

**PARAMOUNT HEALTH CARE**  
**GROUP MEDICAL AND HOSPITAL SERVICE AGREEMENT**

2010

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ATTACHMENT A: Schedule of Benefits

NOTICE TO MEMBERS: 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.

## **I. INTRODUCTION**

1.1 **PARAMOUNT HEALTH CARE.** PARAMOUNT HEALTH CARE (hereinafter referred to as the "Health Plan") is a corporation licensed as a Health Insuring Corporation (HIC) in the State of Ohio. Under the HIC concept, all care, including hospitalization, must be provided, prescribed, or authorized by a Health Plan Physician. *Except for certain Emergency and Urgent Care Conditions (see Part II-E-1, Attachment A) Members will not receive any benefits under this Agreement unless provided, arranged or authorized by a Health Plan Physician.*

1.2 **Coverage.** Group agrees to offer Health Plan's prepaid health care plan to its employees subject to the terms of this Agreement and on at least the substantially similar terms and conditions, as it provides any Alternative Health Benefits Plan for its employees. Health Plan agrees to cover Members in accordance with the Schedule of Benefits set forth in Attachment A to this Agreement and the Endorsement Page(s), subject to all exclusions therein. This Agreement is issued in consideration of each Member's application for Health Plan coverage and receipt of the Group's payment of required prepayments.

## **II. DEFINITIONS**

2.1 **Alternative Health Benefits Plan** means the health benefits plan or plans which Group offers as an alternative to the plan set forth in this Agreement.

2.2 **Authorized Person** is a person, including a spouse, other relative or provider, who has been authorized in writing by the Member to represent the Member in a request for an Internal or External Review.

2.3 **Basic Health Services** as defined in ORC § 1751.01 (A) include; inpatient hospital services, physician services, outpatient medical services, Emergency health services, urgent care services, laboratory and radiology services, diagnostic and treatment services, other than prescription drug services, for biologically based mental illnesses, preventive health services and routine patient care for patients enrolled in an eligible cancer clinical trial pursuant to section 3923.80 of the Ohio Revised Code.

2.4 **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.

2.5 **Child** means natural children, legally adopted children, stepchildren, and children under legal custody (i.e., official court appointed guardianship or custody) of Subscriber or Subscriber's spouse for whom the Subscriber or the Subscriber's spouse has the financial responsibility to provide for health care needs at the time Covered Services are provided.

2.6 **Coinsurance** means a percentage of the allowed provider charges required under this Agreement to be paid by a Member as a condition of the receipt of Covered Services. In accordance with ORC § 1751.12, Coinsurance for a Basic Health Service will not exceed 40% of the average cost for providing the service. Coinsurance is described in the Attachment A and Endorsement Page(s) to this Agreement.

2.7 **Contract Year** means the period of time specified in the "Benefit Period" on the Endorsement Page(s). This may be a calendar year or the anniversary date of the Group.

2.8 **Copayment** means a fixed dollar amount required under this Agreement to be paid by a Member as a condition of the receipt of Covered Services. In accordance with ORC § 1751.12, Copayment for a Basic Health Service will not exceed 40% of the average cost for providing the service. Copayments are described in the Attachment A and Endorsement Page(s) to this Agreement.

2.9 Cosmetic or Plastic Procedures are those procedures that improve physical appearance or treat a mental or emotional condition through a change in body form, but do not correct or materially improve a physiological function.

2.10 Covered Group. A Group consisting of employees, retirees or Dependents receiving Covered Services pursuant to this Agreement.

2.11 Covered Services means the services and benefits provided under this Agreement as set forth in Attachment A hereto that are provided, prescribed or authorized by a Health Plan Physician.

2.12 Dependent means any member of a Subscriber's family who meets all the applicable eligibility requirements of Article III of this Agreement, who has enrolled in accordance with the Article, and for whom the payment required by this Agreement actually has been received by Health Plan.

2.13 Designated Representative means any entity appointed by Health Plan to administer managed care and/or cost containment programs for this Group Medical and Hospital Service Agreement.

2.14 Deductible is the amount to be paid by the Member for Covered Services within each Contract Year before benefits will be paid by Health Plan. 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.

2.15 Eligible Cancer Clinical Trial as defined in 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.

2.16 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 her unborn child, in serious jeopardy;
- B. Serious impairment to bodily functions; or
- C. Serious dysfunction of any bodily organ or part.

The determination as to whether or not an Emergency Medical Condition exists in accordance with the definition stated in this section rests with Health Plan or its Designated Representative.

2.17 Experimental Drugs and Services means those drugs and services determined by Health Plan to fall outside of generally accepted medical practice. This determination is made based on the recommendation of the Medical Advisory Committee, the most recent HAYES Medical Technology Directory and on current evidenced-based medical/scientific publications.

2.18 Group means any sole proprietorship or entity employing two or more full-time eligible employees. Sole proprietors through a Bona Fide Association affiliation must show proof of business enterprise (Tax Schedule C).

2.19 Health Plan Physician means any physician duly licensed to practice in either Ohio and/or Michigan, depending upon where the physician engages in the practice of medicine and who is under contract with Health Plan to provide Covered Services to Members. Health Plan Physicians are comprised of Primary Care Physicians and Specialist Physicians.

2.20 HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended, and the Ohio Health Insurance Portability and Accountability Act, passed as Ohio House Bill 374 in June 1997, and any regulations promulgated thereunder.

2.21 Legal Representative is a person who has been named through legal process as guardian or who has Durable Power of Attorney for Health Care for a Member and is thereby authorized to act on behalf of the Member.

2.22 Medically Necessary means those services determined by Health Plan or its Designated Representative to be (i) preventive, diagnostic and/or therapeutic in nature, and (ii) specifically related to the condition which is being treated/evaluated, and (iii) rendered in the least costly medically appropriate setting, (e.g., inpatient, outpatient, office), based on the severity of illness and intensity of service required, and (iv) not solely for the Member's convenience or that of his or her physician, and (v) is supported by evidence-based medicine.

2.23 Member means any Subscriber or Dependent as defined herein.

2.24 Non-Biologically Based Mental Illness means mental illnesses that are defined in the *Diagnostic and Statistical Manual of Mental Disorders(DSM)* and are not Biologically Based Mental Illnesses.

2.25 Out-of-Pocket Copayment Limit is the maximum amount of Copayments and Coinsurance including the Deductible, if any, the Member will pay every Contract Year on Basic Health Services. Once the Out-of-Pocket Copayment Limit is met, there will be no additional Copayments or Coinsurance on Basic Health Services during the remainder of the Contract Year. Copayments and Coinsurance for Supplemental Health Services and any penalties do not count toward the Out-of-Pocket Copayment Limit. The single Out-of-Pocket Copayment Limit is the amount each Member must pay; the family Out-of-Pocket Copayment Limit is the total amount any two or more covered family members must pay.

2.26 Participating Hospital means any hospital with which Health Plan has contracted or established arrangements to provide Covered Services to Members.

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

2.28 Preventive Health Services means 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. See Preventive Health Services in Attachment A.

2.29 Primary Care Physician means a Health Plan Physician who is designated by Health Plan as a Primary Care Physician responsible for managing and coordinating the full scope of a Member's medical care, including but not limited to performing routine evaluations and treatment, arranging for all necessary referrals to specialists, ordering laboratory tests and x-ray examinations, prescribing required medications, and arranging for a Member's hospitalization or other services when appropriate and who meets all the requirements for Primary Care Physicians contained in Primary Care Physician's Agreement with Health Plan and such other requirements adopted by Health Plan from time to time.

2.30 Schedule of Benefits means the benefits and coverage applicable to a Member which appears in Attachment A or which hereafter may be made a part of this Agreement.

2.31 Service Area means Lucas, Wood, Fulton, Williams, Defiance, Henry, Putnam, Hancock, Ottawa, Sandusky, Seneca, Wyandot, Marion, Crawford, Morrow, Erie, Huron, Richland, Ashland, and parts of Paulding, Allen, Hardin, Delaware, Knox and Lorain Counties in Ohio and such other areas in which Health Plan may from time to time extend its services.

2.32 Specialist Physician means a Health Plan Physician who provides Covered Services to Members within the range of his or her medical specialty, who is designated by the Health Plan as a Specialist Physician, and who meets all the requirements for Specialist Physicians contained in the Specialist Physician's agreement with Health Plan and such other requirements adopted by Health Plan from time to time.

2.33 Subject of a Cancer Clinical Trial means the health care service, item or drug that is being evaluated in the clinical trial and that is not routine patient care.

2.34 Subscriber means a person who meets all applicable eligibility requirements of Article III of this Agreement, who enrolls in accordance with that Article, and for whom the payment required by this Agreement actually has been received by Health Plan.

2.35 Supplemental Health Services set forth in ORC§ 1751.01 (B) shall include, but not be limited to, mental health services excluding diagnostic and treatment services for biologically based mental illness, substance abuse services, home health care services, durable medical equipment, prosthetic devices, vision care services and outpatient prescription drugs.

2.36 Urgent Medical Condition means a medical condition, other than an Emergency Medical Condition, that requires medical attention soon after it appears that is not permanently disabling or life-threatening.

2.37 Urgent Care Services means Covered Services that are provided for an Urgent Medical Condition.

2.38 Value of Medical Benefits Paid is the amount paid by Health Plan to the provider, or in the absence of a cash payment for a specific visit, the fee-for-service equivalent, plus administrative costs and legal fees as permitted by law.

