PARAMOUNT






Paramount Insurance Company

Large Group 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
Large Group FLEX Network Benefits
Member Handbook

Provided by:

PARAMOUNT
FLEX

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.

Grandfathered Health Plan

Paramount believes this plan is a "grandfathered health plan" under the PPACA. As permitted by PPACA, a grandfathered health plan can preserve certain basic health coverage that was already in effect when the law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of PPACA that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, a grandfathered health plan must comply with certain other consumer protections in PPACA, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Paramount Insurance Company at (419) 887-2525; toll-free 1-800-462-3589. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

In Case of Emergency

Call 911, an ambulance or rescue squad or go directly to the nearest emergency facility.

An **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

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	

MEMBER SERVICES DEPARTMENT (419) 887-2525 • Toll-Free 1-800-462-3589
TTY (419) 887-2526 • TTY Toll-Free 1-888-740-5670

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.

ProMedica

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

Your health. Our mission.

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

Table of Contents

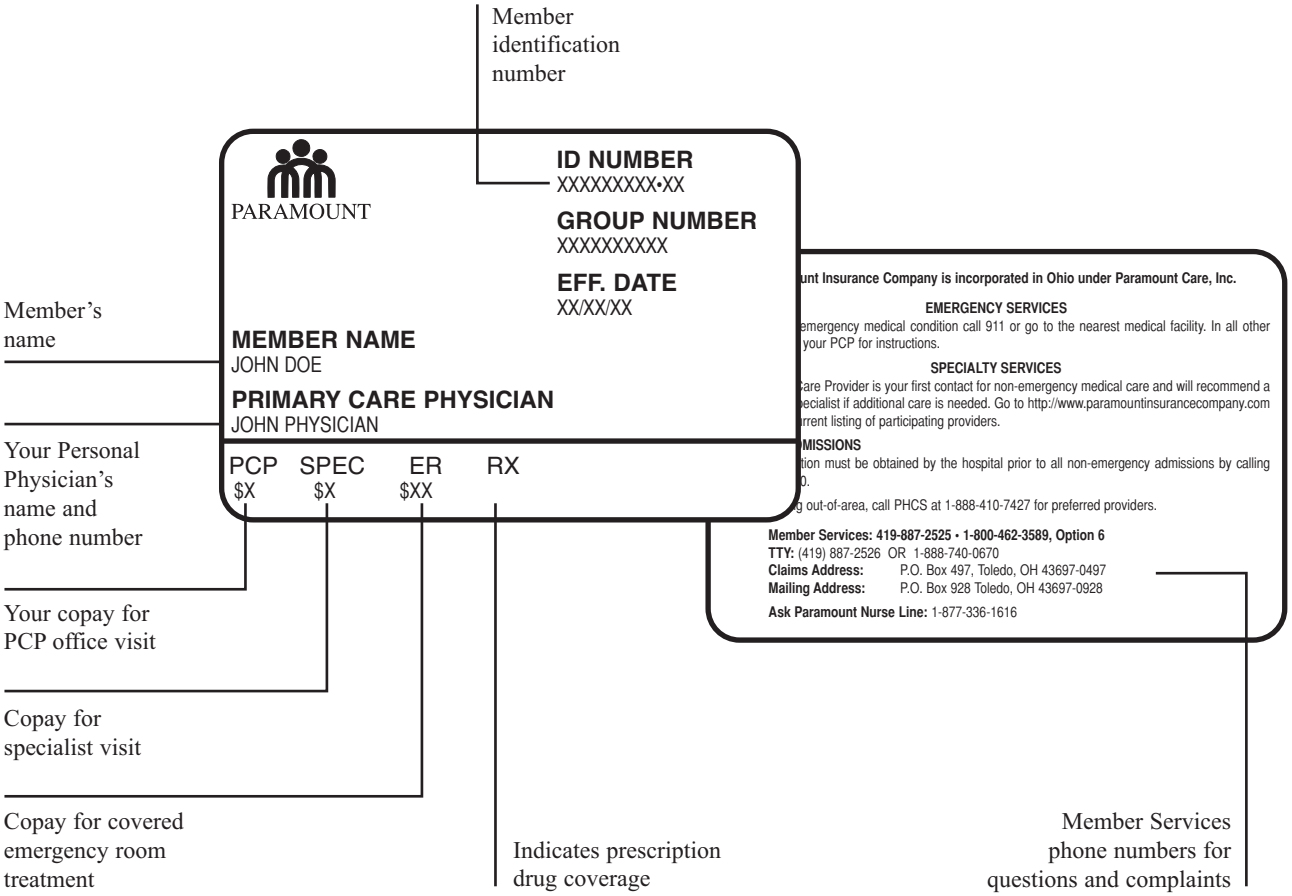
1. THE BASICS

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 receive OB/GYN care from a participating obstetrics/gynecology specialist without Prior Authorization from the Primary Care Provider (PCP). For children, you may designate a pediatrician as the 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 immediately. A new card will be mailed to you promptly

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

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

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

Is There a Pre-existing Condition Restriction?

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.

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 Schedule 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, Your Plan for a list of Preventive Health Services/ Benefits.

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, treatment for 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 Schedule 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 Schedule 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, outpatient physical, occupational and speech therapy, vision care services or 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.
- Be treated with respect, recognition of your dignity and the need for privacy.
- Make recommendations regarding Paramount's member rights and responsibilities policies.
- Voice complaints or appeals about the health plan or care provided.

