# NORTHWEST OHIO BUSINESS ALLIANCE MEWA

## 2 Level Maximum Choice

# CERTIFICATE OF COVERAGE

### NOTICE CONCERNING COORDINATION OF BENEFITS (COB)

**IF YOU OR YOUR FAMILY MEMBERS ARE COVERED BY MORE THAN ONE HEALTH CARE PLAN, YOU MAY NOT BE ABLE TO COLLECT BENEFITS FROM BOTH PLANS. EACH PLAN MAY REQUIRE YOU TO FOLLOW ITS RULES OR USE SPECIFIC DOCTORS AND HOSPITALS, AND IT MAY BE IMPOSSIBLE TO COMPLY WITH BOTH PLANS AT THE SAME TIME. READ ALL OF THE RULES VERY CAREFULLY, INCLUDING THE COORDINATION OF BENEFITS SECTION, AND COMPARE THEM WITH THE RULES OF ANY OTHER PLAN THAT COVERS YOU OR YOUR FAMILY.**

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

**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:**

ܫܝܫ ܐܝܬ ܠܟ ܕܒܪܝܬ ܐܢ ,ܐܝܬ ܠܟ ܕܒܪܝܬ ܐܢ ܫܝܫ :ܐܫܘܪ
ܫܝܫ ܐܝܬ ܠܟ ܕܒܪܝܬ ܐܢ ܫܝܫ .ܐܝܬ ܠܟ ܕܒܪܝܬ ܐܢ ܫܝܫ ,ܐܝܬ ܠܟ ܕܒܪܝܬ ܐܢ ܫܝܫ
1-800-462-3589 ,ܐܢ .ܫܝܫ ܐܝܬ ܠܟ ܕܒܪܝܬ ܐܢ ܫܝܫ .ܐܝܬ ܠܟ ܕܒܪܝܬ ܐܢ ܫܝܫ
(TTY:711) ܐܢ ܫܝܫ ܐܝܬ ܠܟ ܕܒܪܝܬ ܐܢ ܫܝܫ .

**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**

Paramount 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.

Paramount 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 Paramount 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 Paramount's website: www.paramounthealthcare.com

## TABLE OF CONTENTS

## INTRODUCTION

This booklet, referred to as a Certificate of Coverage, including the accompanying Schedule of Benefits is provided to describe the Plan. This Certificate of Coverage has been issued to You as part of the contract between The Plan and the Employer electing to sponsor this Plan. To determine Your benefits for a specific service, You should refer to both this Certificate of Coverage and Your Schedule of Benefits. **You should check both sources for information about the Plan because this Certificate of Coverage presents information about the basic Plan, while the Schedule of Benefits explains the specific benefits provided to You by Your Employer under the Northwestern Ohio Business Alliance MEWA.** Questions regarding Your Plan can also be directed to the Claims Administrator Member Services Departments at; (419)887-2531 or toll-free at 1-866-452-6128.

The Definition Section of this booklet lists the definitions of key terms used in this Certificate of Coverage and Your Schedule of Benefits. Capitalized terms are defined at the end of the Certificate of Coverage.

## SECTION ONE: ELIGIBILITY AND EFFECTIVE DATE

1. **Eligibility**. Eligibility for Plan enrollment will **not** be conditioned on past, present, or future health status, medical condition, or need for Medical Care.

A. **Eligible Employee**. In order to be eligible under The Plan, an employee must be:

(1) Eligible to participate in the Employer's health benefits program under the written benefits eligibility policies of the Employer.

(2) Considered a bona fide employee employed on a permanent basis and working a minimum average of 20 hours per week or such other minimum average that is approved by The Plan;

(3) Actively working or retired employee, enrolled in and eligible for Medicare Part A and B, if the Employer has elected to offer Medicare-primary coverage in accordance with Medicare Secondary Payer Rules and the Employer maintains active employee benefits; and

(4) Not enrolled in any other of the Employer's health benefits plans.

**B. Eligibility for Plan** attached to a Health Savings Account:

a. An employee must be enrolled in a High Deductible Health Plan,

b. Not claimed as a Dependent on another person's tax return,

c. Not covered by any other health plan (except some limited coverages), and

d. Not eligible for Medicare.

Former employees of the Employer Contracting with The Plan who have elected to continue group coverage in accordance with state or federal law may also be eligible. Contact the Employer's personnel or benefits office for further information about eligibility.

**C. Eligible Dependent**. If the employee is eligible for family coverage, he or she also may wish to cover one or more of his or her eligible dependents. The following persons are eligible dependents, provided that they meet any additional eligibility requirements of the Employer:

(1) The employee's legal spouse; or
(2) Any child of the employee or employee's legal spouse who is married or unmarried under the age of twenty-six (26) regardless of student status, and who meet eligibility requirements.

Child includes: any natural children, legally adopted children, children for whom the employee is the legal guardian, stepchildren who are dependent upon the employee for support, and children for whom the employee is the proposed adoptive parent and is legally obligated for total or partial support during the Waiting Period prior to the adoption becoming final. Foster children are not included. The Plan may require proof of dependency.

**D. Extension of Coverage for Older Children.** Coverage for a covered dependent child may be continued beyond the maximum dependent eligibility ages, under the following situations:

(1) The child is incapable of self-support due to intellectual disability or physical handicap; and primarily dependent upon the employee for support and

maintenance.

This disability must have started before the covered dependent age limit was reached and must be medically certified by a Physician. You must notify Your Employer of the disabled dependent's desire to continue coverage prior to or within 31 days of reaching the limiting age. You and Your Physician must complete and sign a form that will provide Your Employer with information that will be used to evaluate eligibility for such disabled dependent status. You may also be required to periodically provide current proof of intellectual disability or physical handicap and dependence, but not more often than annually after the first two years. To obtain the form required to establish disabled dependent status, please contact a Claims Administrator Member Services representative at (419) 887-2531 or toll-free at 1-866-452-6128.

2. **Enrollment**. Eligible employees and eligible dependents may enroll in he Plan as follows.

