



PARAMOUNT



Paramount Insurance Company
Small/Large Group
Ohio Commercial FLEX Network Benefits
Member Handbook

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.

Welcome!

**Paramount Insurance Company
Small/Large Group
Ohio Commercial FLEX Network Benefits
Member Handbook**

Provided by:



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.

In Case of Emergency

For Medical Emergency Conditions such as heart attack, stroke, poisoning, loss of consciousness, inability to breathe, uncontrolled bleeding, convulsions and other conditions in which minutes can save lives, **call 911, an ambulance or rescue squad or go directly to the nearest emergency facility.** For other Emergency Medical Conditions, see page 20.

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

List the names and numbers of the Primary Care Providers for each family member.

Member Name: _____

Primary Care Provider (Name): _____

Number: _____

Member Name: _____

Primary Care Provider (Name): _____

Number: _____

Member Name: _____

Primary Care Provider (Name): _____

Number: _____

Member Name: _____

Primary Care Provider (Name): _____

Number: _____

Member Name: _____

Primary Care Provider (Name): _____

Number: _____

Police	Fire
Rescue	Ambulance
Hospital	Poison Control
Other	

Dear Member:

Welcome to Paramount Insurance Company.

This handbook will help you understand and use your benefits most effectively.

The Primary Care Provider you chose when you joined will help you when you need medical care. ALWAYS CONTACT YOUR PRIMARY CARE PROVIDER FIRST unless there is an Emergency Medical Condition. He or she will help you coordinate all your medical care.

If you did not need to change doctors, be sure to call your Primary Care Provider's office as soon as possible to let them know you are now covered by Paramount Insurance Company.

If you did change doctors, it is a good idea to get to know your doctor so you can feel comfortable asking questions, especially if an Emergency Medical Condition arises. If you are a new patient with your Primary Care Provider, we encourage you to call the doctor's office for an appointment as soon as you can to discuss your medical history and get to know each other.

This Member Handbook also explains who is covered under your plan and how the Plan works. Please take a few minutes to read it.

*If you have any questions or need help understanding your benefits, please **call Member Services, Monday through Friday, 8:00 a.m. to 5:00 p.m.***

We look forward to serving you.

The Member Services Department

The official terms of your enrollment and health benefits through Paramount Insurance Company are stated in the Group Medical and Hospital Service Agreement (GSA) and all applicable Documents as defined in paragraph 13.10 of the GSA, all of which are on file with your employer.

This Member Handbook contains a summary of your rights and obligations regarding your enrollment and health benefits through Paramount Insurance Company.

If there are any inconsistencies between this Member Handbook and the Group Medical and Hospital Service Agreement, the Service Agreement will control.

MISSION STATEMENT

As an integral part of ProMedica Health System, Paramount, a community-based managed health care organization, shall work in collaboration with employers, individual members, physicians, health care providers, and community and governmental agencies to continually improve the health of its Members by providing comprehensive health plans with unsurpassed levels of customer service, quality and cost effectiveness.

This mission will be accomplished by adhering to the values upon which Paramount is based:

- **Access** Provide Members with a choice of physicians and other professionals who meet the highest standard of professional training and experience.

- **Accountability** Hold Paramount and all health care professionals accountable for the quality of service provided and the satisfaction of Members and patients.

- **Compassion** Assure that all Members, employees and other constituents are treated with dignity and respect.

- **Excellence** Improve both clinical and administrative service delivery through a systematic process of quality improvement.

- **Prevention** Personify the belief that keeping Members healthy is as important as caring for them if they become ill.

Paramount is committed to the highest standards of quality, service, professional ethics and integrity, and to the principle that Members come first.

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1. THE BASICS

How Paramount Works

Your Primary Care Provider is your first contact when you need medical care. Your PCP will coordinate your medical care with other Participating Providers in the Paramount network. (Female Members may get receive OB/GYN care from a participating obstetrics/gynecology specialist without Prior Authorization from the Primary Care Provider (PCP). Prior Authorization is required for certain procedures or services. It is the responsibility of the Participating Provider to obtain Prior Authorization from Paramount in advance of these procedures or services.

Your Identification Card

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

If your card is lost or stolen or any information is incorrect, call Member Services.

Is There a Pre-existing Condition Restriction?

Many health benefit plans have pre-existing condition limitations. 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 as long as you follow the procedures described in Section 2, Getting a Doctor's Care.

Lifetime Dollar Limits

The Essential Health Benefits that may be provided by your Plan are not subject to a lifetime dollar limit. Plan benefits that are not defined as Essential Health Benefits may have a lifetime dollar limit. If you have reached a lifetime dollar limit under your Plan before the federal regulation prohibiting lifetime dollar limits for Essential Health Benefits became effective, and you are still eligible under your Plan's terms, and that Plan is still in effect, you will receive a notice that the lifetime dollar limit no longer applies and that you will have an opportunity to enroll or be reinstated under your Plan. If you are eligible for this enrollment opportunity, you will be treated as a special enrollee.

Annual Dollar Limits

Your Plan may have annual dollar limits on the claims the Plan will pay each year for Essential Health Benefits. Your Plan may include other benefits not defined as Essential Health Benefits, and those other benefits may have annual dollar limits. If your Plan has annual dollar limits on Essential Health Benefits they are subject to the following:

- For a plan year beginning on or after September 23, 2010, but before September 23, 2011, the limit can be no less than \$750,000.
- For a plan year beginning on or after September 23, 2011, but before September 23, 2012, the limit can be no less than \$1.25 million.
- For a plan year beginning on or after September 23, 2012, but before December 31, 2013, the limit can be no less than \$2 million.

- For a plan year beginning on or after January 1, 2014, there is no dollar limit for Essential Health Benefits under your Plan.

What Are Deductibles?

A Deductible is the amount you must pay for Covered Services within each Contract Year before benefits will be paid by Paramount. A Deductible cannot exceed \$1,000 per single or \$2,000 per family per Contract Year. If your plan has a Deductible, it will be stated in your Summary of Benefits. The single Deductible is the amount each Member must pay, and the family Deductible is the total amount any two or more covered family members must pay. Preventive Health Services/Benefits and Covered Services requiring a Copayment are not subject to the Deductible. See Section 4, "Preventive Health Services" for a list of Preventive Health Services.

What Are Copayments and Coinsurance?

Paramount members pay Copayments (copays) or Coinsurance for Basic Health Services such as: office visits and services, inpatient services (services you receive while a patient in a hospital or other medical facility), outpatient medical services, emergency services, laboratory and radiology services, services for treatment of Biologically and Non-Biologically Based Mental Illness and substance abuse and Preventive Health Services. There are no lifetime benefit limits on Basic Health Care Services. Copayments or Coinsurance for a Basic Health Service will not exceed 40% of the average cost to Paramount of providing the service. See your Summary of Benefits for Copayments/Coinsurance on specific services. Copayments are payable at the time you receive services.

The Out-of-Pocket Copayment Limit is the maximum amount of Copayments and Coinsurance including the Deductible you pay every Contract Year. Once the Out-of-Pocket Copayment Limit is met, there will be no additional Copayments and Coinsurance on Basic Health Services during the remainder of the Contract Year. The Out-of-Pocket Copayment Limit is stated in your Summary of Benefits. The single Out-of-Pocket Copayment Limit is the amount each Member must pay, and the family Out-of-Pocket Copayment Limit is the total amount any two or more covered family members must pay. This out-of-pocket limit cannot exceed 200% of the average annual premium to Subscribers and Members. Copayments and Coinsurance for Supplemental Health Services such as home health care, durable medical equipment, prosthetic devices, vision care services, prescription drugs and any penalties *do not* count toward the Out-of-Pocket Copayment Limit.

Who to Call for Information

The Paramount Member Services Department is here to help you.

Call, if you:

- Have any questions about your coverage
- Have questions about the providers who participate with Paramount
- Have questions about how to obtain health care services
- Need help understanding how to use your benefits
- Need to change your Primary Care Provider
- Are changing addresses, or need to add a new family member to your plan
- Lose your Paramount identification card
- Or have any other health care coverage concerns

MEMBERS' RIGHTS

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

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

MEMBERS' RESPONSIBILITIES

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

- Provide, to the extent possible, information that Paramount and the Participating Providers need to care for you. Help your PCP fill out current medical records by providing current prescriptions and your previous medical records.
- Engage in a healthy lifestyle, become involved in your health care and follow the plans and instructions for the care that you have agreed on with your PCP or specialists.
- Understand your health problems and participate in developing mutually agreed-upon treatment and goals to the degree possible.

2. GETTING A DOCTOR'S CARE

Start with Your Primary Care Provider (PCP)

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

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

For doctor appointments, call your PCP's office.

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

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

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

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

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

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

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

When your doctor recommends a treatment or test, in most cases it will be covered. However, some treatments may not be covered or are covered only when authorized in advance by Paramount. Your doctor may be working with several Paramount plans; plans are often different from one company to the next. The service your doctor recommends for you may be covered under some similar plans, but not under your particular plan.

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

IF YOU HAVE A QUESTION about whether a service is covered, you can find out by calling Member Services. If you do not have Prior Authorization before you get the services, you may be held responsible for total payment.

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

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

What to Consider When Selecting a Physician or Hospital

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

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

- Professional education – medical school/residency training,
- Current Board Certification status,
- Number of years in practice and
- Languages spoken

The following qualifications are important when selecting a hospital:

- The Joint Commission status (Paramount participating hospitals are required to have Joint Commission accreditation)
- Hospital experience/volume in performing certain procedures.
- Consumer satisfaction and comparable measures of quality on hospitals and outpatient surgical facilities.

If you need a current directory, you may request one by calling the Member Services Department or you may use the on-line Provider Directory available through our web site at www.paramountinsurancecompany.com.

When You Need OB/GYN Care

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

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

When You Are Referred to a Specialist

Most of your health care needs can and should be handled by your Primary Care Provider. If your Primary Care Provider believes you need to see a specialist - a cardiologist, orthopedist or others - your Primary Care Provider will recommend a Participating Specialist. Or you may choose the Participating Specialist you wish to see from those listed in the Participating Physicians and Facilities directory (also available on the website) and make an appointment.

Newly enrolled members of Paramount who are already seeing a specialist should verify that the specialist is participating with Paramount.

Prior Authorization

If a Medically Necessary covered service is not available from any Participating Providers, Paramount will make arrangements for an “out of plan Prior Authorization”. Your Primary Care Provider must request an “out of plan Prior Authorization” in advance. Consultations with Participating Specialists will be required before an “out of plan Prior Authorization” can be considered. If Paramount approves the “out of plan Prior Authorization”, written confirmation will be sent to you, your PCP and the non-participating provider. All eligible authorized services will be covered subject to appropriate Deductible and Copayments/Coinsurance.

If you have a life-threatening, degenerative or disabling condition that requires the services of a participating Specialist over a long period of time, you should discuss this with your Primary Care Provider. If your Primary Care Provider and the Specialist agree that your condition requires the coordination of a Specialist, your PCP will contact Paramount. Together, you, your Primary Care Provider, your Specialist and Paramount will agree on a treatment plan. Once this is approved, the Specialist will be authorized to act as your Primary Care Provider in coordinating your medical care.

Utilization Management

Participating physicians and providers have direct access to Paramount’s Utilization Management Department to authorize certain other services based on medical necessity. It is the responsibility of the participating physician or provider to obtain Prior Authorization when required. **If you experience an Emergency Medical Condition after normal office hours, you should call 911, an ambulance or rescue squad or go to the nearest medical facility. You do not need to obtain prior approval from your PCP or Paramount.** Afterward, you should notify your Primary Care Provider that you were treated.

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

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

Initial Determinations

When Prior Authorization is required, Paramount will make a decision within two (2) working days from obtaining all the necessary information about the admission, or procedure that requires Prior Authorization. Paramount will advise the provider of the decision by telephone within one (1) working day after making the decision. Paramount will send written confirmation of the decision to the provider and the Member within two (2) working days of making the telephone notification.

If Paramount makes an adverse determination (i.e., denies approval or coverage), Paramount will notify the requesting provider by telephone within one (1) working day after making the decision. Paramount will send written confirmation of the decision to the provider and the Member within one (1) working day of the telephone notification. If Paramount does not make a determination within the required timeframe, the Member may request an internal review. See Section 6.

Concurrent Reviews

For concurrent reviews, which are requests to extend coverage that were previously approved for a specified length of time, Paramount will make a decision within one (1) working day after obtaining all the necessary information. Paramount will advise the provider by telephone within one (1) working after making the decision. Paramount will send written confirmation of the decision to the provider and the Member within one (1) working day after the telephone notification. The written notification will include the number of extended days or next review date, the new total number of days approved and the date services were begun.

