PARAMOUNT
Affiliate of ProMedica

Administrative Guideline and Procedures

This guide is intended for small groups, those with less than 50 employees. Large groups may find these guidelines useful as well.

Paramount's Administrative Guide contains the necessary tools to assist you in accessing information that will be helpful in the administration of your employee plan. This is a general guide to use as a resource tool for the administration of your employee plan; please refer to your Employer Group Contract* for specific details of your plans procedures.

**The Employer Group Contract refers to your Group Service Agreement (GSA) or Certificate of Coverage (COC) and Group Policy.*

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Subscriber Eligibility - To be eligible as a subscriber for:

Ohio HMO and Flex - A person must be eligible under the group's eligibility rules, reside in the Paramount service area or be employed in the approved Ohio service area and reside in a county contiguous to the Ohio service area. The service area is all of Ashland, Crawford, Defiance, Erie, Fulton, Hancock, Henry, Huron, Lucas, Marion, Morrow, Ottawa, Putnam, Richland, Sandusky, Seneca, Williams, Wood, Wyandot and portions of Allen, Delaware, Hardin, Knox, Lorain and Paulding counties. Contiguous counties are Lenawee and Monroe counties in Michigan.

- For groups with fewer than fifty (50) employees, the person must be an active employee and working a minimum average of thirty (30) hours per week.; or

- Be an eligible employee on company paid sick leave or disability not to exceed six (6) months if, prior to the sick leave or disability, the employee worked a minimum of twenty (20) hours per week for the proceeding twenty-six (26) weeks; or

- Be an eligible former employee or dependent under group continuation (COBRA) status or twelve (12) month continuation under Ohio revised code;

- Be entitled to participate in the benefits program arranged by your company.

A completed and signed enrollment application form must be submitted within thirty-one (31) days of becoming eligible.

Ohio CHDP - A person must reside or be employed by a company in the state of Ohio.

- Eligible to participate in the employer's health benefits program under the written benefits eligibility policies of the employer; or

- Considered a bona fide employee employed on a permanent basis and working a minimum average of thirty (30) hours per week for employers with fewer than fifty (50) employees; or

- Be an eligible former employee or dependent under group continuation (COBRA) status or twelve (12) month continuation under Ohio revised code;

- Not enrolled in any other employer health benefits plans;

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

A completed and signed enrollment application form must be submitted within thirty-one (31) days of becoming eligible.

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PLEASE NOTE: *As of 1/1/2016, Michigan HMO small group products are no longer sold.*

Michigan HMO - A person must be eligible under the group's eligibility rules, reside in the Paramount service area or be employed in the approved Michigan service area. The service area is all of Lenawee and Monroe counties.

- For groups with fewer than fifty (50) employees, the person must work on a full time basis with a normal work week of thirty (30) or more hours. Eligible employees include employee who works on a full time basis with a normal work week of a minimum of seventeen and a half (17.5) to thirty (30) hours; or;

- Be an eligible employee on company paid sick leave or disability not to exceed six (6) months if, prior to the sick leave or disability, the employee worked a minimum average of twenty (20) hours per week for the proceeding twenty-six (26) weeks; or

- Be an eligible former employee or dependent under group continuation (COBRA) status;

- Be entitled to participate in the benefits program arranged by your company.

A completed and signed enrollment application form must be submitted within thirty-one (31) days of becoming eligible.

Michigan PPO - A person must be employed by a company in the state of Michigan.

- Eligible to participate in the employer's health benefits program under the written benefits eligibility policies of the employer; or

- The person must work on a full time basis with a normal work week of thirty (30) or more hours. Eligible employees include employee who works on a full time basis with a normal work week of a minimum of seventeen and a half (17.5) to thirty (30) hours; or;

- Former employees of the employer contracting with Paramount who have elected to continue group coverage in accordance with state or federal law may also be eligible;

- Not enrolled in any other employer health benefits plans.

A completed and signed enrollment application form must be submitted within thirty-one (31) days of becoming eligible.

Michigan CDHP - A person must be employed by a company in the state of Michigan.

- Eligible to participate in the employer's health benefits program under the written benefits eligibility policies of the employer; or

- The person must work on a full time basis with a normal work week of thirty (30) or more hours. Eligible employees include employee who works on a full time basis with a normal work week of a minimum of seventeen and a half (17.5) to thirty (30) hours; or;

- Former employees of the employer contracting with Paramount who have elected to continue group coverage in accordance with state or federal law may also be eligible;

- Not enrolled in any other employer health benefits plans.