A. **Initial Election Period**. An Election Period will be held prior to the Effective Date of this Plan. An eligible employee and his or her eligible dependents may choose between this Plan and any other health

care benefit plans offered by the Employer during this time, and may enroll in he Plan.

B. **Subsequent Election Period.** An eligible employee and his or her eligible dependents may enroll during any subsequent annual Election Period.

C. **Marriage, Birth, Placement for Adoption, or Adoption**. An eligible employee and his or her eligible dependents may enroll within 31 calendar days of the employee's marriage or the birth, placement for adoption, or adoption of the employee's dependent child. The only other times an eligible employee may enroll an eligible dependent child are during the Employer's open enrollment period or during a special enrollment period.

A newborn dependent child is automatically covered at birth for 31 calendar days for injury or sickness, including Medically Necessary care and treatment of congenital defects and birth abnormalities. To continue coverage for a newborn child beyond the 31-day period, any required additional premium payment must be received within the first thirty-one (31) days following the birth. If appropriate payment is not received, the newborn child will not be eligible for any further benefits after the thirty-one days following the birth.

If a covered dependent child gives birth, the newborn grandchild will not be covered unless the employee adopts or assumes legal guardianship of the child.

When placed for adoption, a child is covered only for the period of time the employee is legally obligated to provide partial or full support for the child.

If an employee acquires a child by birth, placement for adoption, or adoption, the employee (if not already enrolled) and his or her spouse and child may enroll. An eligible employee must enroll or already be enrolled in order for the spouse and/or child to enroll. The eligible employee may enroll even if the child does not enroll.

D. **Special Enrollment Period** If an eligible employee declines enrollment for themselves or their dependents (including their spouse) because of other health insurance coverage, the employee may in the future be able to enroll themselves or their dependents in this Plan, provided that the employee requests enrollment within 31 days after other coverage ends because (1) there is a loss of eligibility for group health plan coverage or health insurance coverage and (2) termination of Employer contributions toward group health plan coverage. Examples of reasons for loss of eligibility include: legal separation, divorce, death of an employee, termination or reduction in hours of employment – voluntary or involuntary (with or without electing COBRA), exhaustion of COBRA, "aging out" under other parent's coverage, moving out of an HMO's service area, and meeting or exceeding lifetime limit on all benefits.

Loss of eligibility for coverage does not include loss due to the individual's failure to pay premiums or termination of coverage for cause, such as fraud.

Loss of eligibility also includes termination of Medicaid or Children's Health Insurance Program (CHIP) coverage and the eligibility for Employment Assistance under Medicaid or CHIP. To be eligible for this special enrollment the employee must request coverage within 60 days after the date the employee or dependent becomes eligible for premium assistance under Medicaid or CHIP or the date the employee or the dependent's Medicaid or CHIP coverage ends.

In addition, if the employee has a new dependent as a result of marriage, birth, adoption, or placement for adoption, the employee may be able to enroll themselves and their dependents, provided that the employee requests enrollment for a dependent spouse within 31 days after the marriage, or remits any necessary additional premium payment within 31 days of the birth, adoption, or placement for adoption of a dependent child.

E. **Newly Eligible**. An eligible employee and his or her eligible dependents may enroll within 31 calendar days of first becoming eligible because the employee is newly hired or newly in the class of employees to which coverage under this Plan is offered (e.g., union vs. non- union employee, employee living in a particular region, part-time employee vs. full-time employee).

F. **Legal Guardianship**. An eligible dependent may be enrolled within 31 calendar days of the date a covered employee assumes legal guardianship.

G. **Court Ordered Coverage**. If a covered or eligible employee is required by a court or administrative order to provide health care coverage for his or her child, and the child is an eligible dependent, the employee may enroll the child without regard to any enrollment period restrictions. If the employee is not already enrolled, he or she must enroll with the child.

If a covered employee fails to enroll the child, the Claims Administrator will enroll the child upon application of the child's other parent or pursuant to an order.

Covered dependents enrolled under this provision may not be terminated (while the employee remains a covered employee) unless the Employer has eliminated family coverage for all of its employees or Your Employer is provided satisfactory written evidence that the court or administrative order is no longer in effect or the child is or will be enrolled under comparable health care coverage provided by another health insurer, to take effect no later than the date of termination under this Plan.

3. **Effective Date**. Coverage begins on the date specified below, so long as the NWOBA Health and Wellness Trust receives payment of the applicable funding rate and a completed enrollment application on behalf of each eligible person to be enrolled in the Plan.

A. **New Hire Policy**. Coverage for eligible employees and those eligible dependents who enroll simultaneously with the eligible employee during the initial or subsequent yearly Election Period is effective in accordance with the New Hire Policy of the Employer. The Waiting Period will not exceed 90 days.

B. **Marriage, Birth Adoption, or Placement for Adoption**. If an eligible employee and/or eligible dependent(s) enrolls because of marriage, birth, adoption, or placement for adoption pursuant to Paragraph
2.C. of this section, coverage is effective as follows:

(1) In the case of marriage, on the date of a legal marriage if a completed enrollment application is received by Your Employer and transmitted to the Claims Administrator within 31 days of the marriage date.

(2) In the case of birth, as of the date of such birth if a completed enrollment application is received by Your Employer and transmitted to the Claims Administrator within 31 days of the birth date; or

(3) In the case of adoption or placement for adoption, the date of adoption or placement for adoption if a completed enrollment application is received by Your Employer and transmitted to the Claims Administrator within 31 days of the date of adoption or placement for adoption.

C. **Special Enrollment Period - Loss of Other Coverage**. If an eligible employee and/or eligible dependent(s) enrolls because of loss of other coverage pursuant to Paragraph 2.D. of this section, coverage is effective on the day following the Effective Date of termination of other coverage if a completed enrollment application is received by Your Employer and transmitted to the Claims Administrator within 31 days of the termination of other coverage.

D. **Newly Eligible**. If an eligible employee and/or eligible dependent(s) enrolls because of newly acquired eligibility pursuant to Paragraph 2.E. of this section, coverage is effective in accordance with the Employer's New Hire Policy. Please contact Your Employer's benefits office for details.

