benefit Determination*. Standard requests for an external review must be provided in writing; requests for expedited external reviews, including *experimental/investigational*, may be submitted orally or electronically.

You may file the request for an external review by contacting the plan:

Paramount Insurance Company, P.O. Box 928, Toledo, Ohio 43697-0928, Attn: Member Services Department Appeals, by telephone at 1-800-462-3589 or email: PHCMbrSvcAppeals@promedica.org. TTY users may call 1-888-740-5670.

Non-urgent request for an external review

Unless the request is for an expedited external review, within five days the plan will provide or transmit all necessary documents and information considered in making the *Adverse Benefit Determination* in question to the assigned *independent review organization* (IRO). The plan will provide you with a notice that it has initiated the external review that includes:

(a) The name and contact information for the assigned *independent review organization* or the superintendent of insurance, as applicable, for the purpose of submitting additional information; and

(b) Except for when an expedited request is made, a statement that you may, within 10 business days after the date of receipt of the notice, submit, in writing, additional information for either the *independent review organization* or the superintendent of insurance to consider when conducting the external review.

If your request is not complete, the plan will notify you in writing and include information about what is needed to make the request complete.

If the plan denies your request for an external review on the basis that the adverse benefit determination is not eligible for an external review, the plan will notify you, in writing, the reasons for the denial and that you have a right to appeal the decision to the superintendent of insurance.

If an Adverse Benefit Determination in which Emergency Services has been determined to be not medically necessary after an external review, the health plan will afford the covered person the opportunity for an external review by the superintendent of insurance.

If the plan denies your request for an external review because you have failed to exhaust the Internal Claims and Appeals Procedure, you may request a written explanation, which the plan will provide to you within 10 days of receipt of your request, explaining the specific reasons for its assertion that you were not eligible for an external review because you did not comply with the required procedures.

Request for external review to superintendent of insurance: If the plan denies your request for an external review, you may file a request for the superintendent of insurance to review the plan's decision by contacting Consumer Services Division at 800-686-1526 between 8:00 a.m. and 5:00 p.m., eastern standard time or by sending a written request addressed to: Consumer Services, The Ohio Department of Insurance, 50 West Town St., Suite 300, Columbus, Ohio 43215. Information about external reviews is also available on the Department's website: www.insurance.ohio.gov.

If superintendent upholds the plan's decision: If you file a request for an external review with the superintendent, and if the superintendent upholds the plan's decision to deny the external review because you did not follow the plan's internal claims and appeals procedures, you must resubmit your appeal according to the plan's internal claims and appeals procedures within 10 days of the date of your receipt of the superintendent's decision. The clock will begin running on all of the required time periods described in the internal claims and appeals procedures when you receive this notice from the superintendent.

If the plan's failure to comply with its obligations under the internal claims and appeals procedures was considered (i) *De Minimis*, (ii) not likely to cause prejudice or harm to you (claimant), (iii) because we had a good reason or our failure was caused by matters beyond our control (iv) in the context of an ongoing good faith exchange of information between the plan and you (claimant) or your *authorized representative* and (v) not part of a pattern or practice of our not following the internal claims and appeals procedures, then

you will not be deemed to have exhausted the internal claims and appeals requirements. You may request an explanation of the basis for the plan's asserting that its actions meet this standard.

Expedited external review : You may have an expedited external review if your treating physician certifies that the *Adverse Benefit Determination* involves a medical condition that could seriously jeopardize the life or health of you (claimant), or would jeopardize your ability to regain maximum function if treated after the time frame for a standard external review; or the *final Adverse Benefit Determination* concerns an admission, availability of care, continued stay, or health care service for which you received Emergency Services, but have not yet been discharged from a facility.

The request may be made orally or electronically by you or your *health care provider*.

Expedited external review for experimental and/or investigational treatment: You may request an external review of an *Adverse Benefit Determination* based on the conclusion that a requested health care service is *experimental* or investigational, except when the requested health care service is explicitly listed as an excluded benefit under the terms of the health benefit plan.

