Northwest Ohio Business Alliance
MEWA

Point of Service
Certificate of Coverage

OHIO INSURANCE DEPARTMENT 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.

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

English: ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-462-3589 (TTY: 711) or speak to your provider.

Spanish: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-800-462-3589 (TTY: 711) o hable con su proveedor.

Arabic:
تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 1-800-462-3589 (711) أو تحدث إلى مقدم الخدمة".

Chinese: 注意：如果您說[中文]，我們可以為您提供免費語言協助服務。也可以免費提供適當的輔助工具與服務，以無障礙格式提供資訊。請致電 1-800-462-3589（TTY：711）或與您的提供者討論。」

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-800-462-3589 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.

Vietnamese: LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin them các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-800-462-3589 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.

Korean: 주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-800-462-3589 (TTY: 711) 번으로 전화하거나 서비스 제공업체에 문의하십시오.

Pennsylvanian Dutch: Wann du Deitsch schwetzscht un hoscht Druwwel fer Englisch verschtehe, kenne mer epper beigriege fer dich helfe unni as es dich ennich eppes koschte zeelt. Mir kenne dich helfe aa wann du Druwwel hoscht fer heere odder sehne. Mir kenne Schtofft lauder mache odder iesier fer lese un sell koscht dich aa nix. Ruf 1-800-462-3589 (TTY: 711) uff odder schwetz mit dei Provider.

Russian ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-800-462-3589 (TTY: 711) или обратитесь к своему поставщику услуг.

Japanese 注：日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル（誰もが利用できるよう配慮された）な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。 1-800-462-3589（TTY: 711）までお電話ください。または、ご利用の事業者にご相談ください。

Assyrian:
ܟܬܒܐ ܟܬܝܒ ܒܐܦ ܒܐ ܦܫ ܚܝܠ ܒܐ ܐܦ .ܒܐ ܠܥܬ ܟܬܒܐ ܬܒܝܒ ܟܬܒܐ ܒܐ ܦܫ ܒܐ ܚܝܠ ,ܟܬܒܐ ܒܝܒ ܒܐ ܚܝ :ܟܬܒ
ܒܐ ܒܝܒ ܐܦ (TTY:711) 1-800-462-3589 ,ܦ .ܟܬܒܐ ܦܥܝܠ ܟܬܒ ܟܝ ܟܬܒܐ ܠܒܝܠ ܟ ܬܒܝ ܟ ܦܫ ܟ ܚܦ ܟ ܠܒ ܟ ܠܒ
.ܟ ܚܦ ܟ ܒܐ ܦܥ

French: ATTENTION: Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-800-462-3589 (TTY : 711) ou parlez à votre fournisseur.

Italian: ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l'1-800-462-3589 (tty: 711) o parla con il tuo fornitore.

Albanian: VINI RE: Nëse flisni [shqip], shërbime falas të ndihmës së gjuhës janë në dispozicion për ju. Ndihma të përshtatshme dhe shërbime shtesë për të siguruar informacion në formate të përdorshme janë gjithashtu në dispozicion falas. Telefononi 1-800-462-3589 (TTY: 711) ose bisedoni me ofruesin tuaj të shërbimit.

Bengali: মনোযোগ দিন: যদি আপনি বাংলা বলেন তাহলে আপনার জন্য বিনামূল্যে ভাষা সহায়তা পরিষেবাদি উপলব্ধ রয়েছে। অ্যাক্সেসযোগ্য ফরম্যাটে তথ্য প্রদানের জন্য উপযুক্ত সহায়ক সহযোগিতা এবং পরিষেবাদিও বিনামূল্যে উপলব্ধ রয়েছে। 1-800-462-3589 (TTY: 711) নম্বরে কল করুন অথবা আপনার প্রদানকারীর সাথে কথা বলুন।

Serbo Croation: PAŽNJA: Ako govorite srpski, na raspolaganju su Vam besplatne usluge jezičke pomoći. Besplatna su i odgovarajuća pomoć i usluge za pružanje informacija u pristupačnim formatima. Pozovite 1-800-462-3589 (TTY: 711) ili razgovarajte sa svojim pružaocem usluga.

Oromo: HUBACHIISA: Yoo Afaan Oromoo dubbattu ta’e, tajaajiloonni gargaarsa afaanii bilisaa isiniif ni argamu. Deeggarsi dabalataa fi tajaajilootni mijaa'oo ta’an odeeffannoo bifa dhaqqabamaa ta'een kennuuf gargaaranis kaffaltii malee ni argamu. Gara 1-800-462-3589 (TTY: 711) tti bilbilaa ykn dhiyeessaa keessan haasofsiisaa.

Dutch: LET OP: als je Nederlands spreekt, zijn er gratis taalhulpdiensten voor je beschikbaar. Passende hulpmiddelen en diensten om informatie in toegankelijke formaten te verstrekken, zijn ook gratis beschikbaar. Bel 1-800-462-3589 (tty: 711) of spreek met je provider.

Romanian: ATENȚIE: Dacă vorbiți [Română], aveți la dispoziție servicii de asistență lingvistică gratuite. De asemenea, sunt disponibile gratuit materiale și servicii auxiliare adecvate pentru furnizarea de informații în formate accesibile. Sunați la 1-800-462-3589 (TTY: 711) sau contactați-vă furnizorul.

Ukranian: УВАГА: Якщо ви розмовляєте українська мова, вам доступні безкоштовні мовні послуги. Відповідні допоміжні засоби та послуги для надання інформації у доступних форматах також доступні безкоштовно. Зателефонуйте за номером 1-800-462-3589 (TTY: 711) або зверніться до свого постачальник

Notice of Non-Discrimination: Discrimination is Against the Law

The Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin (including limited English proficiency and primary language), sex (consistent with the scope of sex discrimination described at 45 CFR § 92.101(a)(2)), age, or disability.

The Plan Provides (free of charge and in a timely manner):

- Reasonable modifications and appropriate auxiliary aids and services for people with disabilities to communicate effectively with us, such as:
    - Qualified interpreters for individuals with disabilities.
    - Information in alternate formats (large print, audio, accessible electronic formats, other formats).
- Language assistance services for people whose primary language is not English, which may include:
    - Qualified oral interpreters.
    - Electronic and written translated documents.

If you need these services, please contact Member Services at 1-800-462-3589 (TTY 711). We are available Monday-Friday, 8:00 a.m. to 5:00 p.m. EST.

If you believe that The Plan has failed to provide these services or discriminated on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator (also called our Section 1557 Coordinator). Our Civil Rights Coordinator can help you with our grievance procedure.

Contact our **Civil Rights Coordinator** at:

- **Mail:** Paramount Civil Rights Coordinator, PO Box 928, Toledo, OH 43697
- **Phone:** 1-800-462-3589 (TTY 711)
- **E-mail:** paramount.memberservices@medmutual.com
- **Fax:** 419-887-2047

You may file a grievance in-person at 300 Madison Avenue, Toledo, Ohio 43604

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights.

- **Online:** Use the Office for Civil Rights Complaint Portal at: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. For more information on filing a complaint, go to http://www.hhs.gov/ocr/office/file/index.html.
- **Mail:** U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, D.C. 20201
- **Phone:** 1-800-368-1019, 800-537-7697 (TDD)

An electronic copy of this notice is available at The Plan's website: www.paramounthealthcare.com

TABLE OF CONTENTS

CERTIFICATE OF COVERAGE 6
SURPRISE BILLING 7
NON-NETWORK SCHEDULE OF INSURANCE 9
MAJOR MEDICAL EXPENSE BENEFIT 9
CONTINUITY OF CARE 9
COVERED EXPENSES 10
LIMITATIONS AND EXCLUSIONS 17
PRIOR AUTHORIZATION 20
ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION DATE 23
WHAT HAPPENS WITH YOUR PLAN 23
GENERAL PROVISIONS 23
INTERNAL CLAIMS AND APPEALS PROCEDURES AND EXTERNAL REVIEW 24
COORDINATION OF BENEFITS 31
REIMBURSEMENT AND SUBROGATION 35
GENERAL DEFINITIONS 36

CERTIFICATE OF COVERAGE

This certificate of coverage describes Non-Network insurance benefits available under the point of service (POS) plan. You will also receive a HMO certificate of coverage that describes Network Benefits, Eligibility, Effective Date, and Termination Date provisions and Continuation information. Network benefits are provided by The Plan, when healthcare services are received from Participating Providers. Non-Network benefits are healthcare services received from Nonparticipating Providers pursuant to the terms of this certificate of coverage. Generally, Non-Network services result in higher out-of-pocket costs for the Insured than Network services.

The POS plan is a plan that offers you a broad selection of participating providers. It also offers the freedom to choose non-participating providers through a standard insurance plan. Under this plan, you must select a participating Primary Care Physician (PCP) to coordinate your medical care. If you see your participating PCP and participating physicians and hospitals, you will receive Network Benefits.