E. **Late Enrollment.** An eligible employee or dependent who did not request enrollment for coverage during the Initial Election Period, or Special Enrollment Period, or a newly eligible dependent who failed to qualify during the Special Enrollment Period and did not enroll within 31 days of the date during which the individual was first entitled to enroll, is considered a Late Enrollee and may only apply for coverage as a Late Enrollee during the Group's Subsequent Election Period.

4. **Terms**. Once enrolled as described in this section, an eligible employee is known as a "covered employee" and an eligible dependent is known as a "covered dependent." A "Covered Person" is a defined term meaning a covered employee or covered dependent. Whenever used in this Certificate of Coverage, "You" or "Your" means a Covered Person.

5. **Pre-Existing Conditions**. This Plan does not include any restrictions on Pre-Existing Conditions. In other words, if You were being treated for a condition before You became a Covered Person, The Plan will provide benefits for Covered Services related to that condition on or after Your Effective Date with The Plan.

6. **Termination of Coverage**.

A. **Employee**. Coverage for You or Your dependents will not be terminated due to health status, health care needs or the exercise of rights under the Plan's internal review procedures. However, a person will not be eligible to re-enroll if they are terminated for any of the reasons listed in this section.

A covered employee's coverage and that of his or her covered dependents will end (subject to Section Two, Continuation of Coverage) on the earliest of the following dates:

(1) The last calendar day of the month in which the covered employee terminates employment, unless the employer's contract with the Claims Administrator provides for a different termination date;

(2) The last calendar day of the month in which the covered employee ceases to be eligible for coverage, unless the employer's contract with the Claims Administrator provides for a different termination date;

(3) The last calendar day of the month preceding the first day of the next month

for which any required funding rate for employee coverage has not been made, unless the employer's contract with the Claims Administrator provides for a different termination date;

(4) The date he Plan is terminated or employee coverage is terminated; or

(5) The date of the covered employee's death.

B. **Dependent**. Coverage for a covered dependent will end (subject to Section Two, Continuation of Coverage) on the earliest of the following dates:

(1) The last calendar day of the month in which the covered dependent becomes ineligible for coverage under the Plan, unless the employer's contract with the Claims Administrator provides for a different termination date;

(2) The date of the death of the covered dependent;

(3) The date dependent coverage terminates or the Plan terminates; or

(4) The last calendar day of the month preceding the first calendar day of the next month for which the required funding rate for dependent coverage has not been made, unless the employer's contract with the Claims Administrator provides for a different termination date.

C. **Termination for Cause**. Your coverage may be terminated or rescinded* for cause upon 30 calendar days prior written notice if You:

(1) Do not make any required payment of the applicable funding rate; or

(2) Perform any act or practice that constitutes fraud or an intentional misrepresentation of material fact under the terms of coverage, including without limitation:

a. Allowing the use of Your Identification card by any other person using another Covered Person's card;

b. Providing untrue, incorrect, or incomplete information on behalf of Yourself or another Covered Person in the application for this Plan, which constitutes an intentional material misrepresentation. You will be responsible for paying charges for all Covered Services provided to You that are related to such untrue, incorrect, or incomplete information; and

c. Committing intentional fraud, forgery, or other deception related to enrollment or coverage. You will be responsible for paying charges for all Covered Services provided to You from the date You were enrolled in the Plan.

*A Rescission of Your coverage means that the coverage may be legally voided all the way back to the day the Plan began to provide You with coverage, just as if You never had coverage under the Plan. Your coverage can only be rescinded if You (or a person seeking coverage on Your behalf), performs an act, practice, or omission that constitutes fraud; or unless You (or a person seeking coverage on Your behalf) makes an intentional misrepresentation of material fact, as prohibited by the terms of Your Plan. Your coverage can also be rescinded due to such an act, practice, omission or intentional misrepresentation by Your Employer.

You will be provided with thirty (30) calendar days' advance notice before Your coverage is rescinded. You have the right to request an internal appeal of a Rescission of Your coverage. Once the internal appeal process is exhausted, You have the additional right to

request an independent external review.

D. **Plan Termination**. Coverage under the Plan may be renewed each year at the option of the Employer; provided that, NWOBA may terminate or non-renew the Employer's participation for one or more of the following reasons:

(1) Failure to pay the required funding rate on time;

(2) Fraud or intentional misrepresentation of a material fact by the Employer in connection with such coverage;

(3) Failure to comply with any contribution and participation requirements;

(4) If there is no longer a Covered Person who lives, resides, or works in the state of Ohio; or

(5) If the membership of the Employer in an association (on the basis of which coverage is provided) ceases.

(6) When the Claims Administrator discontinues offering this Plan in the Large Group market, as applicable, in Ohio and:

a. The Claims Administrator will provide notice to each Employer and Covered Person provided coverage under this Plan in the Large Group Market, as applicable, of such discontinuation at least 90 calendar days prior to the date of discontinuation of such coverage;

b. The Claims Administrator offers each Employer provided coverage in the Large Group Market, as applicable, under this Plan the option to purchase other coverage currently being offered by the Claims Administrator to an Employer or union sponsored Health Benefit Plan in such market(s); and

c. In exercising the option to discontinue coverage of this type and in offering the option of other coverage under this provision, the Claims Administrator acts uniformly without regard to claims experience of those Employers or the health status of any Covered Persons or eligible employees or dependents; or

d. When the Claims Administrator discontinues offering coverage in the Large Group Market in Ohio and after Paramount provides notice to the Ohio Department of Insurance and each Employer and its Covered Persons in the applicable market(s) of such discontinuation at least 180 calendar days prior to the date of discontinuation of such coverage.

7. **Nondiscrimination** No one who is eligible to enroll or renew as a Subscriber, Dependent or Dependent with disabilities will be refused enrollment based on student status, health status related factor, Pre-Existing Condition, genetic testing or the results of such testing, health care needs or age. Coverage for You or Your Dependents will not be terminated due to health status, health care needs or the exercise of rights under the Plan's internal review procedures. However, the Claims Administrator will not re-enroll anyone terminated for any of the reasons listed in the Termination of Coverage section.