If Paramount makes an adverse determination, Paramount will notify the requesting provider by telephone within one (1) working day after making the decision. Paramount will send written notification to the provider and the Member within one (1) working day after the telephone notification. The Member's coverage will be continued, subject to applicable Copayments/Coinsurance, until the Member has been notified of the decision.

Retrospective Reviews

Paramount will make a decision within thirty (30) working days after receiving all necessary information on retrospective reviews. Paramount will notify the provider and the Member in writing.

If Paramount makes an adverse determination, Paramount will notify the provider and the Member in writing within five (5) working days from making the decision.

Expedited Reviews

If the seriousness of the Member's medical condition requires an expedited review, Paramount will make the decision as quickly as the medical condition requires but no later than seventy-two (72) hours after the request has been made.

Paramount will notify the provider of the decision by telephone immediately. A written confirmation will be sent to the provider and the Member within two (2) working days from the decision.

Adverse Determinations

Paramount's written notification will include the principal reason/s for the decision including specific utilization review criteria or benefit provision used in making the determination. Paramount will also include instructions for requesting a written statement of the clinical rationale used to make the decision. Paramount will provide a written statement of the clinical rationale to any Authorized Person making the request and following the instructions.

Obtaining Necessary Information

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

Entering the Hospital

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

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

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

Leaving the Hospital "Against Medical Advice"

If you discharge yourself from any hospital or facility "*against medical advice*" (AMA), there will be a penalty on all charges related to that admission. Also, if a hospital or facility requires your discharge (a "*disciplinary discharge*") for any reason, you will be responsible for a penalty on all charges related to that admission. The total of your copays (if any) and the penalty will not exceed 40% of the average cost of covered services on medical admissions and 50% of the average cost of covered services on substance abuse admissions.

Change in Benefits

Paramount will notify you in writing if any benefits described in this Member Handbook and Summary of Benefits change.

If a Provider Leaves the Plan

If your Primary Care Provider or any Participating Hospital can no longer provide medical services because their Paramount agreement ends, we will notify you in writing within thirty (30) days. We will cover all eligible services they provide between the date of termination and five (5) business days from the date on the postmark.

If a Specialist Leaves the Plan

If you are being seen regularly by a Participating Specialist or a specialty group whose agreement with Paramount ends, you and your PCP will be notified. You may then contact a new Participating Specialist for an appointment.

Continuity of Treatment

If your provider's Paramount agreement terminates and you are undergoing a course of treatment, Paramount will continue to pay for Covered Services rendered by that provider until the course of treatment is completed or until Paramount arranges for the reasonable and medically appropriate transfer of the treatment to another participating provider. In most cases, coverage will be authorized for no more than 90 days. If this situation occurs, you should contact the Member Services Department.

Provider Reimbursement/Filing a Claim

You should always show your Paramount ID card to all providers. You are responsible for paying any office visit Copayments at the time you receive services. Participating Providers must notify Paramount of the services they have rendered within 90 days from the date of service.

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

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

Paramount will send reimbursement directly to Participating Providers for Covered Services. In most cases, reimbursement for Covered Services will be sent directly to a non-participating provider, but instead may be paid directly to you. Claims are processed within 30 days from receipt of a fully completed claim. If any claim is denied, Paramount will send you an "Explanation of Benefits" with the reason for the denial. If you receive a denial on a claim and need further explanation or wish to appeal the denial, you may call the Member Services Department for assistance. The appeal process is also described in Section 6 of this Handbook.

Non-Covered Services

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

If You Receive a Bill

With the exception of a Deductible, Copayments, Coinsurance and non-covered services, Participating Providers may not bill you for Covered Services. If you receive a bill or statement, it is usually just a routine monthly summary of the activity on your account. If you have any questions about any amount(s) shown on the bill or statement, please contact Member Services.

New Technology Assessment

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.

Privacy and Confidentiality

Paramount will keep all documented Member medical and personal information, whether obtained in writing or verbally, in the strictest confidence. Paramount will provide Members the opportunity to approve or deny the release of personal health information, except when such release is required by law. See Paramount's Notice of Privacy Practice for more information.

Ownership and Physician Compensation

Paramount Insurance Company is a wholly owned subsidiary of the ProMedica Health System – one of the largest integrated delivery systems in the country. The ProMedica Health System operates acute care hospitals, ancillary facilities and primary care and specialist physician practices in northwest Ohio and southeast Michigan. ProMedica facilities and providers are participating in the Paramount network.

Paramount contracts with Participating Providers for health care services on an economically competitive basis, while taking steps to ensure that Paramount members receive quality health care. Paramount reimburses Participating Providers through "fee-for-service". Fee-for-service is the payment of a specific amount for each specific service provided by the physician. The amount is determined by Paramount, based on the procedure performed, and the Paramount allowed amount for that procedure. Participating Providers agree to accept the Paramount allowed amount (from a contractual fee schedule) as payment in full. Participating Primary Care Providers are not subject to any risk or financial incentives for hospitalization or referring their patients for specialized services.

Through the Paramount fee schedule, Paramount obtains discounts. When Coinsurance is charged as a percentage of eligible expenses, the amount a Member pays is determined as a percentage of the allowed amount (fee schedule) between Paramount and the participating provider, rather than a percentage of the provider's billed charge. Paramount's allowed amount is ordinarily lower than the participating provider's billed charge. Therefore, the benefit of the discount is passed on to you.

Paramount also offers optional prescription drug riders to employer groups. If your employer has elected to offer a prescription drug rider, the rider is administered by a pharmacy benefit manager (PBM) on behalf of Paramount. Part of this PBM service is to obtain discounts at pharmacies that contract with the PBM. If your drug Copayment is a percentage, the amount you pay is determined as a percentage of the discounted cost, rather than a percentage of the retail cost. Therefore, the benefit of the discount is passed on to you. If the drug costs less than your Copayment, you will pay the lesser of your Copayment or the discounted cost of the drug plus the pharmacist's dispensing fee. Under the Paramount agreement with the PBM, there are also certain administrative costs and rebates. Neither the administrative costs nor the rebates are included in your drug benefit. Paramount pays the administrative costs and retains the rebates to help offset administrative expenses. Not all benefit plans include coverage for outpatient prescription drugs. Refer to your summary of Benefits. Contact the Member Service Department if you have questions.

Patient Safety

Paramount is working with other hospitals, physicians and health plans to educate our Members about patient safety. Here is what **you** can do to improve the safety of your medical care:

- Provide your doctors with a complete health history.
- Be an **active member** of your health care team. Take part in every decision about your health care. Speak up – ask questions.
- Make sure that all of your doctors know about everything that you are taking, including over the counter medications and herbal/dietary supplements.
- Make sure that your doctors know about any allergies and reactions to medications that you have had.
- Ask for test results. Don't assume that no news is good news.
- Advise your doctor of any changes in your health.
- Follow your doctors' advice and the instructions for care that you and your doctor have agreed on.
- Make sure that you can read the prescriptions you get from your doctor.
- Ask your doctor and pharmacist questions about your medications.
 - What is the medication for?
 - What are the brand and generic names of the medication?
 - What does the medication look like?
 - How should it be taken and for how long?
 - What should you do if you miss a dose?
 - How should you store the medication?
 - Does the medication have side effects? What are they? What should you do if they occur?
- When you pick up the medication, ask the pharmacist if this is the medication that was prescribed.
 - Make sure that you understand the instructions on the label.
 - Ask the pharmacist about the best device to measure liquid medications.
 - Read the information that is provided by the pharmacy.

It is always important that you play an active role in decisions about your health and your health care. Take responsibility – **you can make a difference!**

If you ever find yourself in the hospital, you'll likely have many health care workers taking care of you. While they make every effort to provide appropriate care, sometimes errors can happen. By taking an active role in your care and asking questions, you can help make sure the care you receive is right for you.

Should you find yourself needing hospital care, be sure to:

- **Do your homework.** Make sure that the hospital you're being treated in has experience in treating your condition. If you need help getting this information, ask your doctor or call Paramount Member Service Department.
- **See that health care workers wash their hands before caring for you.** This is one way to prevent the spread of germs at home and infections in a hospital. Studies have shown that when patients checked whether health care staff had washed their hands, the workers washed their hands more often and used more soap.
- **Ask about services or tests.** Make sure to ask what test or x-ray is being done to make sure you are getting the right test. In the example of a knee surgery, be sure that the correct knee is prepped for surgery. A tip from the American Academy of Orthopaedic Surgeons urges their physicians to sign their initials on the site to be operated on before surgery.

- **Ask about what to do when you get home.** Before leaving the hospital, be sure the doctor talks to you about any medicines you need to take. Make sure you know how often, what dose to take, and any side effects to expect from the medicine. Also ask when you can return to your regular activities. See if the doctor has advice on things you can do to help your recovery.

If you have any questions or if things just don't seem right after you come home, be sure to call your doctor right away.

3. WHAT TO DO FOR URGENT CARE OR EMERGENCY MEDICAL CONDITIONS

Urgent Care Services

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

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

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

What to do:

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

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

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

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

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

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

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

Emergency Services

Emergency Services which are required as the result of an **Emergency Medical Condition** are covered at any medical facility, anytime, anywhere without prior authorization. The service will be subject to an emergency room, urgent care facility or office visit Copay/Coinsurance, depending on where you receive treatment. Your Copay/Coinsurance may be found in your Summary of Benefits.

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

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

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

Emergency Services means the following:

- a) 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;
- b) Such further medical examination and treatment that are required by federal law to *stabilize* an Emergency Medical Condition and are within the capabilities of the staff and facilities available at the hospital, including any trauma and the burn center of the hospital.

Stabilize 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. In the case of a woman having contractions, "stabilize" means such medical treatment as may be necessary to deliver, including the placenta.

Paramount will cover Emergency Services provided at participating facilities. Your Plan covers Emergency Services for an Emergency Medical Condition treated in any hospital emergency department. Paramount will cover Emergency Services at nonparticipating facilities when one of the following situations occur:

- a) Due to circumstances beyond the Member's control, the Member was unable to utilize a participating facility without serious threat to life or health.

- b) A prudent layperson with an average knowledge of health and medicine would reasonably have believed that the time required to travel to a participating facility could result in one or more adverse health consequences described under Emergency Medical Condition above.
- c) A Paramount representative refers the Member to an emergency room and does not specify a participating emergency room.
- d) An ambulance takes the Member to a non-participating facility other than at the direction of the Member.
- e) The Member is unconscious.
- f) A natural disaster prevented the use of a participating facility.
- g) The status of a participating emergency facility changed to a non-participating emergency facility and Paramount did not inform the Member of the change.

The determination as to whether or not an **Emergency Medical Condition** exists in accordance with the definition stated in this section rests with Paramount. Examples of **Emergency Medical Conditions** include: heart attack, stroke, poisoning, loss of consciousness, inability to breathe, uncontrolled bleeding and convulsions. Paramount may determine that other similarly acute conditions are also **Emergency Medical Conditions**.

What to do:

Inside the Service Area: In the event of an **Emergency Medical Condition**, call 911, an ambulance or rescue squad or go directly to the nearest medical facility. In the event you are unsure about whether a condition is an **Emergency Medical Condition**, you may contact your Primary Care Provider for instructions. Medical care is available through Paramount Physicians seven (7) days a week, 24 hours a day. Paramount will cover Emergency Services from non-participating providers inside the Service Area related to emergency services. Appropriate Copays or Coinsurance will be applicable.

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

Outside the Service Area: Call 911, an ambulance or rescue squad or go to the nearest emergency facility for treatment. Show your Paramount card. In some cases, you may be required to make payment and seek reimbursement from Paramount. Paramount will cover Emergency Services from non-participating providers outside the Service Area related to emergency services. Appropriate Copays or Coinsurance will be applicable.

Follow-up care within the Service Area: Follow-up medical care must be arranged by your Primary Care Provider with participating providers.

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

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

The Paramount Service Area

The Paramount Service Area includes all of Ashland, Crawford, Defiance, Erie, Fulton, Hancock, Henry, Huron, Lucas, Marion, Morrow, Ottawa, Putnam, Richland, Sandusky, Seneca, Williams, Wood, and Wyandot counties, and portions of Allen, Delaware, Hardin, Knox, Lorain and Paulding counties.