You may see non-participating providers and receive Non-Network Benefits for certain services. Under Non-Network Benefits, you will have to meet an annual deductible, pay coinsurance, file claim forms and call for Prior Authorization. Payments for Covered Expenses are based on Usual, Customary, and Reasonable (UCR). See General Definitions section of this certificate for a definition of UCR. **You will be responsible for charges in excess of UCR which will not be counted toward satisfying your Deductible or Out-of-Pocket Maximum.**

You will receive NETWORK BENEFITS	**You will receive NON-NETWORK BENEFITS**
If You: ▪ Receive care from your participating PCP and use participating Providers. ▪ Follow the guidelines described in the HMO certificate of coverage.	**If You:** ▪ Do not have a participating PCP. ▪ Use Non-participating specialists and/or hospitals for certain Covered Expenses.
You are responsible for: ▪ You may be responsible for a deductible for in-network services ▪ Small copayments/coinsurance ▪ No claim forms	**You are responsible for:** ▪ Calling for Prior Authorization ▪ Meeting yearly deductibles ▪ Paying coinsurance and charges in excess of the UCR ▪ Filing claim forms

Please note that an Insured may not receive Network and Non-Network benefits for the same services.

Emergency Medical Conditions

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

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

The decision as to when an Emergency Medical Condition meets the definition stated here rests with The Plan. Examples of Emergency Medical Conditions include: heart attack, stroke, poisoning, loss of consciousness, inability to breathe, uncontrolled bleeding and convulsions. The Plan may decide that other similarly acute conditions are also Emergency Medical Conditions. Emergency Services are available 24

hours a day, seven days a week. The Plan will cover Emergency Services from non-Participating Providers as detailed in the Covered Services section of the certificate. Members are not responsible for a balance bill from non-Participating Providers for services for Emergency Medical Conditions when treated or transported by non-Participating Providers. If you need medical advice after hours, on weekends or holidays, call your doctor's office number. The answering service will take your call. Leave a message for the doctor or a nurse to return your call. A doctor or nurse will call you back with instructions.

Network Benefits Available with Prior Approval

In some cases, your participating PCP may request Network Benefits for services from a non-participating provider. Services from non-participating providers may be covered by Network Benefits only with prior written approval from the Utilization Management Department. Both the PCP's request and Utilization Management Department's response must be made prior to the services being provided. If the requested services are available from participating providers, the request for Network Benefits will be denied.

A detailed statement describing the appeals procedures available to Insured Persons and Insured Dependents can be found in the Internal Claims and Appeals Procedures and External Review section of this certificate.

SURPRISE BILLING

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

Both the Ohio Revised Code (ORC 3902.50 to 3902.54), Ohio Administrative Code Section 3901-8-17 and the federal "No Surprises Act" (Public Law 116-260) establish patient protections against non-participating providers' surprise bills for Emergency Services or, in certain circumstances, for covered services rendered at in-network facilities by non-participating providers. The Plan will comply with state and federal surprise billing requirements as they apply to health plans, including those which relate to the processing of claims from certain out-of-network providers.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.
"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You cannot be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

In addition to the protections of the Federal No Surprises Act, the state in which you receive services may have protections that apply to your visit for emergency or non-emergency services. Your state website can be found at www.insurance.ohio.gov and by searching “no surprises, balance billing or consumer protections”.

Ohioans who get health insurance through plans regulated by the Ohio Department of Insurance are also protected from receiving surprise medical bills under Ohio law. Ohio law provides the following protections when you receive unanticipated out-of-network care:

- No balance billing for emergency services, including emergency services provided by an ambulance, even if they’re provided out-of-network.
- No balance billing by out-of-network providers at an in-network facility when you’re unable to choose an in-network provider.
- Your cost-sharing amounts, such as copayments, coinsurance, and deductibles, are limited to the amount you would pay for in-network services.

You can find additional information at Surprise Billing | Department of Insurance (ohio.gov).

Certain services at an in-network hospital or ambulatory surgical center
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan’s in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers cannot balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you receive other services at these in-network facilities, out-of-network providers cannot balance bill you, unless you provide written consent and give up your protections.

You’re never required to give up your protections from balance billing. You also are not required to get care out-of-network. You can choose a provider or facility in your plan’s network.

In addition to the protections of the Federal No Surprises Act, the state in which you receive services may have protections that apply to non-emergency services at an in-network facility. Your state website can be found at www.insurance.ohio.gov and by searching “no surprises, balance billing or consumer protections”.

For services provided in Ohio, the provider shall not balance bill the covered person unless: (a) the provider informs the covered person that the provider is out-of-network; (b)the provider provides to the covered person a good faith estimate of the cost of the services (containing a disclaimer that the covered person is not required to obtain the health care service at that location or from that provider); and the covered person affirmatively consents to receive the services.

When balance billing isn’t allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network).Your health plan will pay out-of-network providers and facilities directly.

- Your health plan generally must:

    - Cover emergency services without requiring prior authorization.
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you receive a surprise bill that you believe is prohibited by state or federal law, first, try to resolve the dispute yourself with your health insurer and health care provider. If the dispute remains unresolved, contact the Ohio Department of Insurance through www.insurance.ohio.gov, consumer.complaint@insurance.ohio.gov, or 800-686-1526 to file a complaint.

In addition, you may contact Member Services at:
419-887-2525
Toll Free:1-800-462-3589
TTY: 419-887-2526
TTY Toll Free: 1-888-740-5670
Visit www.cms.gov/nosurprises for more information about your rights under federal law.

MAJOR MEDICAL EXPENSE BENEFIT

The Company will pay, after satisfaction of applicable Deductibles and copayments, the Percentage Payable of expenses incurred during a Contract Year by the Insured Person or an Insured Dependent due to an Injury or Sickness, provided:

1. the expense is incurred while insured for this benefit; and
2. the expense is included in the following items of Covered Expenses; and
3. the expense is not a duplication of benefits paid or payable by The Plan under Network benefits.

Such payment will not exceed any applicable Benefit Maximum shown in the Schedule of Insurance and is subject to the Limitations and Exclusions listed below.

CONTINUITY OF CARE

If your provider or facility's agreement terminates, The Plan will notify you of your right to elect continued transitional care from such provider or facility at the time of termination. You will be provided coverage under the same terms and conditions as would have applied and with respect to such services as would have been covered had such termination not occurred. The Plan will continue to pay for Covered Services rendered by that provider or facility until the earlier of: a) the 90-day period beginning on date of provider or facility termination; b) the date on which you are no longer a Continuing Care Patient with respect to such provider or facility. If this situation occurs, you should contact Member Services.

For the purpose of this provision, Continuing Care Patient means an individual who, with respect to a provider or facility, is undergoing a course of treatment for a serious complex condition from the provider or facility; is undergoing a course of institutional or inpatient care from the provider or facility; is scheduled to undergo nonelective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery; is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or is or was determined to be terminally ill and is receiving treatment for such illness from such provider or facility.

Protections apply for patients who are receiving covered services from a provider or facility, and such provider or facility experiences a change in network status due to one of the following:

- The provider or facility's contract with the issuer is terminated.
- The provider or facility's terms of participation change resulting in a termination of benefits with respect to the provider or facility.
- A group health plan's contract with an issuer is terminated.

COVERED EXPENSES

All Covered Expenses and benefits are subject to the conditions, exclusions, limitations, terms and provisions of this certificate of coverage, including any attachments and endorsements. Covered Expenses must be Medically Necessary and not Experimental/Investigative. The fact that a Provider may prescribe, order, recommend or approve a service, treatment or supply does not make it Medically Necessary or a Covered Service and does not guarantee payment. To receive maximum benefits for Covered Expenses, you must follow the terms of the certificate, and any required Prior Authorization must be submitted to The Plan. Our payment for Covered Expenses will be limited by any applicable Coinsurance, Copayment, Deductible, or calendar year limit/maximum in this certificate.

See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and limitations and exclusions information.

1. **Room, Board, and General Nursing Services, Hospital.** Charges for Board and Room and routine nursing services for confinement in a Hospital, limited to the semi-private room rate. If the Hospital does not have semi-private accommodations, the Company will consider the semi-private room rate to be 80% of the daily charges for Hospital Services at its lowest room rate for private accommodations.

2. **Room, Board, and General Nursing Services, Hospital Intensive Care Unit.** Charges for Board and Room and routine nursing services in a Hospital Intensive Care Unit.

3. **Room, Board, and General Nursing Services Extended Care or Nursing Facility.** Charges for Board and Room and routine nursing services provided in an Extended Care or Skilled Nursing Facility.

4. **Surgical Services, Hospital.** Charges for surgery, including Hospital charges for use of a surgical room on an inpatient or outpatient basis.

5. **Physician Office Services.** Charges for medical treatment by or under the direct supervision of a Physician. This includes services of a certified nurse-midwife under the direction and supervision of a licensed Physician.

6. **Other Therapy Services, Pulmonary Rehabilitation.** Charges for respiratory therapy rendered by a certified respiratory therapist.

7. **Anesthesia.** Charges for anesthesia and its administration by a licensed anesthesiologist or certified Registered Nurse anesthetist.

8. **Other Therapy Services, Radiation Therapy and Chemotherapy.** Charges for radiation therapy and chemotherapy. This benefit is limited to x-ray therapy when used in lieu of generally accepted surgical procedures or for the treatment of malignancy or the use of isotopes, radium or radon for diagnosis or treatment.