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 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 Authorizations

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 specific procedures and 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 within three (3) working days after making the decision.

If Paramount makes an adverse determination (i.e., denies approval or coverage), Paramount will notify the requesting provider in writing or electronically within three (3) working days after making the decision.

Concurrent Reviews

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

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

Retrospective Reviews

Paramount will make a decision within twenty-five (25) calendar 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) calendar 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 expeditiously as the medical condition requires but no later than twenty-four (24) hours after the request has been made. Paramount will provide written confirmation of the decision within twenty-four (24) hours of receipt of the request, if the initial decision was not in writing.

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.

Change in Benefits

Paramount will notify you in writing if any benefits described in this Member Handbook and Schedule 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 Schedule 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 rom 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, depending on where you receive treatment. Your Copay/Coinsurance may be found in your Schedule of Benefits.

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

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

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

a) 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.

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

What to do:

Inside the Service Area: In the event of an Emergency Medical Condition, call 911, an ambulance or rescue squad or go directly to the nearest medical facility. In the event you are unsure about whether a condition is an Emergency Medical Condition, you may contact your Primary Care Provider for instructions. Medical care is available through Paramount Physicians seven (7) days a week, 24 hours a day. Paramount will cover Emergency Services from non-participating providers inside the Service Area related to Emergency Services. Appropriate Copays/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/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 an **Emergency Medical Condition** is covered. Any follow-up care outside the Service Area is not covered unless authorized by your Primary Care Provider and Paramount BEFORE the care begins.

If you are admitted to a hospital outside the Paramount Service Area, you 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 Medical Necessity 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 non-participating 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 pregnancy 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 these 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. For these services, see your Schedule 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 Copay 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.

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 Copay 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, ostomy supplies, etc.

Not covered:

- Medical equipment and supplies not covered by Medicare Part B
- Disposable supplies (except for ostomy supplies), test kits (except for diabetic supplies), etc.
- Exercise equipment, air conditioners
- Hearing aids unless 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.

Experimental/Investigative Services Not covered, any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which we determine to be

Experimental/Investigative is not covered. We will deem any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental/Investigative if we determine that one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought. The Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply:

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

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

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

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

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

Paramount will identify and weigh all information and determine all questions pertaining to whether a Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative.

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

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 Weight-loss treatments and 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
- 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 Schedule 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 SCHEDULE 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 cesare an 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 dis charge.

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 (C/L)

- **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 Schedule 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 Participating 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 immunizations 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 Schedule 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 for the 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 Schedule of Benefits for limitations.
- Speech therapy. See Schedule 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 (C/L) 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. 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. Kidney and cornea transplants are covered as any other illness.

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, including full-time students 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 unless prior authorized by Paramount.

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 for support), coverage may continue past age 26. Proof of disability must be provided to Paramount prior to or

within thirty-one (31) days of the Dependent's 26th birthday or within thirty-one days of new Paramount eligibility and may be requested annually.

Extension of Adult Child Coverage to Age 28

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 circumstance 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 at 1-866-452-6128. Paramount will require certification of eligibility and proof of residency or full-time student status if living out of state and continued eligibility certification annually until the child reaches age 28.

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. 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 and parents of Subscriber and/or Subscriber's spouse.

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 continue coverage for a newborn child beyond the 31-day period, a completed enrollment application and any required additional premium payment must be received within the first thirty-one (31) days following the birth. If the application and appropriate payment is not received, the newborn child will not be eligible for any further benefits after the thirty-one days following the birth.

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

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.

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.

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. 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. 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 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 or renew as a Subscriber, Dependent or Dependent with disabilities will be refused enrollment by Paramount based on health status-related factor, pre-existing condition, genetic testing or the results of such testing, or health care needs. 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 exceeded.

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

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

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

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

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

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

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

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

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

E. Closed panel plan is a Plan that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

F. Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding temporary visitation.

Order of Benefit Determination Rules

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

A. The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.

B. (1) Except as provided in Paragraph (2), a Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying plan is primary.

(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide out-of-network benefits.

C. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

D. Each Plan determines its order of benefits using the first of the following rules that apply:

(1) Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary plan and Plan that covers the person as a dependent is the Secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person other than as a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.

(2) Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:

(a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:
- The Plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or
- If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.
- However, if one spouse's plan has some other coordination rule (for example, a "gender rule" which says the father's plan is always primary), This plan will follow the rules of that plan.

(b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
(i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the decree;
(ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;
(iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the

provisions of Subparagraph (a) above shall determine the order of benefits;

(iv) If there is no court decree allocating the responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

- The Plan covering the Custodial parent;
- The Plan covering the spouse of the Custodial parent;
- The Plan covering the non-custodial parent; and then
- The Plan covering the spouse of the non-custodial parent.

(c) For a dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

(3) Active Employee or Retired or Laid-off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering the same person as retired or laid off employee is the Secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(4) COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, The Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber, or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(5) Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary plan and the Plan that covered the person the shorter period of time is the Secondary plan.

(6) If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This plan will not pay more than it would have paid had it been the Primary plan.

