PARAMOUNT






Paramount Preferred Choices

Small Group

2 Level PPO Plan

Certificate of Coverage

www.paramountinsurancecompany.com

Paramount is the health insurance option that offers a diverse line of products, a broad provider network, high quality and local, dependable service.

Paramount Preferred Choices
Small Group
2 Level PPO Plan
Certificate of Coverage

Provided by:

PARAMOUNT

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.

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INTRODUCTION

You have enrolled in a comprehensive program of health care benefits ("Plan") with Paramount Insurance Company ("Paramount"), a licensed insurance company.

This booklet, referred to as a Certificate of Coverage, including the accompanying Schedule of Benefits is provided to describe the Plan. This Certificate of Coverage has been issued to You as part of the Contract between Paramount and the Employer electing to sponsor this Plan. To determine Your Paramount benefits for a specific service, You should refer to both this Certificate of Coverage and Your Schedule of Benefits. **You should check both sources for information about the Plan because this Certificate of Coverage presents information about the basic Plan, while the Schedule of Benefits explains the specific program that the Employer has purchased.** Questions regarding Your Plan can also be directed to the Paramount Member Services Departments at; (419) 887-2531 or toll-free at 1-866-452-6128.

The Definition Section of this booklet lists the definitions of key terms used in this Certificate of Coverage and Your Schedule of Benefits. Capitalized terms are defined at the end of the Certificate of Coverage.

Paramount Insurance Company
1901 Indian Wood Circle
Maumee, OH 43537
(419) 887-2500

SECTION ONE: ELIGIBILITY AND EFFECTIVE DATE

1. Eligibility. No one who is eligible to enroll or renew as a Subscriber, Dependent or Dependent with disabilities will be refused enrollment by Paramount based on student status, health status related factor, pre-existing condition, genetic testing or the results of such testing, health care needs or age.

A. Eligible Employee. In order to be eligible under the Plan, an employee must be:

(1) Eligible to participate in the Employer's health benefits program under the written benefits eligibility policies of the Employer.

(2) Considered a bona fide employee employed on a permanent basis and working at least an average of 25 hours per week; or such other minimum average that is approved by Paramount;

(3) Actively working or retired employee, enrolled in and eligible for Medicare Part A and B, if the Employer has elected to offer Medicare-primary coverage in accordance with Medicare Secondary Payer Rules and the Employer maintains active employee benefits ; and

(4) Not enrolled in any other of the Employer's health benefits plans.

(5) Eligibility for Plan attached to a Health Savings Account:
a. An employee must be enrolled in a high deductible health plan,
b. Not claimed as a Dependent on another person's tax return,
c. Not covered by any other health plan (except some limited coverages), and

Not eligible for Medicare.

Former employees of the Employer contracting with Paramount who have elected to continue group coverage in accordance with state or federal law may also be eligible. Contact the Employer's personnel or benefits office for further information about eligibility.

B. Eligible Dependent. If the employee is eligible for family coverage, he or she also may wish to cover one or more of his or her eligible dependents. The following persons are eligible dependents, provided that they meet any additional eligibility requirements of the Employer:

(1) The employee's legal spouse; or

(2) Married or unmarried child, as defined in this section until your child reaches age 26

Child includes: any natural children, legally adopted children, children for whom the employee is the legal guardian, stepchildren who are dependent upon the employee for support, and children for whom the employee is the proposed adoptive parent and is legally obligated for total or partial support during the Waiting Period prior to the adoption becoming final. Foster children are not included. Paramount may require proof of dependency.

Your Plan will provide coverage, or offer you the opportunity to purchase coverage, for your unmarried natural child, stepchild, or adopted child until your child reaches age 28 if your child is (1) a resident of Ohio or a full-time student at an accredited public or private institution of higher education; and (2) not employed by an employer who offers any health benefit plan under which your child is eligible for coverage; and (3) not eligible for Medicaid or Medicare.

If it is medically necessary for a dependent student to take a leave of absence from school due to a serious illness or injury, coverage will continue for 12 months from the last day of attendance in school or until the dependent reaches an age at which coverage would otherwise terminate, whichever period is shorter. Certification in writing from the dependent's attending physician will be required.

C. Extension of Coverage for Older Children. Coverage for a covered dependent child may be continued beyond the maximum dependent eligibility ages, under the following situations:

(1) The child is incapable of self-support due to mental retardation or physical handicap; and primarily dependent upon the employee for support and maintenance.

This disability must have started before the dependent age limit was reached and must be medically certified by a Physician. You must notify Paramount of the disabled dependents desire to continue coverage prior to or within 31 days of reaching the limiting age. You and Your Physician must complete and sign a form that will provide Paramount with information that will be used to evaluate eligibility for such disabled dependent status. You may also be required to periodically provide current proof of retardation or physical handicap and dependence, but not more often than annually after the first two years. To obtain the form required to establish disabled dependent status, please contact a Paramount Member Services representative at (419)-887-2531 or toll-free at 1-866-452-6128.

(2) **A.** In accordance with ORC 3923.24, and upon the written request of the employee, Paramount will cover an unmarried child under the Employer's health plan until the child reaches age 28, if all of the following is true;

i. The child is the natural child, step-child or adopted child of the employee;
ii. The child is a resident of Ohio or a full-time student at an accredited public or private institution of higher learning;
iii. The child is not employed by an employer that offers any health benefit plan under which the child is eligible for coverage; and
iv. The child is not eligible for coverage under Medicaid or Medicare.

B. A child may be enrolled:

i. When the child reaches the dependent limiting age.
ii. When the child experiences a change in circumstances. Change in circumstance includes moving back to Ohio or the child losing employer-sponsored coverage.
iii. During the Annual Open Enrollment Period of the Employer.

Within 30 days of one of the above events, the employee must certify in writing that the child is eligible under the above conditions. The employee must pay the full cost of the child's coverage to the Employer. To obtain the form required to apply for extension of adult child coverage to age 28, the employee should contact their Employer or a Paramount Member Services representative at (419) 887-2531 or toll-free at 1-866-452-6128. Paramount will require certification of eligibility and proof of residency or full- time student status if living out of state and continued eligibility certification annually until the child reaches age 28.

2. Enrollment. Eligible employees and eligible dependents may enroll in the Plan as follows.

A. Initial Election Period. An Election Period will be held prior to the Effective Date of this Plan. An eligible employee and his or her eligible dependents may choose between this Plan and any other health care benefit plans offered by the Employer during this time, and may enroll in the Plan.

B. Subsequent Election Period. An eligible employee and his or her eligible dependents may enroll during any subsequent annual Election Period.

C. Marriage, Birth, Placement for Adoption, or Adoption. An eligible employee and his or her eligible dependents may enroll within 31 calendar days of the employee's marriage or the birth, placement for adoption, or adoption of the employee's dependent child.

A newborn dependent child is automatically covered at birth for 31 calendar days for injury or sickness, including Medically Necessary care and treatment of congenital defects and birth abnormalities. To continue coverage for a newborn child 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 further benefits after the thirty-one days following the birth.

If a covered dependent child gives birth, the newborn grandchild will not be covered unless the employee adopts or assumes legal guardianship of the child.

When placed for adoption, a child is covered only for the period of time the employee is legally obligated to provide partial or full support for the child.

If an employee acquires a child by birth, placement for adoption, or adoption, the employee (if not already enrolled) and his or her spouse and child may enroll. An eligible employee must enroll or already be enrolled in order for the spouse and/or child to enroll. The eligible employee may enroll even if the child does not enroll.

D. Special Enrollment Period. If an eligible employee declines enrollment for themselves or their dependents (including their spouse) because of other health insurance coverage, the employee may in the future be able to enroll themselves or their dependents in this plan, provided that the employee requests enrollment within 31 days after other coverage ends because (1) there is a loss of eligibility for group health plan coverage or health insurance coverage and (2) termination of employer contributions toward group health plan coverage. Examples of reasons for loss of eligibility include: legal separation, divorce, death of an employee, termination or reduction in hours of employment – voluntary or involuntary (with or without electing COBRA), exhaustion of COBRA, "aging out" under other parent's coverage, moving out of an HMO's service area, and meeting or exceeding lifetime limit on all benefits. Loss of eligibility for coverage does not include loss due to the individual's failure to pay premiums or termination of coverage for cause, such as fraud.

Loss of eligibility also includes termination of Medicaid or Children's Health Insurance Program (CHIP) coverage and the eligibility for Employment Assistance under Medicaid or CHIP. To be eligible for this special enrollment the employee must request coverage within 60 days after the date the employee or dependent becomes eligible for premium assistance under Medicaid or CHIP or the date the employee or the dependent's Medicaid or CHIP coverage ends.

In addition, if the employee has a new dependent as a result of marriage, birth, adoption, or placement for adoption, the employee may be able to enroll themselves and their dependents, provided that the employee requests enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

E. Newly Eligible. An eligible employee and his or her eligible dependents may enroll within 31 calendar days of first becoming eligible because the employee is newly hired or newly in the class of employees to which coverage under this Plan is offered (e.g., union vs. non- union employee, employee living in a particular region, part-time employee vs. full-time employee).

F. Legal Guardianship. An eligible dependent may be enrolled within 31 calendar days of the date a covered employee assumes legal guardianship.

G. Court Ordered Coverage. If a covered or eligible employee is required by a court or administrative order to provide health care coverage for his or her child and the child is an eligible dependent, the employee may enroll the child at any time after the order. If the employee is not already enrolled, he or she must enroll with the child.

If a covered employee fails to enroll the child, Paramount will enroll the child upon application of the child's other parent or pursuant to an order.

Covered dependents enrolled under this provision may not be terminated (while the employee remains a covered employee) unless Paramount is provided satisfactory written evidence that the court or administrative order is no longer in effect or the child is or will be enrolled under comparable health care coverage provided by another health insurer, to take effect no later than the date of termination under this Plan.

3. Effective Date. Coverage begins on the date specified below, so long as Paramount receives payment of applicable premiums and a completed enrollment application on behalf of each eligible person to be enrolled in the Plan.

A. New Hire Policy. Coverage for eligible employees and those eligible dependents who enroll simultaneously with the eligible employee during the initial or subsequent yearly Election Period is effective in accordance with the New Hire Policy of the Employer's Contract with Paramount.