9. **Diagnostic Services.** Charges for X-ray exams, laboratory tests and other diagnostic services. This benefit includes charges for CT, Magnetic Resonance Imaging (MRI), PET and PET/CT. CT, MRI, PET and PET/CT require Prior Authorization. Please see the Prior Authorization section below.

10. **Blood, Plasma, or Blood Derivatives.** Charges for blood, plasma, or blood derivatives only if a volunteer replacement program is not available. This does not include the cost of securing the services of professional donors.

11. **Prosthetic Devices.** Charges for the initial placement of prosthetic devices only when the prosthetic devise replaces a limb or other part of the body after accidental or surgical removal.

12. **Durable Medical Equipment.** Charges for Durable Medical Equipment including oxygen, respiratory equipment, medical appliances, chem-strips, ostomy supplies or medical support hose. Purchase, instead of rental, of such equipment may be covered if, in the judgment of the Company, purchase of the equipment would be less expensive than rental, or such equipment is not available for rental.

13. **Alcohol Abuse.** Charges for treatment, services, or supplies in connection with alcohol-abuse received in a Physician's office, a Hospital, a community mental health facility or an alcoholism treatment facility from or under the clinical supervision of a Physician who is a medical doctor or psychologist. This includes intermediate levels of care such as residential treatment, partial hospitalization and intensive outpatient services. The Hospital or alcohol treatment facility must be approved by The Joint Commission or certified by the state Department of Health. The community mental health facility must be approved as a community mental health facility according to Ohio law.

14. **Substance Abuse.** Charges for treatment, services, or supplies received in connection with drug-abuse received in a Physician's office, a Hospital, a community mental health facility or a drug treatment facility from or under the clinical supervision of a Physician who is a medical doctor or psychologist. This includes intermediate levels of care such as residential treatment, partial hospitalization and intensive outpatient services. The Hospital or drug treatment facility must be approved by The Joint Commission or certified by the state Department of Health. The community mental health facility must be approved as a community mental health facility according to Ohio law.

    NOTE: For members whose policies include prescription drug coverage, The Plan will contact a member by mail when the member fills a prescription for certain opioid medications if that member has not filled a similar prescription in the previous six months. This letter is developed in coordination with The Plan's Pharmacy Benefit Manager to describe the risks and benefits of opioid use and educates the member on how to dispose of unused opioids safely. This communication is intended to help prevent the development of opioid dependency by our members. For additional information on opioid education, you may call Member Services at the number on the back of your identification card.

    To identify members who may be dependent on opioids and to intervene appropriately when a member's opioid use may require care coordination, The Plan's case management clinical team regularly reviews available pharmacy and claims data against other criteria associated with high-risk opioid use. Case management clinical team members may contact a member identified through this effort by telephone to offer case management services which include referral to appropriate providers and community resources, education regarding medical and behavioral health conditions and coordination of care between providers. The care management team is a multi-disciplinary group of clinical case managers, pharmacists, physicians, social workers and other behavioral health professionals, who can interact with Providers and pharmacists to help them treat opioid-use disorder more effectively.

    Providers will treat opioid-use disorder with a monitored drug and therapy protocol called medication assisted treatment. For members whose policies include prescription drug coverage, to facilitate prompt treatment of opioid-use disorder, most medication assisted treatment does not require Prior Authorization. Prior Authorization will be required for a member who has been prescribed medication assisted treatment by an Out-of-Network Provider and the review of the Prior Authorization will be expedited. The Plan's limits on medication assisted treatment are related only to quantity or duration or to potentially disqualifying conditions.

    Prior Authorization for services related to treatment of opioid-use disorder will be expedited.

15. **Hospice.** Charges for Hospice treatment, services, or supplies.

16. **Surgical Services, Free-Standing Surgical Facilities.** Charges for surgery in a Free-Standing Surgical Facility.

17. **Home Health Care Services.** Charges for Home Health Care services. Covered Home Health Care services are limited to 4 hours of treatment within any 24-hour period according to a prescribed treatment plan.

    This benefit does not include:
    a. Charges for the treatment of Mental Illness, drug abuse or alcohol-abuse;
    b. Charges for meals (other than special meals provided through dietary counseling);
    c. Charges for personal comfort items; or
    d. Charges for housekeeping services.

18. **Diagnostic Services, Preadmission Testing.** Charges for preadmission testing. Coverage is limited to diagnostic, x-ray, and laboratory exams made during a Hospital outpatient visit. The exams must be made prior to a Hospital Confinement for which a Board and Room charge is made.

19. **Mammogram.** Coverage for mammography includes:
    - Screening mammography to detect the presence of breast cancer in adult women. One screening mammography every year, including digital breast tomosynthesis;
    - Supplemental breast cancer screening to detect the presence of breast cancer in adult women meeting either of the following conditions:
        - The woman's screening mammography demonstrates, based on the breast imaging reporting and data system established by the American College of Radiology, that the woman has dense breast tissue;
        - The woman is at an increased risk of breast cancer due to family history, prior personal history of breast cancer, ancestry, genetic predisposition, or other reasons as determined by the woman's Health Care Provider.

    For a screening mammography or supplemental breast cancer screening, the maximum cost share a member will be responsible for will not exceed one hundred thirty percent (130%) of the Medicare reimbursement amount, and the provider cannot balance bill for the amount exceeding one hundred thirty percent (130%).

20. **Maternity Services, Delivery.** Charges for treatment, services or supplies received in connection with childbirth. Coverage is provided for:
    a. Forty-eight (48) hours of Hospital Confinement following an uncomplicated vaginal delivery; and
    b. Ninety-six (96) hours of Hospital Confinement following an uncomplicated cesarean section.

    Treatment, services, or supplies shall include medical, educational and any other services that are consistent with the inpatient care recommended in the protocols and guidelines developed by national organizations that represent obstetric and nursing professionals.

    A mother, or person responsible for the mother, may request a shorter length of stay if, in consultation with her attending Physician or certified nurse-midwife in collaboration with a Physician, less time is needed for recovery. A person responsible for the mother means a parent, a guardian or any other person with authority to make medical decisions for the mother.

21. **Maternity Services, Routine Nursery Care.** Charges for routine nursery care, including Physician's services, for a newborn child while the mother is confined following childbirth for:
    a. 48 hours of Hospital Confinement following an uncomplicated vaginal delivery; and

b. 96 hours of Hospital Confinement following an uncomplicated cesarean section.

These charges will be considered separate from the mother's. They will be subject to any Deductible, and Percentage Payable shown in the Schedule of Insurance. The requirement that the covered expenses be incurred as a result of injury or sickness does not apply to this provision. Routine nursery care includes:

a. medical;
b. educational; and
c. any other services that are consistent with the inpatient care recommended in the protocols and guidelines developed by national organizations that represent pediatric and nursing professionals.

A mother, or person responsible for the newborn, may request a shorter length of stay for the newborn if, in consultation with the attending Physician, less time is needed for recovery. A person responsible for the newborn means a parent, a guardian or any other person with authority to make medical decisions for the newborn.

22. **Maternity Services, Follow-up Care.** Charges for treatment, services, or supplies for Physician-directed post-delivery care for the mother and newborn child who requested a shorter length of stay in consultation with her attending Physician or certified nurse-midwife in collaboration with a Physician. Physician-directed post-delivery care will be provided in either a medical setting or through home health care visits and includes:

a. Physician assessment;
b. Parent education;
c. Assistance and training in breast or bottle feeding;
d. Assessment of the home support system;
e. Clinical tests or services as required by the attending Physician, or certified nurse midwife; and
f. Any other treatment, services, or supplies that are consistent with the post-delivery care recommended in the protocols and guidelines developed by national organizations that represent pediatric, obstetric, and nursing professionals.
g. All follow-up care services rendered within 72 hours of discharge, if the discharge occurs sooner than 48 hours following normal vaginal delivery or 96 hours following a cesarean delivery

Coverage for Physician-directed post-delivery care for a mother and newborn child who received forty-eight (48) hours of Hospital Confinement following an uncomplicated vaginal delivery, or ninety-six (96) hours of Hospital Confinement following an uncomplicated cesarean section, will be provided only upon recommendation by the Physician responsible for discharging such mother or newborn child. The requirement that the covered expenses be incurred as a result of injury or sickness does not apply to this provision.

23. **Therapy Services, Physical Therapy.** Charges for physical therapy rendered by a legally qualified physical therapist and charges for occupational therapy performed by a licensed occupational therapist for the purpose of returning the Insured Person or Insured Dependent to the optimum level of activities of daily living. It must be considered progressive therapy, not maintenance therapy. It must not be performed for the purpose of occupational rehabilitation.

24. **Therapy Services, Speech Therapy.** Charges for speech therapy. The speech disorder must result from Injury or Sickness. This therapy must be rendered by a licensed Speech Therapist or licensed Speech Pathologist. The therapy must be considered progressive therapy, not maintenance therapy. This does not include speech therapy for developmental or language disorders, such as: a) aphasia; b) stuttering; c) hyperkinesis; or d) extreme intellectual disability.

25. **Male Sterilization.** Charges for male sterilization procedures.

26. **Infertility Services.** Charges for the diagnosis and treatment of infertility.