Effect on the Benefits of this Plan

A. When This plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, The Secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary plan. The Secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim. In addition, the Secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

B. If a covered person is enrolled in two or more Closed panel plans, and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed panel plan, COB shall not apply between that Plan and the other Closed panel plans.

Right to Receive and Release Needed Information

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

Facility of Payment

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

Right of Recovery

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

Coordination Disputes

If you believe that Paramount has not paid a claim properly, you should first attempt to resolve the problem by contacting Paramount at (419) 887-2525 or refer to Section 6, Internal Claims and Appeals Procedures and External Review. If you are still not satisfied, you may call the Ohio Department of Insurance for instructions on filing a consumer complaint. Call 1-800-686-1526, or visit the Department's website at http://insurance.ohio.gov

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 in attorney's 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 your 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

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 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 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.

If Paramount Ends Operations/Company Insolvency

Paramount is not a Member of any Guaranty Fund. In the event of Paramount's insolvency:

1. A member is protected only to the extent that the hold harmless provision required by section 1751.13 of the Revised Code applies to the health care services rendered.

2. A member may be financially responsible for health care services rendered by a provider or health care facility that is not under contract to Paramount, whether or not Paramount authorized the use of the provider or health care facility.

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. 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.

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.

6. INTERNAL CLAIMS AND APPEALS PROCEDURES AND EXTERNAL REVIEW

Overview

If you need help: If you do not understand your rights or if you need assistance understanding your rights or you do not understand some or all of the information in the following provisions, you may contact Paramount Insurance Company at the Member Services Department, 1901 Indian Wood Circle, Maumee, OH 43537, Attention: Member Services, or by telephone at, 1-800-462-3589 or email: Paramount.memberservices@promedica.org.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Time Limits for an External Appeal: You have 180 days to file for an external review after receipt of the plan's *final adverse benefit determination*.

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

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

- Before the plan can issue a final internal *adverse benefit determination* based on a new or additional rationale, you must be provided, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal *adverse benefit determination* is required to be provided to give you a reasonable opportunity to respond prior to that date.

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

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

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

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

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

Other Resources to help you

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

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

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

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

INTERNAL CLAIMS AND APPEALS

Non-urgent, *pre-service claim* denial

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

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

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

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

Urgent Pre-service Care claim denial

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

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

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

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

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

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

Simultaneous urgent claim and expedited internal review:

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

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

Simultaneous urgent claim, expedited internal review and external review:

You, or your *authorized representative*, may request an expedited external review if both the following apply

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

(2) After a final *adverse benefit determination*, if either of the following applies:
   (a) The treating physician certifies that the *adverse benefit determination* involves a medical condition that could seriously jeopardize the life or health of you, or would jeopardize your ability to regain maximum function, if treated after the time frame of a standard external review;
   (b) The *final adverse benefit determination* concerns an admission, availability of care, continued stay, or health care service for which you received emergency services, but has not yet been discharged from a facility.

Concurrent care decisions

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

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

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

Concurrent urgent care and extension of treatment: Under the concurrent care provisions , any request that involves both urgent care and the extension of a course of treatment beyond the period of time or number of treatments previously approved by the plan must be decided as soon as possible, taking into account the medical urgencies, and notification must be provided to the claimant within 24 hours after receipt of the claim, provided the request is made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

Non-urgent request to extend course of treatment or number of treatments: If a request to extend a course of treatment beyond the period of time or number of treatments previously approved by the plan does not involve urgent care, the request may be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim, e.g., as a *pre-service claim* or a *post-service claim.*

If the request is not made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments, the request must be treated as a *claim involving urgent care* and decided in accordance with the urgent care claim timeframes, e.g., as soon as possible, taking into account the medical emergencies, but not later than 72 hours after receipt.

Post-service appeal of a claim denial (retrospective)

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

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

EXTERNAL REVIEW Right to External Review

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

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

All requests for an external review must be made within 180 days of the date of the notice of the plan's *final adverse benefit determination*. Standard requests for an external review must be provided in writing; requests for expedited external reviews, including *experimental/investigational*, may be submitted orally or electronically. When an oral or electronic request for review is made, written confirmation of the request must be submitted to the plan no later than 5 days after the initial request was made.

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

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

Non-urgent request for an external review

Unless the request is for an expedited external review, the plan will initiate an external review within 5 days after it receives your written request if your request is complete. The plan will provide you with notice that it has initiated the external review that includes:

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

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

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

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

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

Request for external review to superintendent of insurance: If the plan denies your request for an external review, you may file a request for the superintendent of insurance to review the plan's decision by contacting Consumer

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

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

If the plan's failure to comply with its obligations under the internal claims and appeals procedures was considered (i) *de minimis,* (ii) not likely to cause prejudice or harm to you (claimant), (iii) because we had a good reason or our failure was caused by matters beyond our control (iv) in the context of an ongoing good- faith exchange of information between the plan and you (claimant) or your *authorized representative* and (v) not part of a pattern or practice of our not following the internal claims and appeals procedures, then you will not be deemed to have exhausted the internal claims and appeals requirements. You may request an explanation of the basis for the plan's asserting that its actions meet this standard.

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

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

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

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

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

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

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

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

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

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

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

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

After receipt of health care services: No expedited review is available for *adverse benefit determinations* made after receipt of the health care service or services in question.