### **III. ELIGIBILITY**

3.1 Subscriber Eligibility. To be eligible as a Subscriber, a person must be eligible under the Group's eligibility rules, reside in the Health Plan's Service Area or be employed in the approved Service Area and reside in a county contiguous to the Ohio Service Area and:

- A. (1) For Groups with fewer than 50 employees, the person must be in the active employment of Group and working a minimum average of 25 hours per week; For Groups with greater than 50 employees, the person must be in the active employment of Group and working a minimum average of 20 hours per week or such other minimum average that is approved by Health Plan; or
- (2) Be a retired employee, non-Medicare eligible, drawing retirement benefits from Group pension or profit-sharing plan(s), but only if Group is obligated to provide health benefits to all retired employees in the covered group prior to the effective date of this Agreement; or
- (3) Be an eligible employee on company paid sick leave or disability not to exceed 6 months if, prior to sick leave or disability, the employee worked a minimum average of 20 hours per week for the preceding 26 weeks; or
- (4) Be an eligible former employee or Dependent under group continuation (COBRA) status; or
- (5) If the Group has elected to offer a Prestige Rider, to be eligible to enroll as a subscriber thereunder, the subscriber must be an actively working or retired employee of Group, enrolled in and eligible for Medicare Part A and B, Medicare must be primary in accordance with Medicare Coordination of Benefits rules, and the Group must maintain active employee benefits through Health Plan; and , in order to be eligible for coverage under a Prestige Prescription Drug Rider, the subscriber must also be enrolled in Medicare Part D through Paramount Insurance Company.
- B. Be entitled to participate in the medical and hospital care benefits program arranged by Group; and
- C. Submit a completed and signed enrollment application form or electronic enrollment, including all requested information on all Dependents for whom coverage is requested to the Health Plan within 31 days of the effective date of this Agreement.

3.2 Dependent Eligibility. To be eligible as a Dependent, a person must be eligible under the Group's eligibility rules, must reside in the Health Plan's Service Area (or in a county contiguous to the Ohio Service Area), and must submit (or the Subscriber must submit on the Dependent's behalf) a completed and signed enrollment application, and must be:

- A. The legal spouse of the Subscriber (excluding divorce[e]s); or
- B. An unmarried dependent Child of the Subscriber or Subscriber's spouse who is:
  - i. under the limiting age or between the limiting ages specified on the Endorsement Page(s),
  - ii. not employed full-time, and
  - iii. if applicable to Group, attending a recognized college or university, trade or secondary school on a full-time.

As used herein, full time basis for the purposes of attending a college or university means carrying a minimum of 12 credits for undergraduates or 9 credit hours for graduate students.

If it is medically necessary for a Dependent student to take a leave of absence from college, university, trade or secondary school due to a serious illness or injury, dependent eligibility will continue for a period of 12 months from the last day of full time attendance, at such school, or until the Dependent student reaches an age at which coverage would otherwise terminate, whichever period is shorter. Continuation of Dependent Eligibility due to a medically necessary leave of absence is subject to certification of the medical necessity due to a serious illness or injury in writing from the Dependent student's attending physician, within 31 days from the last day of full time attendance at such school; or

- C. An unmarried Child who has reached the limiting age specified on the Endorsement Page(s), is unable to work to support himself or herself and who is primarily dependent on Subscriber for support and maintenance because of mental retardation or physical handicap. Appropriate medical documentation of the incapacity and dependency must be furnished to Health Plan by the Subscriber within 31 days of reaching the limiting age specified on the Endorsement Page (s), and thereafter, at least annually, and the documentation must be satisfactory to Health Plan. In addition, Health Plan may periodically check whether such Child is, and continues to qualify as, a Dependent.

3.3 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 beyond this 31-day period, the Subscriber must submit an enrollment application for the newborn child to Health Plan within this 31-day period. A newborn child of a Dependent is not eligible unless otherwise considered a Child under Section 2.4.

3.4 Adopted Children. To receive coverage, an adopted Child must be enrolled within 31 days from the date of adoptive placement or during an open enrollment period. Coverage will be effective from the date of the adoptive placement. Adoptive placement means the assumption and retention by Subscriber or Subscriber's spouse of a legal obligation for total or partial support of a child in anticipation of the adoption of the child. The placement terminates upon termination of the legal obligation.

3.5 New Employees. New employees or newly transferred employees will have coverage effective in accordance with the new-hire policy established by the Group so long as such person enrolls within 31 days of becoming newly eligible and the applicable prepayment is received by Health Plan in a timely manner. If the Group has fewer than 50 employees, the waiting period imposed by the Group may not exceed 90 days from date of hire.

3.6 New Spouses & Common Law Spouses. New spouses of Subscribers will have coverage effective on the date of a legal marriage so long as such person enrolls within 31 days of the marriage date and the applicable prepayment is timely received by Health Plan. Any person claiming to be the common law spouse of a Subscriber must prove to the satisfaction of Health Plan that their claimed common law marriage with the Subscriber is valid under Ohio law. Health Plan reserves the right to require at any time proof to its satisfaction of the validity of an alleged lawful marriage. Proof must include, but may not be limited to producing information requested by Health Plan that might confirm or dispute the existence of a valid common law marriage under Ohio law.

3.7 Late Enrollment & Waiver. If an eligible employee or Dependent fails to submit an enrollment application within the prescribed time period, that employee or Dependent may not enroll until the submission of a completed application and applicable premium retroactive to the eligibility effective date. If an eligible employee or Dependent waives coverage or declines to pay for coverage from the eligibility effective date, that employee or Dependent may not enroll until the next open enrollment period or during a special enrollment period required under HIPAA.

3.8 Group Eligibility. During the term of this Agreement, Group must comply with the following eligibility requirements for Group Participation and Group Contribution. Upon request, Group must provide appropriate documentation to Health Plan so that Health Plan can determine, in its sole discretion, Group's compliance with the Eligibility Requirements for participation and contribution.

- A. Group Participation. Group must have the following minimum participation of eligible actively working (as set forth in § 3.1(1)) employees enrolled with Health Plan in order to be eligible as a Group:

- 2 through 10 employees must have 100% participating;

- 11 through 12 employees must have 10 participating;
- 13 through 14 employees must have 11 participating;
- 15 employees must have 12 participating;
- 16 through 50 employees must have 75% participation; and
- 51 plus employees participation to be determined by Health Plan.

B. Group Contribution. Groups with more than 50 employees agree to contribute on behalf of the covered employees at least 50% of the total premium or 100% of the single premium applied for all employees. Groups with 2-50 employees must contribute 50% of the total premium for all employees. Provided, however, in the event that employees of Group are receiving benefits from other carriers, Group agrees to contribute on behalf of employees eligible to enroll in Health Plan the amount necessary such that no employee's premium contribution to Health Plan is greater than the employee's premium contribution for other carriers.

#### **IV. EFFECTIVE DATE OF COVERAGE**

4.1 Initial Open Enrollment Period. There will be an initial open enrollment period for Subscribers and their presently eligible Dependents with the dates of such period and the effective date of coverage for persons who enroll during such period as set forth on the Endorsement Page(s) of this Agreement. Completed and signed enrollment applications must be received by the Health Plan within 31 days of the effective date of Group coverage.

4.2 New Hire Policy. Newly hired employees have coverage effective after the probationary/waiting period established by Group and stated on the Endorsement Page(s) of this Agreement. If the Group has fewer than 50 employees, the waiting period imposed by the Group may not exceed 90 days. In all cases, applications must be received by Health Plan within 31 days of the effective date of coverage.

The Group may change the probationary/waiting period for new hires as originally stated on the Endorsement Page(s) of this Agreement by submitting 31 days advance written request to Health Plan. Only one change per twelve-month period will be accepted.

4.3 Recall Policy. If a Member terminates coverage at the time of a layoff and thereafter returns to active employment within 6 months from the effective date of layoff, that employee will be eligible for coverage with Health Plan in accordance with Group-requested specifications, but in no case prior to the effective date of recall. If the previously enrolled employee has been laid off for longer than 6 months, that employee will be considered a new hire for purposes of this Agreement.

4.4 Periodic Open Enrollment Period. In addition to the initial open enrollment period, there will be such other open enrollment period(s) as set forth on the Rate Page of this Agreement. Except for persons who are enrolled during the initial open enrollment period or persons enrolled in accordance with Sections 3.3, 3.4, 3.5, 3.6 or 3.7 of this Agreement, anyone eligible to enroll in Health Plan may do so only during a special enrollment period as required under HIPAA.

4.5 Pre-existing Conditions. Health Plan does not restrict coverage under this Agreement based upon any pre-existing conditions.

#### **V. CHOICE OF HEALTH PLAN PHYSICIAN**

5.1 Selection of a Primary Care Physician. Each Member must select a Primary Care Physician or have one selected on his/her behalf. This Primary Care Physician directs the Member's medical care.

5.2 Contacting the Primary Care Physician. Once selected, the Member must contact his/her Primary Care Physician before seeking non-emergency medical care. Prior authorization from the Primary Care Physician is not required for treatment by Participating Providers for the following: vision care, treatment by participating OB/GYN specialists, allergists, dermatologists, pediatric pulmonologists, hematologists, oncologists, ophthalmology, pediatric ophthalmology, retinology, pain management and other Participating Providers as determined by Health Plan. Members who circumvent their Primary Care Physician, except in the case of an Emergency Medical Condition and those mentioned previously in this section, will be denied coverage on those services provided.

5.3 Obstetrical/Gynecological Care. A female Member may choose to see her Primary Care Physician or any participating gynecologist for treatment of obstetrical/gynecological conditions, including the annual GYN exam. If a Member chooses to see a participating gynecologist, prior authorization from the Primary Care Physician is not required.

5.4 Changing Primary Care Physician. A Member or his/her Primary Care Physician may decide to end his/her physician-patient relationship at any time as allowed by medical ethics and contract. If a Member wishes to change his/her Primary Care Physician, he/she shall notify Health Plan of this intent and follow the same procedure as if the Member was initially selecting a Primary Care Physician. There is no limit on the number of times that a Member may change his/her Primary Care Physician.