27. **Contraceptive Services.** Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for women, as prescribed by a health care provider are covered under Preventive Care Services. These services are subject to Prior Authorization. Please see the Prior Authorization section below.

28. **Emergency Services and Emergency Transportation.** Charges for Emergency Services. This includes transportation by a professional licensed ambulance service in connection with Emergency Services. Ambulance and medical transport services may involve ground, air or sea transport. Emergency Services received outside the Network by Insured Persons or Insured Dependents will be payable as if they were received from a Participating Provider such that the insured will not be balanced billed.

29. **Urgent Care Service.** Charges for Urgent Care Services.

30. **Temporomandibular Joint Disorders.** Charges for treatment of temporomandibular or craniomandibular joint disorders by medical treatment including physical therapy or surgery.

31. **Biologically Based Mental Illness.** Charges for treatment, services, or supplies received during a Hospital Confinement or outpatient basis in connection with a Biologically Based Mental Illness. The Hospital, community mental health facility, or other providers must meet the requirements under applicable state law.

32. **Non-Biologically Based Mental Illness.** Charges for treatment, services, or supplies received during a Hospital Confinement or on an outpatient basis in connection with a Non-Biologically Based Mental Illness. The Hospital, community mental health facility or other providers must meet the requirements under applicable state law.

33. **Clinical Trials.** Coverage is provided to a qualified individual for routine patient care rendered as part of a clinical trial if the services are otherwise covered services under this certificate. A qualified individual is generally a participant or beneficiary who is eligible to participate in an approved clinical trial according to the trial protocol with respect to the treatment of cancer or other life-threatening disease or condition; and either: (1) the referring Health Care Professional is a participating provider and has concluded that the individual's participation in such trial would be appropriate; or (2) the participant or beneficiary provides medical and scientific information establishing that the individual's participation in such trial would be appropriate. The Plan:
(1) may not deny the qualified individual participation in an approved clinical trial with respect to the treatment of cancer or another life-threatening disease or condition;
(2) may not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial; and
(3) may not discriminate against the individual on the basis of the individual's participation in the trial

In Ohio for cancer clinical trials the following applies:
1) Coverage is not limited to a "qualified individual" as defined in federal law.
2) The participant is not required to have a referral from a participating health professional or provide medical and scientific information establishing the appropriateness of participation.

34. **Preventive Care Services.** Preventive Care Services including Outpatient services and Office Services. Screenings and other services are covered as Preventive Care for adults and children with no current symptoms or prior history of a medical condition associated with that screening or service. The requirement that the covered expenses be incurred as a result of injury or sickness does not apply to Preventive Care Services. Services are covered with no cost share when received from in-Network providers.

Insureds who have current symptoms or have been diagnosed with a medical condition are not considered to require Preventive Care for that condition but instead benefits will be considered under the Diagnostic Services benefit.

Preventive Care Services shall meet requirements as determined by federal and state law. These services fall under four broad categories as shown below:

a. Services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of these services are screenings for:

    1. Breast cancer mammography screenings;
    2. Cervical cancer cytologic screenings;
    3. Colorectal cancer;
    4. High Blood Pressure;
    5. Type 2 Diabetes Mellitus;
    6. Cholesterol;
    7. Child and Adult Obesity;
    8. Tobacco cessation services; see below for coverage.

b. Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

c. Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and

d. Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration. You may call Member Services using the number on your ID card for additional information about these services. (or view the federal government's web sites, http://www.healthcare.gov/center/regulations/prevention.html; or http://www.ahrq.gov/clinic/uspstfix.htm; http://www.cdc.gov/vaccines/recs/acip/.)

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

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

Other Covered Expenses are:

- Routine hearing screenings
- Routine children's vision screenings

For those who use tobacco products, at least two tobacco cessation attempts per year will be covered at 100% with no cost to you when provided by a Participating Provider. For this purpose, covering a cessation attempt includes coverage for:

1. Four tobacco cessation counseling sessions of at least 10 minutes each (including telephone counseling, group counseling and individual counseling) without Pre-Authorization; and
2. All Food and Drug Administration (FDA) approved tobacco cessation medications

(including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a health care provider without Pre-Authorization.

3. Tobacco Cessation Programs are offered to Covered Persons over the age of twenty-one (21) at in-plan hospitals or ancillary providers and are covered as a preventive service.
4. Call the Member Services Department for complete details on enrolling in a program. See also Preventive Health Services for additional information.

1. **Habilitative Services.** Habilitative Services: Are health care services and devices that help a person keep, learn, or improve skills and functioning for daily living. This includes but is not limited to habilitative services for members with a medical diagnosis of Autism Spectrum Disorder (ASD) which at a minimum includes: Out-Patient Physical Rehabilitation services including:
    - Speech and Language therapy and/or Occupational therapy, performed by a licensed therapist twenty (20) visits per year of each service; and
    - Clinical Therapeutic Intervention under the supervision of a professional who is licensed, certified, or registered by an appropriate agency of this state to perform the services in accordance with a health treatment plan, twenty (20) hours per week;

2. Mental or Behavioral Health Outpatient Services performed by a licensed Psychologist, Psychiatrist, or Physician providing consultation, assessment, development and oversight of treatment plans.

Coverage provided under this benefit is contingent upon the Covered Person receiving pre-authorization and the services being prescribed or ordered by either a developmental pediatrician or a psychologist trained in autism. The Plan may review the treatment plan annually or more frequently if The Plan and the treating physician or psychologist, agree that a more frequent review is necessary. Treatment for ASD means evidence-based care and related equipment determined to be medically necessary, including any of the following:

- Clinical Therapeutic Intervention
- Pharmacy care
- Psychiatric care
- Psychological care
- Therapeutic care

35. **Hearing Aids and Relates Services.** For Covered Persons under age twenty-two (22) who are verified as being deaf or hearing impaired by a licensed audiologist, an otolaryngologist or other licensed Physician, benefits are provided for Hearing Aids and Related Services, subject to the limitations shown on the Schedule of Benefits. In order to be a Covered Services, Related Services must be prescribed by an otolaryngologist or recommended by a licensed audiologist and dispensed by a licensed audiologist, a licensed hearing aid dealer or fitter or an otolaryngologist.

For the purposes of this coverage, the following definitions apply:

a. “Hearing Aid” means any wearable instrument or device designed or offered for the purpose of aiding or compensating for impaired human hearing, including all attachments, accessories, and arts thereof, except batteries and cords, that is dispensed by a licensed audiologist, a licensed hearing aid dealer or fitter, or any otolaryngologist.
b. “Related Services” means services necessary to assess, select, and appropriately adjust or fit a hearing aid, to ensure optimal performance.

A Covered Person may choose a higher priced hearing aid and may pay the difference in cost above the benefit maximum appearing in the Schedule of Benefits, without any financial or

contractual penalty to the Covered Person or to the Provider of the hearing aid.

Coverage is provided only for hearing aids that are considered medically appropriate to meet the needs of the Covered Person, according to professional standards established by the state speech and hearing professionals' board.

36. **Telehealth Services.** Covered when provided through the use of information and communication technology by a Health Care Professional, within the profession's scope of practice, who is located at a site other than the site where either of the following is located:
    - The patient receiving the services;
    - Another Health Care Professional with whom the provider of the services is consulting regarding the patient.

    This plan will cover Telehealth Services on the same basis and to the same extent that the plan provides coverage for in-person health care services.

LIMITATIONS AND EXCLUSIONS

The exclusions and limitations listed below apply to all provisions of this certificate of coverage. However, certain sections of this certificate may waive an exclusion or limitation or may list additional exclusions or limitations. Please be certain to check the specific provisions of this certificate.

Benefits for the following will not be provided.

1. Charges for treatment, services or supplies that are in excess of NCA and UCR.

2. Charges for Injury or Sickness for which the Insured Person or Insured Dependent has or had a right to payment under any workers' compensation or similar law.

3. Charges for Injury or Sickness arising out of or in the course of past or current work for pay, profit, or gain, unless workers' compensation or benefits under similar law are not required or available.

4. Charges for treatment, services, or supplies provided by the Insured Person or by a person who usually resides in the same household as the Insured Person or is a member of his immediate family or the family of his or her spouse.

5. Charges for confinement, treatment, services or supplies received while under confinement or otherwise under the custody of a law enforcement officer, where care is provided at government expense. Exclusion applies if the injury or sickness for which the services were rendered resulted from an action or omission for which the governmental entity operating the correctional facility, or the governmental entity with which the law enforcement officer is affiliated, is liable.

6. Charges for Injuries sustained while the Insured Person or Insured Dependent was engaging in an illegal occupation, an assault, an attempted assault or a felonious act.

7. Charges for Injuries sustained in which a contributing cause was the Insured Person's or Insured Dependent's commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal occupation.

8. Charges for treatments, procedures, drugs or medicines that the Company determines to be experimental or investigational. This means that one or more of the following is true:
    a. The device, drug or medicine cannot be lawfully marketed without approval of the U. S. Food and Drug Administration and approval for marketing has not been given at the time the device, drug or medicine is furnished.

b. Reliable evidence shows that the treatment, procedure, device, drug or medicine is the subject of ongoing phase, I, II, or III clinical trials or is under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis. This exclusion does not apply to routine patient care of a Covered Person associated with Phase I, II, III, and IV of approved clinical trials.

c. Reliable evidence shows that the consensus of opinion among experts regarding the treatment, procedure, device, drug or medicine is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis. Reliable evidence means only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same treatment, procedure, device, drug or medicine; or the written informed consent used by the treating facility or by another facility studying substantially the same treatment, procedure, device, drug or medicine.