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

A completed and signed enrollment application form must be submitted within thirty-one (31) days of becoming eligible.

Dependent Eligibility - To be eligible as a dependent for:

Ohio HMO and Flex - A person must be eligible under the Group's eligibility rules and be one of the following:

- The legal spouse of the subscriber (excluding divorced spouses) who resides in the Paramount service area (or in a county contiguous to the Ohio service area). If the spouse has a different last name than the subscriber, a copy of the marriage certificate must be submitted with the enrollment application.

- The dependent child, stepchild or legally adopted child of subscriber, under the age of 26, married or unmarried, regardless of student status, and be the child of the subscriber or the subscriber's spouse.

  If the child has a different last name than the subscriber and is not a stepchild, a copy of the birth certificate must be submitted with the enrollment application. Copies of adoption, guardianship, custody and court orders are also required.

- An unmarried child, who has reached age 26, is unable to work to support himself or herself and is primarily dependent on the subscriber for support and maintenance because of mental retardation or physical handicap. Appropriate medical documentation of incapacity and dependency must be furnished to our office by the subscriber within thirty-one (31) days of reaching your group's limiting age, and thereafter, at least annually. The employee and attending physician must complete an Application for Continuation of Coverage form. The documentation must be satisfactory to Paramount. In addition, Paramount may periodically check if the child is, and continues to qualify, as a dependent if the child has a different last name than the subscriber and is not a stepchild, a copy of the birth certificate must be submitted with the enrollment application.

Ohio CDHP - A person must be eligible under the Group's eligibility rules and be one of the following:

- The legal spouse of the subscriber (excluding divorced spouses). If the spouse has a different last name than the subscriber, a copy of the marriage certificate must be submitted with the enrollment application.

- The dependent child, stepchild or legally adopted child of subscriber, under the age of 26, married or unmarried, regardless of student status, and be the child of the subscriber or the subscriber's spouse.

  If the child has a different last name than the subscriber and is not a stepchild, a copy of the birth certificate must be submitted with the enrollment application. Copies of adoption, guardianship, custody and court orders are also required.

- An unmarried child, who has reached age 26, is unable to work to support himself or herself and is primarily dependent on the subscriber for support and maintenance because of mental retardation or physical handicap. Appropriate medical documentation of incapacity and dependency must be furnished to our office by the subscriber within thirty-one (31) days of reaching your group's limiting age, and thereafter, at least annually. The employee and attending physician must complete an Application for Continuation of Coverage form. The documentation must be satisfactory to Paramount. In addition, Paramount may periodically check if the child is, and continues to qualify, as a dependent If the child has a different last name than the subscriber and is not a stepchild, a copy of the birth certificate must be submitted with the enrollment application.

PLEASE NOTE: *As of 1/1/2016, Michigan HMO small group products are no longer sold.*

Michigan HMO - A person must be eligible under the Group's eligibility rules and be one of the following:

- The legal spouse of the subscriber (excluding divorced spouses) who resides in the Paramount service area. If the spouse has a different last name than the subscriber, a copy of the marriage certificate must be submitted with the enrollment application.

- The dependent child, stepchild or legally adopted child of subscriber, under the age of 26, married or unmarried, regardless of student status, and be the child of the subscriber or the subscriber's spouse.

  If the child has a different last name than the subscriber and is not a stepchild, a copy of the birth certificate must be submitted with the enrollment application. Copies of adoption, guardianship, custody and court orders are also required.

- An unmarried child, who has reached age 26, is unable to work to support himself or herself and is primarily dependent on the subscriber for support and maintenance because of mental retardation or physical handicap. Appropriate medical documentation of incapacity and dependency must be furnished to our office by the subscriber within thirty-one (31) days of reaching your group's limiting age, and thereafter, at least annually. The employee and attending physician must complete an Application for Continuation of Coverage form. The documentation must be satisfactory to Paramount. In addition, Paramount may periodically check if the child is, and continues to qualify, as a dependent If the child has a different last name than the subscriber and is not a stepchild, a copy of the birth certificate must be submitted with the enrollment application.