## **VI. PREMIUMS, OUT-OF-POCKET COPAYMENT LIMIT AND DEDUCTIBLE**

6.1 Amount of Premiums. The required premium for this Agreement and the manner of payment are set forth on the Service Agreement Rate Page attached hereto. The rates will be in effect for the rate period set forth on the Rate Page. However, if the state or federal government or Group requires Health Plan to provide additional benefits, the premium may be increased in order to account for the additional/reduced costs. If there is a change in the premium at the end of the rate period set forth on the Rate Page or for any renewal period of this Agreement, Health Plan will provide Group with written notice thereof at least 30 days before the new premium goes into effect.

6.2 Premium Payments. All premiums are due on or before the first day of the month for which coverage is to be provided. Group must pay in accordance with the Health Plan invoice. Any additions or deletions to the invoice must be submitted in writing and credits or additional charges will be made on the next invoice. Only Members for whom the applicable premium is actually received by Health Plan are entitled to Covered Services hereunder and then only for a period for which such premium is applicable. Subscribers with effective dates falling between the first and the fifteenth of the month will be charged a premium from the beginning of the calendar month during which the coverage first became effective. Subscribers with effective dates falling between the sixteenth and the last day of the month will not be charged a premium until the first of the following month.

If payment for any Member is not made within 15 days of the due date or within 30 days of the due date for Members under COBRA continuation coverage, Health Plan will notify Group of late payment and possible termination. On the 30<sup>th</sup> day after the due date Health Plan will terminate coverage of the individual Member or all Members under this Agreement as of the date any delinquent payment was due. If coverage is terminated under the terms of this provision, the Group will be responsible for reimbursement to Health Plan for the Value of Medical Benefits Paid for services and supplies received after the effective date of termination.

If Group is twenty-five (25) days late submitting premium in two (2) out of the last six (6) months, Health Plan will require Group to pay an additional one month premium to be held in reserve. The reserve premium will be retained for the duration of the contract term and applied to the last month's coverage period upon notice of termination of this Agreement by Group. Health Plan reserves the right to charge a service fee for non-sufficient funds or declined payment transactions.

6.3 Out-of-Pocket Copayment Limit. Health Plan agrees to limit annual Copayments and Coinsurance for Basic Health Services as set forth on the Endorsement Page(s).

6.4 Deductible. The Deductible, if applicable, is set forth on the Endorsement Page(s). All Covered Services except for services subject to a Copayment and Preventive Health Services, set forth in Attachment A, are subject to the Deductible each Contract Year, unless otherwise stated herein.

6.5 Deductible Carryover. When a Member pays for Covered Services during the last three (3) months of the Contract Year, which are applied to that year's Deductible, those expenses may be carried over and applied against the Deductible for the next Contract Year.

6.6 Deductible Credit. A new Group enrolling with Health Plan will receive credit toward Health Plan Deductible, if applicable, for expenses applied to Group's previous plan deductible. Sufficient information, in a form acceptable to Health Plan, must be received no later than 90 days from the Group's effective date with Health Plan in order to receive credit.

## **VII. TERMINATION OF COVERAGE**

7.1 Loss of Eligibility. If a Member ceases to meet the eligibility requirements of Article III of this Agreement, then coverage under this Agreement for the Member will terminate automatically at midnight of the last day of the month in which eligibility ceased. Group shall notify Health Plan in writing within thirty (30) days of the date that any Member ceases to meet the eligibility requirements of Article III by completing and submitting to Health Plan a "Termination Notice". Group and Member are obligated, jointly and severally, to pay Health Plan for the Value of Medical Benefits Paid for all health services and benefits received by Member or any of Member's covered Dependents after the last day of the month in which the Member's eligibility ceased.

7.2 Selection of Other Coverage. If a Subscriber elects coverage under an Alternative Health Benefits Plan or under any other plan which is offered by, through or in connection with Group as an option in lieu of coverage under this Agreement, then coverage for the Subscriber and Subscriber's Dependents terminates automatically at midnight of the last day preceding the day that the alternate coverage becomes effective. Group agrees to notify Health Plan immediately in writing in the event a Subscriber has elected other coverage.

7.3 Nonpayment of Premium. If payment of premium for any Member is not made within 15 days of the due date or within 30 days of the due date for Members under COBRA continuation coverage, Health Plan may terminate the coverage of the individual Member or of all Members covered under this Agreement as of the date any delinquent payment was due. If coverage is terminated pursuant to this section, the Group whose coverage was terminated must reimburse Health Plan for the Value of Medical Benefits Paid for services and supplies received after the effective date of termination.

7.4 Failure to Furnish or Furnishing Incorrect or Incomplete Information. Members are required to represent in their enrollment applications (including electronic enrollment) that, to the best of their knowledge and belief, all information contained in such applications or other documents submitted to Health Plan is true, correct and complete. If a Member fails to furnish information required to be furnished by Health Plan or furnishes incorrect or misleading information that is material to Health Plan's decision to provide coverage for the Subscriber or involves fraud, then Health Plan may terminate coverage of the Member involved effective on the date such Member failed to furnish such information or the date such Member furnished incorrect or misleading information, whichever is applicable. Upon termination the Member must pay Health Plan for the cost of services received subsequent to the date of termination, based on the Value of Medical Benefits Paid, less any Copayments made or prepayments paid by the Member for the services. Health Plan may also terminate coverage of all other enrolled Members of such Member's family, effective immediately upon written notice. Health Plan shall notify Group in writing in the event Health Plan terminates coverage hereunder.

7.5 Fraud, Including Misuse of Identification Card. Any person who, with intent to defraud or knowing that he is facilitating a fraud against Health Plan, submits an application or files a claim containing a false or deceptive statement, is guilty of Insurance Fraud under Ohio criminal law, and Health Plan may terminate the coverage of the person upon written notice to the relevant Subscriber and to Group. Health Plan may deem the termination effective as of the date of filing said application or claim.

If any Member permits the use of his/her or any other Member's Health Plan identification card by any other person or uses another person's card or uses an invalid card, then the misused card will be retained by Health Plan, as well as Member's own identification card, and Health Plan may terminate the coverage of the Member or Members involved and may also terminate the coverage of all other enrolled Members of his/her family. Health Plan may deem the termination effective as of the day the card was first misused.

If any Member engages in fraud or deception of any kind in the use of the services or facilities of Health Plan or of Participating Providers or knowingly permits such fraud or deception by another, Health Plan may terminate the coverage to the Member or Members involved and may also terminate the coverage of all other enrolled Members of his/her family. The coverage of the Member or Members involved and the coverage of all the enrolled Members of his/her family may be terminated upon written notice to the relevant Subscriber and to Group. Health Plan may deem the termination effective as of the first day of the fraud or deception.

If Health Plan terminates a Member's coverage under this Section, the Member must pay Health Plan for the cost of services received subsequent to the date of termination, based on the Value of Medical Benefits Paid, less any Copayments made or prepayments paid by the Member for the services.

7.6 Reinstatement. If coverage of a Member is terminated under Article VII, it may be reinstated only upon written request to Health Plan. Reinstatement is within the sole discretion of Health Plan and may be subject to approval of a medical history questionnaire. The application for reinstatement must be accompanied by payment of any outstanding balance of Subscriber's account plus any current premium owed.

7.7 Refunds. If the rights of a Member hereunder are terminated pursuant to Sections 7.4 or 7.5, the premium(s) received on account of the terminated Member or Members applicable to periods after the effective date of termination, less any amounts due Health Plan or Participating Providers, will be refunded to Group within 31 days of the effective date of termination and neither Health Plan nor Health Plan Participating Providers will have any further liability or responsibility.

7.8 Continuation for Current Inpatients. In the event that a Member's coverage terminates while the Member is receiving inpatient care in a hospital, such Member's coverage will continue for the period required under Ohio Revised Code § 1751.11.

## **VIII. COORDINATION OF BENEFITS**

### **8.1 General.**

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.

### **8.2 Definitions for Article VIII**

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

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

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

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

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

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

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

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

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

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

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

- (5) Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary plan and the Plan that covered the person the shorter period of time is the Secondary plan.
- (6) If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This plan will not pay more than it would have paid had it been the Primary plan.

#### 8.4 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.

#### 8.5 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. Health Plan 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. Health Plan need not tell, or get consent of any person to do this. Each person claiming benefits under This plan must give Health Plan any facts it needs to apply those rules and determine benefits payable.

#### 8.6 Facility of Payment

A payment made under another Plan may include an amount that should have been paid under This plan. If it does, Health Plan 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. Health Plan will not have to pay that amount again. The term “payment made” includes providing benefits in the form of services, in which care “payments made” means the reasonable cash value of the benefits provided in the form of services.

#### 8.7 Right of Recovery

If the amount of the payments made by Health Plan 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.

#### 8.8 Coordination Disputes

If the Member believes that Health Plan has not paid a claim properly, The Member should first attempt to resolve the problem by contacting the Health Plan at (419) 887-2525 or refer to Section XI, Internal and External Reviews. If the Member is still not satisfied, the Member 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>

### **IX. REIMBURSEMENT, NON-DUPLICATION AND SUBROGATION**

9.1 Payment and Reimbursement. By executing an enrollment application and/or directly or indirectly presenting claims for payment for Covered Services, Subscribers and their Dependents agree that if sickness or injury to a Member is caused by an act or omission of a third party or the Member, Health Plan may elect to pay for the Covered Services and seek reimbursement or subrogation. If a Member or Member’s legal representative settles or obtains a judgment on a claim for injuries to

Member, Member agrees to reimburse Health Plan from the amounts recovered at the full Value of Medical Benefits Paid, even if the settlement or judgment is partial and does not fully compensate or make the member whole or include full payment for medical costs. Health Plan's reimbursement rights are a first priority claim against any recovery and must be paid before other claims by the Member for damages, and must be paid without any reductions for Member's attorney fees, costs or other expenses. Member agrees to make full reimbursement regardless of how the monetary recovery was designated (e.g., pain and suffering, non-economic loss, etc.), and regardless of whether the settlements or judgments obtained either by the Member or on behalf of the Member are under Member's own insurance, medical payments coverage, excess, umbrella, uninsured and/or underinsured motorist insurance, or any other source (including the party causing such sickness or injury).