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

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

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

7. TERMS AND DEFINITIONS

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

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

   (a) A determination that the health care service does not meet the health plan issuer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, including experimental or investigational treatments;
   (b) A determination of an individual's eligibility for individual health insurance coverage, including coverage offered to individuals through a non-employer group, to participate in a plan or health insurance coverage;
   (c) A determination that a health care service is not a covered benefit;
   (d) The imposition of an exclusion, including exclusions for pre-existing conditions, source of injury, network, or any other limitation on benefits that would otherwise be covered.

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

(3) To rescind coverage on a health benefit plan.
- a denial, reduction, or termination of, or
- a failure to provide or make payment (in whole or in part) for a benefit, including any denial, reduction, termination, or
- failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of,
- or a failure to provide or make payment (in whole or in par) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary.

An "*adverse benefit determination*" also includes a rescission of the participant or beneficiary.

Authorized representative means an individual who represents a you in an internal appeal or external review process of an *adverse benefit determination* who is any of the following:

(1) A person to whom a covered individual has given express, written consent to represent that individual in an internal appeals process or external review process of an adverse benefit determination;

(2) A person authorized by law to provide substituted consent for a covered individual;

(3) A family member but only when the you is unable to provide consent.

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.

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

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

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

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

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.

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.

Coinsurance is your share of the cost of some Covered Services. Coinsurance is a percentage of the allowed provider charges.

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.

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.

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

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.

Effective Date is the date your coverage begins.

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.

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.

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.

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

a) Placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;
b) Serious impairment to bodily functions;
c) Serious dysfunction of any bodily organ or part. 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. 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/Investigative is any drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which we determine to be Experimental/Investigative is not covered. We will deem any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental/ Investigative using evidence-based criteria as defined in this handbook.

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

Health Care Provider means a health care professional or facility.

Health Plan means Paramount.

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

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

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

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

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

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

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

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

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 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 Schedule 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, outpatient physical, occupational and speech therapy, vision care services or prescription drugs and any penalties do not count toward the Out-of-Pocket Copayment Limit.

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

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

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

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

Preventive Health Services/Benefits are those Covered Services that are being provided: 1) to a Member who has developed risk factors (including age and gender) for a disease for which the Member has not yet developed symptoms, and 2) as an immunization to prevent specific diseases. However, any service or benefit intended to treat an ***existing*** illness, injury or condition does not qualify as Preventive Health Services. More information is available in Section 4, What is Covered/What is Not Covered.

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.

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. This period is not to exceed 90 days.

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

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

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

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

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

Urgent 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 Schedule 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 Schedule 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 or binaural 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.

HEARING AID REBATE RIDER

Paramount will reimburse your expenses up to the benefit limit stated in the Schedule 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 Schedule of Benefits.

VISON HARDWARE RIDER

Paramount will reimburse expenses up to a maximum stated on the Schedule 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 mare 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 sun glasses 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.

VISION REBATE RIDER

Paramount will reimburse expenses up to a maximum stated on the Schedule 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.

CHIROPRACTIC RIDER

Paramount will cover the services of participating chiropractors. All services will be subject to the Copay and limitations described in the Schedule 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 Schedule 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 Schedule 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 Schedule 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 Schedule 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 the 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 Schedule 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 Schedule 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 Schedule 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 Schedule 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 Options – See your Schedule 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
- 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.

Affiliate of ProMedica

LS-1541A - Grandfathered
Printed 3/14

Paramount Insurance Company

Large Group Grandfathered HMO/Flex In-Network AMENDMENT

This Amendment amends your health benefit plan (Plan), and becomes a part of your Plan; and revokes/replaces the Amendment issued July 1, 2014 under form name, *PICO: LG HMO GF Amdmt 7.1.2014*. All provisions of this Amendment are effective for plans new/renewing on or after January 1, 2017. Please place this Amendment with your Member Handbook for future reference.

On the Effective Date of this **Amendment**, certain benefits, terms, conditions, limitations, and exclusions in your Plan will be amended. Regardless of the terms and conditions of any other provisions of your Plan, this **Amendment** will control.

The following notices are added:

Notice of Nondiscrimination and Accessibility: Discrimination is Against the Law

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

Paramount provides:

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

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

If you believe that Paramount Entity has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance. You can file a grievance in person or by mail, fax, or email.

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

Email: Paramount.MemberServices@ProMedica.org.

If you need help filing a grievance, Member Services is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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

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

Bantu: ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona 1-800-462-3589 (TTY: 1-888-740-5670).

Bengali: লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১-800-462-3589 (TTY: ১-888-740-5670)।

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

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

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

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

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

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

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

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

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

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

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-462-3589 (TTY: 1-888-740-5670).

Romanian: ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-462-3589 (TTY: 1-888-740-5670).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-462-3589 (телетайп: 1-888-740-5670).

Serbo-Croatian: OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-462-3589 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1-888-740-5670).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-462-3589 (TTY: 1-888-740-5670).

Syriac: ܙܘܗܪܐ: ܐܢ ܐܢܬܘܢ ܟܐ ܗܡܙܡܝܬܘܢ ܠܫܢܐ ܐܬܘܪܝܐ، ܟܐ ܡܨܝܬܘܢ ܕܫܩܠܝܬܘܢ ܡܫܘܚܬܐ ܕܗܝܪܬܐ ܒܠܫܢܐ ܡܓܢܢܐܝܬ. ܡܚܘ ܩܠ ܥܠ ܡܢܝܢܐ1-800-462-3589 (TTY: 1-888-740-5670)

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-462-3589 (TTY: 1-888-740-5670).