Michigan PPO - A person must be eligible under the Group's eligibility rules and be one of the following:

- The legal spouse of the subscriber (excluding divorced spouses) who resides in the Paramount service area. If the spouse has a different last name than the subscriber, a copy of the marriage certificate must be submitted with the enrollment application.

- The dependent child, stepchild or legally adopted child of subscriber, under the age of 26, married or unmarried, regardless of student status, and be the child of the subscriber or the subscriber's spouse.

  If the child has a different last name than the subscriber and is not a stepchild, a copy of the birth certificate must be submitted with the enrollment application. Copies of adoption, guardianship, custody and court orders are also required.

- An unmarried child, who has reached age 26, is unable to work to support himself or herself and is primarily dependent on the subscriber for support and maintenance because of mental retardation or physical handicap. Appropriate medical documentation of incapacity and dependency must be furnished to our office by the subscriber within thirty-one (31) days of reaching your group's limiting age, and thereafter, at least annually. The employee and attending physician must complete an Application for Continuation of Coverage form. The documentation must be satisfactory to Paramount. In addition, Paramount may periodically check if the child is, and continues to qualify, as a dependent If the child has a different last name than the subscriber and is not a stepchild, a copy of the birth certificate must be submitted with the enrollment application

Michigan CDHP-- A person must be eligible under the Group's eligibility rules and be one of the following**:**

- The legal spouse of the subscriber (excluding divorced spouses) who resides in the Paramount service area. If the spouse has a different last name than the subscriber, a copy of the marriage certificate must be submitted with the enrollment application.

- The dependent child, stepchild or legally adopted child of subscriber, under the age of 26, married or unmarried, regardless of student status, and be the child of the subscriber or the subscriber's spouse.

  If the child has a different last name than the subscriber and is not a stepchild, a copy of the birth certificate must be submitted with the enrollment application. Copies of adoption, guardianship, custody and court orders are also required.

- An unmarried child, who has reached age 26, is unable to work to support himself or herself and is primarily dependent on the subscriber for support and maintenance because of mental retardation or physical handicap. Appropriate medical documentation of incapacity and dependency must be furnished to our office by the subscriber within thirty-one (31) days of reaching your group's limiting age, and thereafter, at least annually. The employee and attending physician must complete an Application for Continuation of Coverage form. The documentation must be satisfactory to Paramount. In addition, Paramount may periodically check if the child is, and continues to qualify, as a dependent If the child has a different last name than the subscriber and is not a stepchild, a copy of the birth certificate must be submitted with the enrollment application

Adding New Employees, Recalled Employees or Dependents

New Employees - New employees or newly transferred employees will have coverage effective in accordance with your new hire policy if the person enrolls within thirty-one (31) days of becoming newly eligible. Your new hire policy can be found on the Endorsement Page of your Employer Group Contract.

The new hire waiting period vary by group.

Ohio HMO, Flex and CDHP may not exceed ninety (90) days from the date of hire.

Michigan HMO, PPO and CDHP may not exceed sixty (60) days from date of hire.

Your group may change the probationary/waiting period for new hires as originally stated on the Endorsement Page of the Employer Group Contract by submitting thirty-one (31) days advance written notice to Paramount. Only one (1) change per twelve (12) month period is accepted.

A waiver is required for newly hired employees electing not to join the health plan at the end of their probationary period. The waiver should be kept on file with your Human Resources Department. It does not need to be submitted to Paramount. Once this waiver is executed, an employee must have a qualifying event to elect plan coverage or wait until the open enrollment period for your group.

Recalled Employees - If an employee terminates coverage at the time of a layoff and returns to active employment within six (6) months from the effective date of layoff, the employee will be eligible for coverage in accordance with the group requested specifications, but in no case, prior to the date of recall. If the previously enrolled employee has been laid off for more than six (6) months, the employee will be considered a new hire.

New Spouses or Common Law Spouses - New spouses of subscribers will have coverage effective on the date of a legal marriage if the subscriber submits an application within thirty-one (31) days of the marriage date. If the spouse has a different last name than the subscriber, a copy of the marriage certificate must be submitted with the enrollment application. Any person claiming to be a common law spouse must prove to the satisfaction of Paramount that their claimed common law marriage is valid under state law. Proof must include, but may not be limited to, producing information to confirm or dispute the existence of a valid common law marriage under state law.