## SECTION TWO: CONTINUATION OF COVERAGE

1. **Continuation of Coverage Under COBRA.** If Your coverage under the Plan would otherwise end, You may be eligible for continuation of coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), as amended, or under other federal or state laws.

The Employer's benefits administrator will coordinate continuation of coverage. To obtain specific details and to arrange for continuation of health care benefits, the covered employee should contact the Employer's benefits office.

2. **Continuation of Coverage Under Ohio State Law (if Your Employer is exempt from the Consolidated Omnibus Budget Reconciliation Act of 1985 "COBRA")**. You may continue group coverage for a period of 12 months following the covered employee's termination of employment if the covered employee:

A. Has been covered under any coverage for at least 3 months preceding

the date his or her employment was terminated.

B. Did not voluntarily terminate their employment and the termination of employment is not the result of gross misconduct on the part of the employee; and

C. Is not eligible for or covered by:

(1) Medicare; or

(2) Any other insured or uninsured arrangement that provides Hospital, surgical, or medical coverage.

3. **Continuation of Coverage During Military Service**. Group coverage may be continued, if You are absent from work due to U.S. military service. You may elect to continue coverage (including coverage for Your dependents) for up to a maximum of 24 months. Covered dependents may continue coverage for up to 36 months if any of the following events occurs during the 24 month period:

a. The death of the reservist.
b. The divorce or separation of a reservist from the reservist's spouse.
c. A covered Dependent Child's eligibility under this coverage ends.

The continuation period will begin on the date coverage would have terminated because the reservist was called to active duty. The subscriber and/or Dependent must complete and return to the employer an election form within 31 days of the date coverage would terminate. The subscriber and/or Dependent must pay any required contribution to the employer not to exceed 102% of the group rate.

Continuation coverage will end on the date any of the following occurs:

a. The subscriber or Dependent becomes covered by another group plan without any pre- existing condition restriction.
b. The maximum period of months expires.
c. The subscriber or Dependent does not make the required payment.
d. The group's participation in NWOBA MEWA is terminated.

Whether or not You continue coverage during military service, You may reinstate coverage under the Plan
on Your return to employment provided You continue to meet the Plan eligibility requirements.

Your reinstatement under the Plan will be without any pre-existing condition exclusion. If You dropped coverage for Your dependents under the Plan, they may re-enter the Plan with You subject to the Plan's Special Enrollment rules.

4. **Continuation of Coverage During Family and Medical Leaves of Absence**. You may be eligible for continuation coverage if You are absent from work for periods of time covered under the Family and Medical Leave Act of 1993 (FMLA). The Employer's benefits administrator will coordinate continuation of coverage. To obtain specific details and to arrange for continuation of health care benefits, You should contact Your Employer's benefits office.

5. **Other Approved Leave of Absence or Disability**. You may be eligible for continuation of coverage during an approved leave of absence of disability that causes You to be absent from work. To obtain specific details and to arrange for continuation of health care benefits, You should contact Your Employer's benefits office.

NOTICE: If You elect COBRA continuation coverage, and the provisions of this Certificate of Coverage are changed or revised, the Claims Administrator will notify the employer 31 days before the changes become effective. It is the responsibility of the Employer to notify You. If the

funding rate continues to be made, Your Employer will assume that You have accepted the changes. If You do not consent to the changes, You may end Your coverage by notifying the Employer in writing. Any change in the funding rate, which resulted from a change or revision to the provisions of this Certificate of Coverage, will be made in accordance with the Employer's Application and Participation Agreement with NWOBA.

6. **Continuity of Care.** If your provider or facility's Paramount agreement terminates, Paramount 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. Paramount 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 Paramount 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.

## SECTION THREE: HOW THE MAXIMUM CHOICE PLAN WORKS

1. **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. Paramount 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 Department 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.

2. **Health Care Reimbursement Choices**. This Maximum Choice Plan provides You with two (2) flexible choices for reimbursement any time Covered Services are required. The amount paid for the care You receive depends upon whether care is received from an "In-Network" or "Out-of-Network" Provider.

To receive In-Network benefits, You may seek care from any Preferred Provider Organization (PPO) In- Network Provider when You require medical services. As an alternative, care may be sought from an Out-of- Network Provider.

**In-Network Option** – You may seek care from any In-Network Provider. You must satisfy the Deductible under the In-Network option before any benefits will be paid and Your share of the cost for services will be lower compared to obtaining service from Out-of-Network Providers. Pre-authorization from the Claims Administrator is required for certain services. Preventive Health Services are not subject to the Deductible.

To receive benefits under the In-Network Option, You must use In-Network (Paramount Preferred Options) Providers and facilities to obtain Covered Services, except Emergency Services. **It is Your responsibility to ensure that Covered Services are obtained from In-Network Providers and facilities to be eligible for coverage under the In-Network Option.**

**Out-of-Network Option** – You may seek care from Providers outside the Network. You must satisfy the Deductible under the Out-of-Network option before any benefits will be paid and Your share of the cost for services will be higher. You are also required to obtain pre-authorization from the Claims Administrator for certain services.

**Special Note on Out-of-Network Providers.** Except in the case of Emergency Services rendered by an Out- of-Network Provider, or for Out-of-Network Hospital Providers in Lucas County, the Plan pays for benefits based on the lesser of the Non-Contracting Amount (NCA) that is determined payable by the Plan or the actual charge for the service. For all other Out-of- Network Hospitals, Physicians/Providers, the Plan pays for benefits based on the lesser of the Usual, Customary and Reasonable (UCR) Charge or the actual charge for the service. For Emergency Services provided by an Out-of-Network Provider, please see "Coverage for Emergency Services" in this section.

If the charge billed is greater than the NCA or the Usual, Customary and Reasonable (UCR)

Charge, You must pay the excess portion, also called balance billing. For Covered Services rendered Out-of-Network, Deductibles, Coinsurance and benefit maximums are based on the lesser of the NCA, the UCR Charge or the actual charge for the service. The portion of Out-of-Network amounts in excess of the UCR Charge is not applied toward the maximum out-of-pocket expense for the calendar year.