Ukrainian: УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-462-3589 (телетайп: 1-888-740-5670).

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-462-3589 (TTY: 1-888-740-5670).

The section titled "4. YOUR PLAN" is amended as follows:

Diagnostic services (C/L)

Mammograms and pap smears. Screening mammograms and pap smears are covered when ordered by the PCP or Participating Specialist. Screening mammograms are covered for women between ages 35 and 40 in addition to the Federal preventive care mandate. You may be responsible for cost sharing. The total benefit paid (including any cost sharing) cannot exceed 130% of the Medicare Reimbursement amount.

Maternity care and family planning
Surrogate parenting/ pregnancy and related services are not covered when provided to a person not covered under the Handbook in connection with a surrogate pregnancy (including, but not limited to, the bearing of a Child by another woman for an infertile couple**).**

Mental Health Services (C/L)

Mental Health Services include treatment for Biologically and Non-Biologically Based Mental Illness.

- **Services for a Biologically and/or Non-Biologically Based Mental Illness** (C/L) Covered for inpatient and outpatient services, emergency care and prescription drugs (if a prescription drug program has been added to your coverage) subject to the same Deductible, Copayments and/or Coinsurance, plan standards and medical management processes as any other physical disease or condition. This includes intermediate levels of care such as residential treatment, partial hospitalization and intensive outpatient services. Outpatient office visits are subject to the Primary Care Physician Copayment/Coinsurance.

  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
  - 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

Office visits (C/L) Covered for:

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

- Well-baby/child exams
- Gynecological exams
- Immunizations
- Diagnostic procedures
- Medical/surgical procedures

- Online clinic visits. When available in your area, your coverage will include online clinic visit services. Covered Services include a medical consultation using the internet via a webcam, chat and voice. Non Covered Services include, but are not limited to communications used for:
  - Reporting normal lab or other test results
  - Office appointment requests
  - Billing, insurance coverage or payment questions
  - Requests for referrals to doctors outside the online care panel
  - Benefit precertification

Not covered:

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

Substance Abuse Services (alcohol and drug abuse/addiction) (C/L) Covered for inpatient and outpatient care, emergency care and prescription drugs (if a prescription drug program has been added to your coverage) for the diagnosis, crisis intervention and short-term treatment of substance abuse services. Covered services are subject to the same Deductible, Copayments and/or Coinsurance, plan standards and medical management processes as any other physical disease or condition**.** This includes intermediate levels of care such as residential treatment, partial hospitalization and intensive outpatient services. Outpatient office visits are subject to the Primary Care Physician Copayment/Coinsurance.

Not covered:

- Court-ordered testing or treatment unless determined to be Medically Necessary by Paramount and rendered by a Participating Provider.

Therapy services (C/L) Covered for:

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

Not covered:

- Non-medical services such as vocational rehabilitation, employment counseling and psychological counseling (except for mental health diagnoses).
- 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

Surrogate and/or Gestational Parenting and Pregnancy and related services
Pregnancy is not covered for any services or supplies provided to a person not covered under the Handbook in connection with a surrogate pregnancy (including, but not limited to, the bearing of a Child by another woman for an infertile couple**).**

Transsexual surgery and related services
Not covered unless Medically Necessary for services and supplies related to sex transformation and/or the reversal thereof, or male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This Exclusion includes sexual therapy and counseling. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, Prescription Drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related Diagnostic Testing. Evidence based and nondiscriminatory criteria will be used to determine Medical Necessity.

WHO IS ELIGIBLE

Extension of Adult Child Coverage to Age 28 is deleted.

Group Probationary or Waiting Period is deleted and replaced with:

Group Probationary or Waiting Period New employees will have coverage effective after the probationary or waiting period established by the employer. The probationary or waiting period will not be more than ninety (90) days. See your benefits office for details.

The section titled "5. WHAT HAPPENS WITH YOUR PLAN" is amended as follows:

When Someone Else Is Liable (Subrogation and Reimbursement) is deleted and replaced with:

Subject to ORC 2323.44, to the extent applicable:

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

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

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

Equitable Lien. The Plan's subrogation and reimbursement rights are a first party lien against any recovery and must be paid before any other claims, including claims by the Member for damages (with the exception of claims by the Member pursuant to the property damage provisions of any insurance policy). This lien is not offset or reduced in any way by the Member's attorney fees or costs incurred in obtaining the recovery. The "common fund doctrine", "made whole" rule, or similar common law doctrines do not reduce or affect the Plan's subrogation and reimbursement rights. This means the Member must reimburse the Plan, 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 attorney fees. Member agrees that Plan has the right to obtain injunctive relief prohibiting the Member from accepting or receiving any settlement or other recovery relating to the expenses paid by the Plan until the Plan's right of subrogation and reimbursement are fully satisfied and Member consents to such injunctive relief.

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

Secondary Payor. The Plan is always a secondary payor when there are no fault and/or personal injury protection benefits available to the Member.

Plan Interpretation Clause: The Plan Sponsor has sole discretion to interpret the terms of the Subrogation and Reimbursement provision and reserves the right to make changes as it deems necessary.