B. Marriage, Birth Adoption, or Placement for Adoption. If an eligible employee and/or eligible dependent(s) enrolls because of marriage, birth, adoption, or placement for adoption pursuant to Paragraph 2. C. of this section, coverage is effective as follows:

(1) In the case of marriage, on the date of a legal marriage if a completed enrollment application is received by Paramount within 31 days of the marriage date.

(2) In the case of birth, as of the date of such birth if a completed enrollment application is received by Paramount within 31 days of the birth date; or

(3) In the case of adoption or placement for adoption, the date of adoption or placement for adoption if a completed enrollment application is received by Paramount within 31 days of the date of adoption or placement for adoption.

C. Special Enrollment Period - Loss of Other Coverage. If an eligible employee and/or eligible dependent(s) enrolls because of loss of other coverage pursuant to Paragraph 2.D. of this section, coverage is effective on the day following the effective date of termination of other coverage if a completed enrollment application is received by Paramount within 31 days of the termination of other coverage.

D. Newly Eligible. If an eligible employee and/or eligible dependent(s) enrolls because of newly acquired eligibility pursuant to Paragraph 2.E. of this section, coverage is effective in accordance with the Employer's New Hire Policy. Please contact Your Employer's benefits office for details.

E. Late Enrollment. An eligible employee or dependent who did not request enrollment for coverage during the Initial Election Period, or Special Enrollment Period, or a newly eligible dependent who failed to qualify during the Special Enrollment Period and did not enroll within 31 days of the date during which the individual was first entitled to enroll, is considered a Late Enrollee and may only apply for coverage as a Late Enrollee during the Group's Subsequent Election Period.

4. Terms. Once enrolled as described in this section, an eligible employee is known as a "covered employee" and an eligible dependent is known as a "covered dependent." A "Covered Person" is a defined term meaning a

covered employee or covered dependent. Whenever used in this Certificate of Coverage, "You" or "Your" means a Covered Person.

5. Pre-Existing Conditions. Paramount Insurance Company does not have any restrictions on Pre-Existing conditions. In other words, if you were being treated for a condition before you became a Paramount member, Paramount will provide benefits for Covered Services related to that condition on or after your effective date with Paramount.

6. Termination of Coverage.

A. Employee. Paramount will not terminate coverage for you or your Dependents due to health status, health care needs or the exercise of rights under Paramount's internal review procedures. However, Paramount will not re-enroll anyone terminated for any of the reasons listed in this section.

A covered employee's coverage and that of his or her covered dependents will end (Subject to Section Two, Continuation of Coverage) on the earliest of the following dates:

(1) The last calendar day of the month in which the covered employee terminates employment, unless the Employer's Contract with Paramount provides for a different termination date;

(2) The last calendar day of the month in which the covered employee ceases to be eligible for coverage, unless the Employer's Contract with Paramount provides for a different termination date;

(3) The last calendar day of the month preceding the first day of the next month for which any required contribution for employee coverage has not been made, unless the Employer's Contract with Paramount provides for a different termination date;

(4) The date the Plan is terminated or employee coverage is terminated; or

(5) The date of the covered employee's death.

B. Dependent. Coverage for a covered dependent will end (subject to Section Two, Continuation of Coverage) on the earliest of the following dates:

(1) The last calendar day of the month in which the covered dependent becomes ineligible for coverage under the Plan, unless the Employer's Contract with Paramount provides for a different termination date;

(2) The date of the death of the covered dependent;

(3) The date dependent coverage terminates or the Plan terminates; or

(4) The last calendar day of the month preceding the first calendar day of the next month for which the required payment for dependent coverage has not been made, unless the Employer's Contract with Paramount provides for a different termination date.

C. Termination for Cause. Your coverage may be terminated or rescinded* for cause by Paramount upon 30 calendar days prior written notice if You:

(1) Do not make any required premium contribution; or

(2) Perform any act or practice that constitutes fraud or an intentional misrepresentation of material fact under the terms of coverage, including without limitation:

a. Allowing the use of Your Paramount Identification card by any other person using another Covered Person's card;

b. Providing untrue, incorrect, or incomplete information on behalf of Yourself or another Covered Person in the application for this Plan, which constitutes a material misrepresentation. You will be responsible for paying charges for all Covered Services provided to You through Paramount that are related to such untrue, incorrect, or incomplete information; and

c. Committing fraud, forgery, or other deception related to enrollment or coverage. You will be responsible for paying charges for all Covered Services provided to You from the date You were enrolled in the Plan.

*A rescission of your coverage means that the 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. Your coverage can also be rescinded due to such an act, practice, omission or intentional misrepresentation by your employer.

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.

D. Plan Termination. Coverage under the Plan may be renewed each year at the option of the Employer; provided that, Paramount may terminate or non-renew the Employer's Contract for one or more of the following reasons:

(1) Failure to pay the required premiums on time;

(2) Fraud or intentional misrepresentation of a material fact by the Employer in connection with such coverage;

(3) If there is no longer a Covered Person who lives, resides, or works in the state of Ohio;

(4) If the membership of the Employer in an Alliance (on the basis of which coverage is provided) ceases:

(5) When Paramount discontinues offering this Plan in the Small Group market, as applicable, in Ohio and:

a. Paramount provides notice to each Employer and Covered Person provided coverage under this Plan in the Small Group Market, as applicable, of such discontinuation at least 90 calendar days prior to the date of discontinuation of such coverage;

b. Paramount offers each Employer provided coverage in the Small Group Market, as applicable, under this Plan the option to purchase other coverage currently being offered by Paramount to an Employer or union sponsored health benefit plan in such market(s); and

c. In exercising the option to discontinue coverage of this type and in offering the option of other coverage under this provision, Paramount acts uniformly without regard to claims experience of those Employers or the health status of any Covered Persons or eligible employees or dependents; or

(6) When Paramount discontinues offering coverage in the Small Group Market, in Ohio and after Paramount provides notice to the Ohio Department of Insurance and each Employer and its Covered Persons in the applicable market(s) of such discontinuation at least 180 calendar days prior to the date of discontinuation of such coverage.

SECTION TWO: CONTINUATION OF COVERAGE

1. **Continuation of Coverage Under COBRA.** If Your coverage under the Employer's Contract with Paramount would otherwise end; You may be eligible for continuation of coverage under the Consolidated

Omnibus Budget Reconciliation Act of 1985 ("COBRA"), as amended, or under other federal or state laws.

The Employer's benefits administrator will coordinate continuation of coverage. To obtain specific details and to arrange for continuation of health care benefits, the covered employee should contact the Employer's benefits office.

2. **Continuation of Coverage Under Ohio State Law (for Employers with fewer than 20 Employees).** As an alternative to the continuation of coverage described in Paragraph 1 of this section, You may continue group coverage for a period of 12 months following the covered employee's termination of employment if the covered employee:

A. Has been covered under any coverage for at least 3 months preceding the date his or her employment was terminated.

B. Did not voluntarily terminate their employment and the termination of employment is not the result of gross misconduct on the part of the employee; and

C. Is not eligible for or covered by:

(1) Medicare; or

(2) Any other insured or uninsured arrangement that provides Hospital, surgical, or medical coverage.

3. **Continuation of Coverage During Military Service.** If You are absent from work due to U.S. military service, You may elect to continue coverage (including coverage for Your dependents) for up to a maximum 24 months from the first day of absence or, if earlier, until the day after the date You are required to apply for or return to active employment. Your contributions for the continued coverage will be the same as those paid by similarly situated active employees during the first 30 days of Your absence. Thereafter, Your contributions will be the same as those paid for COBRA continuation of coverage. Whether or not You continue coverage during military service, You may reinstate coverage under the Plan on Your return to employment provided You continue to meet the Plan eligibility requirements.

Your reinstatement under the Plan will be without any Pre-Existing Condition Exclusion. If You dropped coverage for Your dependents under the Plan, they may re-enter the Plan with You subject to the Plan's Special Enrollment rules.

4. **Continuation of Coverage During Family and Medical Leaves of Absence.** You may be eligible for continuation coverage if You are absent from work for periods of time covered under the Family and Medical Leave Act of 1993 (FMLA). The Employer's benefits administrator will coordinate continuation of coverage. To obtain specific details and to arrange for continuation of health care benefits, You should contact Your Employer's benefits office.

5. Other Approved Leave of Absence or Disability. You may be eligible for continuation of coverage during an approved leave of absence of disability that causes You to be absent from work. To obtain specific details and to arrange for continuation of health care benefits, You should contact Your Employer's benefits office.

SECTION THREE: HOW THE PREFERRED CHOICES PLAN WORKS

1. Health Care Reimbursement Choices. Paramount's Preferred Choices Plan provides You with two (2) flexible choices for reimbursement any time Covered Services are required. The amount paid for the care You receive depends upon whether care is received from an "In-Network" or "Out-of-Network" Provider.

To receive In-Network benefits, You may seek care from any Preferred Provider Organization (PPO) In-Network Provider when You require medical services. As an alternative, care may be sought from an Out-of-Network Provider.

In-Network Option – You may seek care from any In-Network Provider. You must satisfy the Deductible under the In-Network option before any benefits will be paid and Your share of the cost for services will be lower compared to obtaining service from Out-of-Network Providers. You are also required to obtain pre-authorization from Paramount for certain services.

To receive benefits under the In-Network Option, You must use In-Network (Paramount Preferred Options) Providers and facilities to obtain Covered Services, except Emergency Services. **It is Your responsibility to ensure that Covered Services are obtained from In-Network Providers and facilities to be eligible for coverage under the In-Network Option.**

Out-of-Network Option – You may seek care from Providers outside the Network. You must satisfy the Deductible under the Out-of-Network option before any benefits will be paid and Your share of the cost for services will be higher. You are also required to obtain pre-authorization from Paramount for certain services.

Special Note on Out-of-Network Providers. For Out-of-Network Hospital Providers in Lucas County, Paramount pays for benefits based on the lesser of the Non-Contracting Amount (NCA) that is determined payable by Paramount or the actual charge for the service. For all other Out-of- Network Hospitals, Physicians/Providers, Paramount pays for benefits based on the lesser of the Usual, Customary and Reasonable (UCR) Charge or the actual charge for the service.