To be eligible for an external review under this provision, your treating physician shall certify that one of the following situations is applicable:

- (1) Standard health care services have not been effective in improving your condition;
- (2) Standard health care services are not medically appropriate for you; or
- (3) There is no available standard health care service covered by the health plan issuer that is more beneficial than requested health care service.

The request for an expedited external review under this provision may be requested orally or electronically. For Expedited/Urgent requests, your *health care provider* can orally make the request on your behalf.

If the request for an expedited external review is complete and eligible, the plan will immediately provide or transmit all necessary documents and information considered in making the *Adverse Benefit Determination* in question to the assigned *independent review organization* (IRO) by telephone, facsimile or other available expeditious method.

If the request is not complete, we will notify you immediately, including what is needed to make the request complete.

Independent Review Organization: An external review is conducted by an *independent review organization* (IRO) selected on a random basis as determined in accordance with Ohio law. The IRO will provide you with a written notice of its decision to either uphold or reverse the plan's *Adverse Benefit Determination* within 30 days from the date of Paramount's receipt of a request for standard external review (not urgent).

If an expedited external review (urgent) was requested, the IRO will provide a determination as soon as possible or within 72 hours from Paramount's receipt of the expedited review request. The IRO's decision is binding on the company. If the IRO reverses the health benefit plan's decision, the plan will immediately provide coverage for the health care service or services in question.

If the superintendent or IRO requires additional information from you or your health care provider, the plan will tell you what is needed to make the request complete.

If the plan reverses its decision: If the plan decides to reverse its *Adverse Benefit Determination* before or during the external review, the plan will notify you, the IRO, and the superintendent of insurance within one business day of the decision.

After receipt of health care services: No expedited review is available for *Adverse Benefit Determinations* made after receipt of the health care service or services in question.

Emergency medical services: If plan denies coverage for an emergency medical service, the plan will also advise at the time of denial that you request an expedited internal and external review of the plan's decision.

Review by the superintendent of insurance: If the plan has made an *Adverse Benefit Determination* based on a contractual issue (e.g., whether a service or services are covered under your contract of insurance), you may request an external review by the superintendent of insurance.

If the IRO and Superintendent uphold the plan's decision, you may have a right to file a lawsuit in any court having jurisdiction.

XVIII. COORDINATION OF BENEFITS

The Coordination of Benefits (COB) provision applies when a person has health care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary plan. The Primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The plan that pays after the Primary plan is the Secondary plan. The Secondary plan may reduce the benefits it pays so that payments from all Plans does not exceed 100% of the total Allowable expense.

Definitions

A. A "Plan" is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for Members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

(1) Plan includes: group and non-group insurance contracts, health insuring corporation (HIC) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

(2) Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; supplemental coverage as described in Revised § sections 3923.37 and 1751.56; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under (1) or (2) is a separate Plan. If a Plan has two parts and COB rules apply to only one of the two, each of the parts are treated as a separate Plan.

B. "This plan" means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of the other plans. Any other part of the contract providing health care benefits is separate from This plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only similar benefits, and may apply another COB provision to coordinate other benefits.

C. The order of benefit determination rules determine whether This plan is a Primary plan or Secondary plan when the person has health care coverage under more than one Plan.

When This plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expenses.

D. "Allowable expense" is a health care expense, including deductibles, Coinsurance and copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable expense. In addition, any expense that a provider by law

or in accordance with a contractual agreement is prohibited from charging a covered person is not an Allowable expense.

The following are examples of expenses that are not Allowable expenses:

- (1) The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable Expense, unless one of the plans provides coverage for private hospital room expenses.
 - (2) If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.
 - (3) If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.
 - (4) If a person is covered by one Plan that calculates its benefits or services on the basis of usual or customary fees or relative value schedule reimbursement methodology or similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fee or payment amount is different than the Primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable expense used by the Secondary plan to determine its benefits.
 - (5) The amount of any benefit reduction by the Primary plan because a covered person has failed to comply with the plan provisions is not an Allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.
- E. Closed panel plan is a Plan that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel Member.
- F. Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the Child resides more than one half of the Calendar Year excluding temporary visitation.