**Example** (assumes the Deductible has already been met):

| | |
|---|---|
| Out-of-Network Provider charge: | $1,000 |
| NCA or UCR limit: | $700 |
| Plan pays 70% of $700: | $490 |
| You pay 30% Coinsurance: | $210 |
| Plus balance of charge above $700 | $300 |
| Your total cost: | $510 |

In this example, only the Coinsurance of $210 would count toward the maximum out-of-pocket expense for the calendar year. When considering using Out-of-Network Providers, You should verify the limitations that may apply to the charges. If the Out-of-Network Provider has waived any portion of Your required Coinsurance payment, Your total cost would be calculated by subtracting the waived Coinsurance from the amount that You were billed by the Provider.

**Benefit Limits** - Some benefits described in this Certificate of Coverage are limited, may vary, or require payment of additional amounts. Please refer to the Schedule of Benefits and to the specific conditions, limitations, exclusions, and/or payment levels that are set forth in the section which describes that benefit in detail and in Section Ten, Exclusions, for a description of services and supplies that are not covered under this Plan. Always call the Claims Administrator at 419-887-2531 or toll-free 1-866-452-6128 if You have any questions about specific conditions, limitations, exclusions, or payment levels.

3. **Pre-Authorization**

The Plan 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/Medically Indicated decisions. These guidelines reflect the standards of practice and medical interventions identified as appropriate medical practice. The Plan reserves the right to review and update these clinical coverage guidelines periodically. Your Certificate takes precedence over these guidelines.

Pre-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.paramounthealthcare.com/priorauth.

Even if You obtain a referral, **pre- authorization is always required before obtaining the above services, procedures and equipment.** If You obtain pre-authorization, these services, procedures and equipment will be covered at the appropriate benefit level indicated in Your Schedule of Benefits if it is Medically Necessary and/or a Covered Service. Pre-authorization is required to avoid a potential reduction in payment of benefits.

Pre-Authorization must be obtained by calling the Claims Administrator at 419-887-2549 or toll free 1- 800-891-2549 (preferably two weeks in advance) before obtaining any of the following.

A. Services requiring pre-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 pre-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 bariatric surgery, 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 pre-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
ix. Orthotics/prosthetics and DME beyond benefit limits
x. Hearing aids/Bone-Anchored Hearing Aids (BAHA)

If You do not obtain the required pre-authorization, a Retrospective Review will be conducted to determine if Your care was Medically Necessary. You are responsible for all charges for services that are not Medically Necessary.

If You ***do not obtain pre-authorization*** and the services are Medically Necessary, any benefit payment for a ***facility fee (including Inpatient facility services under Section Three)*** 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 pre-authorization for care received In-Network will count toward Your Out-of-Pocket Maximum. Financial penalties for care received Out-of-Network will not count toward the Out-of-Pocket Maximum. Also see Transplant Benefit Penalty.

For Emergency admissions to a Hospital or Skilled Nursing Facility, You do not have to obtain pre-authorization in advance. However, You, a family member, or Your Physician must notify the Claims Administrator 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 claim**
When Pre-authorization is required in the case of a non-urgent non-electronic claim, the Claims Administrator will make a decision, and notify you of its decision, within fifteen (15) working days from receipt of the claim that requires Pre-authorization. If circumstances beyond the Claims Administrator's control require that this period be extended, the Claims Administrator may extend this period for up to fifteen (15) days. The Claims Administrator will notify you prior to the expiration of the initial 15-day period of the circumstances requiring the extension of time and the date by which Claims Administrator expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and you will be afforded at least forty-five (45) days from receipt of the notice within which to provide the specified information.

**Urgent non-electronic claim**
In the case of an urgent non-electronic claim, Claims Administrator will make a decision, and advise the claimant of its decision, as soon as possible, but not later than seventy-two (72) hours after receipt of the claim. If insufficient information is received, Claims Administrator will notify the claimant not later than twenty-four (24) hours after receipt, of the specific information needed. The claimant will be afforded not less than forty-eight (48) hours to provide the specified information. Claims Administrator will provide a decision no later than forty-eight (48) hours after the earlier of:

a) Claims Administrator receipt of the specified information
b) The end of the period afforded the claimant to provide the specified information.

**Electronic claims**
Claims Administrator will accept health care provider requests when received electronically. Claims Administrator'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 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, Claims Administrator 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 Claims Administrator acknowledging the request.

Claims Administrator's response will indicate whether the request is approved or denied. If the request is denied, Claims Administrator will provide the specific reason for the denial. If You disagree with Claims Administrator's determinations, You may appeal Claims Administrator's decision by following the appeal procedure set forth in Section Thirteen, Internal Claims and Appeals Procedures and External Review.

**Remember that You must obtain pre-authorization from Claims Administrator before You obtain the services, procedures and equipment listed above.**

**Concurrent Reviews**
Concurrent reviews are requests to extend coverage that was previously approved for a specified length of time.
If Claims Administrator 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. Claims Administrator 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 Claims Administrator must be decided as soon as possible, and notification must be provided within twenty-four (24) hours after receipt of the claim, provided the request is made at least twenty-four (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 Claims Administrator, the request may be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim, e.g., as a *pre-service claim* or a *post-service claim*.

If requests are not made at least twenty-four (24) hours prior to the expiration of the prescribed period of time or number of treatments, the request must be treated as a *claim involving urgent care* and decided in accordance with the urgent care claim timeframes, e.g., as soon as possible, taking into account the medical emergencies, but not later than seventy-two (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 Claims Administrator to evaluate whether a health care service that the Insured has already received was Medically Necessary. For all retrospective reviews, Claims Administrator 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 Claims Administrator for as many as fifteen (15) days, provided that Claims Administrator determines such an extension is necessary due to matters beyond Claims Administrator's control. If an extension is necessary, Claims Administrator 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 Claims Administrator expects to render a decision.