Newborn Children - A newborn child must be enrolled for coverage within 31 days following birth. The subscriber must complete an enrollment application and the effective date will be the date of birth. The newborn is not automatically added as a dependent. If the child has a different last name than the subscriber and is not a stepchild, a copy of the birth certificate must be submitted with the enrollment application.

A newborn child of a dependent is not eligible unless the subscriber or the subscriber's spouse adopts, has legal custody or is the court appointed guardian of the child.

Adopted Children - To receive coverage, an adopted child must be enrolled within thirty-one (31) days from the date of adoptive placement or during an open enrollment period. Coverage will be effective as of the date of adoptive placement. Adoptive placement means the assumption and retention by the subscriber or the 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.

Dependents Reaching Limiting Age - A notice will be mailed to the subscriber when their dependent child reaches the dependent limiting age of 26.

Disability of Dependent - A notice will be mailed to the subscriber when their dependent child reaches limiting age. Eligibility criteria and procedure for applying for continuation of coverage due to disability is defined under the Dependent Eligibility section of the Administration Guide.

Late Enrollment and Waiver - If an eligible employee or dependent fails to submit an enrollment application within the thirty-one (31) day time period, the employee or dependent may not enroll until the group's next annual open enrollment period. If an eligible employee or dependent waives coverage or declines to pay for coverage from the eligibility effective date, the employee or dependent may not enroll until the group's next annual open enrollment period or during a special enrollment period required under HIPAA.

Annual Open Enrollment - There will be an annual open enrollment period for subscribers and their eligible dependents. The effective date of coverage for persons who enroll is identified in the Endorsement Page of the Employer Group Contract. A completed and signed application must be submitted to enroll the subscribers and/or their dependents.

Additional Qualifying Enrollment Events

There are additional qualifying events for eligible employees and dependents. The events are:

Changes in work schedule	Date of full-time to part-time, part-time to full-time, strike, lockout, commencement or return from an unpaid leave of absence
Rehired employees who were involuntarily terminated /Recall from lay off	Date or rehire/recall in accordance with group requested specifications, but in no case prior to date of recall, if a previously enrolled active employee returns to active employment within six (6) months from lay-off or rehire
Marital status	Date of legal marriage, divorce, legal separation, annulment, death of spouse
Loss of other coverage	Date of loss, termination of employee, commencement of employment of employee, spouse or dependent (HIPAA certificate or letter from prior employer is required as proof of loss of coverage)
Court order coverage for dependents	Date specified in court order (Copy of court order is required.)
National Medical Support Notice	Date specified by State (Copy of notice is required.)
Moving into the service area	Date of move
Change in number of dependents	Date of death of spouse or dependent

Enrollment will be delayed or, possibly denied, if the appropriate documentation is not received.

Completion of Application Forms

Paramount application forms, paper or electronic, vary based on the plan(s) your group selected. Application forms completed correctly enable Paramount to assure your group of timely subscriber/member maintenance. All fields of the enrollment forms require completion. The application has an area for other insurance information, which assists Paramount with the proper payment of claims.

Employees are encouraged to print when completing the paper applications. Clear information assists in accurate data entry and clear images as the documents are electronically archived.

Processing delays occur when:

- Primary Care Physicians (PCP) are missing and the plan requires a selection;
- Social security numbers for spouses and dependents are missing:
- The date of hire is not listed;
- Signatures of the employee, spouse and group contact are missing; or
- Additional documentation is not submitted with the application (i.e. birth certificate for dependent with a different last name and is not a step-child; marriage certificate if the spouse's last name is different; Letter of Termination if application is submitted due to loss of coverage, etc).

Letters are sent if additional information is needed. Enrollment will be delayed or, possibly denied, if the appropriate documentation is not received.

Additional Subscriber/Member/Group Maintenance Inquiries

Address Changes - Paramount sends mailings to our subscribers/members and groups. If subscriber or member mail is returned as undeliverable, a letter will be sent to your group requesting a current address. Notification of address changes is encouraged in order for subscribers and groups to receive information on a timely basis. Employee address changes can be done by using MyParamount.org (by the employee), through Jet (by the employer) or by submitting an application. Subscribers can also call the Member Services Department to report the change.

If your group is changing addresses, please contact your broker or Marketing Representative to report the change.

Primary Care Physician (PCP) Changes - If a subscriber/member is in a plan which requires a PCP, the subscriber/member can make the change in a variety of ways. PCP changes can be done by using MyParamount.org or by submitting an application. The subscriber/member can also call the Member Services Department.