9. Charges paid or payable by The Plan under Network Benefits.

10. Charges for weekend admission to a Hospital for non-emergency services. This applies only to Friday through Sunday inclusive.

11. Charges for any confinement, treatment, service or supply that is not Medically Necessary. This limitation does not apply to preventive or other *Health Care Services* specifically listed above as not subject to the requirement that Covered Expenses be incurred as a result of Injury or Sickness.

12. Charges for confinement, treatment, services or supplies not recommended and approved by a Physician.

13. Charges for confinement, treatment, services or supplies received while not under the care and treatment of a Physician.

14. Charges for confinement, treatment, services or supplies received outside the United States. This limitation only applies if the confinement, treatment, services or supplies are not of the type and nature available in the United States.

15. Charges for dental work, treatment or x-ray including but not limited to:
    a. treatment on or to the teeth;
    b. extraction of teeth, including bony impacted wisdom teeth;
    c. replacement or restoration of the teeth;
    d. treatment of granuloma;
    e. treatment of temporomandibular or craniomandibular joint disorders by medical treatment including physical therapy or surgery.
    f. placement, removal or replacement of implants or the teeth or alveolar ridge;
    g. treatment of periodontal disease or abscess;
    h. root canal;
    i. treatment required for or as a result of, biting or chewing; or
    j. braces, retainers and bite plates.

    This exclusion does not apply to the following procedures performed by a dentist or oral surgeon to the extent a valid referral exists and benefits are not available under a dental plan, in which case benefits are available as Surgical Services (Hospital or Free-Standing Surgical Facility), Emergency Services, or Physician Office Visit Services, including charges for Medically Necessary Diagnostic Services and Anesthesia, depending on the location at which services are rendered. These procedures are:
    a. initial first aid treatment received within 48 hours of an accidental Injury to sound natural teeth, the jaw bones, or surrounding issues, to the extent of extraction of teeth and repair of soft tissue;
    b. orthognathic surgery;

c. treatment for tumors and cysts (including pathological examination) of the jaws, cheeks, lips, tongue, roof and floor of the mouth; or
d. repair of fractures and dislocations.

16. Charges for cosmetic or plastic surgery.

17. Charges for orthotic foot devices or charges for repair or replacement of prosthetic devices.

18. Charges for sex transformation, reversal of sterilization or surgery or treatment related to sexual dysfunction.

19. Charges for non-prescription drugs or medicines, vitamins, nutrients and food supplements not covered under Preventive Care Services. This limitation applies even if the item is prescribed by or administered by a Physician.

20. Charges related to birth control drugs or devices not covered under Preventive Care Services.

21. Charges for special education, counseling, therapy or other services related to learning deficiencies or behavioral problems unless deemed Medically Necessary or covered under Preventive Care Services. This limitation applies whether or not associated with manifest mental illness or other disturbances, but does not apply to charges related to Autism Spectrum Disorder under the Habilitative Services benefit.

22. Charges for any treatment by artificial means for the purpose of causing a pregnancy, including drugs, artificial insemination, in vitro fertilization, embryo transplant services (GIFT, ZIFT) or any other assisted reproductive technology.

23. Charges for services or supplies rendered for treatment of obesity or for weight reduction, except obesity counseling and services covered under Preventive Care Services. This exclusion includes surgical procedures or the reversal of a previous surgical procedure.

24. Charges for confinement, treatment, services or supplies that are required only by a court of law or only for insurance, travel, employment, school, camp, or similar purposes.

25. Charges for personal comfort items, including telephones, radios, televisions or barber services.

26. Charges for care the Company determines to be custodial. Custodial care is care which is furnished mainly to assist a person in the activities of daily living and for which professional skills or training is not required. Custodial care includes, but is not limited to, help in eating, getting out of bed, bathing, dressing, toileting and supervision in taking medications.

27. Charges for routine foot care, including trimming of corns and calluses, treatment of flat feet or partial dislocations in the feet.

28. Charges for confinement or treatment not completed in accordance with the attending Physician's orders.

29. Charges for eye exams or treatment for the correction of vision; orthoptic training, the provision or fitting of eyeglasses, contact lenses, or radial keratotomies (laser vision correction).

30. Charges for elective abortions.

31. Charges for prescription drugs, unless received as an inpatient.

32. Charges for organ or tissue donor expenses.

33. Charges for the acquisition cost of any organ or bodily element.

34. Coverage for organ transplants is not provided as a Non-Network benefit. Refer to The Plan's certificate of coverage for more information on coverage for organ transplants.

35. Charges for alternative medicine/therapy including but not limited to: 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.

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

37. Charges for private duty nursing.

38. Charges for penile implants.

39. Charges for Cardiac Rehabilitation, Phase III and Phase IV.

40. Charges for manual manipulation of the spine, including subluxation of the spine.

41. Charges for growth hormones or steroids used for growth and development.

42. Charges for non-emergency transportation.

PRIOR AUTHORIZATION

(Prior Authorization will not result in payment of benefits that would not otherwise be payable.)

We will utilize our clinical coverage guidelines, such as medical policy and other internally developed clinical guidelines, and preventive care clinical coverage guidelines, to assist in making our Medical Necessity decisions. These guidelines reflect the standards of practice and medical interventions identified as appropriate medical practice. We reserve the right to review and update these clinical coverage guidelines periodically. Your certificate and the employer Contract take precedence over these guidelines.

Certain services received by an Insured Person or Insured Dependent under the plan require the Insured Person, Insured Dependent, or the attending Physician, to receive prior authorization from The Plan prior to receiving the service. Prior Authorization is required for, but not limited to, the following list of services, procedures and equipment. A more comprehensive list can be found at www.paramountinsurancecompany.com.

If you obtain Prior Authorization, these services will be covered at the appropriate benefit level indicated in your Schedule of Benefits if it is Medically Necessary and/or a Covered Service. Prior Authorization is required to avoid a potential denial or reduction in payment of benefits.

Prior Authorization must be obtained by calling The Plan at 419-887-2549 or toll free 1-800-891-2549 before (preferably two weeks in advance) obtaining services.

A. Services requiring Prior Authorization not an all-inclusive listing, refer to www.paramounthealthcare.com/priorauth):

   i. Inpatient admission to a Hospital, Intensive Outpatient Programs (IOP), partial hospitalizations (PHP), and Inpatient admissions at rehabilitation/residential facilities; or
   ii. Inpatient admission to a Skilled Nursing Facility; or

iii. Home Health services; or
iv. Organ/Bone Marrow Transplant services.

B. Procedures requiring Prior Authorization not an all-inclusive listing, refer to www.paramounthealthcare.com/priorauth):
   i. Enhanced External Counterpulsation (EECP);
   ii. Prophylactic Mastectomy;
   iii Genetic, molecular diagnostic, and drug testing as identified in the above referenced list
   iv. Orthognathic and maxillofacial surgery
   v. All potentially cosmetic procedures including but not limited to eyelid surgery/lifts (blepharoplasty)
   vi. Cochlear implants
   vii. MRI and CT Imaging
   viii. New Technology (Medical & Behavioral Health Procedures, Diagnostics, Durable Medical Equipment);
   ix. Autism Treatment

C. Equipment requiring Prior Authorization not an all-inclusive listing, refer to www.paramounthealthcare.com/priorauth):
   i. Air fluidized beds;
   ii. Bone stimulators and supplies;
   iii. Power operated vehicles, power wheelchairs and power wheelchair accessories;
   iv. Chest wall oscillation vest (ThAIRapy Vest System);
   v. Enteral nutrition;
   vi. Speech generating devices
   vii. Continuous Blood Glucose Monitoring services – Long Term
   viii. Cranial orthotic remolding device.

If you do not obtain the required Prior Authorization, The Plan will conduct a retrospective review to determine if your care was Medically Necessary. You are responsible for all charges for services The Plan determines are not Medically Necessary.

If you ***do not obtain Prior Authorization*** and the services are Medically Necessary, any benefit payment for a ***facility fee (including inpatient facility services under Section Three, 2.A)*** will be reduced by $500 of the Allowable Amount. The services are then subject to the applicable Deductible, Copayment and/or Coinsurance. Financial penalties for failure to obtain Prior Authorization will count toward your Out-of-Pocket Maximum.

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

Non-urgent non-electronic Prior Authorization
When Prior Authorization is required in the case of a non-urgent non-electronic claim, The Plan will make a decision within two (2) working days from obtaining all the necessary information about the admission, or procedure that requires Prior Authorization. The Plan will advise the provider of the decision within three (3) working days after making the decision.