Additionally, in the event that a claim is submitted for a service where Pre-Authorization was required but not obtained, Claims Administrator will permit a retrospective review of such a 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.

If the claim meets all three conditions, , Claims Administrator will review the claim for coverage and medical necessity once the written request and all necessary information are received. Claims Administrator will not deny a claim for such a new service based solely on the fact that a pre-authorization approval was not received for the new service in question.

Claims Administrator 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 on retrospective reviews.

4. **The Preferred Provider Organization (PPO) Network**. The PPO Network Directory lists all Physicians and other Providers who are part of the PPO Network. The PPO Network Directory will be updated periodically and you may access the PPO Network Directory at; www.paramounthealthcare.com. Or by calling the Claims Administrator Member Service Department at (419) 887-2531 or toll-free 1-866-452-6128.

In-Network Physicians include family practitioners, internists, and pediatricians whom You may select to provide primary care. In-Network specialists include obstetrician/gynecologists, oncologists, cardiologists, orthopedists, and other designated specialists. Other In-Network Providers include psychiatrists and psychologists who provide mental Health Care Services, drug abuse and alcohol abuse treatment.

Please note that a provider's designation as an In-Network Providers should not, in any case, be understood as a guarantee or a warranty of the appropriateness and/or adequacy of the Medical Care rendered by such Provider. In-Network Providers are independent Contractors and are not employees or agents of NWOBA, the Claims Administrator or the Employer. The selection of an In-

Network Provider or any other Provider, and the decision to receive or decline to receive Health Care Services is **Your responsibility**. Health care decisions are made solely by You in consultation with Your Health Care Providers. Health Care Providers are solely responsible for patient care and related clinical decisions once You make Your health care decision.

5. **Filing Claims**. For all Covered Services, a claim form or written proof of loss must be submitted to Claims Administrator. In-Network Providers will submit the required claim forms to Claims Administrator for You. You must show Your identification card to the In-Network Provider. **In-Network Hospitals, Physicians and Providers have agreed to limit their charges through their Contracts with the PPO Network.**

   Out-of-Network Providers may decline to submit claims to Claims Administrator for You. In that case, it is Your responsibility to file appropriate claims in order to receive reimbursement.

   Upon receipt of a notice of claim, Claims Administrator 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 under this plan, the Claims Administrator 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 Claims Administrator, Claims Administrator may request additional medical or other information necessary to process the claim. The claimant must respond to a written request from Claims Administrator 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.

   **Payment of claims:** The Plan will make a payment immediately upon, or within thirty days after, receipt of due written proof of loss.

   **In most cases, reimbursement for Covered Services will be sent directly to the Provider, but in some cases, the Plan may choose to send reimbursement to You.** If You pay for the Covered Services You may request reimbursement from the Plan. Claim forms are available from the Employer's personnel or benefits office or by calling the Claims Administrator Member Services Department at (419) 887-2531 or toll-free 1-866-452-6128**.**

   **Explanation of Benefits (EOB):** After a claim has been filed with Claims Administrator, You will receive an Explanation of Benefits (EOB). The EOB is a summary of the coverage for that claim. The EOB is not a bill, but a statement from Claims Administrator to help You understand the coverage You are receiving. The EOB shows:
   - Total amount charged for services/supplies received;
   - The amount of the charges paid by the Plan; and
   - The amount for which You are responsible (if any).

6. **Payments under This Plan**. Your share in the cost of Covered Services may include a Deductible, Copayment, and Coinsurance as shown in the Schedule of Benefits.

   A. The amount You and Your Dependents must pay for Covered Services including Prescription Drugs within a calendar year, before any benefits will be paid by the Plan. See Your Schedule of Benefits for the Deductible amount that applies to You and Your Dependents. If You have single coverage (self only), the single Deductible is the amount You must pay. If You have family coverage (two or more covered family members), the family Deductible is the total amount any **two** or more covered family members must pay. The Deductible amount of one family member will not exceed that of an individual annual Deductible maximum

amount. Preventive Health Services are not subject to the Deductible. A plan will only be used as a High Deductible Health Plan (HDHP) with a Health Savings Account (HSA) when it follows the minimum and maximum limits for a HDHP. See **Definitions** section of this certificate for more information regarding an HDHP and HSA.

The expenses incurred for Covered Services from In-Network and Out-of- Network Providers including Prescription Drugs] apply to the Deductible.

B. **Copayment.** The fixed dollar amount You must pay each time You receive certain Covered Services. See Your Schedule of Benefits for Copayments that apply to You and Your Dependents.

C. **Coinsurance.** The fixed percentage of charges You must pay toward the cost of certain Covered Services. See Your Schedule of Benefits to determine whether a service requires a Coinsurance payment and the amount for that service. Coinsurance on benefits received from In-Network Providers is a percentage of the Contract charge negotiated between the PPO Network and the Provider. This means that You receive the benefit of any discount. Coinsurance on benefits received from Out-of- Network Providers is a percentage of the NCA or UCR charge that the Plan will pay for the services rendered.

**Special Note**: Deductible, Copayments and Coinsurance are an important part of this benefit plan's design. You are required to make these payments to be eligible for reimbursement.

D. **Out-of-Pocket Maximum**. Your Out-of-Pocket Maximum is stated in Your Schedule of Benefits. After that amount has been paid, there will be no additional Cost Sharing during the remainder of that calendar year. The Out-of-Pocket Maximum is the maximum amount of Copayments and Coinsurance including medical and prescription drug Deductibles (if any) paid by a Covered Person in a calendar year. The single Out-of-Pocket Maximum is the amount each Member must pay, and the family Out- of-Pocket Maximum is the total amount any two or more covered family members must pay. The Out- of-Pocket Maximum of one family member will not exceed that of an individual annual Out-of-Pocket Maximum amount. The following ***do not*** apply to the Out- of-Pocket Maximum:

- Financial penalties imposed for failure to obtain required pre-authorization for care received Out-of-Network;
- Non-Network charges in excess of NCA or UCR.