9.2 Workers' Compensation/Non-Duplication. The benefits which Members are otherwise entitled to receive under Health Plan do not duplicate any benefit to which Members are entitled under Workers' Compensation laws or similar employer liability laws. All sums paid by Workers' Compensation or similar employer liability laws to a Member for Covered Services are deemed to be assigned to Health Plan and subject to the procedures set forth in Sections 9.1 and 9.3.

9.3 Subrogation. As an alternative to reimbursement by Member as provided in Section 9.1 above, Health Plan, at its option, may choose to exercise its rights of subrogation to the Member's rights of recovery and remedies by joining in a Member's lawsuit, assigning its rights to Member to pursue on Health Plan's behalf, or bringing suit in the Member's name, as subrogee. Where a Member has benefits paid by Health Plan as a result of sickness or injury caused by a third party or the Member, the rights of the Member to claim or receive compensation, damages or other payment from any person, organization or insurer, including a Member's own insurer, medical payments coverage, any excess, umbrella, uninsured and/or underinsured motorist insurance, and any other source (including the party causing such sickness or injury), are transferred to Health Plan but only to the extent of the Value of Medical Benefits Paid for Covered Services provided to the Member. Health Plan's subrogation rights are a first priority claim against any recovery and must be paid before any other claims, including claims by the Member for damages, and must be paid without any reductions for Member's attorney fees, costs or other expenses, even if settlement or judgment is partial and does not fully compensate or make the Member whole.

9.4 Cooperation by Members. By executing an enrollment application and/or directly or indirectly presenting claims for payment for Covered Services, the Subscriber and his/her 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 Health Plan or its nominee under this Article. Member may not do anything which might limit, waive or release Health Plan's reimbursement or subrogation rights.

Member agrees not to settle a claim for any sickness or injury caused by a third party or the Member without either providing for full and immediate reimbursement to Health Plan at the Value of Medical Benefits Paid from sums due from the settlement, or agreeing in writing with Health Plan before the settlement on some other payment schedule and security payment. Health Plan's right of reimbursement and subrogation under sections 9.1 and 9.3 of this article apply where Member's sickness or injury arises from any accident, trauma, product, or from the actions or inactions of any person, entity, manufacturer or the Member. Member or Member's Representative must notify Health Plan of the incident causing the sickness or injury within 30 days of the incident. Should the Member be incapacitated for 30 days or longer, the Member or Member's Representative must notify the Health Plan as soon as feasible but no later than the date on which Member or Member's Representative files a lawsuit to recover damages or 120 days prior to the expiration of the statute of limitations, whichever is sooner.

Should Member fail to comply with Sections 9.1, 9.3 or 9.4 of this Article, Member shall pay Health Plan's reasonable collection costs and attorney fees incurred in collecting amounts due Health Plan, or, in the alternative, and at Health Plan's sole option, Health Plan may elect to deny future claims for Covered Services presented by or on behalf of the Member until the sum of any such denied future claims is equal to the amount that Member was obligated to reimburse Health Plan.

9.5 Cooperation by Employers. By executing this Agreement, the Employer agrees to assist Plan in obtaining necessary information from covered employees as may be required and do whatever is necessary to effectuate and protect fully the rights of Health Plan or its nominee under this Article.

## **X. GROUP CONTINUATION AND INDIVIDUAL CONVERSION COVERAGE**

10.1 Group Continuation Coverage. Under certain circumstances Members who cease to meet eligibility requirements under Section III of this Agreement may be eligible for Group continuation coverage under the Group's health benefits plan. Except where COBRA, 29 U.S.C. §§ 1161-67, applies and provides to the contrary, Group continuation coverage will not be available for:

- A. Any person who is, becomes, or could be covered under Medicare as primary coverage; or

- B. Any person who is, becomes or could be covered as an employee, member or dependent by any other plan which covers health services; or
- C. Any person who does not reside in the Health Plan's Service Area; or
- D. Any person from any Group whose coverage was terminated for any reason by Health Plan.

10.2 Conditions of Group Continuation Coverage for Groups with Fewer than 20 Employees. Any eligible employee as defined in Ohio Rev. Code §1751.53 (amended April 1, 2009) may continue coverage under the group contract for the employee and the employee's eligible Dependents, for a period of 12 months after the date that the group coverage would otherwise terminate by reason of the involuntary termination of his/her employment. The Group coverage available under this provision is subject to the limitations contained in Ohio Revised Code §1751.53 and application for continuation coverage must be made in accordance with that section. Group is responsible for sending required documentation to Health Plan concerning election of group continuation coverage and any applicable request for continuation coverage premium subsidy.

10.2.1 Group Continuation Coverage for Subscribers who are Reservists in the Armed Forces. Health Plan will offer continuation coverage for Subscribers who are reservists called to active duty in the Armed Forces of the United States as required by the Uniform Services Employment and Reemployment Rights Act (USERRA) and Ohio Revised Code §1751.54.

10.3 Conditions of Group Continuation Coverage for Groups with 20 or More Employees (Consolidated Omnibus Budget Reconciliation Act). Health Plan will offer group continuation coverage to all Members entitled to such coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA), 29 U.S.C. §1161-67 for the period of time COBRA requires that continuation coverage be provided for the Member. This coverage is subject to the Member's and Group's compliance with all COBRA requirements and with this Agreement. Group continuation coverage will cease upon termination of this Agreement. Unless required otherwise by COBRA, Group continuation coverage under this section will cease upon Member (1) becoming covered under any other group plan without an exclusion relating to a pre-existing condition of such Member or (2) becoming entitled to Medicare benefits.

10.4 COBRA Disabled. Health Plan reserves the right to charge up to 150% of premium after the 18th month of COBRA continuation coverage if the individual was disabled under either Title II or XVI of the Social Security Act at the time of the qualifying event described in 29 U.S.C. Section 1163(2).

10.5 Termination of Group Continuation Coverage. In the event coverage under the Group's continuation coverage ceases other than for reason of nonpayment as stated in Section 6.2 and 7.3 or termination of this Agreement, Subscriber and/or eligible Dependents may convert their enrollment to individual membership without furnishing evidence of insurability. To obtain individual membership, the eligible Member must: (a) continue to reside in the Service Area, (b) submit a completed application for conversion to an individual policy within 31 days after the date of termination of the group continuation coverage, and (c) submit the payment required for the membership. Health Plan will provide notice of the conversion option to the Subscriber as required by Ohio Revised Code § 1751.16.

10.6 Conversion to Individual Coverage.

- A. Individual Conversion Coverage is Available in the Following Situations:
  - (1) Ceasing to be Employed by Group. In the event a Subscriber ceases to be covered under this Agreement solely as a result of the termination of his/her employment with Group, the Subscriber may convert his/her enrollment to individual coverage without furnishing evidence of insurability and without regard to health status or requirements for health care services. It is the Subscriber's responsibility to apply in writing to Health Plan for individual conversion coverage within 31 days after employment with Group terminates.
  - (2) Death or Divorce. In the event that the Dependent of a Subscriber who is legally capable of contracting ceases to be covered under this Agreement solely as a result of the termination of marriage to, or death of, the Subscriber, then the Dependent may convert to individual coverage without furnishing evidence of insurability and without regard to health status or requirements for health care services. It is the Dependent's responsibility to apply in writing to Health Plan for individual conversion coverage within 31 days after the termination of marriage to, or death of, Subscriber.
  - (3) Dependent Child Reaching Limiting Age. In the event the Subscriber's Dependent Child ceases to be covered under this Agreement solely because the Child marries, is

no longer a Dependent of Subscriber, attains the limiting age for an eligible Dependent Child or is no longer incapable of self-support, the Child may convert to individual coverage without furnishing evidence of insurability and without regard to health status or requirements for health care services. It is the Dependent's responsibility to apply in writing to Health Plan for individual conversion coverage within 31 days after the event.

- (4) Group Terminates for Non-Payment of Group Premiums. In the event this Agreement is terminated for non-payment of Group premiums, the Subscriber may convert his/her enrollment to individual coverage within 31 days of the notice of termination of Group coverage, if the Subscriber applies and pays for individual coverage. The Subscriber shall be provided coverage without furnishing evidence of insurability and without regard to health status or requirements for health care services.

B. Notwithstanding anything in this Agreement to the contrary, conversion to individual coverage is NOT available when:

- (1) The Group Medical and Hospital Service Agreement is terminated by the Group for any reason, other than those under 10.6, A, (4); or
- (2) Member does not reside in Service Area; or
- (3) Member is eligible for Medicare or any other health plan coverage.

10.7 Conditions for Individual Conversion Coverage. To be considered for individual conversion coverage, the Member must submit to Health Plan a completed and signed enrollment application within 31 days from the date the Member ceases to meet the eligibility requirements of this Agreement and becomes eligible for individual conversion under Sections 10.5 or 10.6 of this Agreement or within 15 days from receipt of notice of the conversion option from Health Plan, whichever is later. Conditions for entitlement to individual coverage are as follows:

- A. All conversions to individual coverage must be in accordance with Health Plan's rules, regulations, policies and procedures governing conversion and Members who convert to individual coverage must sign and comply with the terms of Health Plan's "Individual Medical and Hospital Service Agreement". The benefits available under conversion coverage may differ from the benefits available under this Agreement.
- B. If a Member eligible for conversion elects to exercise the conversion privilege, the conversion will be retroactively effective as of the date Group coverage terminated and will be subject to the payment of any required amounts due for the 31-day election period.
- C. If a Member eligible for conversion elects not to exercise the conversion privilege, and the Member or any Member of his/her family receives health services or benefits during the 31-day election period, the Member must pay Health Plan for the Value of Medical Benefits Paid for those services, less any Copayments paid for the services.
- D. Member must remit to Health Plan the applicable payment according to the Health Plan's payment schedule as detailed in the "Individual Medical and Hospital Service Agreement."
- E. If Member becomes eligible for coverage under any other health care plan, or under Medicare, eligibility for individual coverage ceases.