4. YOUR PLAN

What Is Covered - In General

Members may receive services described in this handbook, subject to all terms and provisions of the Group Medical and Hospital Service Agreement. (For details, see the Group Medical and Hospital Service Agreement filed with your employer.)

The basic steps you must take to get a doctor's care under your Paramount plan, and situations in which Paramount will not pay for care, are explained in Sections 2 and 3 of this handbook.

To be covered by Paramount, the health services you receive must meet Medically Necessary criteria and be from Paramount Participating Providers, except in emergencies or with written Prior Authorization from Paramount.

What Is Not Covered - In General

These services and supplies are not covered:

1. Services by providers chosen only for convenience (for example, if you use a nonparticipating X-ray or lab provider because their offices are nearby).
2. Any service received from any other nonparticipating physician, hospital, person, institution or organization unless:
 - a. Prior special arrangements are made by Paramount or
 - b. Such services are for Emergency Medical Conditions as described in Section 3/What to Do for Urgent Care or Emergency Medical Conditions.
3. Services received before coverage began or after coverage ended. However, if coverage ends while the Member is a patient in a hospital for a service covered by Paramount, charges related to that hospital stay will be covered according to the plan until the Member is discharged if the Member has no other coverage. If the Member has new coverage, Paramount will cover up to the effective date of the new plan.
4. Non-emergency services from non-participating providers without Prior Authorization from Paramount.
5. Any court-ordered testing, treatment or hospitalization unless determined to be Medically Necessary by Paramount and rendered by a Participating Provider.
6. Care for conditions which state or local laws require to be treated in a public facility or for which a Member is not legally required to pay.
7. Care for disabilities related to military service to which the Member is legally entitled.
8. Care provided to Members by relatives.
9. All charges incurred as a result of a non-covered procedure. (Medically necessary services due to complications of a non-covered procedure are covered.)
10. All charges for completion of reports, transfer of medical records, or missed appointments. Self-help audio cassettes, videos and books.
11. Assisted reproductive technology such as, artificial insemination, in vitro fertilization, embryo transplant services, GIFT, ZIFT and related services, infertility drugs and any other assisted reproductive technology unless specifically required by state regulation.
12. Surrogate parenting/pregnancy including gestational surrogacy and related services.
13. All claims for benefits submitted by or on behalf of the Member after one (1) year from the date of service.
14. Services received in a hospital emergency room for an Urgent Medical Condition without prior direction from your PCP, a participating Paramount physician or Paramount.

The official terms of your enrollment and health benefits under Paramount Insurance Company are stated in the Group Medical and Hospital Service Agreement on file with your employer.

What Is Covered/What Is Not Covered - Specific Services

A Copayment or Coinsurance may be required for Covered Services when this notation (C/L) appears. The notation (C/L) also indicates that there may be additional limitations to services according to your employer's benefit plan. Benefit limits for Supplemental Health Care Services may be day or visit limits or a maximum benefit limit each Contract Year. At the start of a new Contract Year, benefits with limitations will renew. See your Summary of Benefits for your Copayment/Coinsurance requirements and specific limitations on services.

A list of services follows, in alphabetical order:

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

Acupuncture Not covered.

Alcohol abuse/addiction treatment (See Substance Abuse Services.)

Allergy testing and therapy (injections) (C/L) Covered.

Alternative Medicine/Therapy Not covered. Including but not limited to: related laboratory testing, non-prescription drugs or medicines, vitamins, nutrients, food supplements, biofeedback training, neurofeedback training, hypnosis, acupuncture, acupressure, massage therapy, aromatherapy, Chelation therapy, rolfing and related diagnostic tests.

Ambulance (C/L) Covered when medically necessary and to the nearest medically appropriate facility.

Not covered: Transportation services in non-emergency situations and to hospitals beyond the nearest medically appropriate facility.

Asthma Supplies (C/L) The asthma supplies below are covered if the Group has purchased the optional Durable Medical Equipment Rider subject to the Coinsurance and limits of the Durable Medical Equipment Rider.

- Peak expiratory flow rate meter (hand-held),
- Spacers for metered dose inhalers, and
- Masks and tubing for nebulizers.

Biofeedback Not covered.

Blood Covered for the cost of administration and storage of blood and blood products, when a volunteer replacement program is not available.

Breast Augmentation or Reduction Not covered.

Cancer Clinical Trial (C/L) Routine patient care for Members enrolled in an Eligible Cancer Clinical Trial is covered. Routine patient care means all health care services consistent with the coverage under this Plan for the treatment of cancer, including the type and frequency of any diagnostic service, that is typically covered for a cancer patient who is not enrolled in a cancer clinical trial, and that is not necessitated solely because of the trial.

Not covered: A health care service, item or drug that is:

- The subject of a cancer clinical trial;

- A health care service, item, or drug provided solely to satisfy data collection and analysis needs for the cancer 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 cancer clinical trial;
- An item or drug provided by the cancer 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 cancer clinical trial.

Chiropractic services Chiropractors and their services are not covered, unless the Group has purchased an optional rider (C/L).

Contraceptive services (C/L) All FDA Contraceptive Services for women are covered under Preventive Health Services.

Cosmetic therapy or surgery Not covered. Cosmetic therapy or surgery is a procedure primarily for the purpose of altering or improving appearance.

Including but not limited to:

- Skin tags
- Sclerotherapy for spider angiomas (veins)
- Breast reduction/augmentation
- Face lifts, tummy tucks, panniculectomy and liposuction.
- Blepharoplasty (eyelid lift), unless medically necessary).
- Scar revision and correction
- Removal of pigmentation, tattoo removal
- Torn pierced ear lobes.
- Chemical face peels and dermabrasion

Custodial Care Not covered (See Home health care.)

Dental emergency treatment and oral surgery (C/L) A separate dental plan will be primary when available. The following services are covered ONLY for the following limited oral surgical procedures when you have Prior Authorization:

- First aid received within forty-eight (48) hours of an accidental injury to sound natural teeth, the jaw bones or surrounding tissues. This includes only extraction of teeth, emergency treatment of teeth and repair of soft tissue. Not covered: Replacement or restoration of teeth.
- Medically necessary orthognathic (jaw) surgery, as determined by Paramount Treatment for tumors and cysts (including pathological examination) of the jaws, cheeks, lips, tongue, roof and floor of the mouth
- Medically necessary oral surgery to repair fractures and dislocations of the upper and/or lower jawbone only
- Medical treatment for temporomandibular joint syndrome or dysfunction (TMJ)

Not covered: General dental care services, including but not limited to:

- Treatment on or to the teeth, bridges or crowns
- Extraction of teeth, including impacted wisdom teeth

- Treatment of granuloma
- Dental treatment including splints and oral appliances for temporomandibular joint syndrome or dysfunction (TMJ)
- Placement, removal or replacement of implants of the teeth and alveolar ridge including preparatory oral and maxillofacial surgery (bone grafts)
- Treatment of periodontal (gum) disease and abscesses
- Root canals
- Bite plates, retainers, snore guards, splints, orthodontic braces or any appliance or device that is fitted to the mouth
- Any other dental products or services
- Treatment required for an injury as a result of chewing or biting
- Upper and lower jawbone surgery except as required for direct treatment of acute traumatic injury or cancer, or as necessary to safeguard a Member's health due to a non-dental physiological impairment.

Diabetic Supplies (C/L) The diabetic supplies below are covered if the Group has purchased the optional Durable Medical Equipment Rider subject to the Coinsurance and limits of the Durable Medical Equipment Rider.

- Needles with syringes (1cc or less),
- Tubing for insulin pumps,
- Blood glucose monitor, test strips and control solutions, and
- Lancing devices, lancets.

Diagnostic services (C/L) Covered for medically necessary outpatient diagnostic testing by a Participating Provider. Covered Services include:

- X-rays
- Laboratory tests
- EKGs, EEGs
- Hearing tests
- Pre-admission tests
- Mammograms and pap smears. Screening mammograms and pap smears are covered when ordered by the PCP or Participating Specialist.
- Imaging/Nuclear cardiology studies when preauthorized by PCP or Participating Specialist.

Not covered: Court-ordered testing unless determined to be Medically Necessary by Paramount and rendered by a Participating Provider.

Drugs and other medicines (C/L) Covered when given during a hospital stay.

Not covered:

- Outpatient prescription drugs, unless the Group has purchased an optional drug rider
- Specialty Drugs, unless the Group has purchased an optional drug rider
- Growth hormones or steroids used for growth and development, unless the Group has purchased an optional drug rider.

Drug abuse/addiction treatment (See Substance Abuse Services.)

Durable Medical equipment (C/L) Covered from Participating Providers if the Group has purchased optional Durable Medical Equipment Rider, the item serves a medical purpose only and can withstand repeated use. Paramount covers medical equipment and supplies that are covered by Medicare Part B and meet Medicare Part B criteria. This includes but is not limited to: oxygen, crutches, wheelchairs, hospital beds, glucometers, chem-strips, lancets, asthma supplies, ostomy supplies, etc.

Not covered:

- Medical equipment and supplies not covered by Medicare Part B
- Disposable supplies (except for ostomy supplies), test kits etc.
- Exercise equipment, air conditioners
- Hearing aids unless the Group has purchased an optional rider
- Penile implants, erectile devices unless the Group has purchased an optional rider
- Shoes including molds and inserts (foot orthotics) unless covered by Medicare Part B
- Wigs
- Bite plates, retainers, snore guards, splints or any appliance or device which is fitted to the mouth

Emergency services (C/L) Covered for facility and physician services for Emergency Medical Conditions meeting the definition in Section 3 of this handbook. 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.

Employer requested exams and treatment Not covered, unless determined to be Medically Necessary by Paramount and rendered by a Participating Provider.

Experimental organ transplants, drugs, devices, tests, medical or surgical procedures Not covered.

Foot Care (C/L) Covered when properly referred to a Participating Specialist.

Not covered:

- Trimming and/or scraping of calluses, corns and nails except for services with a diagnosis of diabetes or other conditions causing loss of sensation
- Foot orthotics including shoes, shoe molds and inserts, unless the Member's condition meets Medicare Part B criteria.
- Extra Corporeal Shock Wave Therapy (ESWT)

Gastric stapling, by-pass or diversion See Morbid Obesity Surgery.

Growth hormones/steroids Not covered for use to promote growth and development unless the Group has purchased an optional rider.

Home health care (C/L) Covered when properly referred to Participating Providers. Services include:

- Physician services
- Intermittent skilled nursing care
- Physical, occupational and speech therapy
- Other medically necessary services

Not covered:

- Personal comfort and convenience items and services such as meals, housekeeping, bathing and grooming.
- Any services or supplies furnished by a non-eligible institution, which is any institution other than a hospital or skilled nursing facility (for example, custodial, convalescent, domiciliary and intermediate or day care)
- Care provided by family members
- Private-duty nursing in the home unless group has purchased an optional rider
- Trimming of calluses, corns and nails (see Foot Care)
- Custodial or respite care

Hospice services (C/L) Covered when medically necessary for terminally ill patients and when properly referred to Participating Providers.

Hospital and other facility services

Inpatient services: (C/L) Covered for inpatient room, board and general nursing care in non-private rooms. (See Section 2/Entering the Hospital)

Outpatient services: (C/L) Covered; including surgery, observation care and diagnostic testing. Outpatient emergency room care is covered under certain conditions. (See Section 3/Emergency Services and Urgent Care Services.)

Outpatient Surgery: (C/L) Certain benefit plans may have a Copayment or Coinsurance if an outpatient surgical facility or hospital surgical treatment room is used. Outpatient surgical facilities or hospital surgical treatment rooms are used for surgical procedures and other procedures including but not limited to endoscopic procedures such as colonoscopy, arthroscopy, laparoscopy and pain blocks (injections). See your Summary of Benefits.

Professional services: (C/L) The services of physicians and other professionals are covered when related to eligible inpatient and outpatient hospital services. Covered services include:

- Surgery
- Medical Care
- Newborn Care
- Obstetrical Care
- Anesthesiology
- Radiology and pathology

Except in an emergency, admissions must be to Participating Hospitals and must have prior authorization from Paramount.

Services and supplies: Covered when medically necessary if you are an inpatient or outpatient.

Not covered:

- Personal convenience items and services (telephone or television rental, guest meals, etc.)
- Private rooms, unless determined to be medically necessary by Paramount
- Private-duty nursing while an inpatient
- Any services or supplies furnished by a non-eligible institution, which is any institution other than a hospital or skilled nursing facility (for example, custodial, convalescent, domiciliary and intermediate or day care)

PLEASE REFER TO YOUR SUMMARY OF BENEFITS FOR INPATIENT AND OUTPATIENT LIMITATIONS.