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

The section titled "6. INTERNAL CLAIMS AND APPEALS PROCEDURES AND EXTERNAL REVIEW" is deleted and replaced with:

Overview

If you need help: If you do not understand your rights or if you need assistance understanding your rights or you do not understand some or all of the information in the following provisions, you may contact Paramount Insurance Company at the Member Services Department, P.O. Box 928, Toledo, Ohio 43697-0928, Attention: Member Services, or by telephone at, 1-800-462-3589 or email: Paramount.memberservices@promedica.org. TTY users may call 1-888-740-5670.

Internal Claims and Appeals Procedures: When a health insurance plan denies a claim for a treatment or service (a claim for plan benefits, you have already received (*Post-Service Claim Denial*) or denies your request to authorize treatment or service (*Pre-service claim* denial), you, or someone you have authorized to speak on your behalf (an *Authorized Representative*), can request an appeal of the plan's decision. If the plan rescinds your coverage or denies your application for coverage, you may also appeal the plan's decision. When the plan receives your appeal, it is required to review its own decision. When the plan makes a claim decision, it is required to notify you (provide notice of an *Adverse Benefit Determination*). An *Adverse Benefit Determination"* means a denial, reduction, or termination of, or failure to provide or make payment for a benefit, including denial, reductions, or termination of, or failure to provide or make payment based on a determination of beneficiary's eligibility to

participate in a plan, and including denial, reductions, or termination of, or failure to provide or make payment for a benefit resulting from the application of any utilization review, as well as failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

Notification of an *Adverse Benefit Determination* must include:

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

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

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

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

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

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

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

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

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

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

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

***Rescission* of coverage**: If the plan rescinds your coverage, you may file an appeal according to the following procedures. The plan cannot terminate your benefits until all of the appeals have been exhausted. Since a *Rescission* of coverage is a cancellation or discontinuance of coverage that has retroactive effects, if the plan's decision to rescind is upheld, you will be responsible for payment of all claims for your *Health Care Services*.

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

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

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

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

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

- Before the plan can issue a final internal *Adverse Benefit Determination* based on a new or additional rationale, you must be provided, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal *Adverse Benefit Determination* is required to be provided to give you a reasonable opportunity to respond prior to that date.

- The adverse determination must be written in a manner understood by you, or if applicable, your *Authorized Representative* and must include all of the following:

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

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

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

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

Other Resources to help you

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

Department of Labor: If this is a health plan provided through your employer or under a retiree *Health Benefit Plan* through your former employer, your rights are also

protected by ERISA. For information about your rights under ERISA, you may contact the **Employee Benefits Security Administration (**EBSA), an agency of the Department of Labor, at (866) 444-3272.

Language services are available from the *Health Benefit Plan* and from The Ohio Department of Insurance.

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

INTERNAL CLAIMS AND APPEALS

Non-urgent, *Pre-Service Claim* denial

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

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

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

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

Urgent Pre-service Care claim denial

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

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

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

requested as soon as you can but no later than 48 hours after we have asked you for the information.

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

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

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

Simultaneous urgent appeal request and expedited internal review:

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

If the 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 an *Adverse Benefit Determination* would seriously jeopardize your life or health, or jeopardize your ability to regain maximum function, you may file a request for an expedited external review to be conducted simultaneously with the expedited internal appeal, pursuant to section 3922.09 of the Revised Code.

Simultaneous urgent claim, expedited internal review and external review:

You, or your *Authorized Representative*, may request an expedited external review if both the following apply:

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

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

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

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

Concurrent care decisions

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

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

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

Concurrent urgent care and extension of treatment: Under the concurrent care provisions , any request that involves both urgent care and the extension of a course of treatment beyond the period of time or number of treatments previously approved by the plan must be decided as soon as possible, taking into account the medical urgencies, and notification must be provided to the claimant within 24 hours after receipt of the claim, provided the request is made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

Non-urgent request to extend course of treatment or number of treatments: If a request to extend a course of treatment beyond the period of time or number of treatments previously approved by the plan does not involve urgent care, the request may be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim, e.g., as a *Pre-Service Claim* or a *Post-Service Claim*.

If the request is not made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments, the request must be treated as a *claim involving urgent care* and decided in accordance with the urgent care claim timeframes, e.g., as soon as possible, taking into account the medical emergencies, but not later than 72 hours after receipt.

Post-service appeal of a claim denial (retrospective)

If your appeal is for a *Post-Service Claim Denial*, we will notify you of our decision as soon as possible but no later than 30 days after we have received your appeal. If we

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

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

EXTERNAL REVIEW <u>Right to External Review</u>

Under certain circumstances, you have a right to request an external review of our adverse benefit decision by an *Independent Review Organization* or by the *Superintendent* of insurance, or both.

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

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

A *Member* is entitled to an external review by an IRO in the following instances:

> The *Adverse Benefit Determination* involves a medical judgment or is based on any medical information
>
> *The Adverse Benefit Determination* indicates the requested service is experimental or investigational, the requested health care service is not explicitly

excluded in the *Member's Health Benefit Plan*, and the treating physician certifies at least one of the following:

- Standard *Health Care Services* have not been effective in improving the condition of the *Member*
- Standard *Health Care Services* are not medically appropriate for the *Member*
- No available standard health care service covered by Paramount is more beneficial than the requested health care service

A *Member* is entitled to an external review by the Department in the following instances:

The *Adverse Benefit Determination* is based on a contractual issue that does not involve a medical judgment or medical information

The *Adverse Benefit Determination* for an *Emergency Medical Condition* indicates that the medical condition did not meet the definition of emergency and Paramount's decision has already been upheld through an external review by an IRO.