## **XI. INTERNAL AND EXTERNAL REVIEWS**

11.1 Informal Resolution of Complaints. All Member complaints will be resolved informally whenever possible. A Member is encouraged to initially attempt to resolve complaints about medical treatment through his/her Primary Care Physician. If the complaint cannot be satisfactorily resolved in this manner, or if the complaint is not a medical treatment issue, the Member is advised to telephone Health Plan's Member Services Department. A Member Services Representative will be available to receive the call and seek informal resolution of the complaint. If the initial complaint is in writing, a Member Services Representative will telephone the Member to seek informal resolution within two working days after receipt of the letter for urgent clinical issues and within thirty (30) working days for other complaints.

If a complaint is not resolved satisfactorily on an informal basis, the Member Services Representative will inform the Member that he/she may seek formal resolution of the complaint through the internal and external review procedure.

11.2 Internal Review. If a service is denied, reduced, or terminated, the Member may ask Health Plan to review the request for the service again. (The Member may also request an internal review if utilization management fails to

make a decision within the required timeframes under ORC 1751.77, C, D, E.) The Member may make this request orally or in writing. Written request should be sent to:

PARAMOUNT HEALTH CARE  
P. O. Box 928  
Toledo, Ohio 43697-0928

The Member must request an internal review *within one year* from the denial, reduction or termination. The Member, the Member's Legal Representative, an Authorized Person, the provider, or the health care facility may request the review. The provider and health care facility must have the Member's authorization to request a review. A Member does not need the authorization of the provider. The Member will be given the option of attending an administrative staff hearing, or participating in a teleconference to present their appeal. If the service is being denied, reduced or terminated because of contract benefit limits, because the service is not covered under the contract or the case involves a membership or enrollment issue the review will be conducted by administrative staff. Paramount will use a clinical peer for this review if it involves a clinical issue. A clinical peer is a physician or provider who has the same license as the provider who will perform the service. The clinical peer will review the Member's medical records and determine if the service is medically necessary. If the clinical peer determines that the service is medically necessary, Health Plan will pay for the service; if the clinical peer determines that the service is not medically necessary, Health Plan may continue to deny payment for the services. If the payment for the services are denied, the Member has the right to ask for another review.

Health Plan will provide the Member with a written response indicating its decision within 30 calendar days of the receipt date of the written request for an internal review for pre-service appeals and within 60 calendar days for post-service appeals. If the Member's medical condition requires a faster review (called an expedited review), Health Plan will provide a response *within 72 hours*. If Health Plan does not respond to the Member's request for an Internal Review within 60 calendar days or within 7 calendar days for Expedited Reviews, it is considered a denial and the Member has the right to appeal further.

If Health Plan continues to deny payment for the service, the Member will be informed of his or her right to ask for another review. The Member may appeal denials for any of the reasons listed below:

- a) Services are not Covered Services.
- b) Services are not Medically Necessary.
- c) Services are Experimental and the Member has a terminal illness.

11.3 Ohio Department of Insurance Appeals. If Health Plan denies the service because it is not a covered service under the terms of the Health Plan contract, the Member may request a review from the Department of Insurance. The Member should write promptly to the Department of Insurance at 2100 Stella Court, Columbus, OH 43215 or call the Department at 1-800-686-1526. If the Department notifies Health Plan that making a decision requires the resolution of a medical issue, Health Plan will initiate an external review.

11.4 External Review-Medical Necessity. If Health Plan denies, reduces or terminates the service because it is not Medically Necessary and the service and the related expenses will cost the Member more than \$500 if it is not covered by Health Plan (the \$500 does not apply in cases of expedited reviews), the Member may request an external review from an independent review organization (IRO). The IRO is not affiliated with Health Plan.

The Member must request this review *within 180 calendar days* of receiving notice that the claim was denied by the clinical peer. The Member's request must be in writing and include a certification from the provider that the services will *cost the Member more than \$500*. The Member, the Member's Legal Representative, an Authorized Person, the provider, or the health care facility may request the review. The provider and health care facility must have the member's authorization to request a review. The Member does not need the authorization of the provider.

The IRO will review the Member's medical records and determine if the recommended service is Medically Necessary. If the IRO determines that the service is Medically Necessary, Paramount will pay for the service according to the terms of the contract. If the IRO determines that the service is not Medically Necessary, Paramount does not have to pay for the service.

11.5 External Review-Experimental. If the Member has a terminal illness, the Member may also request an external review when the services are denied because Health Plan has determined they are Experimental or investigative. To qualify for this review the Member must meet all of the following criteria:

1. The Member has a terminal condition that according to the current diagnosis has a high probability of

causing death within two years.

2. The Member requests an external review *not later than 180 calendar days* after receipt of notice of the result of the internal review.
3. The Member's physician certifies that one of the following situations applies to your condition:
  - Standard therapies have not been effective in improving the Member's condition
  - Standard therapies are not medically appropriate for the Member
  - There is no standard therapy covered by Paramount that will benefit the Member more than the therapy requested by either the Member or his or her physician.
4. The Member's physician has recommended a drug, device, procedure, or other therapy that he or she certifies in writing is likely to benefit the Member more than standard therapies or the Member has requested a therapy that has been found in a preponderance of peer-reviewed published studies to be associated with effective clinical outcomes for the same condition.
5. The Member has exhausted the internal review process.
6. The drug, device, procedure, or other therapy would be covered if it were not considered to be experimental or investigative.

11.6 Expedited Reviews. When the review must be completed quickly because of the Member's medical condition, the Member may request an external review by phone, fax or e-mail. However, the Member must follow up this request with a written request within five (5) calendar days. The independent review organization (IRO) must provide the Member with a response to an expedited review within seven (7) calendar days of the Member's initial request.

The Member may request an expedited review if delaying the review will do any of the following:

- Place the health of the patient or unborn child in serious jeopardy
- Cause serious impairment to bodily functions
- Cause serious dysfunction of any body organ or part

11.7 Claims or Suits. The Member may not bring an action in court against Health Plan until the Member has exhausted all the applicable procedures described above. In no event shall a Member bring an action in court against Health Plan more than two (2) years after the occurrence upon which the legal action is based. In the event the occurrence upon which the legal action is based concerns denial of a claim for benefits the occurrence shall be deemed to have occurred on the date of service if the service was in fact received.

## **XII. TERM AND TERMINATION OF AGREEMENT**

12.1 Term. The term of this Agreement will be for the contract period set forth on the Implementation Page(s) of this Agreement. Group may not terminate this Agreement during the contract term unless Health Plan has materially breached this Agreement. The Agreement will be automatically renewed from year to year subject to premium rates determined by Health Plan unless terminated at the end of the contract term by either party giving at least 60 days prior written notice to the other. In the event a notice of a rate change is issued to the group less than 60 days prior to the end of the contract term, the contract may be terminated by either party giving prior written notice to the other at least 30 days before the end of the contract term. Health Plan may decline to renew the coverage provided under this Agreement for any reason permitted under HIPAA, including the failure of Group to meet Health Plan's Group eligibility requirements including minimum employer contribution of premium or its group participation rules set forth in Section 3.8. Health Plan shall provide Group with notice of any change in premium rates for any renewal period in accordance with Section 6.1.

### 12.2 Termination of Service Agreement.

A. Upon default in making payments in accordance with Article VI, all rights to benefits hereunder shall terminate at the end of the period for which all required premiums have been made and Health Plan may deem such default as action by Group to cancel this Agreement. In such event, Health Plan shall notify Group and Subscribers of the effective date of termination. In the case of multiple year Agreements, failure to make payments will not terminate the Agreement and Group will remain liable for all outstanding payments.

B. Upon failing to provide documentation to establish Group eligibility or falling below Group participation requirements stated in Section 3.8, Health Plan shall notify Group. Group shall have sixty (60) days to provide sufficient documentation and/or bring participation up to required level. After sixty (60) days, if Group does not provide sufficient documentation and/or meet minimum participation requirement, Health Plan shall notify Group and Subscribers of the effective date of termination.

### **XIII. GENERAL PROVISIONS**

13.1 Assignment. Neither Group nor Member may assign any benefits under this Agreement to any person, corporation or other organization. Any such assignment will be void. Health Plan may assign its rights under this Agreement to any corporation or other entity that controls or is under common control with Health Plan. Any entity that succeeds to the rights and responsibilities of Health Plan is bound by this Agreement.

13.2 Medical Records. In order to implement this Agreement, it may be necessary for Health Plan or any Participating Provider to obtain a Member's medical records and information. By executing an enrollment application and/or directly or indirectly presenting claims for payment for Covered Services, a Member gives Health Plan, its authorized agent(s) and Participating Providers permission to obtain and use those records and that information.

13.3 Identification of Members. Members must be identified as Health Plan Members by means of an identification card to be issued by Health Plan. The identification card itself confers no rights to services or other benefits under this Agreement. To be eligible for benefits, the Health Plan must have received all applicable and other payments as required under this Agreement.

13.4 Notice. Any notice required to be given to Group under this Agreement must be in writing and sent by certified mail, return receipt requested, to Group at the address appearing on the Endorsement Page(s). Notices to Health Plan should be sent by certified mail, return receipt requested, to Health Plan's administrative offices at the address set forth on the Endorsement Page(s) hereof. Notice shall be effective when received.

13.5 Severability. If any provision of this Agreement, on its effective date or thereafter, is determined to be in conflict with Federal law, Ohio law or applicable rules and regulations of the Ohio Department of Insurance, the provision shall be fully severable and the remaining provisions shall continue in full force and effect.