Infertility Services (C/L) Covered for the medically necessary diagnosis and treatment of infertility conditions.

Not Covered:

- Infertility drugs
- Any assisted reproduction 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.

Kidney disease treatments (C/L) Covered for:

- Hemodialysis
- Peritoneal dialysis
- Kidney transplant services (see Transplants)
- If the patient qualifies for End-Stage Renal Disease (ESRD) benefits under Medicare, we will coordinate benefits as the secondary carrier. All Paramount procedures must be followed.

Laser Treatment including Candela, V-Beam and photodynamic therapy for rosacea, port wine stains and other skin disorders Not covered.**Maternity care and family planning** (C/L) Covered for:

- Prenatal and postnatal care (office visit copay does not apply to prenatal and postnatal visits)
- Delivery including complications of pregnancy, hospitalization and anesthesia. A minimum hospitalization of forty-eight (48) hours will be allowed for normal vaginal delivery and ninety-six (96) hours for cesarean delivery unless you and your physician determine otherwise. If you are discharged earlier, follow-up home health care by a participating provider will be covered for at least seventy-two (72) hours after discharge.

Not covered:

- Voluntary sterilization (unless the Group has purchased an optional benefit rider)
- Surrogate parenting/ pregnancy and related services when the adoptive parents are responsible for the surrogate mother's medical expenses.
- Abortions, unless medically necessary (i.e., to save the life or protect the health of the mother)
- Outpatient self-administered prescription drugs

Mental Health Services

- **Services for a Biologically and/or Non-Biologically Based Mental Illness** (C/L) Covered for inpatient and outpatient care subject to the same Deductible, Copayments and/or Coinsurance as any other physical disease or condition. See your Summary of Benefits for further details.

Not covered:

- Court-ordered testing or treatment unless determined to be Medically Necessary by Paramount and rendered by a Participating Provider
- Testing and treatment for learning disabilities and mental retardation
- Residential treatment
- Marriage or relationship counseling
- Hypnosis and biofeedback
- Social skills classes, behavioral modification and other training programs including but not limited to, Applied Behavioral Analysis (ABA) programs

Morbid Obesity Surgery Not covered, including, gastric reservoir reduction, gastric stapling or diversion for weight loss.**Office visits** (C/L) Covered for:

- Your Primary Care Provider (PCP)
- Participating OB/GYNs and other Paramount Specialists
- Eligible services provided during each visit, may include:
 - Periodic physical exams
 - Well-baby/child exams
 - Gynecological exams
 - Immunizations

- Diagnostic procedures
- Medical/surgical procedures

Not covered:

- Charges for completion of reports, transfer of records, or missed appointments.

Oral surgery (See Dental service and oral surgery.)

Plastic surgery (See Reconstructive surgery.)

Penile implants Not covered unless the Group has purchased an optional rider.

Physical exams (C/L) Covered if exams are periodic physical exams as considered medically necessary by the physician.

Not covered when requested for:

- Obtaining or maintaining employment or governmental licensure
- Employer-requested annual physical exams
- Court-ordered or forensic evaluations unless determined to be Medically Necessary by Paramount and rendered by a Participating Provider
- Physicals and immunization required for travel

Preventive Health Services/Benefits

Under Ohio law, the following preventive health benefits are required to be provided in your Plan:

- Initial Mammography starting at age 35
- Annual screening for cervical cancer
- Child Health Supervision

Your Plan provides additional coverage for selected preventive services without a copayment, coinsurance or deductible **when these services are delivered by a Participating Provider**. Depending upon your age, services may include:

- Screenings and tests for diseases
- Mental Health screenings, including substance abuse
- Healthy lifestyle counseling
- Vaccines and immunizations
- Pregnancy counseling and screenings
- Well baby and well child visits through age 21
- Periodic physical exams

Eligible services have been determined by recommendations and comprehensive guidelines of governmental scientific committees and organizations. You will be notified, at least sixty (60) days in advance, if any item or service is removed from the list of eligible services. Eligible services will be updated annually to include any new recommendations or guidelines.

Please contact us at **www.paramountinsurancecompany.com or (419)-887-2525**, if you have any questions or need to determine whether a service is eligible for coverage as a preventive service. For a comprehensive list of recommended preventive services, please visit www.healthcare.gov/center/regulations/prevention.html.

Private-duty nursing Not covered in the home unless the Group has purchased an optional rider.

Prosthetic devices (C/L) Covered from a Participating Provider if the Group has purchased optional Prosthetics Rider. Refer to your Summary of Benefits for further Copayment/Coinsurance or limits. Paramount covers prosthetic devices that are covered by Medicare Part B and meet Medicare Part B criteria. Repair and replacement of a prosthetic device is covered subject to meeting Medicare Part B criteria. A Prosthetic Device is an artificial substitute that replaces all or part of a missing body part and its adjoining tissues.

Not Covered:

- Prosthetic devices not covered by or eligible under Medicare Part B

Radial keratotomy or refractive surgery (LASIK) (surgery on the eyes to correct near-sightedness or far-sightedness) Not covered

Reconstructive surgery Covered when required for:

- Repair of anatomical impairment to improve or correct functional disability within 2 years of accident or injury or up to age 18 if a congenital anatomical functional impairment.
- Breast reconstruction following a mastectomy; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas in accordance with the Women's Health and Cancer Rights Act of 1998.
- Plastic surgery following an accidental injury that results in a significant defect or deformity within 2 years of the accident.
- A malignant or non-malignant neoplasm within 2 years following initial surgery for neoplasm.

Not covered:

- Cosmetic therapy and surgery
- Breast reduction/augmentation
- Staged procedures and surgeries when performed in preparation of a non-covered reconstructive surgery

Sclerotherapy for spider angiomas (veins) Not covered

Skilled nursing facility (C/L) Covered when medically necessary with prior authorization from Paramount. Services must be at a Participating Facility approved by Paramount. Paramount will provide coverage for eligible services in a non-participating facility if all the conditions below apply:

- The Member or the Member's spouse resided in or had a contract to reside in a non-participating facility on or before September 1, 1997,
- Immediately prior to being hospitalized the Member or the Member's spouse resided in any part of the non-participating facility, and following hospitalization, the Member or the Member's spouse resides in a part of the non-participating facility that is a skilled nursing facility,
- The non-participating facility provides the Member with the skilled level of care the Member requires,
- The non-participating facility is willing to accept the terms and conditions that apply to Paramount's participating skilled nursing facilities.

Not covered: Custodial care

Skin tag removal Not covered.

Sleep Studies (C/L) Coverage is available in participating facilities for certain clinical indications of obstructive sleep apnea, narcolepsy and seizure disorder when approved in advance by Paramount.

Not covered: Sleep studies for sexual dysfunction

Smoking cessation classes (C/L) Covered at Participating Hospitals.

Substance Abuse Services (alcohol and drug abuse/addiction) (C/L) Covered for inpatient and outpatient care, if the group has purchased an optional rider, for diagnosis, crisis intervention and short-term treatment of substance abuse services. Covered services are subject to the same Deductible, Copayments and/or Coinsurance as any other physical disease or condition.

Partial hospitalization (comprehensive outpatient treatment) and intensive outpatient programs (comprehensive and primarily educational programs for substance abuse and some mental health conditions) are available when approved in advance by Paramount.

Not covered:

- Court-ordered testing or treatment unless determined to be Medically Necessary by Paramount and rendered by a Participating Provider
- Residential treatment
- Long-term rehabilitation

Surrogate and/or Gestational Parenting and Pregnancy and related services Not covered.

Therapy services (C/L) Covered for:

- Chemotherapy, radiotherapy and radiation therapy
- Outpatient physical/occupational therapy. See Summary of Benefits for limitations.
- Speech therapy. See Summary of Benefits for limitations.

Not covered:

- Non-medical services such as vocational rehabilitation, employment counseling and psychological counseling (except for mental health diagnoses under mental health rider)
- Testing, training and educational therapy for learning disabilities including development delays in children. Equestrian therapy.
- Physical/occupational therapy beyond benefit limits.
- Speech therapy beyond benefit limits.
- Extra Corporeal Shock Wave Therapy (ESWT) for conditions of the feet, elbows and shoulders.

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, your PCP and Specialist 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 lodging and meals (not to exceed \$30.00 per day 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.

Not covered:

- Services related to a Paramount organ/bone marrow donor for a non-Paramount recipient.
- Any transplant not approved by the Ohio Solid Organ Transplant Consortium or the Ohio Bone Marrow Transplant Consortium
- Coverage of non-Paramount donor unless no other coverage exists.
- Any services rendered at a non-Paramount Center of Excellence transplant site.

Transsexual surgery and related services Not covered.

Trimming of nails, calluses and corns Not covered except for services with a diagnosis of diabetes or other conditions causing loss of sensation.

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

Not covered:

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

Vision care (C/L) Covered as needed for treatment related to a medical condition or disease of the eyes. One routine vision exam every twelve (12) months to monitor refractory disorders of the eyes will be covered, unless a separate vision program is available. Service must be rendered by a Participating Specialist.

Not covered:

- Routine vision exams more often than every twelve (12) months
- Orthoptic training
- Contact lenses, eyeglasses and other corrective lenses except following cataract surgery unless the group has purchased an optional rider

Weight loss/maintenance programs and treatments Not covered, including; weight-loss programs, and prescription drugs for weight loss.

Dietary or nutritional supplements for gaining or maintaining weight are not covered, except for charges for non-milk, non-soy formula. The non-milk, non-soy formula must be required to treat diagnosed diseases and disorders of amino acid or organic acid metabolism, protein sensitivity resulting in severe chronic diarrhea, and severe malabsorption syndrome resulting in malnutrition, provided the formula is prescribed by a Participating Physician, and the Physician furnishes supporting documentation to Paramount. The benefits will be limited to those conditions where the formula is the primary source of nutrition as certified by the treating physician by diagnosis.

WHO IS ELIGIBLE

The following persons are eligible for coverage. They must reside in the Paramount Service Area and the Subscriber (employee) must list them on the enrollment application.

Subscriber The employee who meets eligibility requirements established by employer and in accordance with the Group Medical and Hospital Service Agreement.

Spouse The legal spouse of the Subscriber.

Dependent children This Plan will cover your married or unmarried child as defined in this Member Handbook until your child reaches age 26.

If a Subscriber or Subscriber's spouse has been court-ordered to maintain health care coverage on their dependent child who resides outside the Paramount Insurance Company Service Area, that child shall be eligible to enroll in this plan.

Coverage for service rendered outside the Service Area by non-participating providers will be limited to Emergency Medical Conditions.

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

Extension of Adult Child Coverage to Age 28 (effective at the first group renewal after July 1, 2010).

In accordance with ORC 1751.14, and upon the written request of the Subscriber, 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:

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

A child may be enrolled:

1. When the child reaches the dependent limiting age.
2. When the child experiences a change in circumstances. Change in circumstances includes moving back to the Paramount Service Area or the child losing employer-sponsored coverage.
3. During the Annual Open Enrollment Period of the Employer.

Within 30 days of one of the above events, the Subscriber must certify in writing that the child is eligible under the above conditions. The Subscriber must pay the full cost of the child's coverage to the employer. To obtain the form required to apply for extension of child coverage to age 28, the Subscriber should contact their employer or a Paramount Member Services representative at (419) 887-2531 or toll-free 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.

If the Dependent does not meet these requirements, he or she may be eligible for continuation coverage under the employer group's health benefit plan or individual conversion coverage. See your benefits officer with questions.

Dependent students Dependent students are covered up to age 26.

Paramount, through its Student Coverage 101 Program, provides coverage for emergency, urgent and follow-up care as well as care provided by student health centers while your Dependent student is away at school outside of the Paramount Service Area. If your Dependent student needs medical care away from home that is not available from the student health center and it is not an emergency or urgent condition, before seeking services You or Your Dependent student should contact our Utilization Management Department to obtain prior authorization. In the event of an Emergency Medical Condition, call 911, an ambulance or rescue squad or go directly to the nearest medical facility.

Paramount's Utilization Management Department is also available to assist You and/or Your Dependent student in locating providers outside of the Paramount Service Area; contact Utilization Management at (419) 887-2520 or 1-800-891-2520.

Not eligible: Grandchildren, parents and married dependents.

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

The only other time you may enroll a child is during your employer's open enrollment period, or a special enrollment period (see pg. 32).