Order of Benefit Determination Rules

When a person is covered by two or more Plans, the rules for determining the order of benefits payments are as follows:

- A. The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.
- B. (1) Except as provided in Paragraph (2), a Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying plan is primary.
- (2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide out-of-network benefits.

- C. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.
- D. Each Plan determines its order of benefits using the first of the following rules that apply:
- (1) Non-Dependent or Dependent. The Plan that covers the person other than as a Dependent, for example as an employee, Member, policyholder, Subscriber or retiree is the Primary plan and Plan that covers the person as a Dependent is the Secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person other than as a Dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, Member, policyholder, Subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.
 - (2) Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a Dependent Child is covered by more than one Plan the order of benefits is determined as follows:
 - (a) For a Dependent Child whose parents are married or are living together, whether or not they have ever been married:
 - The Plan of the parent whose birthday falls earlier in the Calendar Year is the Primary plan; or
 - If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.
 - However, if one spouse's plan has some other coordination rule (for example, a "gender rule" which says the father's plan is always primary), This plan will follow the rules of that plan.
 - (b) For a Dependent Child whose parents are divorced or separated or not living together, whether or not they have ever been married:
 - (i) If a court decree states that one of the parents is responsible for the Dependent Child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the decree;
 - (ii) If a court decree states that both parents are responsible for the Dependent Child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;
 - (iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent Child, the provisions of Subparagraph (a) above shall determine the order of benefits;
 - (iv) If there is no court decree allocating the responsibility for the Dependent Child's health care expenses or health care coverage, the order of benefits for the Child are as follows:
 - The Plan covering the Custodial parent;
 - The Plan covering the spouse of the Custodial parent;
 - The Plan covering the non-custodial parent; and then
 - The Plan covering the spouse of the non-custodial parent.

- (c) For a Dependent Child covered under more than one Plan of individuals who are not the parents of the Child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the Child.
- (3) Active Employee or Retired or Laid-off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering the same person as retired or laid off employee is the Secondary plan. The same would hold true if a person is a Dependent of an active employee and that same person is a Dependent of a retired or laid off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.
- (4) COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, The Plan covering the person as an employee, Member, Subscriber or retiree or covering the person as a Dependent of an employee, Member, Subscriber, or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.
- (5) Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, Member, policyholder, Subscriber or retiree longer is the Primary plan and the Plan that covered the person the shorter period of time is the Secondary plan.
- (6) If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This plan will not pay more than it would have paid had it been the Primary plan.

Effect on the Benefits of this Plan

- A. When This plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, The Secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary plan. The Secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim. In addition, the Secondary plan shall credit to its plan Deductible any amounts it would have credited to its Deductible in the absence of other health care coverage.
- B. If a covered person is enrolled in two or more Closed panel plans, and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed panel plan, COB shall not apply between that Plan and the other Closed panel plans.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This plan and other Plans. Paramount may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining

benefits payable under This plan and other Plans covering the person claiming benefits. Paramount need not tell, or get consent of any person to do this. Each person claiming benefits under This plan must give Paramount any facts it needs to apply those rules and determine benefits payable.

Facility of Payment

A payment made under another Plan may include an amount that should have been paid under This plan. If it does, Paramount may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid under This plan. Paramount will not have to pay that amount again. The term “payment made” includes providing benefits in the form of services, in which case “payments made” means the reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by Paramount is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; any other person or organization that may be responsible for the benefits or services provided for the covered person. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

Coordination Disputes

If you believe that Paramount has not paid a claim properly, you should first attempt to resolve the problem by contacting Paramount at (419) 887-2525 or refer to Section XVII, What to do When You Have Questions, Suggestions, Complaints and Appeals. If you are still not satisfied, you may call the Ohio Department of Insurance for instructions on filing a consumer complaint. Call 1-800-686-1526, or visit the Department’s website at <http://insurance.ohio.gov>

XIX. WORKERS’ COMPENSATION

If you or your Dependents receive health care services due to an injury which may be covered by Workers’ Compensation, you must notify Paramount Member Services as soon as possible. If you filed a claim for Workers’ Compensation, the Plan will withhold payment to your providers until the case is settled. If the Plan has made any payment to your provider and services are covered by Workers’ Compensation, you are expected to reimburse the Plan for the amounts paid.