13.6 Waiver. The waiver by either party of any breach of any provision of this Agreement may not be construed as a waiver of any subsequent breach of the same or any other provision. The failure to exercise any right hereunder may not operate as a waiver of such right.

13.7 Relationship Among Parties. Neither of the parties hereto, nor any of their respective employees, may be construed to be the agent or representative of the other. In addition, a Member is not the agent or representative of Health Plan, and will not be liable for any acts or omissions of Health Plan, its agents or employees or of any Participating Provider. The relationship between Health Plan and Group and between Health Plan and Participating Providers is an independent contractual relationship. Participating Providers are not agents or employees of Health Plan, nor is Health Plan, or any employee of Health Plan, an agent or employee of the Participating Providers.

13.8 Relationship between Health Plan and Participating Providers. Participating Providers are acting as independent contractors and are not employees of the Health Plan. The final responsibility for all decisions with respect to medical care rests with the Participating Providers. Health Plan is not responsible for providing Covered Services, but rather for payment of those services. No claim may be made against Health Plan or its Board Members, officers, employees, agents, successors or assigns for actions of any Participating Provider.

13.9 Governing Law. This Agreement will be governed in all respects by the laws of the State of Ohio.

13.10 Entire Agreement. This Agreement, and each Member's enrollment application, member handbook, riders, explanation of benefits, endorsements, summary of benefits, amendments, and any other attachments to this Agreement, are incorporated and made part hereof, (hereinafter referred to as "Documents") which constitute the entire agreement between the parties and, as of the effective date, supersedes all other agreements and any representations, both written and oral, by and/or between the parties. The Group Medical and Hospital Service Agreement will be the controlling document if there are disputes or inconsistencies in the Documents. No amendments to this Agreement shall be valid unless in writing and agreed to by the parties as set forth in the Agreement.

13.11 Confidentiality/Privacy/Security. Health Plan is a covered entity under the Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Standards and the parties shall comply with the HIPAA requirements. Health Plan is permitted to use, obtain and disclose Member protected health information to perform Health Plan services in accordance with HIPAA and "Paramount's Notice of Privacy Practices". Pursuant to the requirements of 45 C.F.R. § 164.314(b)(2), Group warrants and represents that it will:

A. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic protected health information that it creates, receives, maintains, or transmits on behalf of Health Plan;

B. Ensure that the adequate separation required by 45 C.F.R. § 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;

C. Ensure that any agent, including a subcontractor, to whom Group provides this information agrees to implement reasonable and appropriate security measures to protect the information; and

D. Report to Health Plan any security incident of which Group becomes aware.

13.12 Participating Providers. Health Plan does not guarantee that any one physician, hospital, or other provider will be available and/or remain under contract with Health Plan. Termination of any provider from Health Plan network does not constitute breach of this Agreement.

13.13 Claim Processing and Payment. Health Plan shall process claims for benefits and pay such claims using Health Plan's normal claim determination, payment and audit procedures, and applicable cost control standards in accordance with the benefits described under Attachment A and state and federal or ERISA regulations. Health Plan contracts with providers for health care services on an economically competitive basis, while taking steps to ensure that Health Plan members receive quality health care. Through Health Plan contracts with providers, Health Plan 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 between Health Plan and the participating provider, rather than a percentage of the provider's billed charge. Health Plan's allowed amount is ordinarily lower than the participating provider's billed charge. If a prescription drug plan is offered through Health Plan, Health Plan will retain all pharmaceutical drug rebates. All claims submitted by or on behalf of the Member after one (1) year from date of service shall be denied.

13.14 Submission of Claims. It is Member's obligation to individually submit claims for benefits when appropriate, or to ensure that claims for benefits are submitted through the Provider and/or Hospital providing services to Member. Group is not eligible to submit claims for benefits on Member's behalf, and does not have standing to initiate a legal action against Health Plan on Member's behalf.

13.15 Benefit Period, Renewal. Health Plan will administer the application of benefit provisions such as Deductible, Copayments, Coinsurance, Out-of-Pocket Copayment Limit and any benefit limitations (day, visit or maximum dollar) according to a Contract Year or calendar year period as set forth on the Endorsement Page(s). At the start of a new Contract Year or calendar year, the Member's benefits will renew. If the benefits renew each calendar year and the Group changes benefits prior to renewal, the new benefits will be effective as of the date of the benefit change.

13.16 Indemnification. Group shall indemnify and hold Health Plan harmless against and from any and all claims, damages, losses, judgments, awards and/or expenses of any kind, including, but not limited to, reasonable attorney fees and costs incurred by Health Plan, due to Group's failure to make the premium payments required by the terms and conditions of this Agreement, Group's breach of the terms and conditions of this Agreement, or the negligence and/or intentional acts or omissions of Group, its employees or agents, in connection with this Agreement.

Attachment A: Schedule of Benefits

**ATTACHMENT A  
PARAMOUNT CARE, INC.  
SCHEDULE OF BENEFITS AND COVERAGE**

COVERED SERVICES ARE SPECIFICALLY LISTED IN PARTS I, II AND III, BELOW. ALL OTHER SERVICES AND/OR SUPPLIES ARE NOT COVERED SERVICES. UNLESS SPECIFICALLY PROVIDED OTHERWISE, SERVICES MUST BE PRESCRIBED, PROVIDED BY OR AUTHORIZED BY A HEALTH PLAN PHYSICIAN IN ORDER TO BE COVERED SERVICES. HEALTH PLAN WILL NOT PAY FOR ANY SERVICES THAT ARE NOT COVERED SERVICES. PAYMENT FOR SERVICES THAT ARE NOT COVERED SERVICES IS THE RESPONSIBILITY OF THE MEMBER. **CERTAIN SERVICES ARE SUBJECT TO DEDUCTIBLE, COPAYMENTS AND/OR COINSURANCE BY MEMBERS AND MAY BE SUBJECT TO MONETARY AND/OR QUANTITY LIMITS AS SO NOTED ON THE ENDORSEMENT PAGE (S).**

I. PROFESSIONAL MEDICAL SERVICES AND SUPPLIES

A. Medical Services

- 1) Physician office visits. See Endorsement Page(s) for Copayment amount.
- 2) Provision of, or Primary Care Physician referral for, Emergency care on a 24-hour per day, 7-day per week basis.
- 3) Diagnostic/Therapeutic
  - a) Diagnostic and treatment services as performed, requested or directed by a Primary Care Physician or participating gynecologist, including, but not limited to, consultation and treatment by Specialist Physicians, routine eye examinations limited to one per Member every 12 months, surgical procedures, laboratory, x-ray services, injections, application of casts and dressings, radiotherapy and administration of anesthesia. Certain diagnostic procedures require prior authorization from the Health Plan. A listing of the diagnostic procedures that require prior authorization from Health Plan is available upon request, but subject to change at Health Plan's sole discretion.
  - b) Obstetrical/gynecological care may be provided or referred by a participating gynecologist without the prior authorization of the Member's Primary Care Physician. Care rendered by Participating vision care, allergists, dermatologists, pediatric pulmonologists, hematologists, oncologists, ophthalmology, pediatric ophthalmology, retinology, pain management providers and other Participating Providers as determined by Health Plan do not require a referral from the Member's Primary Care Physician.
  - c) Prescribed x-ray and laboratory tests, services and materials, e.g., diagnostic x-rays, mammograms, x-ray therapy, chemotherapy, fluoroscopy, electrocardiograms, electroencephalograms, and therapeutic radiology services.

- d) Physician office visits for allergy testing. See Endorsement Page(s) for copay amount.
- 4) Preventive Health Services  
Preventive Health Services include the following:
- a) Well-baby and well-child care including hearing screenings,
  - b) Childhood immunizations,
  - c) Annual physical examinations,
  - d) Cytologic screenings (Pap smears),
  - e) Mammography screenings ,
  - f) Immunizations for influenza, tetanus pneumonia and HPV,
  - g) Pre-natal care,
  - h) Prostate screening (PSA), and
  - i) Colorectal screening.
- 5) Other Professional Services
- a) Voluntary sterilization and Contraceptive methods are covered when optional rider is purchased. See Endorsement Page(s). Contraceptive Services are limited to the following: Depo-Provera injections, IUD, diaphragms and Norplant.
  - b) Routine vision and hearing screening in the Primary Care Physician's office. A routine eye exam every 12 months by a Specialist Physician is covered without a referral from Primary Care Physician. Hearing examination by Participating Provider when ordered by a Health Plan Physician. A separate vision insurance plan will be primary. Health Plan will be primary to a discount plan.
  - c) Primary Care Physicians and other Providers may provide counseling and literature on issues including, but not limited to, diet, alcohol and drug abuse, exercise, smoking and family planning.
  - d) Health Plan will reimburse for one smoking cessation class at a participating Health Plan facility.
- 6) Maternal, Newborns and Infertility
- a) Full hospital and medical services including prenatal and postpartum care, including use of delivery room and nursery, general medical services, operations and special procedures, Caesarean sections, administration of anesthesia and injectables, and x-ray and laboratory services. All office visits for pre-and post-natal care are covered in full with no Copayment.
  - b) Services related to the diagnosis and treatment of infertility. See Section IV-B, 16, regarding exclusions of all services related to in vitro fertilization, embryo transplant services, reversal of voluntary sterilization and outpatient self-administered prescription drugs.
  - c) Care of a newborn Child of Subscriber.

B. Oral Surgical Services

1) Covered Oral Surgical Procedures

General dental services are not covered. Certain limited oral surgical procedures are covered when referred by the Primary Care Physician, rendered by a participating oral surgeon and approved in advance by Health Plan. Inpatient services require specific Health Plan approval as detailed in Section II. Only the following oral surgical procedures are eligible for coverage:

- a) Initial first aid treatment received within 48 hours of an accidental injury to sound natural teeth, the jaw bones, or surrounding tissues. This includes only extraction of teeth and repair of soft tissue. A dental insurance plan will be primary. Replacement and restoration of teeth are not covered.
- b) Medically Necessary orthognathic surgery.
- c) Treatment for tumors and cysts (including pathological examination) of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
- d) Medically Necessary oral surgery to repair fractures and dislocations.
- e) Medical treatment for temporomandibular joint syndrome (TMJ).