Adopted children Coverage for newly adopted children will be effective from the date of adoptive placement. Adoptive placement means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of the adoption of the child. The child's placement with a person terminates upon termination of the legal obligation. The adopted child must be enrolled within thirty-one (31) days from the event.

The only other time you may enroll adopted children or stepchildren is during your employer's open enrollment period, or a special enrollment period (see pg. 32).

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

The only other time you may enroll your spouse is during your employer's open enrollment period, or a special enrollment period (see pg. 32).

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

Any ineligible Dependents may be eligible for continuation coverage under the employer group's health benefits plan or individual conversion coverage. See your benefits office for details.

Death of a subscriber Dependents of a deceased Subscriber may be eligible for continuation coverage under the employer group's health benefits plan or individual conversion coverage. See your benefits office for details.

Adding and Removing Members When you need to change the number of Members covered under your plan, it is your responsibility to notify your employer and Paramount promptly. **YOU MUST COMPLETE AN ENROLLMENT APPLICATION WHEN YOU NEED TO ADD A MEMBER TO OR REMOVE A MEMBER FROM YOUR PLAN. Contact your benefits office.**

Group Affiliation, Probationary or Waiting Period New employees of employers with more than fifty (50) employees will have coverage effective after the affiliation, probationary or waiting period established by the employer. For employers with less than fifty (50) employees, the affiliation, probationary or waiting period for new employees will not be more than sixty (60) days and not more than ninety (90) days for late enrollees. See your benefits office for details.

Group Annual Open Enrollment Period If you have a new Dependent due to marriage, adoption (including placement) or birth of a baby, they may be added to this plan if the Subscriber completes and submits an application to the employer within thirty-one (31) days from the event. If you do not enroll eligible Dependents for coverage during the first employer enrollment period or within thirty-one (31) days of eligibility, you must wait until your employer's next annual open enrollment period to add them. See your benefits office for details.

Special Enrollment Period If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 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 you 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 you or your dependent’s Medicaid or CHIP coverage ends.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Coverage under the special enrollment period will be effective on the day following the date other coverage ends or the date of the event. See your benefits office for details.

Nondiscrimination No one who is eligible to enroll as a Subscriber, Dependent or Dependent with disabilities will be refused enrollment by Paramount based on health status, health care needs or age. 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 the Termination of Coverage section.

Renewal of Coverage

If all the conditions of group eligibility are met, the group coverage will be renewed. Renewal of coverage is not based on the Member’s health condition and is not subject to any genetic testing or the results of such testing.

Paramount will renew coverage at the option of the employer group. Paramount will not renew group coverage only under the following conditions;

- Non-payment of premiums
- Fraud
- The group falls below minimum contribution or participation rules

Termination of Member Coverage

A Member’s coverage under Paramount may end for any of the following reasons:

- You fail to pay, or have paid for you, the required prepayments.
- You no longer meet the eligibility requirements.
- You no longer reside in the Paramount Service Area (except for court-ordered dependents).
- You have performed an act or practice that constitutes fraud or material misrepresentation of material fact under the terms of the coverage.

The termination may not be based, either directly or indirectly, on any health status-related factor concerning the Member. Do not use your ID card after your coverage ends.

Rescission of Coverage

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.

Benefits After Cancellation of Coverage

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

- The effective date of any new coverage.
- The date of discharge,
- The attending physician certifies that inpatient care is no longer medically indicated,
- The maximum in benefits have been reached.

Certificate of Creditable Coverage

If your coverage with Paramount ends for any reason, you will receive a Certificate of Creditable Coverage indicating the length of time you were covered by Paramount without a sixty-three (63) day lapse in coverage. If you buy health insurance through another plan, this certificate may help you obtain coverage without a pre-existing condition exclusion.

5. WHAT HAPPENS WITH YOUR PLAN

When You Have Other Coverage - How Coordination of Benefits Works

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 § sections 3923.37 and 1751.56; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

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

- B. “This plan” means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of the other plans. Any other part of the contract providing health care benefits is separate from This plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only similar benefits, and may apply another COB provision to coordinate other benefits.
- C. The order of benefit determination rules determine whether This plan is a Primary plan or Secondary plan when the person has health care coverage under more than one Plan.

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

- D. “Allowable expense” is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an Allowable expense.

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

- (1) The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable Expense, unless one of the Plans provides coverage for private hospital room expenses.
- (2) If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.
- (3) If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.
- (4) If a person is covered by one Plan that calculates its benefits or services on the basis of usual or customary fees or relative value schedule reimbursement methodology or similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fee or payment amount is different than the Primary Plan’s payment arrangement and if the provider’s contract permits, the negotiated fee or payment shall be the Allowable expense used by the Secondary plan to determine its benefits.

- (5) The amount of any benefit reduction by the Primary plan because a covered person has failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.
- E. Closed panel plan is a Plan that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.
- F. Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding temporary visitation.

Order of Benefit Determination Rules

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

- A. The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.
- B. (1) Except as provided in Paragraph (2), a Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying plan is primary.
- (2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide out-of-network benefits.
- C. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.
- D. Each Plan determines its order of benefits using the first of the following rules that apply:
- (1) Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary plan and Plan that covers the person as a dependent is the Secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person other than as a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.
- (2) Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:
- (a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

- The Plan of the parent whose birthday falls earlier in the in the calendar year is the Primary plan;or
 - If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.
 - However, if one spouse’s plan has some other coordination rule (for example, a “gender rule” which says the father’s plan is always primary), This plan will follow the rules of that plan.
- (b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
- (i) If a court decree states that one of the parents is responsible for the dependent child’s health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the decree;
 - (ii) If a court decree states that both parents are responsible for the dependent child’s health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;
 - (iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits;
 - (iv) If there is no court decree allocating the responsibility for the dependent child’s health care expenses or health care coverage, the order of benefits for the child are as follows:
 - The Plan covering the Custodial parent;
 - The Plan covering the spouse of the Custodial parent;
 - The Plan covering the non-custodial parent; and then
 - The Plan covering the spouse of the non-custodial parent.
- (c) For a dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.
- (3) Active Employee or Retired or Laid-off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering the same person as retired or laid off employee is the Secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.
- (4) COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, The Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber, or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.
- (5) Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary plan and the Plan that covered the person the shorter period of time is the Secondary plan.
- (6) If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared

equally between the Plans meeting the definition of Plan. In addition, This plan will not pay more than it would have paid had it been the Primary plan.

Effect on the Benefits of this Plan

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

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This plan and other Plans. Paramount may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This plan and other Plans covering the person claiming benefits. Paramount need not tell, or get consent of any person to do this. Each person claiming benefits under This plan must give Paramount any facts it needs to apply those rules and determine benefits payable.

Facility of Payment

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

Right of Recovery

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

Coordination Disputes

If 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 6, What to do When You Have Questions, Suggestions,

Complaints and Appeals. If you are still not satisfied, you may call the Ohio Department of Insurance for instructions on filing a consumer complaint. Call 1-800-686-1526, or visit the Department's website at <http://insurance.ohio.gov>

When You Are Eligible for Medicare

If any enrolled Member is entitled to Medicare benefits, federal law will control whether Paramount or Medicare is primary. Contact your employer for current guidelines.

When You Qualify for Worker's Compensation

If you or your Dependents receive health care services due to an injury which may be covered by Worker's Compensation, you must notify Paramount as soon as possible.

If you filed a claim for Worker's Compensation, Paramount will withhold payment to your providers until the case is settled. If Paramount has made any payment to your provider and services are covered by Worker's Compensation, you are expected to reimburse Paramount for the amounts paid. Please refer to the Group Medical and Hospital Service Agreement filed with your employer for further details.

When Someone Else Is Liable (Subrogation and Reimbursement)

Where a Member has benefits paid by Paramount for the treatment of sickness or injury caused by a third party or the Member, these are conditional payments that must be reimbursed by the Member if the Member receives compensation, damages or other payment as a result of the sickness or injury from any person, organization or insurer, including the Member's own insurer, and any uninsured and/or underinsured motorist insurance. Paramount may subrogate to the Member's rights of recovery.

Paramount has reimbursement and subrogation rights equal to the value of medical benefits paid for Covered Services provided to the Member. Paramount subrogation rights are a first party claim against any recovery and must be paid before any other claims, including claims by the Member for damages (with the exception of claims by the Member pursuant to the property damage provisions of any insurance policy). This means the Member must reimburse Paramount, in an amount not to exceed the total recovery, even when the Member's settlement or judgment is for less than the Member's total damages and must be paid without any reductions for attorneys fees.

When You Leave Your Job

Members who no longer meet eligibility requirements under Section 4 of this handbook may be eligible for continuation coverage under the employer group's health benefits plan.

How You May Continue Group Coverage

To get group continuation coverage when you are no longer eligible for the employer's group plan, you must live in the Paramount Service Area, and you must pay the required monthly prepayment (the share your former employer used to pay) to the group plan, your former employer. How long you are allowed to continue your coverage depends on the circumstances and the conditions provided in your employer group's plan.

The following are conditions under which you may continue Paramount coverage under your current plan. See your benefits office for further information.

1. If your employer group has **20 or fewer** employees and your employment ends, you and your eligible Dependents may be able to continue your Paramount group coverage through that employer for up to twelve (12) months under state law. To be eligible for state group continuation coverage, you must also meet the guidelines below:
 - You must have been employed for at least three (3) months before termination of your employment
 - You did not voluntarily terminate your employment and the termination is not the result of gross misconduct
 - You must not be or become eligible for Medicare coverage or any other group health coverage

2. If any of the following events occur and your employer group has **more than 20** employees, you or your Dependents may be able to continue your coverage under the federal Consolidated Omnibus Budget Reconciliation Act (COBRA):
 - Termination of your employment (for reasons other than gross misconduct) or reduction of hours of employment
 - Termination of your employment due to Chapter 11 Reorganization by your employer
 - Your death
 - Your divorce or legal separation
 - The end of a child's status as a dependent under the plan
 - Your eligibility for Medicare benefits

The conversion option must be offered to you by your former employer **during the 180 days before the expiration of continuation (COBRA) coverage.**

Group Coverage may be continued, if a covered Subscriber (employee) is called to active duty in the Armed Forces of the United States including the Ohio National Guard and Ohio Air National Guard.

- 1) The covered Subscriber and Dependents may continue coverage for up to eighteen (18) or twenty-four (24) months.
- 2) Covered Dependents may continue coverage for up to thirty-six (36) months if any of the following events occurs during the eighteen (18) or twenty-four (24) month period;
 - a) The death of the reservist.
 - b) The divorce or separation of a reservist from the reservist's spouse.
 - c) A covered Dependent child's eligibility under this coverage ends.
- 3) The continuation period begins on the date coverage would have terminated because the reservist was called to active duty.
- 4) The Subscriber and/or Dependent must complete and return to the employer an election form within thirty-one (31) days of the date coverage would terminate.
- 5) The Subscriber and/or Dependent must pay any required contribution to the employer not to exceed 102% of the group rate.
- 6) Continuation coverage will end on the date any of the following occurs:
 - a) The subscriber or Dependent becomes covered by another group plan without any pre-existing condition restriction.
 - b) The maximum period of months expires.
 - c) The Subscriber or Dependent does not make the required payment
 - d) The group contract with Paramount is terminated.

How to Convert to Individual Coverage (When Group Coverage Is No Longer Available)

If your group coverage or continuation coverage ends, you and/or your eligible Dependents can convert to individual membership without providing evidence of insurability. You may call Paramount's Member Services Department and they will send you a summary of conversion benefits available and a payment schedule. A Member who meets the definition of a Federally Eligible Individual will have the option to convert to a basic or standard plan.

To obtain individual membership, you must meet all of the following conditions:

- You must live in the Service Area (except for court-ordered Dependents)
- You must submit a complete application for conversion to an individual policy within thirty-one (31) days after the date your group coverage ends
- You must submit any prepayment required. Details of the current prepayment rates will be sent to you at your request for conversion information.

Please be aware that an individual plan may not offer all the same benefits as your group coverage plan.

Conditions of Individual Conversion

- Conversion to individual coverage will be available to Members who live in the Paramount Service Area, are not eligible for Medicare benefits or any other policy of insurance or health care plan providing comparable benefits, and have lost eligibility due to termination of employment conditions or Dependent eligibility requirements explained in Section 4.
- Your former employer's Group Medical and Hospital Service Agreement must be in effect at the time of conversion in order to be eligible for this option.
- If a Member chooses to apply for conversion, the conversion will be effective retroactively from the date group or continuation coverage ended. If a Member chooses not to apply for conversion and receives health services or benefits during the 31-day decision period, that Member must pay for those services.
- The Member is responsible for the required payment according to the plan's prepayment schedule as detailed in the individual plan document ("Individual Medical and Hospital Service Agreement").