Urgent non-electronic Prior Authorization
In the case of an urgent non-electronic claim, The Plan will make a decision, and advise the claimant of its decision, as soon as possible, but not later than 72 hours after receipt of the claim. If insufficient information is received, The Plan will notify the claimant not later than 24 hours after receipt, of the specific information needed. The claimant will be afforded not less than 48 hours to provide the specified information. The Plan will provide a decision no later than 48 hours after the earlier of:

a) The Plan's receipt of the specified information
b) The end of the period afforded the claimant to provide the specified information.

Electronic Prior Authorization
The Plan will accept health care provider requests when received electronically. The Plan's response will be sent within forty-eight (48) hours of its receipt of the request for urgent care services, or within ten (10) calendar days of its receipt of the request for non-urgent care services. These timeframe requirements do not apply to emergency services. For electronically received determinations, urgent care services means a medical care or other service for a condition where application of the timeframe for making routine or non-life threatening care determinations is either of the following:

a) Could seriously jeopardize the life, health, or safety of the patient or others due to the patient's psychological state;

b) In the opinion of a practitioner with knowledge of the patient's medical or behavioral condition, would subject the patient to adverse health consequences without the care or treatment that is the subject of the request.

If the electronic request is incomplete, The Plan will indicate the specific additional information that is required to process the request within twenty-four (24) hours of receipt of the request. The health care provider must provide a receipt to The Plan acknowledging the request.

The Plan's response will indicate whether the request is approved or denied. If the request is denied, The Plan will provide the specific reason for the denial. The Insured may utilize the internal and external appeals process explained in this certificate to request review of this decision.

Concurrent Reviews
Concurrent reviews are requests to extend coverage that was previously approved for a specified length of time.

If The Plan reduces or terminates a course of treatment (other than by plan amendment or termination) before the end of such period of time or number of treatments, this constitutes an Adverse Benefit Determination. The Plan will notify the Insured (in cases where the Insured will have financial liability) and requesting provider of the Adverse Benefit Determination, in writing or electronically, at a time sufficiently in advance of that reduction or termination to allow the claimant to utilize the internal and external appeals process explained in this certificate to request review of this decision..

Any request that involves both urgent care and the extension of a course of treatment previously approved by The Plan must be decided as soon as possible, and notification must be provided within 24 hours after receipt of the claim, provided the request is made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

Any non-urgent request to extend a course of treatment previously approved by The Plan, the request may be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim, e.g., as a *pre-service claim* or a *post-service claim*.

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

If coverage is denied, the Insured may utilize the internal and external appeals process explained in this certificate to request review of this decision.

Retrospective review
A retrospective review is a request for The Plan to evaluate whether a health care service that the Insured has already received was Medically Necessary. For all retrospective reviews, The Plan will make a decision, and will notify the provider and the Insured of its decision, within thirty (30) business days after receiving the request for retrospective review. This period may be extended one time by The Plan for as many as fifteen (15) days, provided that The Plan determines such an extension is necessary due to matters beyond The Plan's control. If an extension is necessary, The Plan will notify the Insured, prior to

the expiration of the initial 30-day period, of the circumstances requiring an extension and of the date by which The Plan expects to render a decision.

Additionally, in the event that a claim is submitted for a service where Prior Authorization was required but not obtained, The Plan will permit a retrospective review of such claim if the service in question meets all of the following:

(i) The service is directly related to another service for which pre-approval has already been obtained and that has already been performed.
(ii) The new service was not known to be needed at the time the original pre-notified service was performed.
(iii) The need for the new service was revealed at the time the original authorized service was performed.

Once the written request and all necessary information are received, The Plan will review the claim for coverage and medical necessity. The Plan will not deny a claim for such a new service based solely on the fact that a Prior Authorization approval was not received for the new service in question.

The Plan will make a decision regarding the claim, and notify the Provider and the Insured of its decision within thirty (30) calendar days after receiving all necessary information.

ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION DATE

Reference your HMO certificate of coverage for details.

WHAT HAPPENS WITH YOUR PLAN

Reference your HMO certificate of coverage for details.

GENERAL PROVISIONS

TIME EFFECTIVE: The effective time for any dates used is 12:01 A.M. at the address of the Policyholder.

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

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

EXAM AND AUTOPSY: When reasonably necessary, the Company, at its own expense, may require medical exams of the person for whom claim is made or perform an autopsy if not forbidden by law.

MONEY PAYABLE: All sums payable by or to the Company must be paid in the lawful currency of the United States.

LIMITATION ON LEGAL ACTIONS: No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with

the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

PAYMENT OF CLAIMS: The Plan will make payment immediately upon, or within thirty days after, receipt of due written proof of loss.

CLAIM FORMS: For all Covered Services, a claim form or written proof of loss must be submitted to Paramount. Out-of-Network Providers may decline to submit claims to Paramount for You. In that case, it is Your responsibility to file appropriate claims in order to receive reimbursement from Paramount.

NOTICE OF CLAIM: Upon receipt of a notice of claim, The Plan will furnish to you the necessary forms for filing proof of loss. If such forms are not furnished within fifteen days after receiving notice, you shall be deemed to have complied with the requirements of this policy as to proof of loss submitting, within the time fixed in this policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

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

INTERNAL CLAIMS AND APPEALS PROCEDURES AND EXTERNAL REVIEW

Overview

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

Internal Claims and Appeals Procedures: When a health insurance plan denies a claim for a treatment or service (a claim for plan benefits, you have already received (*Post-Service Claim Denial*) or denies your request to authorize treatment or service (*Pre-Service Claim* denial), you, or someone you have authorized to speak on your behalf (an *Authorized Representative*), can request an appeal of the plan's decision. If the plan rescinds your coverage or denies your application for coverage, you may also appeal the plan's decision. When the plan receives your appeal, it is required to review its own decision. When the plan makes a claim decision, it is required to notify you (provide notice of an *Adverse Benefit Determination*). See **Definitions** section of this certificate for more information regarding an *Adverse Benefit Determination* and *Rescission* of coverage.

Notification of an *Adverse Benefit Determination* must include:

- The reasons for the plan's decision;
- Your right to appeal the claim decision
- Your right to request an external review; and

- The availability of a Consumer Assistance Program at The Ohio Department of Insurance.

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

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

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

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

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

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

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

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

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

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

Rescission of coverage: If the plan rescinds your coverage, you may file an appeal according to the following procedures. The plan cannot terminate your benefits until all of the appeals have been exhausted. Since *Rescission* of coverage is a cancellation or discontinuance of coverage that has retroactive effects,

if the plan's decision to rescind is upheld, you will be responsible for payment of all claims for your *Health Care Services*.

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

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

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

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

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

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

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

  Information sufficient to identify the claim involved, including the date of service, the Health Care Provider;

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

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

Other Resources to help you

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

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

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

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

INTERNAL CLAIMS AND APPEALS

An appeal will be between the Health Care Provider requesting the service in question and a clinical peer. If the appeal does not resolve the disagreement, either you or your Authorized Representative may request an external review.

Non-urgent, *Pre-Service Claim* denial

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

Urgent Pre-service Care claim denial

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

If the request for benefits is one *involving urgent care*, we will notify you of our decision as soon as possible, but no later than 72 hours after we receive your request.

Electronic Pre-service Non-urgent and Urgent Care claim denial

For electronic pre-service urgent care services, an appeal will be considered within forty-eight hours after receipt. Electronic pre-service appeals for non-urgent care services will be considered within ten calendar days of receipt.

Simultaneous Urgent appeal request and expedited internal review:

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

Additionally, you, or your *Authorized Representative*, may simultaneously request an expedited external review if both the following apply

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

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

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

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

Post-service appeal of a claim denial (retrospective)

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

EXTERNAL REVIEW

Right to External Review

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

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

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

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

The *Adverse Benefit Determination* involves a medical judgment or is based on any medical information

The Adverse Benefit Determination indicates the requested service is experimental or investigational, the requested health care service is not explicitly excluded in the *Covered Person's Health Benefit Plan*, and the treating physician certifies at least one of the following:

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

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

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

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

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

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

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

Non-urgent request for an external review

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

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

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

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

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

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

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

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

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

Expedited external review : You may have an expedited external review if your treating physician certifies that the *Adverse Benefit Determin*ation involves a medical condition that could seriously jeopardize your life or health , or would jeopardize your ability to regain maximum function if treated after the time frame for a standard external review; or the *Final Adverse Benefit Determination* concerns an admission, availability of care, continued stay, or health care service for which you received *Emergency Services*, but have not yet been discharged from a facility.

The request may be made orally or electronically by you or your Health Care Provider.

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

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

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

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

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

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

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

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

The IRO written notice must include the following information:

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

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

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

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

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

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

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

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

COORDINATION OF BENEFITS

The Coordination of Benefits (COB) provision applies when a person has health care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the primary plan. The primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all Plans does not exceed 100% of the total Allowable expense.

DEFINITIONS:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

- The Plan of the parent whose birthday falls earlier in the in the calendar year is the primary plan; or
- If both parents have the same birthday, the Plan that has Covered the parent the longest is the primary plan.
- However, if one spouse's plan has some other coordination rule (for example, a "gender rule" which says the father's plan always primary), This plan will follow the rules of that plan.