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

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

A completed authorization for release of your medical records must be provided with the request.

Non-urgent request for an external review

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

(a) The name and contact information for the assigned *Independent Review Organization* or the *Superintendent* of insurance, as applicable, for the purpose of submitting additional information; and

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

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

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

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

Request for external review to *Superintendent* of insurance: If the plan denies your request for an external review, you may file a request for the *Superintendent* of insurance to review the plan's decision by contacting Consumer Affairs Division at 800-686-1526 between 8:00 a.m. and 5:00 p.m., eastern standard time or by sending a written request addressed to: Consumer Affairs, The Ohio Department of Insurance, 50 West Town St., Suite 300, Columbus, Ohio 43215. Information about external reviews is also available on the Department's website: www.insurance.ohio.gov. The Ohio Department of Insurance may determine the request is eligible for external review regardless of Paramount's decision and require that the request be referred for external review. The Department's decision will be made in accordance with the terms of the *Health Benefit Plan* and all applicable provisions of the law.

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

If the plan's failure to comply with its obligations under the internal claims and appeals procedures was considered (i) *de minimis*, (ii) not likely to cause prejudice or harm to you (claimant), (iii) because we had a good reason or our failure was caused by matters beyond our control (iv) in the context of an ongoing good- faith exchange of information between the plan and you (claimant) or your *Authorized Representative* and (v) not part of a pattern or practice of our not following the internal claims and appeals procedures, then *you* will not be deemed to have exhausted the internal claims and appeals requirements. You may request an explanation of the basis for the plan's asserting that its actions meet this standard.

Expedited external review : You may have an expedited external review if your treating physician certifies that the *Adverse Benefit Determin*ation 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 for a standard external review; or the *Final Adverse Benefit Determination* concerns an admission, availability of care, continued stay, or health care service for which you received *Emergency Services*, but have not yet been discharged from a facility.

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

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

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

(1) Standard *Health Care Services* have not been effective in improving your condition;
(2) Standard *Health Care Services* are not medically appropriate for you; or
(3) There is no available standard health care service covered by the *Health Plan Issuer* that is more beneficial than requested health care service.

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

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

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

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

If an expedited external review (urgent) was requested, the IRO will provide a determination as soon as possible or within 72 hours of receipt of the expedited request.

The IRO written notice must include the following information:

- A general description of the reason for the request for external review
- The date the *Independent Review Organization* was assigned by the Ohio Department of Insurance to conduct the external review
- The dates over which the external review was conducted
- The date on which the *Independent Review Organization*'s decision was made
- The rationale for its decision
- References to the evidence or documentation, including any evidence-based standards, that was used or considered in reaching its decision
- Decisions that involve a health care treatment or service that is stated to be experimental or investigational also includes the principle reason(s) for the IRO's decision and the written opinion of each clinical reviewer including their recommendation and their rationale for the recommendation

The IRO's decision is binding on Paramount and the *Member*. A *Member* may not file a subsequent request for an external review involving the same *Adverse Benefit Determination* that was previously reviewed unless new medical or scientific evidence is submitted to Paramount. If the IRO reverses the *Health Benefit Plan's* decision, the plan will immediately provide coverage for the health care service or services in question.

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

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

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

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

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

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

OPTIONAL RIDERS Section is revised as follows:

PRESCRIPTION DRUG PROGRAM is deleted and replaced with:

Prescription Drug Program

If you have a Prescription Drug Program it is stated in your Schedule of Benefits. Some benefits described here may not be covered. Refer to your Schedule of Benefits for the specific program your Employer has purchased and for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

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

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, Specialty Drugs, Preventive Drugs, Infertility Drugs, and Sexual Dysfunction Drugs. Refer to your Schedule 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” “closed” or “modified open”. Your specific drug formulary is indicated on your Schedule 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.

Standard & Expedited Exceptions Process (for closed and modified open formulary Prescription Drug Programs): An enrollee or physician can submit a standard exception request of a clinically appropriate non-formulary drug in non-exigent circumstances and receive a decision within 72 hours of a request. For expedited exception requests based on exigent circumstances determination and notification will be provided no later than 24 hours following receipt of the request. If request is approved, coverage continues for

a duration determined to be appropriate for the specific medication. If the request is denied, members may appeal to an accredited Independent Review Organization (IRO). Enrollee and physician will be notified of the IRO's decision no later than 24 hours following receipt of request for expedited exception request and 72 hours following receipt of a standard request. An exigent circumstance (Expedited Exception Request) exist when a member is suffering from a health condition that may seriously jeopardize the enrollee's life, health, or ability to regain maximum function or when a member is undergoing a current course of treatment using a non-formulary drug.

For more information, to request coverage of a non-formulary drug or appeal a denial, contact the Member Services Department.

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

Copay Type

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 Prescription Drug formulary and your Schedule of Benefits to determine if certain brand name drugs are covered.