For details, see the Group Medical and Hospital Service Agreement available from your employer's benefit office, or call Member Services.

If Paramount Ends Operations

In the event Paramount would end operations, Members' benefits would be covered until the Group Medical and Hospital Service Agreement expired. All prepayments must be made in accordance with the terms of the agreement. Since Paramount Insurance Company is not part of the guaranty fund, Members are protected only to the extent of the hold harmless provision required by ORC 1751.13. The hold harmless provision states with the exception of a Deductible, Copayments, Coinsurance and non-covered services, Participating Providers may not bill a Member for Covered Services. If you are receiving a course of treatment when Paramount ends operations, Covered Services will continue to be provided by Participating Providers as needed to complete any medically necessary follow-up care for that course of treatment. If a Member is receiving Inpatient care at a hospital, coverage will be continued for up to thirty (30) days after the end of operations. If you need additional information, call the Member Services Department at (419) 897-2525 or 1-800-462-3589. If Paramount ends operations, a Member may have to pay for health care services rendered by a non-participating provider whether or not Paramount authorized the service.

6. WHAT TO DO WHEN YOU HAVE QUESTIONS, SUGGESTIONS, COMPLAINTS or APPEALS

Paramount's Member Services Department is available to assist you with any questions from 8:00 A.M. to 5:00 P.M., Monday through Friday.

If you call the Member Services Department after hours, you may leave a message and we will call you back on the next working day. You may also Email us through the Paramount web site at www.paramountinsurancecompany.com

The Member Services Department's goal is to help you with any questions about procedures, benefits, participating providers, payment for services, enrollment, etc. We encourage you to call us with any questions. Paramount provides a TTY number for members who are hearing impaired. Paramount will also provide translation services for members who don't speak English. If a Member needs foreign language translation services, they should call the Member Services Department. If you have any suggestions for improving our service or if you wish to recommend changes in procedures or benefits, please write us or call us. We also encourage you to develop a good relationship with your physician so that you fully understand the diagnosis and treatment prescribed.

Should you have any questions you may contact the Ohio Department of Insurance at:

Department of Insurance
50 W. Town Street,
Third Floor--Suite 300
Columbus, Ohio 43215
Telephone: (614) 644-2673
Toll Free: (800) 686-1526

How to Handle a Complaint

All Member complaints will be resolved informally whenever possible. You are encouraged to initially attempt to resolve complaints about medical treatment through your Primary Care Provider. If the complaint cannot be satisfactorily resolved in this manner, or if the complaint is not a medical treatment issue, you may telephone Paramount's Member Services Department. A Member Services Representative will be available to receive the call and seek informal resolution of the complaint. If your complaint is not resolved satisfactorily on an informal basis, the Member Services Representative will inform you of your right to seek formal resolution of the complaint through the internal appeals procedures described below.

Appeal to Paramount

An Adverse Benefit Determination eligible for internal appeal is a decision by Paramount to do any of the following:

- (1) Deny, reduce or terminate requested health care service or payment in whole or part;
- (2) Not issue health insurance coverage to an applicant in the individual and non-employer group markets; or
- (3) Rescind coverage under a health benefit plan.

If Paramount makes an Adverse Benefit Determination you will receive a written notification that includes:

- (1) Information sufficient to identify the claim involved, including the date of service, the health care provider and the claim amount.
- (2) The specific reasons for the adverse benefit determination;
- (3) A reference to the specific Plan provision upon which the adverse benefit determination is based;
- (4) A description of any additional material or information necessary for you to perfect your claim and an explanation of why such material or information is necessary;

- (5) The contact information for any applicable office of health insurance consumer assistance established to assist with the internal appeal and external review process; and
- (6) A description of the Plan's appeal procedures, the time limits applicable to such procedures, information on how to initiate an appeal and a statement of your right to bring a civil action under section 502(a) of ERISA;

You (the member), your Legal Representative, an Authorized Person, the provider, or the health care facility has the right to request an internal appeal of an Adverse Benefit Determination by contacting Paramount as set forth below in the section titled "Instructions for Requesting an Internal Review".

A provider or health care facility must have your authorization to request an appeal. You do not need the authorization of the provider. You may request an appeal of an Adverse Benefit Determination regardless of the actual or estimated cost of the health care service.

You will receive an acknowledgement from Paramount within five (5) days from receipt of your request for an internal appeal. You will be given the opportunity to attend a hearing before an administrative review panel. If you cannot attend the hearing, you may attend by teleconference or submit a written statement.

Instructions for Requesting an Internal Appeal

You may appeal an Adverse Benefit Determination at any time within 180 days of receiving notification of the Adverse Benefit Determination.

You must request an internal appeal in writing, unless the claim involves urgent care, in which case the appeal may also be requested orally. A claim involving "urgent care" is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations (a) could seriously jeopardize your life or health or your ability to regain maximum function; or (b) in the opinion of a physician with knowledge of the your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. If the claim involves urgent care, all necessary information, including Paramount's benefit determination on review, will be transmitted between you and Paramount by telephone, facsimile, or other available similarly expeditious method.

In connection with your written request for an internal appeal, you should submit comments, documents, records, and other information you believe is important to the claim for benefits that is the subject your request for an internal appeal.

Appeals to Paramount should be sent to the following address, or if a claim involves urgent care, you may contact Paramount by using the telephone, facsimile or e-mail below:

Paramount Insurance Company
Member Service Department-Appeals
P.O. Box 928
Toledo, Ohio 43697-0928
Telephone: (419) 887-2525
Toll Free: 1 (800) 462-3589
Facsimile: (419) 887-2037
E-mail: PHCMbrSvcAppeals@ProMedica.org

In connection with your right to an internal appeal of an Adverse Benefit Determination, you:

- (1) may submit written comments, documents, records, and other information relating to the claim for benefits;

- (2) may request free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits;
- (3) will receive, free of charge, any new or additional evidence or rationale considered, relied upon, or generated by Paramount sufficiently in advance of the date on which the notice of benefit determination on review is required to be provided to allow you a reasonable opportunity to respond prior to that date; and
- (4) will be provided, upon request, with the identification of the health care professional whose advice was obtained on behalf of the plan in connection with the Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination.

The appeal will be conducted by an appeal representative of Paramount who will issue a written decision within the time frames listed below:

Pre and Post Service Claims	30 calendar days from receipt of the appeal
Urgent Care Claims	Not later than 72 hours from receipt of the appeal

Full and Fair Review

To ensure you are provided with a full and fair review:

- (1) The review will take into account all comments, documents, records, and other information that you submit relating to the claim, without regard to whether this information was submitted or considered in the initial benefit determination;
- (2) The review will not afford deference to the initial adverse benefit determination and will be conducted by an appeal representative of Paramount and/or reviewed by a health care professional who is neither the individual who made or was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal, nor his or her subordinate;
- (3) The review will be conducted by an appeal representative of Paramount in consultation with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate;
- (4) The review will be conducted in a manner designed to avoid conflicts of interest by ensuring the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual will not be made based upon the likelihood that the individual will support the denial of benefits; and
- (5) There will be no reduction or termination of an ongoing course of treatment without advance notice from Paramount or an opportunity for advance review.

Concurrent Internal Appeal and External Review

If you are in the process of an internal appeal of an urgent care claim, you may also request that an expedited external review be conducted simultaneously in either of the following circumstances:

- (1) Your treating physician certifies in writing that you have a medical condition where the time frame for completion of an expedited review of an internal appeal involving the Adverse Benefit Determination would seriously jeopardize your life or health or your ability to regain maximum function; or
- (2) In the case of experimental or investigational treatment that otherwise meets the criteria for an external review, you may request an expedited review orally or by electronic means, if your treating physician also certifies in writing that the requested health care service would be significantly less effective if not promptly initiated.

If Your Appeal is Denied

If your appeal is denied, the appeal representative of Paramount will provide you with a written or electronic notification of the determination. The notification will be called a Final Adverse Benefit Determination.

The Final Adverse Benefit Determination will tell you the specific reason(s) for the denial, the specific plan provisions on which the determination is based, that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits and a statement of the right to bring an action under section 502(a) of ERISA. The Final Adverse Benefit Determination will also inform you of the right to pursue an external review, and explain the procedures for initiating the review including the time frames within which you must request external review.

If the claim involves urgent care, the notice may be provided to you orally within the time frames for urgent care claims described above. A written or electronic notice will be furnished to you within three days after the oral notice.

Your Right to an Additional Appeal

If Paramount issues a Final Adverse Benefit Determination for any of the reasons listed below, you, your Legal Representative or an Authorized Person has the right to ask for an external review:

- (1) You are entitled to an external review by an Independent Review Organization (IRO) if:
 - a. the Adverse Benefit Determination involves a medical judgment or is based on any medical information (this includes a decision that a covered person sought services at an emergency room for a condition that did not meet the prudent layperson definition of an emergency); or
 - b. the Adverse Benefit Determination indicates the requested service is experimental or investigational, is not specifically listed as an excluded benefit, and the treating physician certifies one of the following:
 - i. Standard health care services have not been effective in improving your condition;
 - ii. Standard health care services are not medically appropriate for you;
 - iii. No available standard health care service covered by Paramount is more beneficial than the requested health care service.
- (2) You are entitled to an external review by the Department of Insurance if:
 - a. the Adverse Benefit Determination is based on a contractual issue that does not involve medical judgment or any medical information; or
 - b. the Adverse Benefit Determination indicates that emergency medical services did not meet the prudent layperson definition of emergency and Paramount's decision has already been upheld through an external review by an IRO.

Exhaustion Requirements

You must exhaust the internal appeals process prior to initiating an external review except in the following circumstances:

- (1) Paramount agrees to waive the exhaustion requirement;
- (2) You did not receive a written decision on your internal appeal within the required time frame;
- (3) Paramount fails to meet all of the requirements of the internal appeal process unless the failure:
 - a. was de minimis;
 - b. does not cause or is not likely to cause you prejudice or harm;
 - c. was for good cause and beyond Paramount's control; and
 - d. is not reflective of a pattern or practice of non-compliance.

If Paramount denies your request for external review under subsection (3) above, you may request written explanation from Paramount, and Paramount shall provide explanation within ten (10) days, including a specific description of the reasons, if any, for asserting that the delay should not cause the internal appeals process to be considered exhausted. You may then request review by the Department of Insurance of the Paramount's explanation and if the Department affirms Paramount's explanation, you may, within ten (10) days of the Department's notice of decision, resubmit and pursue the internal appeals process. Time periods for re-filing the internal appeal shall begin to run upon your receipt of such notice.

You may not request an external review of an Adverse Benefit Determination involving a retrospective utilization review decision until Paramount's internal appeals process has been exhausted unless Paramount agrees to waive the exhaustion requirement.

Instructions for Requesting External Review

You may request an external review at any time *within 180 calendar days* of the date of the Final Adverse Benefit Determination.

When filing a request for external review, you will be required to authorize the release of your medical records as necessary to conduct the review. An authorization for the release of your medical records will be provided to you with the Final Adverse Benefit Determination. The completed authorization form must be returned with your request for external review or confirmation of your request for an expedited external review.

All requests for external review shall be made in writing, except when making a request for an expedited review. Requests for an expedited external review may be requested orally or by electronic means. When an oral or electronic request for review is made, written confirmation of the request must be submitted to Paramount no later than five days after the initial request was made.

In connection with your written request for external review, you should submit comments, documents, records, and other information you believe is important to the claim for benefits that is the subject your request for external review.

Please be sure to reference the paragraphs titled **Expedited External Review and External Review of Experimental or Investigational Health Care Services** for additional requirements in connection with a request for an expedited external review or an external review that involves experimental or investigational treatment.

Requests for external review should be sent to the following address, or if a claim involves a request for expedited review, you may contact Paramount by using the telephone, facsimile or e-mail below:

Paramount Insurance Company
Member Service Department-Appeals
P.O. Box 928
Toledo, Ohio 43697-0928
Telephone: (419) 887-2525
Toll Free: 1 (800) 462-3589
Facsimile: (419) 887-2037
E-mail: PHCMbrSvcAppeals@ProMedica.org

Upon receipt of a request for an external review, Paramount will review it for completeness. If the request is complete, Paramount will initiate the external review and notify you, in writing, that the request is complete. If the request for external review is not complete, Paramount will inform you, in writing, of the information needed to make the request complete.