If the charge billed is greater than the NCA ore Usual, Customary and Reasonable (UCR) Charge, You must pay the excess portion. For Covered Services rendered Out-of-Network, Deductibles, Coinsurance and benefit maximums are based on the lesser of the NCA, the UCR Charge or the actual charge for the service.

Example (assumes the Deductible has already been met):

Out-of-Network Provider charge:	$1,000
NCA or UCR limit:	$700
Plan pays 70% of $700:	$490
You pay 30% Coinsurance:	$210
Plus balance of charge above $700	$300
Your total cost:	$510

In this example, only the Coinsurance of $210 would count toward the maximum out-of-pocket expense for the calendar year. When considering using Out-of-Network Providers, You should verify the limitations that may apply to the charges. If the Out-of-Network Provider has waived any portion of Your required Coinsurance payment, Your total cost would be calculated by subtracting the waived Coinsurance from the amount that You were billed by the Provider.

Benefit Limits - Some benefits described in this Certificate of Coverage are limited, may vary, or require payment of additional amounts. Please refer to the Schedule of Benefits and to the specific conditions, limitations, exclusions, and/or payment levels that are set forth in the section which describes that benefit in detail and in Section Five, Non-Covered Services/Exclusions, for a description of services and supplies that are not covered under this Plan. Always call Paramount at 419-887-2531 or toll-free 1-8660452-6128 if You have any questions about specific conditions, limitations, exclusions, or payment levels.

2. **Pre-Authorization**. Pre-authorization must be obtained by calling Paramount at 419-887-2549 or toll free 1-800-891-2549 before (preferably two weeks in advance) obtaining any of the following. Participating Providers are responsible for pre-authorization for In-Network care; You are responsible for pre-authorization for Out-of-Network care.

A. Services requiring pre-authorization:

i. Inpatient admission to a Hospital, including Inpatient admissions for Mental Illness, drug abuse or alcohol abuse treatment and Inpatient admissions at rehabilitation facilities; or
ii. Inpatient admission to a Skilled Nursing Facility; or
iii. Hospice or Home Health services; or
iv. Organ/Bone Marrow Transplant services.

B. Procedures requiring pre-authorization:

i. Enhanced External Counterpulsation (EECP);
ii. Occular Photodynamic Therapy;
iii. Positron Emission Tomography (PET scans);
iv. Prophylactic Mastectomy; and
v. BRCA Testing
vi. Orthognathic and maxillofacial surgery
vii. Eyelid surgery/lifts (bleparoplasty)
viii. Sleep studies
ix. Cochlear implants
x. Imaging/Nuclear cardiology studies

C. Equipment requiring pre-authorization:

i. Air fluidized beds;
ii. Bone stimulators and supplies;
iii. Power operated vehicles, power wheelchairs and power wheelchair accessories over $5,000;
iv. Chest wall oscillation vest (ThAIRapy Vest System);
v. Total parenteral nutrition (TPN) and enteral nutrition and supplies; and
vi. Speech generating devices.

Even if You obtain a referral from an Out-of-Network Physician, **pre-authorization is always required before obtaining the above services, procedures and equipment.** If You obtain pre-authorization, these services, procedures and equipment will be covered at the appropriate benefit level indicated in Your Schedule of Benefits. Pre-authorization is required to avoid a potential denial or reduction in payment of benefits.

If You do not obtain the required pre-authorization, Paramount will conduct a retrospective review to determine if your care was Medically Necessary. You are responsible for all charges for services Paramount determines are not Medically Necessary.

If You ***do not obtain pre-authorization*** and the services are Medically Necessary, any benefit payment for a ***facility fee (including inpatient facility services and outpatient facility services*** will be reduced by $500 of the Allowable Amount. The services are then subject to the applicable Deductible, Copayment and/or Coinsurance. The $500 penalty does not count toward the Out-of-Pocket Maximum. Also see Transplant Benefit Penalty.

Notification of pre-authorization Decision. Paramount will make its decision regarding coverage and notify You within two (2) business days of receiving all necessary information.

For Emergency admissions to a Hospital or Skilled Nursing Facility, You do not have to obtain pre-authorization in advance. However, You, a family member, or Your Physician must notify Paramount within 48 hours of an Emergency admission, or as soon as possible. If You have any questions, or to provide notice, call 419-887-2549 or toll-free 1-800-891-2549.

If You disagree with Paramount's determinations, You may appeal Paramount's decision by following the appeal procedure set forth in Section Eight, Internal Claims And Appeals Procedures And External Review.

Remember that You must obtain pre-authorization from Paramount before You obtain the services, procedures and equipment listed above when using Out-of-Network Providers.

3. **The Preferred Provider Organization (PPO) Network.** The PPO Network Directory lists all Physicians and other Providers who are part of the PPO Network. The PPO Network Directory will be updated periodically and You may access the PPO Network Directory at; www.paramountinsurancecompany.com. Or by calling the Member Service Department at (419) 887-2531 or toll-free 1-866-452-6128.

   In-Network Physicians include family practitioners, internists, and pediatricians whom You may select to provide primary care. In-Network specialists include obstetrician/gynecologists, oncologists, cardiologists, orthopedists, and other designated specialists. Other In-Network Providers include psychiatrists and psychologists who provide mental health care services, drug abuse and alcohol abuse treatment.

   Please note that Paramount's contracting and credentialing with In-Network Providers should not, in any case, be understood as a guarantee or a warranty of the appropriateness and/or adequacy of the medical care rendered by such Provider. In-Network Providers are independent contractors and are not employees or agents of Paramount. The selection of an In-Network Provider or any other Provider, and the decision to receive or decline to receive health care services is **Your responsibility.** Health care decisions are made solely by You in consultation with Your health care Providers. Health care Providers are solely responsible for patient care and related clinical decisions once You make Your health care decision.

4. **Filing Claims.** For all Covered Services, a claim form or written proof of loss must be submitted to Paramount. In-Network Providers will submit the required claim forms to Paramount for You. You must show Your Paramount identification card to the In-Network Provider. **In-Network Hospitals, Physicians and Providers have agreed to limit their charges through their contracts with the PPO Network.**

   Out-of-Network Providers may decline to submit claims to Paramount for You. In that case, it is Your responsibility to file appropriate claims in order to receive reimbursement from Paramount.

   In order for Paramount to make payments under this Plan, Paramount must receive claims for benefits within 90 calendar days after a service is received. Failure to submit a completed claim within that time will neither invalidate nor reduce any claim if it is shown that: 1) it was not reasonably possible to furnish a claim within that time; and 2) such claim was furnished as soon as reasonably possible. In no event, in the absence of legal capacity, may a claim be furnished later than 1 year from the time the claim is otherwise required. After an initial claim is submitted to Paramount, Paramount may request additional medical or other information necessary to process the claim. The claimant must respond to a written request from Paramount for additional information within 6 months of the receipt of the request for additional information. Failure to respond within this timeframe may invalidate the claim.

   In most cases, reimbursement for Covered Services will be sent directly to the provider, but in some cases, Paramount may choose to send reimbursement to you. If You pay for the Covered Services you may request reimbursement from Paramount. Claim forms are available from the Employer's personnel or benefits office or by calling the Paramount Member Services Department at (419) 887-2531 or toll-free 1-866-452-6128.

Explanation of Benefits (EOB): After a claim has been filed with Paramount, You will receive an Explanation of Benefits (EOB). The EOB is a summary of the coverage for that claim. The EOB is not a bill, but a statement from Paramount to help You understand the coverage You are receiving. The EOB shows:

- Total amount charged for services/supplies received;
- The amount of the charges paid by Your coverage; and
- The amount for which You are responsible (if any).

5. Payments under This Plan. Your share in the cost of Covered Services may include a Deductible, Copayment, and Coinsurance as shown in the Schedule of Benefits.

A. Aggregate Deductible. The amount You and Your Dependents must pay for Covered Services including Prescription Drugs within a calendar year, before any benefits will be paid by the Plan. If You have single coverage (self only), the single Deductible is the amount You must pay. If You have family coverage (two or more covered family members), the family Deductible is the total amount any one or more covered family members must pay. All Covered Services except for Preventive Health Services and services requiring a Copayment are subject to the Deductible.

Embedded Deductible. The amount You and Your Dependents must pay for Covered Services Including Prescription Drugs 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. All Covered Services except for Preventive Health Services and services requiring a Copayment are subject to the Deductible.

See your Schedule of Benefits for the type of Deductible and Deductible amount under your Plan.

The expenses incurred for Covered Services received from In-Network and Out-of-Network Providers including Prescription Drugs apply to the Deductible.

B. Copayment. The fixed dollar amount You must pay each time You receive certain Covered Services. See Your Schedule of Benefits for Copayments that apply to You and Your Dependents.

C. Coinsurance. The fixed percentage of charges You must pay toward the cost of certain Covered Services. See Your Schedule of Benefits to determine whether a service requires a Coinsurance payment and the amount for that service. Coinsurance on benefits received from In-Network Providers is a percentage of the contract charge negotiated between the PPO Network and the Provider. This means that You receive the benefit of any discount. Coinsurance on benefits received from Out-of- Network Providers is a percentage of the NCA or UCR charge that Paramount will pay for the services rendered.

Special Note: Deductible, Copayments and Coinsurance are an important part of this benefit plan's design. You are required to make these payments to be eligible for reimbursement.

D. Out-of-Pocket Maximum. Similar to your Deductible, you may have an Embedded or Aggregate Out-of-Pocket Maximum. Your Out-of-Pocket Maximum is stated in Your Schedule of Benefits. After that amount has been paid, there will be no additional Cost Sharing for Essential Health Benefits during the remainder of that calendar year. The Out-of-Pocket Maximum includes Deductible, Coinsurance and Copayments incurred by a Covered Person in a calendar year. The following ***do not*** apply to the Out- of-Pocket Maximum:

- Financial penalties imposed for failure to obtain required pre-authorization;
- Non-Network charges in excess of NCA or UCR.