(b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

(i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the decree;

(ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;

(iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits;

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

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

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

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

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

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

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

EFFECT ON THE BENEFITS OF THIS PLAN:

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

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

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION: Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This plan and other plans. The 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. The Plan need not tell, or get consent of any person to do this. Each person claiming benefits under this plan must give The Plan any facts it needs to apply those rules and determine benefits payable.

FACILITY OF PAYMENT: A payment made under another plan may include an amount that should have been paid under this plan. If it does, The 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. The 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.

RIGHT OF RECOVERY: If the amount of the payments made by The 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.

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

REIMBURSEMENT AND SUBROGATION

REIMBURSEMENT AND SUBROGATION: Subject to ORC 2323.44, to the extent applicable:

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

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

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

Equitable Lien. The Plan's subrogation and reimbursement rights are a first party lien against any recovery and must be paid before any other claims, including claims by the covered person for damages (with the exception of claims by the covered person pursuant to the property damage provisions of any insurance policy). This lien is not offset or reduced in any way by the covered person's attorney fees or costs incurred in obtaining the recovery. The "common fund doctrine", "made whole" rule, or similar common law doctrines do not reduce or affect the Plan's subrogation and reimbursement rights. This means the covered person must reimburse the Plan, in an amount not to exceed the total recovery, even when the covered person's settlement or judgment is for less than the covered person's total damages and must be paid without any reductions for attorney fees. If less than the full value of the tort action is recovered for comparative negligence or by reason of the collectability of the full value of the claim for injury, death, or loss to person

resulting from limited liability insurance or any other cause, the subrogee's or other person's or entity's claim shall be diminished in the same proportion as the injured party's interest is diminished. Covered person agrees that Plan has the right to obtain injunctive relief prohibiting the covered person from accepting or receiving any settlement or other recovery relating to the expenses paid by the Plan until the Plan's right of subrogation and reimbursement are fully satisfied and covered person consents to such injunctive relief.

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

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

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

WORKERS' COMPENSATION/NON-DUPLICATION: The benefits which you are entitled to receive under the Company's insured plans do not duplicate any benefit to which you are entitled under Workers' Compensation laws or similar Employer liability laws. All sums paid for services provided to any Insured Person pursuant to Workers' Compensation are deemed to be assigned to the Company.

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

COOPERATION BY EMPLOYER: By executing the Group Policy, the Employer agrees to assist the Company in obtaining the necessary information from covered employees as may be required and to do whatever is necessary to effectuate and protect fully the rights of the Company or its nominee under this Section.

GENERAL DEFINITIONS

The following terms have special meaning throughout the certificate.

ADVERSE BENEFIT DETERMINATION: Means a decision by a Health Plan Issuer:

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

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

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

(3) To rescind coverage on a Health Benefit Plan. See definition of rescission in this section.

AUTHORIZED REPRESENTATIVE: Means an individual who represents a you in an internal appeal or external review process of an Adverse Benefit Determination who is any of the following:

(1) A person to whom a covered individual has given express, written consent to represent that individual in an internal appeals process or external review process of an adverse benefit determination;
(2) A person authorized by law to provide substituted consent for a covered individual;
(3) A family member or treating Health Care Professional, but only when you are unable to provide consent.

AUTISM SPECTRUM DISORDER: Means any of the pervasive developmental disorders or autism spectrum disorder as defined by the most recent edition of the diagnostic and statistical manual of mental disorders published by the American psychiatric association available at the time an individual is first evaluated for suspected developmental delay.

BIOLOGICALLY BASED MENTAL ILLNESS: Biologically Based Mental Illness as defined by ORC 3923.281, (A), (1) 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.

BOARD AND ROOM: Means any charges made by a Hospital on its own behalf for necessary medical services and supplies actually administered during any Hospital Confinement.

BODY ORGAN: Means 1) kidney; 2) heart; 3) lung; 4) heart and lung together; 5) liver; 6) pancreas (when the condition is not treatable by use of insulin therapy); 7) bone marrow; 8) kidney - pancreas; 9) cornea; or bowel.

CLINICAL PEER: Means a Physician who may evaluate the clinical appropriateness of services provided by another Physician. If services are provided by a provider who is not a Physician, it means a Physician or provider holding the same license as the provider of the services.

CLAIM INVOLVING URGENT CARE: Means any claim for medical care or treatment with respect to the application of the time periods for making non-urgent care determinations

- Could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or,

- In the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment is the subject of the claim.

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

CLINICAL THERAPEUTIC INTERVENTION: Means therapies supported by empirical evidence, which include, but are not limited to, applied behavioral analysis, that satisfy both of the following: (a) Are necessary to develop, maintain, or restore, to the maximum extent practicable, the function of an individual; (b) Are provided by or under the supervision of any of the following: (i) A certified Ohio behavior analyst as defined in section 4783.01 of the Revised Code; (ii) An individual licensed under Chapter 4732 of the Revised Code to practice psychology; (iii) An individual licensed under Chapter 4757. of the Revised Code to practice professional counseling, social work, or marriage and family therapy.

CLINICAL TRIAL: Means a research investigation in which people volunteer to test new treatments, interventions or tests as a means to prevent, detect, treat or manage various diseases or medical conditions.

COINSURANCE: The fixed percentage of charges that you must pay toward the cost of certain Covered Expenses. See your Schedule of Insurance to determine whether a service requires a Coinsurance payment and the amount for that service.

CONTRACT YEAR: Means a period of time: 1) beginning with the Group Policy Effective Date of any year and terminating on the same date of the succeeding year or 2) a calendar year. If the Group Policy Effective Date is February 29, such date will be considered to be February 28 in any year having no such date.

COPAYMENT: The fixed dollar amount you must pay each time you receive certain Covered Expenses. See your Schedule of Benefits for a list of those services that require Copayments. Copayments for specific dollar amounts are due and payable at the time services are provided.

COVERED BENEFITS: Means those health care services to which a covered person is entitled under the terms of a health benefit plan.

COVERED PERSON: Means a policyholder, subscriber, enrollee, member, or individual covered by a health benefit plan. "Covered person" does include the covered person's authorized representative with regard to an internal appeal or external review.

DEDUCTIBLE: The Deductible which each Insured Person or Insured Dependent must satisfy each Contract Year prior to receiving benefits for Covered Expenses is shown in the Schedule of Insurance. Deductible amounts incurred for services by a Non-Network provider will apply to the Non-Network Deductible only. Deductible amounts incurred for services by a Network provider will apply to the Network Deductible only. Any amount by which a Provider's billed charges exceed the NCA or UCR amount will not be counted toward satisfying the Insured's Deductible.

DE MINIMIS: Means some something not important; something so minor that it can be ignored.

DEPENDENT: Means any member of an Insured's family who meets all of the applicable eligibility requirements stated in this certificate, **Eligibility, Effective Date, And Termination Date**, who has enrolled in the Flex plan, and for whom the required payment has actually been received.

DURABLE MEDICAL EQUIPMENT: Means equipment which is: 1) prescribed by a Physician as essential in the treatment of the Injury or Sickness; 2) able to withstand repeated use; 3) not useful generally to an individual in the absence of an Injury or Sickness; and 4) manufactured or sold by a medical supply company. The term does not include: artificial aids; hearing aids; repair or replacement of prosthetic devices; exercise equipment; support devices; shoes, shoe molds and inserts, bite plates, dental braces or retainers for TMJ treatment; disposable medical supplies except for diabetic supplies; TENS units; or wigs.

EMERGENCY SERVICES: Means the following:

a) A medical screening examination, as required by federal law, that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department, to evaluate an Emergency Medical Condition;

b) Such further medical examination and treatment that are required by federal law to Stabilize

an Emergency Medical Condition and are within the capabilities of the staff and facilities available at the hospital, including any trauma and the burn center of the hospital.

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

a) Placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;

b) Serious impairment to bodily functions;

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

When Emergency Services are required, you should be evaluated at the emergency room of a Hospital. You may call 911 or your local emergency telephone number. Your Plan covers Emergency Services for an Emergency Medical Condition treated in any hospital emergency department. The Plan will cover Emergency Services at nonparticipating facilities such that the insured will not be balance billed.

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:

1) placing the health of the covered person or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;
2) serious impairment of bodily functions,
3) serious dysfunction of any bodily organ or part.

EXPERIMENTAL/ INVESTIGATIONAL: Is Any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which we determine to be Experimental/Investigative is not covered. We will deem any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental/Investigative using evidence-based criteria as defined in this certificate.

EXTENDED CARE OR SKILLED NURSING FACILITY: Means an institution or a distinct part thereof, including an intermediate nursing facility, which:

1. is licensed pursuant to state and local laws;
2. is operated primarily for the purpose of providing skilled nursing care and treatment for individuals convalescing from Injury or Sickness;
3. is approved by and is a participating facility with Medicare;
4. has organized facilities for medical treatment;
5. provides 24-hour-a-day nursing service under the full-time supervision of a Physician or Registered Nurse;
6. maintains daily clinical records on each patient;
7. has available the services of a Physician under an established agreement;
8. provides appropriate methods for dispensing and administering drugs and medicines;
9. has transfer arrangements with one or more Hospitals; a utilization review plan in effect; and operational policies developed with the advice of and reviewed by a professional group including at least one Physician; and
10. is not an institution which is mainly a rest home or a home for the aged.