The expenses incurred for Covered Services received from In-Network Providers apply toward satisfying the In- Network **Out-of-Pocket Maximum** and the expenses incurred for Covered Services received from. Out-of-Network Providers apply toward satisfying the In-Network and Out-of-Network **Out-of-Pocket Maximums**. The expenses incurred for Covered Services received from In-Network and Out- of-Network Providers apply toward satisfaction of the **Out-of-Pocket Maximum**.

7. **Medically Necessary**. Covered Services must be Medically Necessary (see the Definition Section). Claims Administrator will determine what is Medically Necessary after considering the advice of trained medical professionals. The fact that Your Provider prescribed the care or service does not automatically mean that the care is Medically Necessary or that it qualifies for coverage.

   Examples of care which are <u>not</u> Medically Necessary include without limitation: Inpatient Hospital admission for care that could have been provided safely either in a doctor's office or on an Outpatient basis; a Hospital stay longer than is Medically Necessary to treat Your condition; or a surgical procedure performed instead of a medical treatment which could have achieved equally satisfactory management of Your condition.

   **The Plan will not make any payment for care which is not Medically Necessary.**

**8. Coverage for Emergency Services**. If You have an Emergency Medical Condition, You may seek Emergency Services (see the Definition Section) 24 hours a day and 7 days a week at the nearest

health care facility. An Emergency Medical Condition is 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 individual or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

Paramount will cover Emergency Services from non-Participating Providers for Emergency Medical Conditions meeting the definition in this Certificate of Coverage. 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. Appropriate Copayments/Coinsurance will be applicable. Please contact Paramount Member Services if you receive a balance bill for services for Emergency Medical Conditions when treated or transported by Non-Participating Providers.

The application of benefits explained above for Emergency Services received from Out-of-Network Providers is limited to Emergency Services required before You can, without medically harmful results, return to the care of In-Network Providers. Please see Section Five: HOSPITAL CARE in this certificate.

## SECTION FOUR: MEDICAL SERVICES

**Covered Medical Services.** The Plan will provide benefits for the Medically Necessary services described in this section when they are performed or ordered by a licensed Physician. The level of benefits for these services will depend on whether these services are obtained through In-Network or Out-of-Network Providers.

1. **Physician Office Visit Fees.** A Copayment and/or Coinsurance must be paid for each office or home visit with an In-Network or Out-of-Network Physician. Please refer to the Schedule of Benefits for details.

2. **Physician Office Visit Coverage.** You are entitled to benefits for the following services at a Physician's office:

   A. **Diagnosis and Treatment:** Services of Physicians and other medical personnel for diagnosis and treatment of disease, injury, or other conditions; and Urgent Care Services and Emergency Services provided 24 hours a day and 7 days a week. This includes surgical procedures performed in a Physician's office and consultations with specialists. Non Covered Services include, but are not limited to communications used for:

   - Reporting normal lab or other test results
   - Office appointment requests
   - Billing, insurance coverage or payment questions
   - Requests for referrals to doctors outside the online care panel
   - Benefit precertification

   B. **Allergy Tests and Treatment:** Allergy tests which are performed and related to a specific diagnosis. Desensitization treatments are also covered.

   C. **X-Ray and Laboratory Services:** X-ray and laboratory tests and services when ordered by a Physician. This includes prescribed diagnostic X-rays, electrocardiograms, laboratory tests and diagnostic clinical isotope services.

   D. **Physical and Occupational Therapy:** Physical and occupational therapy services, up to the maximum indicated in Your Schedule of Benefits.

   E. **Speech Therapy:** Speech and speech therapy services for medical conditions up to the maximum indicated in Your Schedule of Benefits. This does not include non-medical conditions such as stuttering, lisping, articulation disorders, tongue thrust and delayed onset of speech.

   F. **Radiation Therapy and Chemotherapy.**

G. **Medications Used in The Physician's Office:** Short-term medications (e.g., antibiotics, steroids, etc.), injectables, radioactive materials, dressings and casts, administered or applied by a Physician or other Provider in the Physician's office for preventive or therapeutic purposes.

H. **Second Surgical Opinion.**

I. **Spinal Manipulation Services:** Spinal manipulation services up to the annual maximum indicated in the Schedule of Benefits.

J. **Preventive Health Services:** Please refer to Your Schedule of Benefits for coverage levels. The level of benefits will depend on whether care is obtained through In-Network or Out-of-Network Providers. Preventive Health Services will be payable without a Copayment, Coinsurance or Deductible when services are delivered by an In-Network Provider. Deductible, Copayment and Coinsurance can be applied for Preventive Health Services provided Out-of-Network. If You use an Out-of-Network Provider, You may be responsible for additional charges up to and including the balance of the amount billed as outlined in SECTION THREE: HOW THE MAXIMUM CHOICE PLAN WORKS. For a comprehensive list of preventive services, please visit www.hhs.gov/healthcare/prevention/index.html.

Preventive Health Services include:

1. Services with an "A" or "B" rating from the United States Preventive Services Task Force.

   Examples of these services are screenings for:

   a. Breast cancer mammography screenings;
   b. Cervical cancer;
   c. Colorectal cancer;
   d. High Blood Pressure;
   e. Type 2 Diabetes Mellitus;
   f. Cholesterol;
   g. Child and Adult Obesity;
   h. Tobacco Cessation Programs, see below for coverage.

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

3. 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

4. Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration including:

   a. All FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling for women with reproductive capacity, as prescribed by a health care provider. The Plan must cover without cost sharing at least one form of contraception within each method the FDA has identified. Within each contraceptive method, the Plan may use reasonable medical management techniques to control costs and promote efficient delivery of care. For example, the Plan may discourage use of brand name pharmacy items over generic pharmacy items by imposing cost sharing for brand name pharmacy items. See Section Four, **COVERED SERVICES**, for the Standard & Expedited Exceptions Process under bullet 18, Prescription Drug Benefits for the contraceptive exception process. If your attending provider recommends a particular service or FDA-approved item based on medical necessity, Claims Administrator will defer to the determination of the provider and cover that particular service or item without cost sharing.

b. Breastfeeding support, supplies, and counseling. Benefits for breast pumps are limited to one pump per benefit period.