The expenses incurred for Covered Services received from In-Network Providers apply toward satisfying the In-Network **Out-of-Pocket Maximum** and the expenses incurred for Covered Services received from Out-of-Network Providers apply toward satisfying the In-Network and Out-of-Network **Out-of- Pocket Maximums.**

6. **Medically Necessary.** Covered Services must be Medically Necessary (see the Definition Section). Paramount will determine what is Medically Necessary after considering the advice of trained medical professionals. The fact that Your Provider prescribed the care or service does not automatically mean that the care is Medically Necessary or that it qualifies for coverage.

   Examples of care which are **not** Medically Necessary include without limitation: Inpatient Hospital admission for care that could have been provided safely either in a doctor's office or on an Outpatient basis; a Hospital stay longer than is Medically Necessary to treat Your condition; or a surgical procedure performed instead of a medical treatment which could have achieved equally satisfactory management of Your condition.

   Paramount will not make any payment for care which is not Medically Necessary.

7. **Coverage for Emergency Services.** Usually, services obtained from Out-of-Network Providers are covered at the Out-of-Network benefit level. However, if You have an accident, unforeseen illness, or injury that requires immediate care, You may seek Emergency Services (see the Definition Section) 24 hours a day and 7 days a week at the nearest health care facility, and You will receive the In-Network benefits level based on the lesser of the Usual, Customary and Reasonable (UCR) Charge or the actual charge for the service. Paramount must be notified within 48 hours of an Emergency admission, or as soon as possible, so Your benefits can be verified for the Provider. In-Network benefits for care received from Out-of-Network Providers are limited to Emergency Services required before You can, without medically harmful results, return to the care of In-Network Providers

SECTION FOUR: 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 Participating Provider, except for Emergency Services. Services which are not received from a Participating Provider or approved with a Prior Authorization will be considered a non-covered service, except as specified above. 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 Certificate, 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 Certificate, including receipt of care from a Participating Provider, and obtain any required Prior Authorization. Our payment for Covered Services will be limited by any applicable Coinsurance, Copayment, Deductible, or Calendar Year Limit/Maximum in this Certificate.

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

1. **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 ambulettes, 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.

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.

2. **Behavioral Health Services.** Services for mental illness are covered for inpatient and outpatient care subject to the same Deductible, Copayments and/or Coinsurance as any other physical disease or condition.

Covered Services include but are not limited to:

- **Inpatient services** – individual or group psychotherapy, psychological testing, family counseling with family members to assist in your diagnosis and treatment, convulsive therapy including electroshock treatment or convulsive drug therapy.

- **Partial hospitalization** - an intensive structured setting providing 3 or more hours of treatment or programming per day or evening, in a program that is available 5 days a week. The intensity of services is similar to Inpatient settings. Skilled nursing care and daily psychiatric care (and Substance Abuse care if the patient is being treated in a partial hospital Substance Abuse program) are available, and treatment is provided by a multidisciplinary team of Behavioral Health professionals.

- **Intensive Outpatient treatment or day treatment** - a structured array of treatment services, offered by practice groups or facilities to treat Behavioral Health Conditions. Intensive Outpatient Programs provide 3 hours of treatment per day, and the program is available at least 2-3 days per week. Intensive Outpatient Programs may offer group, DBT, individual, and family services.

- **Outpatient treatment, or individual or group treatment** - office-based services, for example Diagnostic evaluation, counseling, psychotherapy, family therapy, and medication evaluation. The service may be provided by a licensed mental health professional and is coordinated with the psychiatrist.

  Two (2) days of partial hospitalization treatment or intensive Outpatient treatment are the equivalent of one (1) day as an Inpatient.

Non-Covered Behavioral Health Services (please also see Non Covered Services/Exclusions of thisCertificate)

- Residential Treatment services. Residential treatment means individualized and intensive treatment in a residential setting, including observation and assessment by a psychiatrist weekly or more frequently, an individualized program of rehabilitation, therapy, education, and recreational or social activities.

- 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 for your condition.

- Services or care provided or billed by a residential treatment center, school, halfway house, custodial care center for the developmentally disabled, residential programs for drug and alcohol, or outward bound programs, even if psychotherapy is included.

- Services related to non-compliance of care if the Member ends treatment for substance abuse against the medical advice of the Provider.

3. **Clinical Trials.** Benefits are available for services for routine patient care rendered as part of a clinical trial if the services are otherwise Covered Services under this Certificate and the clinical trial meets all of the following criteria:

- The purpose of the trial is to test whether the intervention potentially improves the trial participant's health or the treatment is given with the intention of improving the trial participants health, and is not designed simply to test toxicity or disease pathophysiology;

- **The trial does one of the following:**
  1. Tests how to administer a health care service, item, or drug for treatment;
  2. Tests responses to a health care service, item, or drug for treatment;
  3. Compares the effectiveness of health care services, items, or drugs for treatment; or
  4. Studies new uses of health care services, items, or drugs for treatment;

- **The trial is approved or funded by one or more of the following:**
  1. The National Institute of Health, or one of its cooperative groups or centers under the United States Department of Health and Human Services;
  2. The Centers for Disease Control and Prevention.
  3. The Agency for Health Care Research and Quality.
  4. The Centers for Medicare & Medicaid Services.
  5. Cooperative group or center of any of the entities described in clauses 1-4 or the Department of Defense or the Department of Veterans Affairs.
  6. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Heatlh for center support grants.

Benefits do not, however, include the following:

- A health care service, item, or drug that is the subject of the clinical trial or is provided solely to satisfy data collection and analysis needs for the clinical trial that is not used in the direct clinical management of the patient;

- An investigational or experimental drug or device that has not been approved for market by the United States Food and Drug Administration;

- Transportation, lodging, food, or other expenses for the patient, or a family member or companion of the patient, that are associated with the travel to or from a facility providing the clinical trial;

- An item or drug provided by the clinical trial sponsors free of charge for any patient;

- A service, item, or drug that is eligible for reimbursement by a person other than the insurer, including the sponsor of the clinical trial.

4. 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.

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 - Dental X rays, supplies & appliances and all associated expenses, including hospitalization and anesthesia **as required by law,** and;

- transplant preparation
- initiation of immunosuppresives
- direct treatment of cancer or cleft palate.

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.

NOTE: Pediatric stand-alone dental plans are available. Contact the Paramount Marketing Department for information.

Non-Covered Dental Services - For dental treatment, regardless of origin or cause, except as specified elsewhere in this Certificate. "Dental treatment" includes but is not limited to: Preventive care, diagnosis, treatment of or related to the teeth, jawbones (except that TMJ is a Covered Service) or gums, including but not limited to:

- extraction, restoration and replacement of teeth.
- medical or surgical treatments of dental conditions.
- services to improve dental clinical outcomes.
- Dental braces

- Dental implants
- 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 transplant preparation, initiation of immuno suppresives, direct treatment of acute traumatic injury, cancer or cleft palate.
- For treatment of the teeth, jawbone or gums that is required as a result of a medical condition except as expressly required by law or specifically stated as a Covered Service.
- Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly.

5. **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 Care Services” “Physician Home Visits and Office services”.

6. **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
- Electrocorticograms

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.

7. **Emergency Services**. Covered for facility and physician services for Emergency Medical Conditions meeting the definition in Section Eleven, Definitions of this Certificate. 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.

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.

8. **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 in order to be covered.

Not covered:

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

9. **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 Schedule 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

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, and continuous subcutaneous), Total Parenteral Nutrition (TPN), Enteral nutrition therapy, Antibiotic therapy, pain management and chemotherapy.

10. **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.

11. **Infertility Services.** Covered for the medically necessary diagnosis and treatment of infertility conditions.

12. **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 pro longed 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.

13. **Maternity 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.

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.

Physician-directed follow-up care after delivery is also covered. 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 health care professional who conducts the visit is knowledgeable and experienced in maternity and newborn care.

Coverage for a length of stay shorter than the minimum period mentioned above may be permitted if your attending 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 post discharge follow-up to verify the condition of the infant after discharge.

- Covered Services include at-home post-delivery care visits at your residence by a Physician or Nurse 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.

14. 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 are 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 are 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 include, but are not limited to:

- **Medical and surgical supplies** - Certain supplies and equipment for the management of disease that we approve are covered under the Prescription Drug benefit. Covered Services do not include items usually stocked in the home for general use like Band-Aids, thermometers, and petroleum jelly.

  Covered Services 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.

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

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 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 the Member's condition.

  Non-covered items 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 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 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.

15. 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 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.

16. 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 Care Services", "Maternity Services", "Home Care Services" and "Behavioral Health Services for services covered by the Health Plan.

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.

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.

Online clinic visits. When available in your area, your coverage will include online clinic visit services. Covered Services include a medical consultation using the internet via a webcam, chat or voice. Non Covered Services include, but are not limited to communications used for:

- Reporting normal lab or other test results
- Office appointment requests
- Billing, insurance coverage or payment questions
- Requests for referrals to doctors outside the online care panel
- Benefit precertification
- Physician to Physician consultation

17. Prescription Drug Benefits

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

Pharmacy and Therapeutics (P&T) Committee

The Plan has a P&T 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.

Pharmacy Benefits Manager

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

Example services that the PBM provides include managing a network of retail pharmacies, operating a Mail Service pharmacy and claims processing. The PBM, in consultation with the Plan, 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, and 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 may 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 Heatlh Plan, or utilization guidelines.

- Prescription Legend Drugs.
- Specialty Drugs.
- Injectable insulin and syringes used for administration of insulin.
- Contraceptive Drugs.
- Certain supplies and equipment obtained by Mail Service or from a Network Pharmacy (such as those for diabetes and asthma) are covered. Contact Paramount to determine approved covered supplies. If certain supplies, equipment or appliances are not obtained by Mail Service or from a Network Pharmacy then they are covered as Medical Supplies, Equipment and Appliances instead of under Prescription Drug benefits.
- 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.

How to Obtain Prescription Drug Benefits

How you obtain your benefits depends upon whether you go to a Network or a Non-Network Pharmacy.

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.

Non-Network Pharmacy - You will be charged the full retail price of the prescription at the point of purchase. Refer to your Schedule of Benefits for coverage of non-network pharmacies. If you have non-network pharmacy coverage, 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 when non-network pharmacy benefits are present.