XX. SUBROGATION AND REIMBURSEMENT

When Someone Else Is Liable (Subrogation and Reimbursement)

Subject to ORC 2323.44, to the extent applicable:

Subrogation and Reimbursement. The Plan’s subrogation and reimbursement rights are equal to the value of medical benefits paid for Covered Services provided to the covered person.

Subrogation. Where a covered person has benefits paid by Plan as a result of sickness or injury caused by a third party and/or the covered person, the rights of the covered person to claim or receive compensation, damages, first party benefits, medical payments coverage, any excess, umbrella, uninsured and/or underinsured motorist insurance or any other payment from any person, organization, insurer or any other source, including the covered person’s own insurer and/or the party causing such sickness or injury, are assigned and transferred to Plan to the extent of the value of medical benefits paid for Covered Services provided to the covered person.

Reimbursement. Where a covered person has benefits paid by the Plan for the treatment of sickness or

injury caused by a third party and/or the covered person, these are conditional payments that must be reimbursed by the covered person to the extent that the covered person receives, as a result of the sickness or injury, compensation, damages, first party benefits, medical payments coverage, any excess, umbrella, uninsured and/or underinsured motorist insurance or any other payment from any person, organization, insurer or any other source, including the covered person's own insurer and/or the party causing such sickness or injury.

Equitable Lien. The Plan's subrogation and reimbursement rights are a first party lien against any recovery and must be paid before any other claims, including claims by the covered person for damages (with the exception of claims by the covered person pursuant to the property damage provisions of any insurance policy). This lien is not offset or reduced in any way by the covered person's attorney fees or costs incurred in obtaining the recovery. The "common fund doctrine", "made whole" rule, or similar common law doctrines do not reduce or affect the Plan's subrogation and reimbursement rights. This means the covered person must reimburse the Plan, in an amount not to exceed the total recovery, even when the covered person's settlement or judgment is for less than the covered person's total damages and must be paid without any reductions for attorney fees. If less than the full value of the tort action is recovered for comparative negligence or by reason of the collectability of the full value of the claim for injury, death, or loss to person resulting from limited liability insurance or any other cause, the subrogee's or other person's or entity's claim shall be diminished in the same proportion as the injured party's interest is diminished. Covered person agrees that Plan has the right to obtain injunctive relief prohibiting the covered person from accepting or receiving any settlement or other recovery relating to the expenses paid by the Plan until the Plan's right of subrogation and reimbursement are fully satisfied and covered person consents to such injunctive relief.

Plan Assets. If a covered person receives compensation, damages, first party benefits, medical payments coverage, any excess, umbrella, uninsured and/or underinsured motorist insurance or any other payment, as a result of the sickness or injury, from any person, organization, insurer or any other source, including the covered person's own insurer and/or the party causing such sickness or injury, such amounts shall be considered a Plan asset to the extent of the value of medical benefits paid for Covered Services provided to the covered person. The covered person is, therefore, a fiduciary of the Plan with respect to such amounts.

Cooperation by Covered Persons. By enrolling in this Plan, You and Your covered dependents agree to execute and deliver all assignments or other documents as may be required and do whatever is necessary to effectuate and protect fully the rights of the Plan or its nominee. You may not do anything which might limit, waive or release the Plan's subrogation or reimbursement rights. The covered person shall give the Plan written notice of any claim against a third-party as soon as the covered person becomes aware that the covered person may recover damages from a third-party. The covered person will be deemed to be aware that the covered person may recover damages from a third-party upon the date the covered person retains an attorney or the date written notice of the claim is presented to the third-party or the third-party's insurer by covered person, covered person's insurer or covered person's attorney, whichever is earlier. The covered person will not compromise or settle a claim without prior written consent of the Plan. If covered person fails to provide the Plan with written notice of a claim as required or if covered person compromises or settles a claim without prior written consent, the Plan will deem the covered person to have committed fraud or misrepresentation in a claim for benefits and will terminate the covered person's participation in the Plan.