- Generic Mandate means when an identical generic is available for a prescribed brand drug, only the generic drug will be covered on the formulary. The brand name drug will no longer be considered a covered formulary drug when the generic becomes available. If the physician believes the brand name drug is medically necessary they may submit a non-formulary medication request on your behalf. If Paramount approves the request for the brand name medication you will pay the copay associated with the highest cost brand tier on your benefit. If the request is denied by Paramount and you still wish to receive the brand name medication, you will be required to pay 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, 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 Schedule 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 Schedule 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 Schedule 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. Paramount does not cover products that are not FDA approved prescription medications.

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 Schedule 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.

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

Covered Drug Benefits:

- Federal Legend Drugs – medicinal substances, which bear the legend “Federal Law Prohibits Dispensing Without a Prescription.”
- State Restricted Drugs – medicinal substances that may be dispensed only by prescription according to state law.
- Select Over-the-Counter drugs approved by Paramount.
- Off label use of FDA approved drugs as defined in ORC 1751.66. Paramount shall not limit or exclude coverage for any drug approved by the United States food and drug administration on the basis that the drug has not been approved by the United States food and drug administration for the treatment of the particular indication for which the drug has been prescribed, provided the drug has been recognized as safe and effective for treatment of that indication in one or more of the standard medical reference compendia adopted by the United States department of health and human services.

Oral Chemotherapy

Plan shall not provide coverage or impose cost sharing for a prescribed, orally administered cancer medication on a less favorable basis than the coverage it provides or cost sharing it imposes for intravenously administered or injected cancer medications. Paramount's standard is to utilize the safe harbor option by capping oral chemotherapy costs not to exceed $100. The exception to this standard is if Your Employer has purchased a High Deductible Health Plan (HDHP). For High Deductible Health Plans, the plan deductible and coinsurance will apply up to the Out-of-Pocket Copayment Limit. Refer to your Schedule of Benefits for the specific program your Employer has purchased.

Additional Options you may have – Refer to your Schedule of Benefits for the specific program your Employer has purchased and for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Specialty Drugs 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 Drugs: Prescription Drugs for the treatment of infertility when covered under your benefits are subject to the Deductible, Infertility Copay or Coinsurance, Infertility Drug Limit stated in the Schedule of Benefits.

Prescription Drug Exclusions:

- Therapeutic devices, support garments; and other supplies or substances which may be obtained without a prescription.
- Prescriptions Drug or Refills either in excess of the number prescribed by the physician or those dispensed more than one (1) year after the physician's order.
- Dietary supplements and some Prescription vitamins (other than prenatal vitamins). The level of benefits will depend on whether care is obtained through In-Network or Out-of-Network Providers. If You use an Out-of-Network Provider, You may receive a bill for the difference between the provider's charge and the fee that the In-Network Provider pays for that service. For a comprehensive list of preventive services, please visit www.hhs.gov/healthcare/prevention/index.html.
- Prescription Drugs used for cosmetic purposes such as: drugs used to decrease wrinkles, drugs to promote hair growth, drugs to control perspiration, or scar treatments.
- Prescription Drugs for the amount dispensed (days supply or quantity limit) that exceeds the supply limit.

- Drugs that do not require a prescription for dispensing known as “Over-the-Counter” drugs unless approved by Paramount. The level of benefits will depend on whether care is obtained through In-Network or Out-of-Network Providers. If You use an Out-of-Network Provider, You may receive a bill for the difference between the provider’s charge and the fee that the In-Network Provider is paid for that service. For a comprehensive list of preventive services, please visit www.hhs.gov/healthcare/prevention/index.html.
- Any drugs that are labeled as experimental, investigational or unproven.
- Prescription Drugs used to enhance athletic performance.
- Compounded medications in which the active ingredients do not require a Prescription Order or Refill. Paramount will not pay any preparation fee for compounded medications. Some compounded medications may be covered when billed electronically to PBM by a Network Pharmacy. The compound must include at least one federal legend drug with a valid NDC number. In addition there must be good medical evidence to support the safety and efficacy of the product for that specific formulation and dose when used to treat your medical condition. Documentation of medical necessity may be required to be submitted by your physician for evaluation by Paramount.
- Prescription Drugs requiring prior authorization that are dispensed without approval.
- Any Prescription Drug which is determined to have been abused or otherwise misused by a Covered Person.
- Any claim for Prescription Drug(s) submitted to Paramount or the PBM for reimbursement more than **one (1) year** from the time proof is otherwise required will not be eligible for reimbursement.
- Prescription Drugs for which the cost is recoverable under any workers’ compensation or occupations disease law or any federal or state agency or any drug for which no charge is made.
- Prescription Drugs that are prescribed, dispensed or intended for use while you are an inpatient in a hospital or skilled nursing facility.
- Prescription Drugs related to in vitro fertilization, embryo transplant services, GIFT, ZIFT and zygote transfer unless specifically listed in your schedule of benefits.
- Prescription drugs used to treat sexual dysfunction unless specifically listed in your schedule of benefits.
- Prescription Drugs not approved for your Formulary.

This **Amendment** takes effect for plans new/renewing on or after January 1, 2017. This **Amendment** terminates concurrently with the Plan to which it is attached. It is subject to all the definitions, limitations, exclusions and conditions of the Plan except as stated.

IN WITNESS WHEREOF:
Paramount Insurance Company

John C. Randolph, President