The Mail Service Program – Refer to your Schedule 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.

Specialty Pharmacy Network

Paramount's Specialty Pharmacy Network is available to Members who use Specialty Drugs. 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.

Days Supply

The number of days supply of a Drug which you receive may be limited based upon the type of pharmacy and network status. The days supply limit applicable to Prescription Drug coverage is shown in the Schedule 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 Schedule 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 appli cable 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. 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 Schedule of Benefits for any applicable Deductible and Coinsurance/ Copayment.

Tier and Formulary Assignment Process

Your Copayment/Coinsurance amount may vary 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 Schedule of Benefits.

The determination of tiers and formulary assignment is made by the Plan with assistance by the Plan's 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.

1-Tier/Single Copayment or Coinsurance

Refer to the Schedule of Benefits for exceptions that may apply to drugs subject to DAW Status or Additional Benefits and Programs.

- **Tier 1** Prescription Drugs have one Coinsurance or Copayment.

2-Tier Copayment or Coinsurance

Refer to the Schedule of Benefits for exceptions that may apply to drugs subject to DAW Status or Additional Benefits and Programs.

- **Tier 1** Generic Prescription Drugs with a lower Coinsurance or Copayment.
- **Tier 2** Brand Prescription Drugs with a higher Coinsurance or Copayment than those in Tier 1.

3-Tier Copayment

Refer to the Schedule of Benefits for exceptions that may apply to drugs subject to DAW Status or Additional Benefits and Programs.

- **Tier 1** Generic Prescription Drugs with a lower Coinsurance or Copayment.
- **Tier 2** Preferred Brand Prescription Drugs with a higher Coinsurance or Copayment than those in Tier 1.

- **Tier 3** Non-Preferred Brand Prescription Drugs with a higher Coinsurance or Copayment than those in Tier 2.

4-Tier Copayment

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

- **Tier 1** Generic Prescription Drugs have the lowest Coinsurance or Copayment.
- **Tier 2** Preferred Brand Prescription Drugs will have a higher Coinsurance or Copayment than those in Tier 1.
- **Tier 3** Non-Preferred Brand Prescription Drugs will have a higher Coinsurance or Copayment than those in Tier 2.
- **Tier 4** Multi-Source Brand Prescription Drugs will have a higher Coinsurance or Copayment than those in Tier 3.

5-Tier Copayment

Refer to the Schedule of Benefits for exceptions that may 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** Specialty and Injectable Prescription Drugs will have a higher Coinsurance or Copayment than those in Tier 4.

DAW Status

Dispense As Written (DAW) is a designation that you or the 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 Schedule of Benefits for an explanation of how these drugs are covered.

Preferred Brand Drug List

Members can obtain a copy of the Plan's Preferred Brand Drug List by calling the Member Services telephone number on the back of their ID card, or is available for review on the internet at www.paramountinsurancecompany.com. The Preferred Brand Drug 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.

Prior Authorization

Prior Authorization is required for certain Prescription Drugs (or the prescribed quantity of a particular Drug). Prior Authorization helps promote appropriate use of dangerous drugs 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 our Pharmacy and Therapeutics 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.

If Prior Authorization is denied, you have the right to appeal through the appeals process outlined in Section Eight, Internal Claims And Appeals Procedures And External Review of this Certificate.

For a list of the current Drugs requiring Prior Authorization, please contact the Member Services telephone number on the back of your ID card. 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 Certificate. Refer to the Covered Prescription Drug benefit sections in this Certificate 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.

Step Therapy

Step therapy protocol means that a Member may need to use other medication(s) before a certain medication may be 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 monitored medication is needed the Prior Authorization process is applied.

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.

Special Promotions

From time to time we may 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 may involve reducing or waiving Copayments or Coinsurance for certain Drugs or preferred products for a limited period of time.

18. Preventive Care Services. Preventive Care services include, Outpatient services and Office Services. Screenings and other services are covered as Preventive Care 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 Care Services in this section shall meet requirements as determined by federal and state law. Many preventive care services are covered by this Certificate 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;
b. Cervical cancer;
c. Colorectal cancer;
d. High Blood Pressure;
e. Type 2 Diabetes Mellitus;
f. Cholesterol;
g. Child and Adult Obesity.

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. 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/.)

Covered Services also include the following services required by state and federal law:

- Child health supervision services from the moment of birth until age nine. Child health supervision services mean periodic review of a Child's physical and emotional status performed by a physician, by a health care professional under the supervision of a physician, or, in the case of hearing screening, by an individual acting in accordance with Ohio law. Periodic review means a review performed in accordance with the recommendations of the American academy of pediatrics and includes a history, complete physical examination, developmental assessment, anticipatory guidance, appropriate immunizations, and laboratory tests.

Other Covered Services are:
- Routine hearing screenings
- Routine children's vision screenings

19. Surgical Services. Coverage for Surgical Services when provided as part of Physician Home Visits and Office Services, Inpatient Services, or Outpatient Services includes but is 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.

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.

Covered Surgical Services include, but are not limited to:
- 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.

20. Reconstructive Services. Certain reconstructive services required to correct a deformity caused by disease, trauma, congenital anomalies, or previous therapeutic process are covered. Reconstructive services required due to prior therapeutic process are payable only if the original procedure would have been a Covered Service under this Plan. Covered Services are limited to the following:

- Necessary care and treatment of medically diagnosed congenital defects and birth abnormalities of a new born Child.
- Breast reconstruction resulting from a mastectomy. See "Mastectomy Notice" below for further coverage details.
- Hemangiomas, and port wine stains of the head and neck areas for children ages 18 years of age or younger;
- Limb deformities such as club hand, club foot, syndactyly (webbed digits), polydactyly (supernumerary digits), macrodactylia;
- Otoplasty when performed to improve hearing by directing sound in the ear canal, when ear or ears are absent or deformed from trauma, surgery, disease, or congenital defect;
- Tongue release for diagnosis of tongue-tied;
- Congenital disorders that cause skull deformity such as Crouzon's disease;
- Cleft lip;
- Cleft palate.

21. Mastectomy Notice. A Member who is receiving benefits for a covered mastectomy or for follow-up care in connection with a covered mastectomy, on or after the date the Women's Health & Cancer Rights Act became effective for this Plan, 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.

22. **Sterilization.** Sterilization is a Covered Service.

23. **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.

24. **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; adaptions 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 Schedule 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 else where classified, and other counseling. Pulmonary rehabilitation in the acute Inpatient rehabilitation setting is not a Covered Service.

Physical Medicine and Rehabilitation and Habilitative Services

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.

A structured therapeutic program of an intensity that requires a multidisciplinary coordinated team approach to upgrade the patients 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.

Covered Services include **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; 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, 30 visits per year total.

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 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.

25. **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 Care" 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 the "Prosthetics" benefit.

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.

These additional services are not part of the "Preventive Care" benefit and will be based on the setting which services are received.

Additional Covered Services discussed below are only available for Members under age 19:

- Standard Eyeglass Lenses: Contact lenses may be obtained in lieu of glasses.
- Frames

26. **Transplants.** Covered for certain clinical indications with written Prior Authorization at a Paramount approved Center of Excellence for heart, lung, liver, pancreas, heart-lung, kidney-pancreas, bowel and bone marrow transplants. (Kidney and cornea transplants are covered as any other illness.) Please notify Member Services as soon as possible after you are recommended for a transplant. This will enable a Paramount Nurse Case Manager to work with you, and your physician to coordinate your care.

When Paramount selects a Center of Excellence for transplant services outside the Service Area, Paramount will reimburse IRS allowance on mileage for car travel or coach commercial air travel. Reasonable costs for lodging and meals (excluding alcohol) for the transplant candidate only during medically necessary, approved visits to the institution will be reimbursed. Any eligible reimbursement will be made following receipt of itemized statements. Paramount does not cover travel, lodging or meal expenses for donors or family Members.

SECTION FIVE: 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. This information is provided as an aid to identify certain common items which may be misconstrued as Covered Services, but is in no way a limitation upon, or a complete listing of, such items considered not to be Covered Services. Paramount has the discretionary authority to determine Medical Necessity under the Plan.

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 appeal rights under Internal Claims And Appeals Procedures And External Review section of this certificate.

2. Received from an individual or entity that is not a Provider, as defined in this Certificate, or recognized by Paramount.

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 appeal rights under Internal Claims And Appeals Procedures And External Review section of this certificate.

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 any illness or injury that occurs while serving in the armed forces, including as a result of any act of war, declared or undeclared.

7. For a condition resulting from direct participation in a riot, civil disobedience, nuclear explosion, or nuclear accident.

8. For court ordered testing or care unless Medically Necessary.

9. For which you have no legal obligation to pay in the absence of this or like coverage.

10. For the following:
- Physician or Other Practitioners' charges for consulting with Members by telephone, facsimile machine, electronic mail systems or other consultation or medical management service not involving direct (face-to-face) care with the Member except as otherwise described in this Certificate.
- Surcharges for furnishing and/or receiving medical records and reports.
- Charges for doing research with Providers not directly responsible for your care.
- Charges that are not documented in Provider records.
- 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.

- 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.

11. 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.

12. 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.

13. For completion of claim forms or charges for medical records or reports unless otherwise required by law.

14. For missed or canceled appointments.

15. For mileage, lodging and meals costs, and other Member travel related expenses, except as authorized by Paramount or specifically stated as a Covered Service.

16. For which benefits are payable under Medicare Parts A and/or B or would have been payable if a Member had applied for Parts A and/or B, except, as specified elsewhere in this Certificate or as otherwise prohibited by federal law. 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.

17. Incurred prior to your Effective Date.

18. Incurred after the termination date of this coverage except as specified elsewhere in this Certificate.

19. 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).

20. 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.

21. 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.
- Care provided or billed by residential treatment centers or facilities, unless those centers or facilities are required to be covered under state law. This includes but is not limited to individualized and intensive treatment in a residential facility, including observation and assessment by a Provider weekly or more frequently, an individualized program of rehabilitation, therapy, education, and recreational or social activities.
- Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, residential programs for drug and alcohol, or outward bound programs, even if psychotherapy is included.
- Wilderness camps.

22. 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.