XXI. GENERAL PROVISIONS

A. Governing Law

This Evidence of Coverage is made and shall be interpreted under the laws of the State of Ohio.

B. Assignment

The benefits provided under this Evidence of Coverage are for the personal benefit of the Subscriber and cannot be transferred or assigned. Any attempt to assign this contract will automatically terminate all rights.

C. Entire Contract

This Evidence of Coverage, applicable riders, and the completed application form constitute the entire contract between the parties. As of the Effective Date, all other agreements between the parties are superseded.

D. Waiver by Agents

No agent or other person, except an executive officer of Paramount, has authority to waive any conditions or restrictions of this document or the Summary of Benefits. No change in this document shall be valid unless evidenced by an endorsement or amendment signed by an authorized executive officer of Paramount.

E. Amendments

Paramount may change the benefits, rates, or other terms of this Evidence of Coverage. Paramount will give you at least thirty (30) days advance written notice of any change. We will mail the notice to the address as shown on our records.

F. If Paramount Ends Operations/Company Insolvency

1) Company is not a member of any guaranty fund:

In the event Paramount would end operations, Members' benefits would be covered until the expiration of this Evidence of Coverage. All prepayments must be made in accordance with the terms of the agreement. Since Paramount is not part of the guaranty fund, Members are protected only to the extent of the hold harmless provision required by 1751.13. The hold harmless provision states with the exception of a Deductible, Copayments, Coinsurance and non-covered services, Participating Providers may not bill a Member for Covered Services. If you are receiving a course of treatment when Paramount ends operations, Covered Services will continue to be provided by Participating Providers as needed to complete any medically necessary follow-up care for that course of treatment. If a Member is receiving Inpatient care at a hospital, coverage will be continued for up to thirty (30) days after the end of operations. If you need additional information, call the Member Service Department at (419) 887-2525 or 1-800-462-3589.

2) Enrollee financial obligations:

If Paramount ends operations, a Member may have to pay for health care services rendered by a non-Participating Provider whether or not Paramount authorized the service.

G. Limitation of Actions

No legal action may be taken against Paramount prior to exhausting all available rights of appeal under the grievance procedures or later than two (2) years after the occurrence upon which the

legal action is based.

H. Notice of Claim

Proof of claim for services must be filed within 120 days of receiving the service in order to receive reimbursement. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than 365 days after receiving the service.

I. Relationship Between Paramount And Participating Physicians/Provider

Physicians participating with Paramount are acting as independent agents and are not employees of the Health Plan. The final responsibility for all decisions with respect to medical care rests with the physician. Paramount is not responsible for providing medical services but rather for payment of those services. No claim may be made against Paramount for the actions of any provider.

J. New Technology Assessment

Paramount investigates all requests for coverage of new technology using the HAYES Medical Technology Directory as a guide. If further information is needed, Paramount utilizes additional sources including Medicare and Medicaid policy, Food and Drug Administration (FDA) releases and current medical literature.

K. Confidentiality

Medical records, which Paramount receives from providers, are confidential. Paramount will use your individually identifiable personal health information only in performance of treatment, payment, or health care operations in accordance with Paramount's Notice of Privacy Practices. See Paramount's Notice of Privacy Practices for further details.

XXII. DEFINITIONS

Active Course of Treatment means 1) an ongoing course of treatment for a life-threatening condition, defined as a disease or condition for which likelihood of death is probable unless the course of the disease or condition is interrupted; 2) an ongoing course of treatment for a serious acute condition, defined as a disease or condition requiring complex ongoing care which the Member is currently receiving, such as chemotherapy, radiation therapy, or post-operative visits; 3) the second or third trimester of pregnancy through the postpartum period; or 4) an ongoing course of treatment for a health condition for which a treating physician or health care provider attests that discontinuing care by that physician or health care provider would worsen the condition or interfere with anticipated outcomes. An ongoing course of treatment includes mental health and substance abuse disorder treatments.