If Paramount denies a request for external review on the grounds that the Final Adverse Benefit Determination is not eligible for external review, you may appeal the denial to the Department of Insurance.

Expedited External Review

You may make a request for an expedited external review of a Final Adverse Benefit Determination under the following circumstances:

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

An expedited external review may not be provided for retrospective Final Adverse Benefit Determinations.

External Review of Experimental or Investigational Health Care Services

You may request an external review of a Final 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.

- (1) To request an external review of a Final Adverse Benefit Determination based on the conclusion that a requested health care service is experimental or investigational, your treating physician must certify that one of the following situations is applicable:
 - a. Standard health care services have not been effective in improving the condition of the Member;
 - b. Standard health care services are not medically appropriate for the covered person; or
 - c. There is no available standard health care service covered by the Paramount that is more beneficial than the requested health care service.

External Review Determination

An IRO assigned to review a Final Adverse Benefit Determination will provide you written notice of its decision to either uphold or reverse the determination within 30 days of receipt of a request for standard review or a standard review involving experimental or investigational treatment, or within 72 hours of receipt of an expedited request.

If the IRO issues a decision to reverse the Final Adverse Benefit Determination, Paramount will immediately provide coverage for the service or services in question.

For appeals to the Department of Insurance, if the Department notifies Paramount that making a decision requires the resolution of a medical issue, Paramount will initiate an external review with an IRO. If the Department determines that the health service is a covered service, Paramount will cover the service. If the Department determines that the health care service is not a covered service, Paramount is not required to cover the service or afford you further external review.

An external review decision is binding on you and Paramount except to the extent you or Paramount have other remedies available under applicable federal or state law, or unless the Department of Insurance determines that, due to the facts and circumstances of an external review, a second external review is required.

Limitation on Legal Actions

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.

7. TERMS AND DEFINITIONS

AFFILIATION, PROBATIONARY OR WAITING PERIOD is the period between the date the individual files a substantially complete application for coverage and the first day of coverage.

BASIC HEALTH CARE SERVICES as defined by Section 1751.01 of the Ohio Revised Code are: Physician's services, inpatient hospital services, outpatient medical services, emergency health services, diagnostic laboratory services and diagnostic and therapeutic radiology services, diagnostic and treatment services, other than prescription drug services, for biologically based mental illnesses, preventative health services including family planning, infertility services, periodic physical examinations, prenatal obstetrical care and well-child care; and routine patient care for patients enrolled in an eligible cancer clinical trial pursuant to section 3923.80 of the Ohio Revised Code.

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

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.

COINSURANCE is your share of the cost of some Covered Services (a percentage of the amount allowed). For example, you may be responsible for 20% of the average charge allowed for Covered Services.

CONTRACT YEAR is a calendar year or the term for which the employer group has an agreement with Paramount to provide Covered Services to eligible Subscribers and their Dependents.

COPAY/COPAYMENT is your share of the cost of some Covered Services. Copayment is a specific dollar amount, such as \$5.00 or \$10.00. Copayments for specific dollar amounts are due and payable at the time services are provided.

COVERED SERVICES are authorized services shown in our list of services covered and rendered by a provider for which Paramount will provide payment. A Covered Service may be subject to a Copayment/Coinsurance or other limitations.

CREDITABLE COVERAGE is the period of prior health plan coverage of an individual enrollee which may entitle the enrollee to reduce the effective time period of a pre-existing condition exclusion that may be present in future coverage sought by the individual. Upon termination of your coverage with Paramount, you are entitled to receive a Certificate of Creditable Coverage which provides information regarding prior coverage with Paramount. Creditable coverage does not include coverage solely for dental, vision or prescription drug benefits.

DEDUCTIBLE is the amount you must pay for Covered Services within each Contract Year before benefits will be paid by Paramount. The single Deductible is the amount each Member must pay; the family Deductible is the total amount any two or more covered family members must pay.

DEPENDENT means any member of a Subscriber's family who meets all the applicable eligibility requirements, has been enrolled in the plan and for whom the payment required by the employer's group agreement has been received by Paramount.

DESIGNATED REPRESENTATIVE means a provider appointed by Paramount to administer managed care and/or cost containment programs for this coverage.

ELIGIBLE CANCER CLINICAL TRIAL under ORC 3923.80 means a cancer clinical trial that meets all of the following criteria:

- a) A purpose of the trial is to test whether the intervention potentially improves the trial participant's health outcomes.
- b) The treatment provided as part of the trial is given with the intention of improving the trial participant's health outcomes.
- c) The trial has a therapeutic intent and is not designed exclusively to test toxicity or disease pathophysiology.
- d) The trial does one of the following:
 - (i) Tests how to administer a health care service, item, or drug for the treatment of cancer;
 - (ii) Tests responses to a health care service, item, or drug for the treatment of cancer;
 - (iii) Compares the effectiveness of a health care service, item, or drug for the treatment of cancer with that of other health care services, items, or drugs for the treatment of cancer;
 - (iv) Studies new uses of a health care service, item, or drug for the treatment of cancer.
- e) The trial is approved by one of the following entities:
 - (i) The national institutes of health or one of its cooperative groups or centers under the United States department of health and human services;
 - (ii) The United States food and drug administration;
 - (iii) The United States department of defense;
 - (iv) The United States department of veterans' affairs.

EFFECTIVE DATE is the date your coverage begins.

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

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

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

EMERGENCY SERVICES means the following:

- a) 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;
- b) Such further medical examination and treatment that are required by federal law to stabilize an Emergency Medical Condition and are within the capabilities of the staff and facilities available at the hospital, including any trauma and the burn center of the hospital.

Stabilize 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. In the case of a woman having contractions, "stabilize" means such medical treatment as may be necessary to deliver, including the placenta.

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. Your plan may contain some or all of these types of benefits prior to 2014 when they become mandatory. If your plan contains any of these benefits, there are certain requirements that may apply to those benefits, as provided in this Member Handbook.

EXPERIMENTAL is any treatment, procedure, facility, equipment, drug, device or supply which Paramount does not recognize as accepted medical practice or which did not have required governmental approval when you received it. This includes treatments and procedures which:

- Are still in the investigative or research state,
- Have not been adopted for general clinical use,
- Have not been approved or accepted by the appropriate review body, or
- Are not generally accepted by the local medical community as safe, appropriate and effective treatment

This determination is based on the recommendation of the Medical Advisory Committee, the most recent *HAYES Medical Technology Directory*® and on current evidenced-based medical/scientific publications.

FEDERALLY ELIGIBLE INDIVIDUAL is an individual who meets the qualifications listed below:

1. The individual has at least 18 months of creditable coverage without a significant break (63 days) in coverage as of the date on which the individual seeks coverage.
2. The individual's most recent prior creditable coverage was under a group health plan, government plan, or church plan (or health insurance coverage offered in connection with any of these plans).
3. The individual is not eligible for coverage under any of the following:
 - (I) A group health plan.
 - (II) Part A or Part B of Title XVIII (Medicare) of the Social Security Act.
 - (III) A state plan under Title XIX (Medicaid) of the Social Security Act (or any successor program).
4. The individual does not have other health insurance coverage.
5. The individual's most recent coverage was not terminated because of nonpayment of premiums or fraud.
6. If the individual has been offered the option of continuation under a COBRA continuation provision or a similar State program, the individual has both elected and exhausted the continuation coverage.

INPATIENT is a patient who stays overnight in a hospital or other medical facility.

MEDICAL NECESSITY means the service you receive must be:

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

MEMBER means any Subscriber or Dependent as defined in Section 4/Who Is Eligible.

NON-BIOLOGICALLY BASED MENTAL ILLNESS means mental illnesses that are not Biologically Based Mental Illnesses as defined in this Member Handbook.

OUT-OF-POCKET COPAYMENT LIMIT is the maximum amount of Copayments and Coinsurance you pay every Contract Year on Basic Health Services. Once the Out-of-Pocket Copayment Limit is met, there will be no additional Copayments and Coinsurance on Basic Health Services during the remainder of the Contract Year. The single Out-of-Pocket Copayment Limit is the amount each Member must pay, the family Out-of-Pocket Copayment Limit is the total amount any two or more covered family members must pay.

OUTPATIENT refers to services or supplies provided to someone who has not been admitted as an inpatient to a hospital. Observation care is considered Outpatient service.

PARAMOUNT SERVICE AREA means all of Ashland, Crawford, Defiance, Erie, Fulton, Hancock, Henry, Huron, Lucas, Marion, Morrow, Ottawa, Putnam, Richland, Sandusky, Seneca, Williams, Wood, and Wyandot counties, and portions of Allen, Delaware, Hardin, Knox, Lorain and Paulding counties In Ohio and Lenawee and Monroe counties in Michigan.

PARTICIPATING HOSPITAL means any hospital with which Paramount has contracted or established arrangements for inpatient/outpatient hospital services and/or emergency services.

PARTICIPATING PROVIDER means a physician, hospital or other health professional or facility that has a contract with Paramount to provide Covered Services to Members.

PARTICIPATING SPECIALIST means a physician who provides Covered Services to members within the range of his or her medical specialty and has chosen to be designated as a specialist physician by Paramount.

PREVENTIVE HEALTH SERVICES/BENEFITS are those Covered Services that are being provided: 1) to a Member who has developed risk factors (including age and gender) for a disease for which the Member has not yet developed symptoms, and 2) as an immunization to prevent specific diseases. However, any service or benefit intended to treat an existing illness, injury or condition does not qualify as Preventive Health Services.

PRIMARY CARE PROVIDER means a physician or other provider who specializes in family practice, internal medicine or pediatrics and is designated by Paramount as a Primary Care Provider.

PRIOR AUTHORIZATION is required for certain procedures or services. It is the responsibility of the Participating Provider to obtain Prior Authorization from Paramount in advance of these procedures or services.

SPECIALTY DRUGS are complex Prescription Drugs as determined by Paramount's Pharmacy & Therapeutics Working Group (P & T) used to treat chronic conditions such as multiple sclerosis, cancer, hepatitis and rheumatoid arthritis. These drugs are self-administered as injectable or oral drugs and often require special handling and monitoring.

SUBSCRIBER means a person who meets all applicable eligibility requirements, is employed by an employer who has a contract in effect with Paramount and enrolls with an employer as the subscriber.

SUPPLEMENTAL HEALTH CARE SERVICES as defined by Section 1751.01 of the Ohio Revised Code are: Services of intermediate, long-term care facilities; dental care; vision care; optometric services including lenses and frames; podiatric care; mental health services excluding diagnostic and treatment services for biologically based mental illness; short-term outpatient evaluative and crisis intervention mental health services; medical or psychological treatment and referral services for alcohol and drug abuse or addiction; home health services;

prescription drugs; nursing services; services of a dietician licensed under Chapter 4759 of the Revised Code; physical therapy services; chiropractic services and any other category approved by the superintendent of insurance.

URGENT MEDICAL CONDITION is an unforeseen condition of a kind that usually requires medical attention without delay but that does not pose a threat to the life, limb or permanent health of the injured or ill person.

URGENT CARE SERVICES means covered services provided for an Urgent Medical Condition and may include such health care services for an Urgent Medical Condition provided out of the Paramount Service Area.

OPTIONAL RIDERS

The following riders may be part of your benefit plan, if purchased by your employer group. Refer to your Summary of Benefits for any optional riders available under your plan.

HEARING AID RIDER

One (1) Standard Hearing Aid and fitting is covered up to the maximum benefit every 36 months per Member when ordered from a Participating Provider and determined to be Medically Necessary by a Paramount Physician or a participating Audiologist. See the Summary of Benefits for the maximum benefit. Replacement of a Standard Hearing Aid is covered every 36 months from acquisition of the previous Hearing Aid. This benefit does not apply to the Out-of-Pocket Copayment Limit.

Hearing tests for fitting and post performance evaluation of a Hearing Aid are covered in full per Contract Year when prescribed by a participating Audiologist.

A Standard Hearing Aid is defined as; in-the-ear (ITE), or behind-the-ear (BTE), monaural (one ear) or binaural (both ears) basic or programmable models.