23. For surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.

24. Weight loss programs, whether or not they are pursued under medical or Physician supervision, unless specifically listed as covered in this Certificate. This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

25. 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.

26. For marital counseling.

27. 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.

28. For vision orthoptic training.

29. For hearing aids or examinations to prescribe/fit them, unless otherwise specified within this Certificate.

30. For services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein.

31. For services to reverse voluntarily induced sterility.

32. 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.

33. 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.

34. 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.

35. For telephone consultations or consultations via electronic mail or internet/web site, except as required by law, authorized by Paramount, or as otherwise described in this Certificate.

36. For care received in an emergency room which is not Emergency Care, except as specified in this Certificate. This includes, but is not limited to suture removal in an emergency room.

37. 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.

38. For self-help training and other forms of non-medical self care, except as otherwise provided in this Certificate.

39. For examinations relating to research screenings.

40. For stand-by charges of a Physician.

41. Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes.

42. 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.

43. For Manipulation Therapy services rendered in the home as part of Home Care Services.

44. 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.

45. 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, bioenergial synchronization technique (BEST), iridology-study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy, electromagnetic therapy, and neurofeedback.

46. For any services or supplies provided to a person not covered under the Certificate in connection with a surrogate pregnancy (including, but not limited to, the bearing of a Child by another woman for an infertile couple).

47. For surgical treatment of gynecomastia.

48. For treatment of hyperhidrosis (excessive sweating).

49. For any service for which you are responsible under the terms of this Certificate to pay a Copayment, Coinsurance or Deductible, and the Copayment, Coinsurance or Deductible is waived by a Non-Participating Provider.

50. 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.

51. For Drugs, devices, products, or supplies not covered under Preventive 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.

52. 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.

53. Treatment of telangiectatic dermal veins (spider veins) by any method.

54. Reconstructive services except as specifically stated in the Covered Services section of this Certificate, or as required by law.

55. Nutritional and/or dietary supplements, except as provided in this Certificate 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.

56. Abortion is not covered, unless medically necessary (i.e., to save the life or protect the health of the mother).

NON COVERED PRESCRIPTION DRUG BENEFITS

1. Prescription Drugs dispensed by any Mail Service program other than the PBM's Mail Service, unless prohibited by law.

2. Drugs, devices and products, or Prescription Legend Drugs with over the counter equivalents and any Drugs, devices or products that are therapeutically comparable to an over the counter Drug, device, or product.

3. Drugs in quantities exceeding the quantity prescribed, or for any refill dispensed later than one year after the date of the original Prescription Order.

4. Drugs not approved by the FDA.

5. Charges for the administration of any Drug.

6. Drugs consumed at the time and place where dispensed or where the Prescription Order is issued, including but not limited to samples provided by a Physician. This does not apply to Drugs used in conjunction with a Diagnostic Service, with Chemotherapy performed in the office or Drugs eligible for coverage under the Medical Supplies benefit; they are Covered Services.

7. Any Drug which is primarily for weight loss unless specified in Additional Benefits and Programs.

8. Human Growth Hormone unless specified in Additional Benefits and Programs.

9. Drugs not requiring a prescription by federal law (including Drugs requiring a prescription by state law, but not by federal law), except for injectable insulin.

10. Drugs in quantities which exceed the limits established by the Health Plan, or which exceed any age limits established by Paramount.

11. Drugs for treatment of sexual or erectile dysfunctions or inadequacies, regardless of origin or cause unless specified in Additional Benefits and Programs.

12. Fertility Drugs unless specified in Additional Benefits and Programs.

13. Contraceptive devices, oral immunizations, and biologicals, although they are federal legend Drugs, are 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.

14. Drugs in quantities which exceed the limits established by the Health Plan.

15. Compound Drugs without at least one ingredient that requires a prescription.

16. Compound Drugs with an equivalent commercially available product.

17. Certain Prescription Legend Drugs are not Covered Services when any version or strength becomes available over the counter. Please contact Paramount for additional information on these Drugs.

18. Refills of lost or stolen medications.

19. Certain Prescription Drugs may not be covered when clinically equivalent alternatives are available, unless otherwise required by law. "Clinically equivalent" means Drugs that, for the majority of Members, can be expected to produce similar therapeutic outcomes for a disease or condition. If you have questions regarding whether a particular drug is covered and which drugs fall into this category, please call the member services number on the back of your Identification Card, or visit Our website at www.paramountinsurancecompany.com. If you or your Physician believe you require continued coverage for a certain Prescription Drug, please have your Physician or Pharmacist contact Paramount. We will cover your current Prescription Drug only if we agree that it is Medically Necessary and appropriate over its clinically equivalent alternative. Continued coverage of the Prescription Drug will be subject to periodic review by Paramount.

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.

SECTION SIX: 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 nongroup 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 Code 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 mote 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 2 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 2 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-net work 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 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, as 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 pro vision 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 care “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 the 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 Eight: Internal Claims And Appeals Procedures And External Review. 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

SECTION SEVEN: MEDICARE AND YOUR COVERAGE

You may have coverage under the Plan and under Medicare. Medicare means the benefits offered under Title XVIII of the Social Security Act, and includes all of the benefits provided by Parts A and B of Medicare. In general, when You have coverage under both the Plan and Medicare, the Plan will pay primary benefits for:

1. An active employee who is age 65 and over (only if the Employer has 20 or more employees);
2. An active employee's spouse age 65 or over;
3. An active employee under age 65 entitled to Medicare because of disability (only if the Employer has 100 or more employees);
4. An active employee's covered dependent(s) under age 65 entitled to Medicare because of disability (only if the Employer has 100 or more employees); or
5. Up to 30 months after Your treatment for end stage renal disease begins.

If You do not fall into any of the categories 1 through 5 above, the Plan will pay benefits secondary to Medicare. If You do not elect Part B coverage, the payment to be made by the Plan will be made as if You had elected Part B. When the Plan is secondary, You must first submit the claim to Medicare. After Medicare makes payment, You may submit the claim to the Plan for payment.

These rules are based on regulations issued by the Centers for Medicare and Medicaid Services (CMS), and may be amended or changed at any time. It is the intent of the Plan to abide by the Medicare Secondary Payer Rules. If the Plan in any way conflicts with regulations issued by CMS, the Plan will pay benefits in accordance with CMS regulations.

SECTION EIGHT: 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, 1901 Indian Wood Circle, Maumee, OH 43537, Attention: Member Services, or by telephone at, 1-800-462-3589 or email: Paramount.memberservices@promedica.org.

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. 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 file 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 for appeals of denials of non-urgent care you have not yet received.
- 60 days 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 **Terms and Definitions** section of this Member Handbook.

Emergency medical services: If the plan denies a 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 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, 1901 Indian Wood Circle, Maumee, OH 43537, Attn: Member Services, by telephone at 1-800-462-3589 or email: Paramount.memberservices@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.

In general, the health plan may unilaterally extend the time for providing a decision on both pre-service and *post-service claims* for 15 days after the expiration of the initial period, if the plan determines that such an extension is necessary for reasons beyond the control of the plan. There is no provision for extensions in the case of claims involving urgent care.

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, 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 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

Non-urgent, *pre-service claim* denial

For a non-urgent *pre-service claim*, the plan will notify you of its decision as soon as possible but no later than 15 days after receipt of the claim.

If the plan needs more time, it will contact you, in writing, telling you the reasons why it needs more time and the date when it expects to have a decision for you, which should be no later than 15 days.

If the plan needs additional information from you before it can make its decision, it will provide a notice to you, describing the information needed. You will have 45 days from the date of the plan's notice to provide the information. If you do not provide the additional information, the plan can deny your claim. In which case, you may file an appeal.

The plan must make its decision within 48 hours after receipt of the information or at the end of the 45 days, whichever comes first.

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 claim, orally or in writing.

If the claim for benefits is one involving urgent care, we will notify you of our decision as soon as possible, but no later than 72 hours after we receive your claim provided you have given us information sufficient to make a decision.

If you have not given us sufficient information, we will contact you as soon as possible but no more than 24 hours after we receive your claim to let you know the specific information we will need to make a decision. You must give us the specific information requested as soon as you can but no later than 48 hours after we have asked you for the information.

We will notify you of our decision as soon as possible but no later than 48 hours after we have received the needed information or the end of the 48 hours you had to provide the additional information.

To assure you receive notice of our decision, we will contact you by telephone or facsimile (fax) or by another method meant to provide the decision to you quickly.

In determining whether a claim involves urgent care, the plan must apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine. **However, if a physician with knowledge of your medical condition determines that a claim involves urgent care, or an emergency, the claim must be treated as an urgent care claim.**

Simultaneous urgent claim and expedited internal review:

In the case of a *claim involving urgent care*, you or your authorized representative may also request an expedited internal review. A request for expedited internal review may be submitted orally or in writing by the claimant; 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.

The physician, if the physician certifies, in writing, that you has a medical condition where the time frame for completion of an expedited review of an internal appeal involving an *adverse benefit determination* would seriously jeopardize the life or health of you or jeopardize your ability to regain maximum function, you may file a request for an expedited external review to be conducted simultaneously with the expedited internal appeal, pursuant to section 3922.09 of the Revised Code.

Simultaneous urgent claim, expedited internal review and external review:

You, or your authorized representative, may 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) The treating physician certifies that the adverse benefit determination involves a medical condition that could seriously jeopardize the life or health of you, 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.

Concurrent care decisions

Reduction or termination of ongoing plan of treatment: If we have approved an ongoing plan or course of treatment that will continue over a period of time or a certain number of treatments and we notify you that we have decided to reduce or terminate the treatment, we will give you notice of that decision allowing sufficient time to appeal the determination and to receive a decision from us before any interruption of care occurs.

Request to extend ongoing treatment: If you have received approval for an ongoing treatment and wish to extend the treatment beyond what has already been approved, we will consider your appeal as a request for urgent care. If you request an extension of treatment at least 24 hours before the end of the treatment period, we must notify you soon as possible but no later than 24 hours after receipt of the claim.

An appeal of this decision is conducted according to the urgent care appeals procedures.

Concurrent urgent care and extension of treatment: Under the concurrent care provisions , any request that involves both urgent care and the extension of a course of treatment beyond the period of time or number of treatments previously approved by the plan must be decided as soon as possible, taking into account the medical urgencies, and

notification must be provided to the claimant 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.