Adverse Benefit Determination means a decision by a health plan issuer:

(1) To deny, reduce, or terminate a requested health care service or payment in whole or in part, including all of the following:

- (a) A determination that the health care service does not meet the health plan issuer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, including experimental or investigational treatments;
- (b) A determination of an individual's eligibility for individual health insurance coverage, including coverage offered to individuals through a non-employer group, to participate in a plan or health

- insurance coverage;
- (c) A determination that a health care service is not a covered benefit;
- (d) The imposition of an exclusion, including exclusions for pre-existing conditions, source of injury, network, or any other limitation on benefits that would otherwise be covered.

(2) Not to issue individual health insurance coverage to an applicant, including coverage offered to individuals through a non-employer group;

(3) To rescind coverage on a health benefit plan See definition of rescission in this section.

Authorized representative means an individual who represents *you* in an internal appeal or external review process of an Adverse Benefit Determination who is any of the following:

- (1) A person to whom a covered individual has given express, written consent to represent that individual in an internal appeals process or external review process of an Adverse Benefit Determination;
- (2) A person authorized by law to provide substituted consent for a covered individual;
- (3) A family member but only when you are unable to provide consent.

Biologically Based Mental Illness as defined by ORC 1751.01, (D) means schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder and panic disorders as these terms are defined in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* published by the American Psychiatric Association.

Calendar Year means January 1 through December 31.

Child means the natural children, legally adopted children, stepchildren, and children under legal custody (i.e., official court appointed guardianship or custody) of Subscriber or Subscriber's spouse.

Claim involving urgent care means any claim for medical care or treatment with respect to the application of the time periods for making non-urgent care determinations

- Could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or,
- In the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment is the subject of the claim.

The determination whether a claim is a "claim involving urgent care" will be determined by the plan; or, by a physician with knowledge of the claimant's medical condition.

Coinsurance is your share of the cost of some Covered Services (a percentage of the amount allowed). For, example, you may be responsible for 30% of the charge allowed for Covered Services.

Copayment is your share of the cost of some Covered Services. Copay is a specific dollar amount such as \$25.00. Copays are due and payable at the time services are provided.

Covered Services means an authorized service shown in this Summary of Benefits and rendered by a provider for which Paramount will provide benefits. A Covered Service may be subject to a copay.

Custodial Care is treatment or services that could be learned and performed by a person not medically

skilled, regardless of where they are to be provided. Custodial Care includes, but is not limited to:

1. personal care such as help in walking, getting in and out of bed, bathing, eating, tube or gastrostomy feeding, exercising, dressing, enema and using the toilet.
2. homemaking, such as preparing meals or special diets;
3. moving the patient;
4. suctioning;
5. catheter care;
6. acting as a companion or sitter;
7. supervising medication which is usually self-administered, and
8. preparation/supervision over medical supplies and/or medical equipment not requiring constant attention of trained medical personnel.

Deductible is the amount you must pay for Covered Services within each Calendar Year before benefits will be paid by Paramount. The single Deductible is the amount each Member must pay; the family Deductible is the total amount any two or more family members must pay. The deductible of one family member will not exceed that of an individual annual deductible maximum amount. Preventive Health Services are not subject to the Deductible.

De Minimis means something not important; something so minor that it can be ignored.

Dependent means any family member who meets all the applicable eligibility requirements, who has enrolled, and for whom the payment required by this agreement actually has been received by Paramount.

Effective Date is the date your coverage begins under this Evidence of Coverage.

Emergency Medical Condition means a medical condition that manifests itself by such acute symptoms of sufficient severity, including severe pain that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:

1. Placing the health of the individual or, with respect to a pregnant woman, the health of the woman or the unborn Child, in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

An Emergency Medical Condition also includes a behavioral health emergency where the Member is acutely suicidal or homicidal.

Emergency Services means the following:

1. A medical screening examination, as required by federal law, that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department, to evaluate an Emergency Medical Condition;
2. Such further medical examination and treatment that are required by federal law to stabilize an Emergency Medical Condition and are within the capabilities of the staff and facilities available at the hospital, including any trauma and the burn center of the hospital.

Essential Health Benefits is defined under federal law (PPACA) as including benefits in at least the following categories: ambulatory patient services; Emergency Services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive

and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Exigent Circumstances (Expedited Exception Request) exist when a member is suffering from a health condition that may seriously jeopardize the enrollee's life, health, or ability to regain maximum function or when a member is undergoing a current course of treatment using a non-formulary drug.