Not Covered:

- Hearing Aids ordered prior to the effective date of coverage under this Rider, even if delivered after the effective date of coverage.
 - Replacement sooner than 36 months of Hearing Aids that are lost or broken or a different make or model is prescribed.
 - Replacement and repair of Hearing Aids resulting from misuse.
 - Batteries for Hearing Aids.
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HEARING AID REBATE RIDER

Paramount will reimburse your expenses up to the benefit limit stated in the Summary of Benefits for the cost of hearing aids and hearing aid related services including but not limited to; hearing aid molds, audiometric testing, hearing aid evaluations and batteries, **once every thirty-six (36) months**. Benefits under the Hearing Aid Rebate Rider are not subject to the Out-of-Pocket Copayment Limit.

To receive this benefit, send a copy of your paid, itemized receipt from **any hearing aid provider** to the address below. Clearly indicate your identification number on the receipt.

**Paramount Insurance Company
Hearing Aid Rebate Plan
P.O. Box 928
Toledo, OH 43697-0928**

Reimbursement will be sent directly to the Subscriber. If submitted charges do not exceed the benefit limit, reimbursement will be for the amount submitted.

Not Covered:

- Hearing aids and hearing aid related services including but not limited to; hearing aid molds, audiometric testing, hearing aid evaluations and batteries ordered more often than once every thirty-six (36) months.
- Hearing aids and hearing aid related services including but not limited to; hearing aid molds, audiometric testing, hearing aid evaluations and batteries purchased before this coverage began or after this coverage ended.

PRIVATE DUTY NURSING RIDER

Private Duty Nursing is covered when medically necessary. Services must be ordered by a Participating Provider and be approved in advance by Paramount. If you have this Rider it is stated on your Summary of Benefits.

VISON HARDWARE RIDER

Paramount will reimburse expenses up to a maximum stated on the Summary of Benefits to each Member toward the cost of prescription lenses, contact lenses and /or frames once every twenty-four (24) months. The following benefits are available to Members when provided through participating Ophthalmologists or Optometrists.

Covered Benefits

- Frames are covered up to the allowance once every 24 months. Frames may not be provided more frequently than once in any twenty-four (24) month period, regardless of any prescription lenses change
- Standard lenses, are defined as for single, bifocal (FT-25,28,round), trifocal (FT-25) or aphakic vision and not exceeding 65 millimeters in diameter. Such Lenses may include prism, slab-offs, myodisc or pink or rose #1 or #2 lens tints or equivalent. Replacement of Lenses is provided once during each twelve (12) month period if a change in prescription is made or once during each twenty-four (24) month period, if there is no prescription change.
- Contact lenses, along with any applicable examination and fitting for single, bifocal, or trifocal vision, are covered up to the allowance once during each twelve (12) month period with a change in prescription or once in any twenty-four (24) month period without a change in prescription.

Not Covered

- The cost of lenses, contact lenses and frames in excess of the limitations stated in this Rider or ordered from non-participating providers.
- Lenses, contact lenses or frames ordered before the effective date of this Rider or after the termination date of this Rider. Lenses or frames ordered while covered under this Rider but delivered more than 60 days after coverage termination.
- No-line bifocal or trifocal lenses to the extent the costs for such lenses exceeds the benefit amount for lined bifocal or trifocal lenses.

- Sunglasses, to the extent the cost of such lenses exceeds the benefit amount of regular lenses. As provided in this Rider, lenses with a tint other than the equivalent of Rose Tints #1 and #2 are considered to be sunglasses for the purpose of this exclusion.
 - Photosensitive or anti-reflective lenses to the extent the cost for such lenses exceeds the benefit amount for regular lenses provided under this Rider.
 - Replacement of lenses, contact lenses, and frames which are lost, broken or stolen unless at the time of replacement the Member is eligible for replacement as set forth above.
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VISION REBATE RIDER

Paramount will reimburse expenses up to a maximum stated on the Summary of Benefits to each Member toward the cost of prescription lenses, contact lenses and /or frames once every twenty-four (24) months.

To receive the benefit, send a copy of the paid, itemized receipt from any vision provider to the address below. Clearly indicate the Member's Paramount Identification number on the receipt.

Paramount Insurance Company
Vision Rebate Plan
P.O. Box 928
Toledo, OH 43697-0928

Reimbursement will be sent directly to the Subscriber. If submitted charges do not exceed the stated maximum, reimbursement will be for the amount submitted.

Not Covered:

- Lenses, contact lenses or frames ordered more often than once every twenty-four (24) months.
 - Lenses, contact lenses or frames purchased before this coverage began or after this coverage ended.
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CHIROPRACTIC RIDER

Paramount will cover the services of participating chiropractors. All services will be subject to the Copay and limitations described in the Summary of Benefits. Copayments/ Coinsurance under this benefit do not apply to the Out-of-Pocket Copayment Limit.

Not Covered:

- Services rendered by non-participating chiropractors.
- Services in excess of benefit or visit limits.

PRESCRIPTION DRUG PROGRAM

If you have a Prescription Drug Program it is stated on your Summary of Benefits.

Paramount uses a pharmacy benefits manager (PBM) to manage the benefits under the Prescription Drug Program. The PBM has a national network of participating pharmacies referred to as Network Pharmacies. If you have prescription drug coverage as part of your health plan, the PBM is indicated on your Paramount identification card.

You may be enrolled in one or more of the following programs - Retail Pharmacy Program, Mail Order Pharmacy Program, and/or one or more of the following optional Riders; Limited Medical Supplies, Specialty Drugs, Contraception/Birth Control Drugs, Infertility Drugs, Sexual Dysfunction Drugs and Smoking Cessation. Refer to your Summary of Benefits for details.

All Prescription Drug Programs have a drug formulary associated with them. A drug formulary is a list of approved medications for your doctor to use when treating you. A drug formulary may be “open” or “modified open”. Your specific drug formulary is indicated on your Summary of Benefits. If it is medically necessary for you to take a prescription drug that is not on the approved formulary, your doctor must first have it approved through Paramount. Questions regarding your specific drug formulary may be answered by calling the Paramount Member Services Department. Information on the Prescription Drug Program is also available on the Paramount website at: www.paramountinsurancecompany.com

To get the greatest savings on prescription drugs, it’s important to request a generic drug, when available, instead of a brand name drug. Your Prescription Drug Program may have Generic Mandate or Generic Substitution. Refer to your Summary of Benefits.

- Generic Mandate means when a brand name drug, for which there is a generic drug available, has been prescribed, the benefit will be limited to the cost of the generic drug. If the physician has specified “Dispense as Written” (DAW) for a brand name drug or you insist on the brand name drug, you will be financially responsible for the amount by which the brand name drug price exceeds the generic drug price, plus the applicable Copayment required for a brand name drug or the entire retail cost of the medication.
- Generic Substitution means generic drugs, when available, will be dispensed in place of a brand name drug.
 - Single Copay - If the Physician has specified “Dispense as Written” (“DAW”), the Member will pay the Single Copayment. If the Member requests a Brand Name Drug and the Physician has not specified “DAW”, the Member will pay the amount by which the Brand Name Drug price exceeds the Generic Drug price, plus the Single Copayment.
 - 2-tier and 3-tier Copay - If the Physician has specified “Dispense as Written” (“DAW”), the Member will pay the Copayment required for a Brand Name Drug. If the Member requests a Brand Name Drug and the Physician has not specified “DAW”, the Member will pay the amount by which the Brand Name Drug price exceeds the Generic Drug price, plus the highest Drug Copay within the Copayment arrangement.
 - 4-tier Copay - If the Physician has specified “Dispense as Written” (“DAW”), or the Member requests a Brand Name Drug for which a Generic Drug is available, the Member will pay the Multi Source Drug Copayment. A Multi Source Drug is a drug that has a generic, over-the-counter or isomeric brand drug equivalent. An isomeric brand drug is a drug with a molecular structure similar to an existing drug already on the market (e.g. enantiomer having a mirror image relationship to a drug already on the market.). Examples include Clarinex (desloratadine) is an isomeric brand drug of Claritin (loratadine) and Xopenex (levalbuterol) is an isomeric brand drug of Proventil (albuterol).

- Specialty Drug - If the Physician has specified “Dispense as Written” (“DAW”), the Member will pay the Specialty Drug Copay/Coinsurance. If the Member requests a Brand Name Drug and the Physician has not specified “DAW”, the Member will pay the amount by which the Brand Name Drug price exceeds the Generic Drug price, plus the Specialty Drug Copay/Coinsurance.

Preferred drugs are a list of commonly prescribed brand name drugs selected by Paramount based on clinical and cost-effectiveness. You can save money by asking your doctor to prescribe preferred drugs.

The Prescription Drug Program requires that you pay a Copay. There are several Copay arrangements. The Copay arrangement for your plan is stated on your Summary of Benefits. The following are the various Copay arrangements.

- Single Copay – You pay the same single Copay amount for any covered prescription drug.
- 2-Tier Copay – You pay the lowest Copay for a generic drug and a brand name drug has a higher Copay.
- 3-Tier Copay – You pay the lowest Copay for a generic drug; a preferred drug has a mid-level Copay and the non-preferred drug has the highest Copay.
- 4-Tier Copay - You pay the lowest Copay for a generic drug; a single source preferred drug has a mid-level Copay; a single source non-preferred drug has a higher Copay; and a multi-source brand drug has the highest Copay.

In a tiered Copay arrangement, your Copay depends on the specific prescription drug dispensed and the Copay arrangement indicated on your Summary of Benefits.

The amount you pay for Copayments under any benefit of a Prescription Drug Program does not count toward your Out-of-Pocket Copayment Limit.

The “days supply” is the maximum number of days a prescription drug will be dispensed under a single prescription order. The “days supply” is stated on your Summary of Benefits. Additionally, some prescription drugs have quantity limits and may require prior authorization before your prescription can be filled. Quantity limits are assigned to medications that are frequently taken inappropriately or used in amounts that exceed dosage or length of treatment recommendations. This is an accepted medical practice. Limits are set based on Food and Drug Administration (FDA) and manufacturer recommendations. If your prescription has a quantity limit, the Network Pharmacy will only dispense enough pills to match the limit. Further, Paramount does not cover products that are approved by the Federal Drug Administration (FDA) for cosmetic use or weight loss or that are considered experimental/investigational.

Retail Pharmacy Program

If you have the Retail Pharmacy Program, show your Paramount identification card to the pharmacist when purchasing prescription drugs and certain over-the-counter medications approved by Paramount. When you use a network pharmacy, you will be responsible for your drug Copay and the pharmacist will submit your claim electronically to the PBM. Prescription Drugs dispensed by a Non-Network Pharmacy are not covered.

Mail Order Pharmacy Program

If you have the Mail-Order Pharmacy Program, it is stated on your Summary of Benefits. A convenient network mail order service is beneficial for those who take medications regularly for chronic conditions. If your physician prescribes this type of medication, you may want to use the Mail Order Pharmacy Program. Specialty Drugs are not available through the standard Mail Order Program. Certain medications are required to be obtained through a mail order pharmacy. Your medication will be mailed directly to your home.

Additional Drug Options – See your Summary of Benefits for additional details.

Limited Medical Supplies Rider covers diabetic, asthma and other supplies as determined by Paramount's Pharmacy & Therapeutics Working Group (P & T). The supplies covered under the Limited Medical Supplies Rider are:

- Syringes with needles (except for insulin syringes)
- Disposable supplies for implantable infusion pump
- Disposable supplies for external drug infusion and supplies
- Blood glucose monitor, test strips and supplies
- Lancing devices, lancets
- Peak expiratory flow rate meter (hand-held)
- Spacers for metered dose inhaler and disposable nebulizer supplies

Specialty Drugs Rider covers Prescription Drugs which are self-administered for treatment of certain complex, chronic conditions as determined by Paramount's P & T. See the HMO Specialty Drug List. The Prescription Drugs under the Specialty Drug benefit are not covered under the Member's medical benefit plan. Specialty Drugs must be obtained through a limited Specialty Network administered by Paramount's PBM. Prior authorization and limits are required for certain Specialty Drugs and Paramount reserves the right to modify the list of Specialty Drugs.

Infertility Drug Rider covers prescription drugs for the treatment of infertility. Prescription drugs related to in vitro fertilization, embryo transplant services, GIFT, ZIFT and zygote transfer are not covered.

Contraception/Birth Control Drugs Rider covers prescription drugs for contraception and birth control.

Sexual Dysfunction Drugs Rider covers prescription drugs for the treatment of sexual dysfunction.

Smoking Cessation Drugs Rider covers prescription drugs and over-the-counter medications for smoking cessation.

Note: Coordination of Benefits applies to the Prescription Drug Program. Prescription drug benefits will be coordinated with those of any other health coverage plan.

(Rev. 4.2013)