Non-urgent request to extend course of treatment or number of treatments: If a request to extend a course of treatment beyond the period of time or number of treatments previously approved by the plan does not involve urgent care, 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 the request is 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 72 hours after receipt.

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. If we need more time, we will contact you, telling you about the reasons why we need more time and the date when we expect to have a decision for you, which should be no later than 15 days, provided that the we determine that such an extension is necessary due to matters beyond our control, and we notify you prior to the expiration of the initial 30 days period. If the reason we need more time to make a decision is because you have not given us necessary information, you will have 45 days from the date we notify you to give us the information. We will describe the information needed to make our decision in the notice we send you. This is also known as a "*retrospective review*." The plan will notify you of its determination as soon as possible but no later than 5 days after the benefit determination is made.

The plan will let you know before the end of the first 30-day period, explaining the reason for the delay, requesting any additional information needed, and advising you when a final decision is expected. If more information is requested, you have at least 45 days to supply it. The claim then must be decided no later than 15 days after you supply the additional information or the period given by the plan to do so ends, whichever comes first. The plan must get your consent if it wants more time after its first extension. The plan must give you notice that your claim has been denied in whole or in part (paying less than 100% of the claim) before the end of the time allotted for the decision.

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. When an oral or electronic request for review is made, written confirmation of the request must be submitted to the plan no later than 5 days after the initial request was made.

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

Paramount Insurance Company, 1901 Indian Wood Circle, Maumee, OH 43537, Attn: Member Services, by telephone at 1-800-462-3589 or email: Paramount.memberservices@promedica.org

Non-urgent request for an external review

Unless the request is for an expedited external review, the plan will initiate an external review within 5 days after it receives your written request if your request is complete. The plan will provide you with 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, with 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 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 by 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 of receipt of a 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 of receipt of the expedited 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 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.

SECTION NINE: REIMBURSEMENT/SUBROGATION

1. **Reimbursement and Subrogation.** Where a Covered Person has benefits paid by Paramount for the treatment of sickness or injury caused by a third party or the Covered Person, these are conditional payments that must be reimbursed by the Covered Person if the Covered Person receives compensation, damages or other payment as a result of the sickness or injury from any person, organization or insurer, including the Covered Person's own insurer and any uninsured and/or underinsured motorist insurance. Paramount may subrogate to the Covered Person's rights of recovery. Paramount has reimbursement and subrogation rights equal to the value of medical benefits paid for Covered Services provided to the Covered Person. Paramount subrogation rights are a first party claim 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 means the Covered Person must reimburse Paramount, 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 in attorneys fees.

2. **Workers' Compensation/Non-Duplication.** The benefits which You are entitled to receive under Paramount's insured plans do not duplicate any benefit to which You are entitled under Workers' Compensation laws or similar Employer liability laws. All sums paid for services provided to any Covered Person pursuant to Workers' Compensation are deemed to be assigned to Paramount.

3. **Cooperation by Covered Persons.** By executing an enrollment application, 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 Paramount or its nominee under this Section. You may not do anything which might limit, waive or release Paramount's reimbursement or subrogation rights.

4. **Cooperation by Employer.** By executing the Group Policy, the Employer agrees to assist Paramount in obtaining the necessary information from covered employees as may be required and to do whatever is necessary to effectuate and protect fully the rights of Paramount or its nominee under this Section.

SECTION TEN: MISCELLANEOUS PROVISIONS

1. **No Assignment.** You may not assign any benefits or monies under this Plan to any person, corporation, organization, or other entity. Any such assignment will be void and have no effect. Assignment means the transfer to another person, corporation, organization, or other entity of a right to the benefits provided under this Plan. The Plan will not prevent a Provider from receiving payment for eligible charges for Covered Services rendered under a valid assignment. Paramount will determine whether an assignment of benefits to a Provider is a valid assignment.

2. **Notice.** Any notice which the Employer or Paramount gives to You will be in writing and mailed to You at the address as it appears on the records. If You have to give the Employer or Paramount any notice, it should be in writing and mailed to the address set forth in the Introduction section of this Certificate of Coverage.

3. **Medical Records.** Paramount is a covered entity under HIPAA and is permitted to use, obtain and disclose protected health information to perform Paramount operations in accordance with Paramount's Notice of Privacy Practices. Paramount may obtain Your medical records and information relating to Your care from Physicians, Hospitals, Skilled Nursing Facilities, pharmacies, or other treating Providers in order to pay claims or carry out other health care operations as explained in Paramount's Notice of Privacy Practices. Paramount will not use or disclose Your protected health information other than for the purposes allowed by HIPAA without Your authorization.

4. **Genetic Testing.** Paramount will not seek or use genetic screening or test results for the purpose of determining group health care plan rates or eligibility for enrollment.

5. **Recovery of Overpayments.** On occasion, a payment may be made to or for You when You are not covered, for a service which is not covered, or which is more than is appropriate for that service. When this happens, Paramount will explain the problem, and You must return to Paramount within 60 calendar days the amount of the mistaken payment, or provide Paramount with written notice stating the reasons why You may be entitled to such payment. In accordance with and to the extent permitted by applicable law, Paramount may reduce future payments to You in order to recover any mistaken payment. Overpayments and mistaken payments made to Providers will be recovered directly from them.

6. **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.

7. **Right To Develop Guidelines.** Paramount reserves the right to develop or adopt criteria which set forth in more detail the instances and procedures when Paramount will make payments of benefits under the Plan. Examples of the use of the criteria are: to determine whether care was Medically Necessary, whether Emergency Services in the Outpatient department of a Hospital were Medically Necessary, or whether certain services are skilled care. These criteria will be interpretive and illustrative only and will not be contrary to any term or provision of the Plan. If You have a question about the criteria which applies to a particular benefit, You may contact Paramount for further information.

8. **Review.** If a claim for benefits is denied, a review of the denial may be obtained through the appeal procedure described in Section Eight, Internal Claims And Appeals Procedures And External Review.

9. **Limitation on Benefits of This Plan.** No person or entity other than the Employer, Paramount, and Covered Persons hereunder is or shall be entitled to bring any action to enforce any provision of the Plan against the Employer, Paramount, or Covered Persons hereunder, and the covenants, undertakings and agreements set forth in the Employer's Contract with Paramount and this Certificate of Coverage shall be solely for the benefit of, and shall be enforceable only by the Employer, Paramount, and the Covered Persons covered under this Plan.

10. **Action at Law.** No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

12. **Applicable Law.** The Plan, the rights and responsibilities of Paramount and Covered Persons under the Plan, and any claims or disputes relating thereto, shall be governed by and construed and administered in accordance with the laws of the State of Ohio and any applicable federal law.

13. **Qualified Medical Child Support Orders.** Paramount will comply with all valid medical child support orders (QMCSOs) that are determined by Paramount to meet the requirements of the Employee Retirement Income Security Act of 1974, as amended.

14. **Facility of Payment.** If an Insured Person dies while benefits under the Group Plan remain unpaid, the Company may, at its option, make direct payment to the Provider on whose charges the claim is based; or to the surviving spouse of the Insured Person; or if none, to his or her surviving child or children (including legally adopted child or children) share and share alike; or if none, to the executors or administrators of the Insured Person's estate.

15. **Time Effective.** The effective time for any dates used is 12:01 A.M. at the address of the Insured Person.

16. **Incontestability.** In the absence of fraud, any statement made by the Insured Person in applying for insurance under the Group Plan will be considered a representation and not a warranty. After the Group Plan has been in force for 2 years, its validity cannot be contested except for nonpayment of premiums or fraudulent misstatement. After an Insured Person's insurance has been in force for 2 years during his or her lifetime, its validity cannot be contested due to misstatement other than a fraudulent misstatement. Only statements that are in writing and signed by the Insured Person can be used in a contest.

17. **Misstatement of Age.** If the age of any person insured under the Group Plan has been misstated: 1) premiums shall be adjusted to correspond to his or her true age; and 2) if benefits are affected by a change in age, benefits will be corrected accordingly (in which case the premium adjustment will take the correction into account).

SECTION ELEVEN: DEFINITIONS

When capitalized in this Certificate of Coverage or the Schedule of Benefits or italicized in Section Eight, Internal Claims And Appeals Procedures And External Review, the terms listed below will have these meanings:

Allowable Amount – The maximum amount that Paramount determines is reasonable for the Covered Services received.

Ambulatory review means utilization review of health care services performed or provided in an outpatient setting.

Applicable non-English language. With respect to an address in any United States county to which a notice is sent, a non-English language is an applicable non-English language if ten percent or more of the population residing in the county is literate only in the same non-English language, as determined in guidance published by the Secretary.

Authorized representative means an individual who represents a *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 the *you* is unable to provide consent.

Brand Name Drug - A Prescription Drug that is dispensed under a proprietary name and classified as a brand by a national drug-pricing source.

Certificate of Coverage - This document, which includes the Schedule of Benefits.

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

Child Health Supervision Services - Periodic review of a child's physical and emotional status performed by a Physician or by a health care professional under the supervision of a Physician. Periodic reviews are performed in

accordance with the recommendations of the American Academy of Pediatrics and include a history, complete physical examination, developmental assessment, anticipatory guidance, appropriate immunizations, and laboratory tests.

Claim involving urgent care means any claim for Medicare 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.

You means a policyholder, subscriber, enrollee, member, or individual covered by a health benefit plan. "*You*" does include *your* authorized representative with regard to an internal appeal or external review. "*You*" does not include the your representative in any other context.

Coinsurance – The fixed percentage of charges that You must pay toward the cost of certain Covered Services. See Your Schedule of Benefits to determine whether a service requires a Coinsurance payment and the amount for that service. Coinsurance on benefits received from In-Network Providers is a percentage of the contract charge negotiated between the PPO Network and the Provider. This means that You receive the benefit of any discount. Coinsurance on benefits received from Out-of-Network Providers is a percentage of the NCA or UCR charge that Paramount will pay for the services rendered.