FINAL ADVERSE BENEFIT DETERMINATION: Means an adverse benefit determination that is upheld at the completion of a Health Plan Issuer's internal appeals process.

FREE-STANDING SURGICAL FACILITY: Means a legally operated institution which:

1. has permanent operating rooms;
2. has at least one recovery room;
3. has all necessary equipment for use before, during and after surgery;
4. is supervised by an organized medical staff, including Registered Nurses available for care in an operating or recovery room;
5. has a contract with at least one nearby Hospital for immediate acceptance of patients who require Hospital care following care in the Free-Standing Surgical Facility;
6. is other than: a) a private office or clinic of one or more Physicians; or b) part of a Hospital; and
7. requires that admission and discharge take place within the same working day.

HEALTH BENEFIT PLAN: Means a policy, contract, certificate, or agreement offered by a *Health Plan Issuer* to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

HEALTH CARE PROFESSIONAL: Means a physician, psychologist, nurse practitioner, physician assistant or other health care practitioner licensed, accredited, or certified to perform health care services consistent with state law.

HEALTH CARE SERVICES: Means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

HEALTH PLAN ISSUER: Means an entity subject to the insurance laws and rules of this state, or subject to the jurisdiction of the superintendent of insurance, that contracts, or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services under a health benefit plan, including a sickness and accident insurance company, a health insuring corporation, a fraternal benefit society, a self-funded multiple employer welfare arrangement, or a nonfederal, government health plan. "Health plan issuer" includes a third party administrator to the extent that the benefits that such an entity is contracted to administer under a health benefit plan are subject to the insurance laws and rules of this state or subject to the jurisdiction of the superintendent.

HOME HEALTH CARE: Means services provided by a public or private agency that provides skilled nursing functions or activities in the Insured Person's or Insured Dependent's home. The services must be provided by an agency that is licensed as such (or if no license is required, approved as such) by a state department or agency having authority over home health agencies.

HOSPICE: Means a facility operated by a Hospital or other licensed health care institution. It is not a convalescent home; a nursing home; or an Extended Care or Skilled Nursing Facility or similar institution. Its purpose is to provide an alternative environment with palliative and supportive care for terminally ill patients either directly or on a consulting basis with the patient's Physician or another community agency, such as a visiting nurses' association. For purposes hereof, a terminally ill patient is any patient whose life expectancy, as determined by a Physician, is not greater than 6 months.

HOSPITAL: Means an institution which:

1. is legally operated in the jurisdiction where it is located;
2. is engaged mainly in providing inpatient medical care and treatment for Injury and Sickness in return for compensation;
3. has organized facilities for diagnosis and major surgery on its premises;
4. is supervised by a staff of at least two Physicians;
5. has 24-hour-a-day nursing service by Registered Nurses; and
6. is not a facility specializing in dentistry; or an institution which is mainly a rest home; a home for the aged; a convalescent home; a nursing home; or an Extended Care or Skilled Nursing Facility or similar institution.

HOSPITAL CONFINEMENT: Means being registered as a bed patient in a Hospital upon the recommendation of a Physician.

INDEPENDENT REVIEW ORGANIZATION (IRO): Means an entity that is accredited to conduct independent external reviews of adverse benefit determinations.

INJURY: Means accidental bodily Injury of an Insured Person or Insured Dependent.

INSURED DEPENDENT: Means a Dependent whose insurance under the Group Policy: 1) became effective; and 2) has not terminated.

INSURED MEMBERS OF A FAMILY: Means an Insured Person or any of his or her Insured Dependents.

INSURED PERSON: Means an eligible employee or Subscriber whose insurance under the Group Policy: 1) became effective; and 2) has not terminated.

INTENSIVE CARE UNIT: Means a section, ward or wing within the Hospital which:

1. is separated from other Hospital facilities;
2. is operated exclusively for the purpose of providing professional care and treatment for critically ill patients;
3. has special supplies and equipment necessary for such care and treatment available on a standby basis for immediate use;
4. provides Board and Room; and
5. provides constant observation and care by Registered Nurses or other specially trained Hospital personnel.

LICENSED PRACTICAL NURSE: Means an individual who has received: 1) specialized nursing training; and 2) practical nursing experience. He or she is licensed to perform nursing service by the state in which he or she performs such service. This definition will include licensed vocational nurses with the above qualifications.

MEDICALLY NECESSARY: means the service you receive must be:

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

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

MEDICARE: Means Parts A and B of the United States Social Security Act, Title XVIII, including amendments.

NETWORK: Means the Physicians, Hospitals and other providers who are under contract with The Plan to provide medical services to enrollees of the NWOBA MEWA HMO. These providers are listed in the The Plan Provider Directory.

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.

NON-NETWORK: Means Physicians, Hospitals and other providers who are not part of the The Plan's Network.

NONPARTICIPATING PROVIDER: Means an organization, Physician, or Hospital that, at the time Covered Expenses are incurred, does not have a contract with The Plan.

OUT-OF-POCKET MAXIMUM: Means the maximum amount of expenses the Insured Person or Insured Dependent may incur each Contract Year as shown in the Schedule of Insurance. The Out-of-Pocket Maximum of one family member will not exceed that of an individual annual out-of-pocket maximum amount. Coinsurance expenses incurred for services by a Non-Network provider will apply to the Non-Network Out-of-Pocket Maximum only. Coinsurance expenses incurred for services by a Network provider will apply to the Network Out-of-Pocket Maximum only. The insured members will continue to have coinsurance and copay responsibilities after the deductible has been satisfied. Expenses paid due to failure to comply with Prior Authorization requirements and the amount by which billed charges exceed NCA or UCR, will not count toward the Out-of-Pocket Maximum.

PARTICIPATING PROVIDER: Means an organization, Physician, or Hospital that, at the time Covered Expenses are incurred has contracted with The Plan to provide medical care to Insured Persons and Insured Dependents and is listed in the most current Provider Directory then available from the employer.

PERCENTAGE PAYABLE: Means that percentage of Covered Expenses to be paid by the Company as shown in the Schedule of Insurance.

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

POST-SERVICE CLAIM: Means any claim for a benefit under a group health plan that is not a "pre-service claim.

PRE-SERVICE CLAIM: Means any claim for a benefit under a group health plan, with respect to which the terms of the plan condition receipt of the benefit, in completely or in part, on approval of the benefit in advance of obtaining medical care.

PRIMARY CARE PHYSICIAN (PCP): Means a Physician who is under contract with The Plan, who is designated as a Primary Care Physician responsible for managing and coordinating the full scope of an Insured Person's or Insured Dependent'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 an Insured Person's or Insured Dependent's hospitalization or other services when appropriate and who meets all the requirements for Primary Care Physicians as specified by The Plan.

PRIOR AUTHORIZATION: (Also known as Pre-Certification, Authorization, Certification, or Pre-Authorization): The process of obtaining authorization prior to the Insured Person receiving services. The purpose of the Prior Authorization function is for The Plan to determine insured eligibility, benefit coverage, medical necessity, location and appropriateness of services. Prior Authorization is required for certain procedures and services.

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

RESCISSION or to "rescind": Means a cancellation or discontinuance of coverage that has a retroactive

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

RETROSPECTIVE REVIEW: Means a review conducted after services have been provided to a covered person.

SCHEDULE OF BENEFITS: Provides information on the limits and maximums of the plan and Deductible, Copayment, and Coinsurance amounts that you must pay and explains the specific program the Employer has purchased.

REGISTERED NURSE: Means a professional nurse who has the right to use the title Registered Nurse (R.N.) in the state in which services are provided.

SEMIPRIVATE ROOM RATE: In the case of a Hospital which does not have semiprivate accommodations: the standard daily Semiprivate Room Rate will, for purposes of this benefit, be 80% of the daily charges for regular Hospital services at its lowest rate for private accommodations.

SICKNESS: Means illness or a disease of an Insured Person or Insured Dependent. Sickness will include congenital defects or birth abnormalities.

STABILIZE: Means the provision of such medical treatment as may be necessary to assure, within reasonable medical probability that no material deterioration of a covered person's medical condition is likely to result from or occur during a transfer, if the medical condition could result in any of the following:

• Placing the health of the covered person or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;

Serious impairment to bodily functions;
Serious dysfunction of any bodily organ or part.

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

SUBSCRIBER: Means an Insured Person who meets all applicable eligibility requirements, is employed by an employer who has a contract in effect with The Plan, and enrolls with an employer as the subscriber.

SUPERINTENDENT: Means the superintendent of insurance.

TELEHEALTH: Health care services provided through the use of information and communication technology by a Health Care Professional, within the professional's scope of practice, who is located at a site other than the site where either of the recipient following is located:

- The patient receiving the services;
- Another Health Care Professional with whom the provider of the services is consulting regarding the patient.

URGENT CARE CENTER: Means a facility operated to provide health care services for an unexpected Injury or Sickness. It is not part of a Hospital. Medical diagnosis or care is required soon after the injury or Sickness appears. The Injury or Sickness is not permanently disabling or life threatening. This includes but is not limited to: 1) persistent high fever; 2) a cold or 3) a sprain.

USUAL, CUSTOMARY, AND REASONABLE (UCR): The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.