Group Contact Change - Your group assigns an internal contact that can be called if Paramount has questions. If your internal contact is changed, please notify your broker or Marketing Representative to process the change.

Premium Rates - Your premium rates are listed in your Employer Group Contract. If you have any questions on your premium rates, please contact your broker or Marketing Representative.

Medicare Eligibility

Reaching Age Sixty-Five (65) - An employee or spouse may become eligible for Medicare due to reaching age sixty-five (65). Depending on the size of your group and the employment status of the employee, Paramount or Medicare is primary for coverage. For purposes of Medicare eligibility based on age, a small group is defined as an employer with fewer than twenty (20) full-time and part-time employees for each working day in at least thirty-three (33) or more calendar weeks in the current calendar year or the preceding calendar year. Correspondingly, a large group is defined as an employer with twenty (20) or more full-time or part-time employees for each working day of at least twenty (20) calendar weeks in the current calendar year or the preceding calendar year.

Actively working employees and their spouses, who are entitled to Medicare benefits due to reaching age sixty-five (65), are primary under Paramount if your group has more than twenty (20) employees. If your group has less than twenty (20) employees, Medicare is primary.

Disability under age sixty-five (65) - An actively working employee, spouse or dependent, which is under the age of sixty-five (65), may become eligible for Medicare due to disability. Medicare is primary if the group has less than one hundred (100) employees. The criteria to determine if a group has more than one hundred (100) employees is:

- Having more than one hundred (100) full and part-time employees for more than fifty percent (50%) [Twenty-six (26) weeks] of the preceding year.

End Stage Renal Disease - An actively working employee, spouse or dependent may become eligible for Medicare due to end stage renal disease (ESRD). Medicare entitlement usually begins three (3) months after an individual starts receiving dialysis treatment. Therefore, primary/secondary coverage is as follows:

Months	Primary	Secondary
1-3	Paramount	N/A
4-30	Paramount	Medicare
31+	Medicare	Paramount

Group size does not determine primary payment in this case. Medicare ends 36 months after a transplant.

Medicare is primary - Once Medicare is primary, the employee, spouse or dependent should contact the Elite Marketing Department to discuss available coverage options. The phone numbers are 419-887-2582 or toll free at 1-888-891-0707 during the hours of 8:30 am to 5:00 pm Monday through Friday. An application, with the employee, spouse or dependent's Medicare number, Part A and B effective date, should also be sent to Paramount for accurate claim processing until an available coverage option is selected.

Terminations

When subscribers or dependents become ineligible or elect to cancel their coverage, a termination form should be completed and received by our office within thirty-one (31 days) of the event even though continuation of coverage may be available. Typically, coverage is terminated as of midnight on the last day of the month in which eligibility ceased. If the termination form is not received within the thirty-one (31) day period, the termination date will be based on our receipt date and effective the end of the preceding month. Retroactive adjustments will not be made. All claims for services rendered on or after the termination date will be denied. A termination letter and upon request a Creditable Coverage certificate will be sent to the subscriber or dependent(s).

Continuation of Coverage Options

A subscriber and/or dependent(s) may be able to continue coverage after termination of benefits. The following are possible options for continuation of coverage.

Twelve (12) Month Ohio State Continuation (Section 1751.53 of the Ohio Revised Code) - Employees of employers with fewer than twenty (20) employees may choose to extend group health benefits for a twelve (12) month period following termination of employment. The eligibility criteria are:

- Be employed for at least three (3) months before the termination of employment;
- Be entitled to unemployment compensation at the time employment is terminated;
- The Employee did not voluntarily terminate the employment and the termination of employment is not a result of any gross misconduct on the part of the employee**;** and
- Not be or become eligible for Medicare coverage or any other health care coverage at the date of termination or at any other time during the continuation period.

Employee must enroll in order to cover any dependents. Employee can select single coverage even if their group coverage included dependents. An application for continuation of coverage must be submitted to Paramount.

COBRA - COBRA applies to employers that offer their employees' group health coverage and that employ twenty (20) or more workers on at least 50% of its typical business days during the preceding calendar year. In counting the twenty (20) employees, each part-time employee counts as a fraction of an employee. The following individuals are not included in determining the size of the employer:

- Self-employed individuals
- Independent contractors (and their employees and independent contractors);
- Leased employees who are not common law employees of the employers; and
- Non-employee directors (in case of a corporation).