Experimental Any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which we determine to be Experimental/Investigative is not covered under the Health Plan. We will deem any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental/Investigative using evidence-based criteria as defined in the Non-Covered Services/Exclusions section of this handbook.

Final Adverse Benefit Determination means an Adverse Benefit Determination that is upheld at the completion of a health plan issuer's internal appeals process.

Health Care Professional means a physician, psychologist, nurse practitioner, physician assistant or other health care practitioner licensed, accredited, or certified to perform health care services consistent with state law.

Health Plan means Paramount.

Health Plan Physician means any physician duly licensed to practice in the State of Ohio who is under contract with Paramount to provide Covered Services to Members. Health Plan Physicians are comprised of PCPs and Participating Specialists.

Health Savings Account (HSA) is a tax-exempt trust or custodial account you set up with a qualified HSA trustee to pay or reimburse certain medical expenses you incur. You must be an eligible individual to qualify for an HSA. To be an eligible individual and qualify for an HSA, you must meet the following requirements.

- You must be covered under a high deductible health plan (HDHP).
- You have no other health coverage except as permitted and explained in IRS Publication 969.
- You are not enrolled in Medicare.
- You cannot be claimed as a dependent on someone else's tax return.

High Deductible Health Plan (HDHP). An HDHP has:

- A higher annual deductible than typical health plans, and
- A maximum limit on the sum of the annual deductible and out-of-pocket medical expenses that you must pay for covered expenses. Out-of-pocket expenses include copayments and other amounts, but do not include premiums.

A HDHP provides Preventive Health Services not subject to a deductible.

Home Health Agency is a facility or program that is licensed, certified or otherwise authorized pursuant to the laws of the State of Ohio as a Home Health Agency. It is under contract with Paramount to provide the home health care covered by this Summary of Benefits.

Independent Review Organization (IRO) means an entity that is accredited by a nationally recognized private accrediting organization to conduct independent external reviews of Adverse Benefit Determinations and by the superintendent of insurance in accordance with Ohio law.

Life-Threatening Disease or Condition means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted

Maximum Allowable Amount is the maximum amount the Health Plan will allow for Covered Services you receive.

Medical Necessity/Medically Necessary means the service you receive must be:

1. Needed to prevent, diagnose and/or treat a specific condition.
2. Specifically related to the condition being treated or evaluated.
3. Provided in the most medically appropriate setting; that is, an outpatient setting must be used, rather than a hospital or inpatient facility, unless the services cannot be provided safely in an outpatient setting.

Member means any Subscriber or Dependent as defined here.

Member Identification (I.D.) Card is a card that Paramount will issue to each covered Member. The I.D. card indicated the Member's PCP and certain copays.

Minimum Essential Coverage (MEC) is any health coverage that meets certain benefit and cost-sharing standards and satisfies the requirement that people maintain health coverage or pay a penalty. Most insurance, such as coverage provided by employers, Medicare, and most Medicaid, is MEC.

Non-Biologically Based Mental Illness means mental illnesses that are not Biologically Based Mental Illnesses as defined in this Member Handbook.

Out-of-Pocket Maximum is the maximum amount of Copayments and Coinsurance including the Deductible you pay every Calendar Year. Once the Out-of-Pocket Maximum is met, there will be no additional Copayments and Coinsurance on Essential Health Benefits during the remainder of the Calendar Year. The Out-of-Pocket Maximum is stated in your Summary of Benefits. The single Out-of-Pocket Maximum is the amount each Member must pay, and the family Out-of-Pocket Maximum is the total amount any two or more covered family members must pay. The Out-of-Pocket Maximum of one family member will not exceed that of an individual annual Out-of-Pocket Maximum amount.

The Paramount Service Area includes Defiance, Erie, Fulton, Henry, Huron, Lucas, Ottawa, Sandusky, Seneca, Williams, Wood and Wyandot counties in Ohio.

Participating Hospital means any hospital with which Paramount has a contract or established arrangements to furnish Covered Services to Members.