2) Primacy of Dental Plan

Notwithstanding Article VIII of the Agreement, a dental plan will be primary when available in addition to this coverage.

C. Reconstructive Surgery

Covered when required, as determined by Health Plan, for:

- a) a malignant or non-malignant neoplasm within 2 years following initial surgery for neoplasm;
- b) repair of anatomical impairment to improve or correct a physiological functional disability within 2 years of accident or injury or up to age 18 if a congenital anatomical functional impairment;
- c) breast reconstruction following a covered mastectomy in accordance with the Women's Health and Cancer Rights Act of 1998; and
- d) plastic surgery following an accidental injury within 2 years of the accident;

D. Durable Medical Equipment and Prosthetic Devices

1) Durable Medical Equipment.

Medically Necessary durable medical equipment and supplies approved by Medicare Part B and subject to Medicare Part B criteria and limitations on quantity. See exceptions under c) below. Durable medical equipment and supplies must be ordered by a Health Plan Physician from a participating provider. Certain items require prior authorization from the Health Plan.

- a) See additional reference under "Home Health Services", page A-10.
- b) Electrical versus manual equipment is at the discretion of Health Plan. The option to

purchase or rent is at the discretion of Health Plan. Repair and replacement of equipment will be covered at the discretion of Health Plan.

- c) Specifically Excluded: Any items not approved by Medicare Part B, except for diabetic supplies such as syringes with needles, refill kit for implantable infusion pump, external drug infusion and supplies, blood glucose monitors, test strips, lancing devices and lancets; and asthma supplies such as peak expiratory flow rate meters (hand-held) and spacers for metered-dose inhalers. Any exceptions are at the sole discretion of Health Plan.

2) Prosthetic Devices

Prosthetic Devices as determined to be Medically Necessary, and when ordered or approved by a Health Plan Physician and such devices meet the criteria for coverage under the rules of eligibility for Medicare. Repair of and/or replacement devices if such devices meet the criteria for coverage under the rules of eligibility for Medicare. A Prosthetic Device is an artificial substitute that replaces all or part of a missing body part and its adjoining tissues.

3) Penile Implants and Erectile Devices

Penile implants and erectile devices are not covered unless the Group has purchased an optional rider. See Endorsement Page(s).

E. Cancer Clinical Trial

Routine patient care for Members enrolled in an Eligible Cancer Clinical Trial in accordance with ORC 3923.80 is covered. Routine patient care under ORC 3923.80 means all health care services consistent with the coverage hereunder for the treatment of cancer, including the type and frequency of any diagnostic modality, 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.

F. Health Education Newsletter

In order to facilitate a preventive approach to medical care, Health Plan has provided for a newsletter to be distributed to Subscribers by direct mail on a periodic basis. Information will be included which updates Health Plan's procedures. Items of general health interest, nutritional education, reminders of existing procedures for obtaining services and referrals will be included.

II. HOSPITAL SERVICES

A. Medical/Surgical

The following acute inpatient services are provided at hospitals and skilled nursing facilities under contract with Health Plan when, except in the case of Emergency admissions, they are ordered by a Health Plan Physician and Health Plan gives prior written authorization. Benefits will be provided for care rendered in a non-participating institution only with prior written authorization by Health Plan, except in the case of certain Emergencies as specified in Section II.E.(3). Services related

to a hospital admission where the patient discharges himself Against Medical Advice (AMA), or when the facility requires a disciplinary discharge, will be subject to an additional Coinsurance not to exceed 40% Coinsurance on medical/surgical admissions and 50% Coinsurance on mental health/chemical dependency admissions. For the application of additional Copayments and/or Coinsurance for Hospital Services, see the Endorsement Page(s) of this Agreement. Benefits include:

- 1) Room and board for semi-private accommodations. Private accommodations and special diets will be covered if Medically Necessary as determined by Health Plan's Medical Director in consultation with the Member's Health Plan Physician.
- 2) Diagnostic and interventional radiology services, clinical laboratory and other diagnostic tests, anesthesia, oxygen services, radiation and respiratory therapy, encephalography, cardiography, nuclear medicine and chemotherapy.
- 3) FDA approved drugs, medications and biologicals.
- 4) Use of operating room, intensive and coronary care units, recovery room and special treatment rooms. Use of outpatient hospital surgical treatment rooms or outpatient surgical facilities.
- 5) Physical, speech, occupational and respiratory therapies.
- 6) Administration of blood and blood products. The cost of these products is not covered when a volunteer replacement program is available.
- 7) Pre-and post-hospital planning and referral to community and social welfare resources.
- 8) Heart, lung, heart/lung, liver, pancreas, pancreas/kidney, bone marrow and bowel transplants are covered if, and only if:
  - a) specific clinical indications are present; and
  - b) the procedure is not considered to be an Experimental Service for the diagnosis and circumstances present; and
  - c) approval is obtained from Health Plan in advance of transplant, and confirmed in writing; and
  - d) services are rendered in an institution specifically approved by Health Plan.

Payments related to the search for a bone marrow donor are limited to \$20,000 per Member per lifetime.

When Health Plan selects or approves an institution for transplant services outside the Service Area, Health Plan will reimburse mileage for car travel or economy class air travel and reasonable lodging and meals (excluding alcoholic beverages) for the transplant candidate only.

**B. Physical Rehabilitation.**

1) Inpatient

Short-term Inpatient rehabilitation services due to injury, trauma or surgery will be provided when prescribed by a Health Plan Physician and authorized in advance by Health Plan.

2) Outpatient

Physical, occupational and speech therapy on an outpatient basis will be covered.

Outpatient services must be prescribed by a Health Plan Physician and rendered by Participating Providers.

C. Kidney Disease and Dialysis

1) All Medically Necessary services for hemodialysis for renal disease and for kidney transplants, subject to all federal and state requirements regarding end-stage renal disease including equipment, training, and medical supplies required for home dialysis, and directly related reasonable medical and hospital expenses of a donor or prospective donor who is a Member of Health Plan.

2) Should the Member qualify for Medicare benefits for end-stage renal disease, Health Plan will coordinate benefits as noted in Article VIII of this Agreement. Services are covered only upon referral by a Primary Care Physician at facilities in the Service Area under contract with Health Plan.

D. Mental Illness/Substance Abuse Services

1) Mental Illness

Inpatient and outpatient treatment of Biologically and Non-Biologically Based Mental Illness is covered subject to the same terms, Deductible, Copayments and/or Coinsurance as any other physical disease or condition. See the Endorsement Page for further details.

2) Substance Abuse (Drug and Alcohol Abuse/Addiction)

The following substance abuse services are covered, subject to the same terms, Deductible, Copayments and/or Coinsurance as any other physical disease or condition. See the Endorsement Page for further details.

- a) Inpatient services at a Participating Hospital on order of a Health Plan Physician and approved by Health Plan or its Designated Representative for the direct care and treatment of the acute phase of a substance abuse condition.
- b) Partial hospitalization (comprehensive outpatient treatment arranged through case management process). Services must be approved in advance by Health Plan or its Designated Representative.
- c) Intensive outpatient programs (comprehensive and primarily educational programs for substance abuse conditions). Services must be approved in advance by Health Plan.
- d) Outpatient services of a Participating Provider for the direct care and treatment of the acute phase or rehabilitation for

substance abuse conditions. Benefits are paid for individual, group or family therapy, evaluation and consultations and must be approved in advance by Health Plan or its Designated Representative.

E. Emergency and Urgent Care Services

1) Emergency Services are those services that are needed to evaluate or stabilize an Emergency Medical Condition. Examples of an Emergency Medical Condition include, but are not limited to, symptoms of heart attack, stroke, poisoning, labor, loss of consciousness or respiration, hemorrhaging, and convulsions. During retrospective claim review, the determination as to whether or not an Emergency Medical Condition existed will rest with Health Plan.

2) Emergency Services Within the Plan Service Area

a) Medical Care and Notification. In case of an Emergency Medical Condition, Members are to proceed directly to the nearest medical facility. In the event a Member is unsure about whether a condition is an Emergency Medical Condition, the Member may contact his/her Primary Care Physician for instructions. Medical care is available through Health Plan Physicians 7 days a week, 24 hours a day. The determination of whether or not an Emergency Medical Condition exists rests with Health Plan.

b) Payment for Non-Participating Providers. Payment for Emergency Services of Non-Participating Providers shall be limited to expenses for such care required before the Member can, without serious threat to life or health, utilize the services of Participating Providers. Coverage for Emergency Services provided to a Member by a Non-Participating Provider will also be provided if a prudent layperson with an average knowledge of health and medicine would have reasonably believed that, under the circumstances, the time required to travel to a Participating Hospital's emergency room could result in one or more of the adverse health consequences described in Section 2.8 of this Agreement.

c) Follow-Up Care. All follow-up care must be authorized in advance by the Primary Care Physician.

3) Out-of-Area Emergency Services

a) Medical Care and Notification. If the Member is outside the Service Area and suffers an injury or illness which requires Emergency Services, benefits will be provided.