Contract - The agreement between the Employer and Paramount which consists of the following documents (all of which are on file with your employer):

- The Small Group Policy
- The Certificate of Coverage (Insurance)
- The Employer's application
- The Employee's application, if any
- Amendments or Endorsements to any of the above documents
- Riders
- Explanation of Benefits

Copayment - The fixed dollar amount You must pay each time You receive certain Covered Services. See Your Schedule of Benefits for a list of those services that require Copayments. Copayments for specific dollar amounts are due and payable at the time services are provided

Cost Sharing is any expenditure required by or on behalf of a Member with respect to Essential Health Benefits; the term includes Deductibles, Coinsurance, Copayments, or similar charges, but excludes premiums, balance billing amount for non-network providers, spending for non-covered services and for cost-sharing for services obtained out-of-network.

Covered Person - An eligible employee and/or his or her eligible dependents who elect coverage, become covered, and remain covered under this Plan, continuing to meet the Plan's eligibility requirements.

Covered Services - The health care services and items described in this Certificate of Coverage and updated in the Schedule of Benefits, for which Paramount provides benefits to You.

Deductible - The amount You and Your Dependents must pay for Covered Services, including Prescription Drug benefits, within a calendar year, before benefits will be paid by the Plan. See Your Schedule of Benefits for the Deductible amount that applies to You and Your dependents.

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

Effective Date - The first day You are covered under the Plan or the first day after the last day of the Employer's Waiting Period.

Election Period - The annual period of time during which an eligible employee and/or his or her dependents may select or turn down coverage under an Employer-sponsored health care benefit plan. An eligible employee and/or his or her eligible dependents may also change from one Employer sponsored health care benefit plan to another at this time.

Elective - Any activity pertaining to a condition that does not require immediate medical attention and for which reasonable delays will not adversely affect Your health or recovery. A foreseeable Hospital admission, such as the birth of a child, is also considered Elective.

Emergency or Emergency Medical Condition - 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 women, the health of the woman or her unborn child, in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

Emergency Services - 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; 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 burn center of the Hospital.

As used when referring to *emergency services* or *emergency medical condition*, *Stabilize* 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:

a) 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;
b) Serious impairment to bodily functions;
c) Serious dysfunction of any bodily organ or part.
d) In the case of a woman having contractions, "stabilize" means such medical treatment as may be necessary to deliver, including the placenta.

Employer - The Employer that elected to sponsor this Plan for its eligible employees/members and their eligible dependents.

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.

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 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 using evidence-based criteria as defined in the Non-Covered Services/Exclusions section of this Member Certificate.

Generic Drug - Any Prescription Drug that is dispensed under a non-proprietary name and classified as a generic by a national drug-pricing source.

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

Health Care Provider - Means a health care professional or facility.

Hospital - An institution that: (1) provides medical care and treatment of sick and injured persons on an Inpatient basis; (2) is properly licensed or permitted legally to operate as such; (3) has a Physician on call at all times; (4) has licensed graduate registered nurses on duty 24 hours a day; and (5) maintains facilities for the diagnosis and treatment of illness and for major surgery.

The definition of Hospital may also include one or more of the following: (1) alcoholism or drug addiction treatment facility; (2) psychiatric Hospital; (3) ambulatory surgical facility; (4) freestanding birth center; and (5) hospice facility – provided the facility is licensed in the state in which the facility operates and is operating within the scope of its license.

The definition of Hospital does not include an institution or any part of one that is a convalescent/extended care facility, or any institution which is used primarily as: (1) a rest facility; (2) a nursing facility; (3) a facility for the aged; or (4) a place for custodial care.

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.

In-Network - A group of Providers who participate in the Preferred Provider Organization (PPO) Network to provide Covered Services, as set forth in this Certificate of Coverage.

In-Network Physician/Provider - Any Physician, Hospital, or other health services Provider who has a contract with the PPO Network to provide Covered Services to Covered Persons.

Inpatient - You will be considered an Inpatient if You are treated in a Hospital as a registered bed patient incurring a charge for room and board, upon the recommendation of a Physician.

Language assistance means translation services provided if requested. Contact Member Services if oral or written services are needed.

(1) The plan or issuer must provide oral language services (such as a telephone customer assistance hotline) that include answering questions in any applicable non-English language and providing assistance with filing claims and appeals (including external review) in any applicable non-English language;

(2) The plan or issuer must provide, upon request, a notice in any applicable non-English language; and

(3) The plan or issuer must include in the English versions of all notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the plan or issuer.

Mail Order Pharmacy - A mail order pharmacy that is contracted with Paramount or PBM to provide mail order Prescription Drug benefits for Covered Persons.

Medical care means the diagnosis, cure, mitigation, treatment, or prevention of disease or for the purpose of affecting any structure or function of the body and for transportation primarily for and essential to the provision of such care.

Medical Director - A duly licensed Physician or his or her designee who has been designated by Paramount to monitor the provision of Covered Services to Covered Persons.

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.

Paramount investigates all requests for coverage of new technology using the *HAYES Medical Technology Directory®* and current evidenced-based medical/scientific publications. If further information is needed, Paramount utilizes additional sources including Medicare and Medicaid policy and Food and Drug Administration (FDA) releases. This information is evaluated by Paramount's Medical Director and other physician advisors. See Internal Claims And Appeals Procedures And External Review section in this certificate.

Mental Disorder or Illness - Any disorder or disability described in the most current edition of *Diagnostic and Statistical Manual of Mental Disorders*,(DSM)

Network Pharmacy - A retail pharmacy that is contracted with Paramount or PBM to provide Prescription Drug benefits for Covered Persons.

Non-Contracting Amount (NCA) - The maximum amount determined as payable and allowed by Paramount for a Covered Service provided by an Out-of-Network Hospital Provider in Lucas County.

Non-Preferred Brand Drug – A Prescription Drug that is denoted as "Non-Preferred" by Paramount as determined by Paramount's P&T.

Outpatient - You will be considered to be an Outpatient if treated on a basis other than as an Inpatient in a Hospital or other covered facility. Outpatient care includes services and supplies provided and used at a Hospital or other covered facility under the direction of a Physician to treat a person not admitted as an Inpatient.

Out-of-Network Physician/Provider - Any Physician, Hospital or health services Provider who does not have a contract with the Preferred Provider Organization (PPO) Network to provide Covered Services to Covered Persons.

Out-of-Pocket Maximum - Your Out-of-Pocket Maximum is stated in Your Schedule of Benefits. After that amount has been paid, there will be no additional Cost Sharing for Essential Health Benefits during the remainder of that calendar year. The Out-of-Pocket Maximum includes Deductible, Coinsurance and Copayments incurred by a Covered Person in a calendar year.

Pharmacy and Therapeutics Working Group (P & T) - A Paramount committee comprised of physicians and pharmacists that reviews medications for safety, efficacy and value. This committee continually monitors and updates the Paramount Formulary and Maintenance List and makes periodic revisions to plan guidelines regarding coverage for specific drugs and/or therapeutic categories.

Physician means a provider who holds a certificate under Ohio law authorizing the practice of medicine and surgery or osteopathic medicine and surgery or a comparable license or certificate from another state.

Plan - The Paramount plan of health benefits described in this Certificate of Coverage and the Schedule of Benefits.

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

Preferred Brand Drug - A Prescription Drug that is approved for coverage as a "Preferred Brand Drug" by Paramount as determined by Paramount's P & T.

Prescription or Prescription Drug - A drug which has been approved by the U.S. Food and Drug Administration (FDA) and which may, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. For the purpose of coverage under this Rider, this definition shall include insulin.

Prescription Order or Refill - An authorization for a Prescription Drug issued by a Physician who is duly licensed to make such an authorization in the ordinary course of his or her professional practice.

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 – Preventive Health Services are those Covered Services that are being provided: 1) to a Covered Person who has developed risk factors (including age and gender) for a disease for which the Covered Person 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. See Preventive Health Services in Section Four, Covered Services in this Certificate for details.

Provider - A person or organization responsible for furnishing health care services, including a: Hospital, Skilled Nursing Facility, Physician, Doctor of Podiatry (D.P.M.), Licensed Psychologist, Certified Nurse Midwife acting within the scope of her or her license, under the direction and supervision of a licensed Physician; Licensed Physician Therapist (L.P.T.); Licensed Occupational Therapist (L.O.T.); Licensed Speech Therapist (L.S.T.); Licensed Optometrist; Certified Mechanotherapist acting within the scope of his or her license, and performing services ordered by a Physician; Professional Clinical Counselor; Professional Counselor; or Independent Social Worker.

Rescission means a cancellation or discontinuance of coverage that has a retroactive effect. "Rescission" does not include a cancellation or discontinuance of coverage that has only a prospective effect or a cancellation or discontinuance of coverage that is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

Schedule of Benefits – The insert included with this Certificate of Coverage 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.

Single Source Brand Drug - A Brand Name Drug that is marketed under a registered trade name or trademark and is available from only one manufacturer. These drugs are generally patent protected for a period of time.

Skilled Nursing Facility - A specially qualified licensed facility which has staff and equipment to provide skilled nursing care or rehabilitation services and other related health services.

Usual, Customary and Reasonable (UCR) Charges - Charges for hospital services, except for those located in Lucas County, professional, medical services and/or supplies that do not exceed the amount charged by most Providers of like and/or similar services and supplies in the locality where the services and/or supplies are received. Determination of whether or not a charge is UCR will be made by Paramount.

Urgent care claims - If *your* claim involves *urgent care*, we will notify you as soon as possible but no later than 72 hour after we have received the appeal for a denied claim for urgent care.

Urgent Care Services - Health care services that are appropriate and necessary for the diagnosis and treatment of an unforeseen condition that requires medical attention without delay, but does not pose a threat to the life, limb, or permanent health of the injured or ill person.

Waiting Period - A period of time that must pass before an employee or dependent's coverage is effective under the terms of an Employer or union sponsored health benefit plan. If an employee or dependent enrolls under an enrollment period similar to one described in Section One, Paragraph 2.C., Marriage, Birth, Placement for Adoption, or Adoption or 2.D, Special Enrollment -Loss of Other Coverage, any period before such enrollment is not a Waiting Period.

You, Your, Yourself - Refers to a Covered Person

(1.2014)

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LS-1537B - Non-Grandfathered
Revised 1/14