Employers who do not meet this test are exempt from COBRA. Other employers that are exempt from COBRA requirements are:

- State and local government plans;
- Federal government; and
- Employers that operate as a church plans.

Under COBRA, qualified beneficiaries have the right to elect continuation of group health coverage at their expense. Qualified beneficiaries are employees,

former employees and their spouses and dependents who were covered under the group health plan on the day before one of the following events and who lost coverage as a result of the event. The events are:

- The employee's termination (either voluntary or involuntary for reasons other than gross misconduct);
- The employee's reduction in hours (strike, layoff, leave of absence, full-time to part-time);
- Death of the employee;
- Divorce or legal separation of an employee;
- Dependent child ceasing to be a dependent under the definition of the plan: or
- Employee's entitlement to Medicare.
- Reservist call to active duty

Paramount will offer continuation coverage for employees 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).

COBRA will not be available for:

- Any person covered under a group whose Employer Group Contract with Paramount has been terminated for any reason; or
- Any person whose payment is not received within COBRA or the plan's guidelines.

Group continuation of coverage will extend eighteen (18) months for employees and dependents, twenty-four (24) for employees who are reservists and dependents called to active duty on or after December 10, 2004 and thirty-six (36) months for dependents only. The employee/dependent coverage period may be less than eighteen (18), twenty-four (24) or thirty-six (36) months with Paramount, if your group was enrolled with another carrier when COBRA was effective. The difference between the other carrier effective date with COBRA and when Paramount was effective will be the time remaining.

If the Social Security Administration determines that the employee or his or her spouse or dependent child(ren) were disabled during the first sixty (60) days of COBRA coverage, the eighteen (18) month period should be extended to twenty-nine (29) months for all individuals covered under COBRA coverage from the date of the qualifying event. The administrator must be notified of the determination within sixty (60) days and before the end of the original eighteen (18) month period for this extension to apply.

The following events will cause COBRA coverage to terminate:

- Failure to make timely payment;

- Qualified beneficiary is covered by a group plan;
- The date on which the qualified beneficiary first becomes, after the date of the election, entitled to Medicare; or
- First of the month following 30 days after being deemed no longer disabled (This applies within the 11 month Disability Extension only).

Paramount has partnered a COBRA administrator for your COBRA administration. The administrator can assist you with the complexities of COBRA. If you already have a COBRA administrator, you can continue your agreement with the company. If you do not have an administrator, please contact your Paramount Account Executive to get set up. Our administrator will:

- Send qualifying event notices to the qualified beneficiaries
- Monitor timely COBRA elections by qualified beneficiaries;
- Answer qualified beneficiary questions;
- Bill and collect premiums for qualified beneficiaries;
- Remit monthly premiums to the employer group; and
- Report COBRA activity to employer group.

*The COBRA information is accurate as of printing date of this document.

Confidentiality/Privacy

Paramount is a covered entity under the Health Insurance Portability and Accessibility Act (HIPAA) Privacy Standards and Paramount will comply with the HIPAA requirements. Paramount is permitted to use, obtain and disclose member protected health information to perform our services in accordance with HIPAA and “Paramount’s Notice of Privacy Practices.”
The information contained in this document is accurate as of the printing date.
For the most current information, please visit our website at www.paramounthealthcare.com.

Coordination of Benefits

NOTICE: 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.

Coordination of Benefits (COB) is the industry standard practice used to share the cost of care when a member is covered by more than one benefit plan. The COB process is explained below. If you have Coordination of Benefit specific questions, feel free to contact the Member Services Department for assistance at (417) 887-2525 or toll free at (800) 462-3589.

Paramount coordinates benefits with other payers when a member is covered by two or more benefit plans. It is a contractual provision of most benefit contracts. Paramount complies with federal and state regulations as it pertains to Coordination of Benefits and follows COB guidelines that are established by the National Association of Insurance Commissioner's (NAIC) and adopted by the State of Ohio.

A primary plan shall pay or provide its benefits as if a secondary plan does not exist.

A secondary plan shall calculate the benefits it would have paid on the claim in the absence of other benefits and apply that calculated amount toward any allowable expense under its plan that is unpaid by the primary plan.