If the Member is unable to contact Health Plan due to shock or unconsciousness, and immediate Emergency treatment is necessary, all Professional and Hospital Services will be covered. However, the Member must, at the earliest time reasonably possible, contact Primary Care Physician to receive authorization for follow-up care.

b) Follow-Up care. Continuing or follow-up treatment for accidental injury or an Emergency Medical Condition must be approved in advance by Health Plan and is limited to care required before the Member can, without medically harmful or injurious consequences, return to the Service Area. Benefits for continuing or follow-up treatment are otherwise provided only in the Service Area, subject to all provisions of this Agreement. Failure to contact Health Plan will result in denial of payment of all claims for services.

c) Limitation. Out-of-area benefits and services are limited to situations in which care is required immediately and unexpectedly; elective or specialized care required as a result of circumstances which could reasonably have been foreseen prior to departure from the Service Area is not covered. For example, normal term childbirth outside the Service Area is not covered. However, complications of pregnancy or unexpected delivery are covered outside the Service Area.

4) Transportation Services

In cases of an Emergency Medical Condition, or when authorized by the Primary Care Physician and Health Plan, transportation services to the nearest medically appropriate facility are covered. Certified air ambulance will be covered if Medically Necessary.

5) Urgent Care Services

Urgent Care Services are those services provided for an Urgent Medical Condition. An Urgent Medical Condition is an unexpected illness or injury requiring medical attention soon after it appears that is not permanently disabling or life-threatening. Services received at a participating urgent care facility or physician's office for an Urgent Medical Condition are covered. The determination of whether or not an Urgent Medical Condition exists rests with Health Plan. Other than specifically set forth herein, services received for an Urgent Medical Condition are not covered.

6) Emergency Room and Urgent Care Facility Copays

Hospital emergency room and urgent care facility visits are subject to a Copayment or Coinsurance for each incident.

### III. OTHER FACILITY SERVICES

A. Skilled Nursing Facility Services

1) Coverage. Medically Necessary services rendered in a skilled nursing facility under contract with Health Plan are covered

when prescribed by a Health Plan Physician and authorized, in advance, by Health Plan. Medically Necessary services rendered in a skilled nursing facility not under contract with Health Plan are covered only as required under Ohio Revised Code § 1751.68.

B. Home Health Services

Home Health Services are covered upon the order of a Health Plan Physician and approved in advance by Health Plan. All Home Health Service benefits are coordinated through the case management process. Examples of Medically Necessary services which may be arranged through case management include: physician services, skilled nursing care, physical, occupation and other related therapies, supplies and equipment as determined by Health Plan. Convalescent and custodial services are not covered. Coverage for personal comfort and convenience items and services, such as meals and housekeeping, are not covered.

C. Hospice Services

Inpatient and outpatient hospice services, including care provided by an Ohio-licensed hospice, for treatment directed at controlling pain, relieving other symptoms and such other supportive services as are regularly provided by the hospice in support of terminally ill patients. Covered Services must be upon the order of a Health Plan Physician and approved in advance by Health Plan.

IV. RESTRICTIONS AND EXCLUSIONS

A. Restrictions on Choice of Providers. The following are excluded from coverage:

- 1) Services rendered by Specialist Physicians not listed in I (A)(3)(b) in a non-Emergency situation without Member first consulting, and obtaining a written Health Plan authorization through, his/her Primary Care Physician.
- 2) Services obtained from non-Participating Providers in a non-Emergency situation without prior referral from a Health Plan Physician and written authorization from Health Plan.
- 3) Services of chiropractors, unless Group has purchased an optional chiropractic rider.
- 4) Any services or supplies furnished by a non-eligible institution, which is defined as other than a hospital, outpatient surgical facility or skilled nursing facility, i.e., custodial, domiciliary, residential treatment facility, convalescent and intermediate or day care.
- 5) Any court-ordered testing, treatment or hospitalization unless determined to be Medically Necessary by Health Plan and rendered by a participating provider.
- 6) Care rendered to self or to a Member by a relative.
- 7) Non-Emergency Services from hospital emergency facilities and providers unless prior direction is received from the Primary Care Physician and/or Health Plan.

B) Excluded Benefits. Unless specifically referenced as Covered Services, services and/or supplies are not Covered Services and, therefore, are excluded from

coverage. The following services and benefits are among those services excluded from coverage:

- 1) Services rendered before coverage began or after coverage ended.
- 2) Benefits in skilled nursing facilities except as specifically provided in Section III-A of this Attachment.
- 3) Examinations, reports and immunizations for the purpose of obtaining or maintaining employment, insurance, governmental licensure, travel, employer-requested annual physical exams/treatment, court-ordered or forensic evaluations, or for premarital or paternity purposes.
- 4) Cosmetic or plastic procedures including surgery except as Medically Necessary and provided in Section I-C. Cosmetic or plastic procedures including surgery are those procedures that improve physical appearance or treat a mental or emotional condition through a change in body form, but do not correct or materially improve a physiological function.
- 5) Dental care, except for Medically Necessary oral surgery incidental to fracture, dislocations and tumors or as otherwise provided in Section I-B of this Attachment. Exclusions include, but are not limited to:
  - Treatment on or to the teeth
  - Extraction of teeth, including bony impacted wisdom teeth
  - Treatment of dental abscess or granuloma
  - Dental treatment for temporomandibular joint syndrome or dysfunction
  - Placement, removal or replacement of implants of the teeth and alveolar ridge including preparatory oral and maxillofacial surgery (bone grafts)
  - Treatment of periodontal disease and abscess
  - Root canal
  - Treatment required for, or as a result of, biting or chewing
  - Braces, retainers, bite plates, snore guards or any appliance or device which is fitted to the mouth
- 6) Treatment for mental retardation and mental deficiency. Psychological counseling, training and educational therapy for learning disabilities and developmental disorders/delay. Social skills classes, Behavioral modification and other training programs including but not limited to Applied Behavioral Analysis (ABA) programs. Long-term rehabilitation and residential treatment.
- 7) Weight loss treatment including but not limited to gastric reservoir reduction surgery, gastric stapling, by-pass or diversion and any other weight reduction programs. Dietary or nutritional supplements for gaining or maintaining weight are excluded, except for charges for nonmilk or nonsoy formula required to treat diagnosed diseases and disorders of amino acid or organic acid metabolism, protein sensitivity resulting 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 Health Plan. 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.

- 8) Refractive eye surgery including radial keratotomy, LASIK and implantable corrective lens (except for lens following cataract surgery), Orthoptic (vision) training.
- 9) Custodial or domiciliary care; personal comfort items such as television, telephone, private rooms (except as Medically Necessary) in a hospital or skilled nursing facility; housekeeping services and meal services as a part of Home Health Care.
- 10) Experimental medical, surgical, or other health procedures including experimental drugs as determined by Health Plan. Health Plan will make this determination based on the recommendation of the Medical Advisory Committee and the most recent HAYES Medical Technology Directory. In addition, pharmaceuticals and devices which have not received FDA approval are considered experimental.
- 11) Care for conditions which state or local law requires to be treated in a public facility or for which a Member has no legal obligation to pay.
- 12) Care for military service connected disabilities to which the Member is legally entitled, at a military, veteran or other federal health care facility.
- 13) Transportation services other than as set forth in Section II-E-4 of this Attachment.
- 14) Durable Medical Equipment, appliances and supplies for home use not approved by Medicare Part B.
- 15) Trimming of corns, calluses and nails except for diabetic conditions approved in advance by Paramount.
- 16) In vitro fertilization (IVF), embryo transplant services (GIFT, ZIFT), artificial insemination, reversal of voluntary sterilization, ovarian tissue transplant and related services and outpatient self-administered infertility prescription drugs. Infertility injections or medications normally self-administered by the Member will not be covered in the Physician office.
- 17) Abortions and any related procedures, unless Medically Necessary.
- 18) Oral contraceptives, unless Group has purchased optional rider.
- 19) Transsexual surgery and related services.
- 20) Physical therapy and occupational therapy, except as provided under Section II-B of this Attachment; non-medical services such as vocational rehabilitation, employment counseling, and equestrian therapy.
- 21) Speech therapy except as provided in Section II-B-2 of this Attachment.

- 22) Prescription drugs except those provided on an inpatient basis in Section II-A-3 of this Attachment, unless Group has purchased optional rider.
- 23) Experimental organ transplants (See Article II, "Definitions" of Agreement and Section II-A-8 of this Attachment).
- 24) Private duty nursing, unless Group has purchased optional rider.
- 25) Contact and corrective lenses and eyeglasses, unless Group has purchased optional rider.
- 26) Growth hormones or steroids used for growth and development.
- 27) Cranial electrotherapy units.
- 28) Counseling for marital or relationship conflicts, employment counseling and vocational rehabilitation counseling services.
- 29) Sclerotherapy for spider angiomas.
- 30) Breast augmentation and/or reduction surgery.
- 31) Hearing aids, unless Group has purchased optional rider.
- 32) Penile implants and erectile devices, unless Group has purchased optional rider.
- 33) Services rendered primarily for the convenience of a Member in the absence of a specific clinical requirement.
- 34) Charges for completion of forms and reports other than for the patient's medical record.
- 35) All services related to organ donations from a living donor who is not a Health Plan Member, unless no other coverage is available. Travel, lodging or meals for a donor who is not a Health Plan Member. And all services related to a Health Plan Member who is donating to a recipient who is not a Health Plan Member.
- 36) Surrogate and/or gestational pregnancy and any related procedures.
- 37) 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. Surgery for the treatment of the temporomandibular joint which is dental in nature.
- 38) Staged procedures or surgeries when performed in preparation of a non-covered reconstructive surgery.
- 39) Alternative medicine/therapy 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.

- 40) Laser treatment including Candela, V-beam and photodynamic therapy for rosacea, port wine stains and other skin disorders.
- 41) Extra Corporeal Shock Wave Therapy (ESWT) for conditions of the feet, elbows and shoulders.
- 42) Removal of skin tags.
- 43) In connection with a cancer clinical trial;
  - a. A health care service, item or drug that is the subject of a cancer clinical trial;
  - b. 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;
  - c. An investigational or experimental drug or device that has not been approved for market by the United States food and drug administration;
  - d. 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;
  - e. An item or drug provided by the cancer clinical trial sponsors free of charge for any patient;
  - f. 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.