Participating Provider means a Health Plan physician, Participating Hospital, or other licensed health professional or licensed facility who or which, at the time care is rendered to a Member, has a contract with Paramount to furnish Covered Services to Members.

Participating Specialist means a physician who provides Covered Services to Members within the range of his or her medical specialty and has chosen to be designated as a Participating Specialist by Paramount.

Post-service claim means any claim for a benefit under a group health plan that is not a "pre-service claim."

Pre-service claim means any claim for a benefit under a group health plan, with respect to which the terms of the plan condition receipt of the benefit, in completely or in part, on approval of the benefit in advance of obtaining medical care.

Preventive Health Services Benefits are those Covered Services that are being provided: 1) to a

Member who has developed risk factors (including age and gender) for a disease for which the Member has not yet developed symptoms, and 2) as an immunization to prevent specific diseases. However, any service or benefit intended to treat an **existing** illness, injury or condition does not qualify as Preventive Health Services.

Primary Care Provider (PCP) means a Participating Provider who is designated by Health Plan as a PCP. PCPs are those specializing in family practice, internal medicine, or pediatrics.

Prior Authorization includes prospective or utilization review procedures conducted prior to providing health care service, device, or drug. Prior Authorization is required for certain procedures or services. It is the responsibility of the Participating Provider to obtain Prior Authorization from Paramount in advance of these procedures or services. It is the Member's responsibility to make sure procedures and services are provided by a Participating Provider or that an out-of-plan Prior Authorization is obtained. See **Prior Authorizations** in this handbook for more information.

ProMedica OnDemand Visit is a live video consultation with a board-certified Provider scheduled by you or your Dependents via the webpage or downloadable mobile device application located at <https://www.promedica.org/Pages/medical-services/ondemand/default.aspx>.

Rescission means that your coverage may be legally voided all the way back to the day the plan began to provide you with coverage, just as if you never had coverage under the plan. Your coverage can only be rescinded if you (or a person seeking coverage on your behalf), performs an act, practice, or omission that constitutes fraud; or unless you (or a person seeking coverage on your behalf) makes an intentional misrepresentation of material fact, as prohibited by the terms of your Plan.

You will be provided with thirty (30) calendar days' advance notice before your coverage is rescinded. You have the right to request an internal appeal of a Rescission of your coverage. Once the internal appeal process is exhausted, you have the additional right to request an independent external review.

Retrospective Review means a review conducted after services have been provided to a covered person.

Stabilize/Stabilized means the provision of such medical treatment as may be necessary to assure, within reasonable medical probability that no material deterioration of an individual's medical condition is likely to result from or occur during a transfer, if the medical condition could result in any of the following:

1. Placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn Child, in serious jeopardy;
2. Serious impairment to bodily functions;
3. Serious dysfunction of any bodily organ or part. In the case of a woman having contractions, "Stabilize" means such medical treatment as may be necessary to deliver, including the placenta.

Subscriber means a person who meets all applicable eligibility requirements. This person enrolls as the contract holder in accordance with those requirements, and is responsible for payment.

Summary of Benefits is the insert included with this Member Handbook that provides information on the limits and maximums of the Plan and Deductible, Copayment, and Coinsurance amounts that You must pay and explains the specific program the Employer has purchased.

Telemedicine Services means a mode of providing health care services through synchronous or asynchronous information and communication technology by a health care professional, within the professional's scope of practice, who is located at a site other than the site where the recipient is located.

Urgent Medical Condition is an unexpected illness or injury requiring medical attention soon after it appears that is not permanently disabling or life-threatening.

Urgent Care Services means those health care services that are appropriately provided for an unforeseen condition of a kind that usually requires medical attention without delay but that does not pose a threat to the life, limb, or permanent health of the injured or ill person, and may include such health care services provided out of Paramount's approved service area.

Wellness Visit means a yearly appointment with your Primary Care Provider to create or update a personalized prevention plan.

PARAMOUNT INSURANCE COMPANY

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(419) 887-2500

Mailing Address:
P.O. Box 928
Toledo, OH 43697-0928

MEMBER SERVICES

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