Plan
For the purposes of Coordination of Benefits "plan" means a form of coverage with which coordination is allowed i.e. group, group type and non-group coverage through a health insuring corporation.

The term "plan" does not include individual contracts, fixed or hospital indemnity coverage, accident only coverage, supplemental sickness and accident coverage including school accident policies, benefits provided in long term care policies for non-medical related services, Medicare supplemental policies or governmental plans when by law its benefits are in excess of those provided by any private insurance plan i.e. State Medicaid coverage which is considered the payer of last resort.

Non-Coordinating Plan
A plan that does not contain order of benefit determination provisions consistent with NAIC regulation is always the primary plan unless the provisions of both plans state that the complying plan is primary.

Primary vs. Secondary
Paramount applies the following NAIC guidelines adopted by the State of Ohio, to determine which carrier is the primary carrier and which is secondary. Paramount will use the first rule that applies to your specific situation, when making its determination.

- **Non-Dependent or Dependent:**
  The plan covering an individual as an employee, member or subscriber rather than covering the individual as a dependent, would be considered the primary plan.

- **Dependent child covered under more than one plan:**
  For a dependent child whose parents are married or are living together, whether or not they have ever married the primary plan is the plan of the parent whose birthday falls earlier in the calendar year.

  For dependents whose parents have divorced or separated or are not living together the specific terms of the court order/decree determine which carrier is primary and which is secondary

  If there is no court order/decree defining responsibility for the children's health care expenses the custodial parent's carrier, then the carrier of the custodial parent's spouse would be primary before coverage the child has under the non-custodial parent and the non-custodial spouse.

- **Active vs. Inactive:**
  When the policyholder is the same, the plan covering the policyholder or dependent as an active employee would be primary over the plan covering the person or dependent as laid off or retired.

- **COBRA:**
  If a person is covered under a right of continuation policy the plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is the primary plan.

- **Longer vs. Shorter:**
  If none of the previous previsions apply the primary plan will be based on which plan has covered the person for the longer period of time.

Right to Receive or Release Necessary Information
To ensure proper coordination between carriers, Paramount may give or obtain any information it deems necessary for the purpose of coordinating benefits, from another carrier or any other source. This information may be given or obtained without the consent of or notice to the subscriber or member.

Medicaid/Medicare Members
For information regarding Coordination of Benefits and MEDICAID refer to web site www.medicaid.ohio.gov.

For information regarding Coordination of Benefits and MEDICARE, refer to the CMS Web site at www.medicare.gov and use the search bar to query COB.

Notification
The member is required to provide Paramount with Coordination of Benefits information any time the effective dates of newly acquired coverage overlaps current coverage under an existing plan.

This information will be used to facilitate prompt claims processing and avoid delays in claims payment.

Notice to covered members
If you are covered by more than one benefit plan, you should file all claims with each plan.

Secondary Claim Consideration

- When Paramount is the secondary plan, Paramount will not consider your claim until after the primary plan pays its benefits. Then Paramount may pay part or all of the unpaid allowable expense which may include deductibles, co-insurance and co-pays.

- When coordinating benefits with a primary HMO or In-network only plan, Paramount will not consider any excess charges i.e. amounts in excess of the primary carriers allowed fee for the service provided. Participating providers in the primary carrier's network agree to accept contracted fees as payment in full.

- When the primary plan is a HMO or In-network only plan and the covered person fails to receive their services from an in-network provider, any allowable charges not covered by the primary plan will not be considered by Paramount as the secondary plan.

- When the provider of service meet both the primary and secondary in network requirements, Paramount as the secondary plan, may pay part or all of the unpaid allowable expense which may include deductibles, co-insurance and co-pays.

Right of Recovery
If Paramount has paid more than it should have paid, under Coordination of Benefits provisions, it has the right to recover the excess from one or more of the persons it has paid or for whom it has paid; or from 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” which includes the reasonable cash value of any benefits provided in the form of services.

Coordination of Benefit Disputes
Paramount members’ who believe that a claim was not paid properly due to Coordination of Benefits or disagree with a COB determination that was made on their behalf, should first attempt to resolve the issue by contacting Paramount directly at (419) 887-2525 or toll free at (800) 462-3589

If you are still dissatisfied and would like instructions on filing a consumer complaint you may call the Ohio Department of Insurance, Consumer Services Division, at (800) 686-1526.