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/).

You will be notified, at least sixty (60) days in advance, if any item or service is removed from the list of eligible services. Eligible services will be updated annually to include any new recommendations or guidelines.

In addition to the services with an "A" or "B" rating from the United States Preventive Services Task Force, the Plan also covers the following services:

- 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.

K. **Habilitative Services**: Are health care services and devices that help a person keep, learn, or improve skills and functioning for daily living. Coverage is provided for the screening, diagnosis, and treatment of Autism Spectrum Disorder (ASD) for Covered Persons under the age of twenty-one (21), and at a minimum includes:

1. 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. Claims Administrator may review the treatment plan annually or more frequently if Claims Administrator 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

L. **Dental Services**. The following procedures performed by a dentist or oral surgeon are covered when benefits are not available under a separate 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:

- initial first aid treatment received within 72 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;
- treatment for tumors and cysts (including pathological examination) of the jaws, cheeks, lips, tongue, roof and floor of the mouth; or
- repair of fractures and dislocations.

M. **Telehealth Services.** When 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 following is located:

1. The patient receiving the services;
2. 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.

N. **Mammography.** Coverage for mammography includes:
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%).

3. **Visits to an Urgent Care Center.** If Your Physician is not available, diagnosis and treatment may be obtained from an urgent care center for the sudden occurrence of a condition that requires medical attention without delay, but that does not pose a threat to Your life, limb or permanent health.

4. **Medical Services While Hospitalized.** During any period of covered hospitalization the following are covered:

A. **Surgery** includes:

1. The performance of generally accepted operative and other invasive procedures;
2. The correction of fractures and dislocations;
3. Usual and related preoperative and post-operative care: and
4. Other procedures as reasonably approved by Claims Administrator.

The Plan will also cover medical and surgical procedures for:

1. Correction of functional defect or functional impairment which results from an acquired and/or congenital disease or injury; and
2. Reconstructive surgery to correct congenital malformations or anomalies resulting in a functional defect or functional impairment of a covered child 19 or younger; and
3. Breast reconstruction following a covered mastectomy including:
   a. Reconstruction of the breast on which the mastectomy was performed;
   b. Surgery and construction of the other breast to produce a symmetrical appearance; and
   c. Prostheses and physical complication during all stages of the mastectomy, including lyphedemas.

The Plan will not cover surgery for the purpose of improving physical appearance other than what is specifically provided for in this section (See Section Ten, Exclusions, Cosmetic or Plastic Surgery).

The benefit amount payable for surgery includes payment for related care by the surgeon before and after the operation. In other words, the one payment covers the operation and the surgeon's care before and after the operation.

Payment for surgery is also subject to the following limitation: When multiple surgical procedures are performed at the same operative session, the Plan will cover the major or first procedure at the level of reimbursement in the Schedule of Benefits, depending on whether these services are performed by In-Network or Out-of-Network Providers. The Plan will cover the lesser or subsequent surgical procedures at one-half of the payment otherwise payable.

B. **Medical Visits in a Hospital:** Medical visits by a Physician while You are a registered Inpatient in a Hospital. The medical visits are for the care of illnesses or conditions other than those related to surgery or maternity care.

C. **Complication in a Hospital:** Services of a second Physician in a Hospital when You have an Exceptional Complication during the course of surgery, maternity, or Inpatient Hospital care. An "Exceptional Complication" is a condition which is not related to the condition for which You were admitted to the Hospital, or a condition which is so unusual that it requires more than the customary surgical, maternity, or Medical Care.

D. **Anesthesia in a Hospital:** A Physician's administration of anesthesia in connection with surgery or maternity care. However, no payment will be made if the Physician who administers the anesthesia also performs the care, or assists the Physician who performs the care, and receives payment for that care.

E. **Consultations in a Hospital:** Consultation by a Physician who is called in by Your Physician if both the following conditions are met:

1. The consulting Physician is a Specialist Physician in Your illness or disease; and
2. The consultation takes place while You are a registered Inpatient in a Hospital.

F. **Diagnostic X-rays:** Diagnostic x-rays performed by, or on the order of, Your Physician to diagnose a condition or illness for which You showed symptoms.

G. **Radiation Services:** Radiation services performed by, or on the order of, Your Physician to diagnose a condition or illness for which You showed symptoms.

H. **Laboratory Services:** Laboratory test performed by, or on the order of, Your Physician.

5. **Services at Home:** These services include:

A. **Home Visits by a Physician:** A home visit (house call) by a Physician who provides care to You in Your home or other place of residence.

B. **Home Health Care by Home Health Agency Personnel:** Visits by home health agency personnel in Your home or other place of residence, up to a maximum indicated in the Schedule of Benefits. If home health care is recommended, Claims Administrator must approve benefits for such care in advance. If You obtain pre-authorization, these services, procedures and equipment will be covered at the appropriate benefit level indicated in Your Schedule of Benefits. Pre- authorization is required to avoid a potential reduction of benefits.

If You do not obtain the required pre-authorization, a Retrospective Review will be done to determine if Your care was Medically Necessary. You are responsible for all charges for services Claims Administrator determines are not Medically Necessary.

Home health care includes any of the following:

1. Part-time or intermittent home nursing care by or under the supervision of a registered nurse;
2. Part-time or intermittent home health aide services which consist primarily of caring for You under the supervision of a registered nurse; and
3. Skilled treatments performed by licensed or certified home health agency personnel, including the non-prescription medical supplies and drugs used or furnished during a visit

by home health agency personnel. Non-prescription medical supplies and drugs may include surgical dressings and saline solutions, but do not include prescription drugs, certain intravenous solutions, or insulin.

Each visit by a member of a home care team is counted as one home care visit. Four hours of home health aide service are counted as one home care visit.

C. **Oxygen and Oxygen Related Equipment:** These items are covered when ordered by a Physician.

6. **Medical Supplies.** These items are covered when ordered by a Physician, supplied by a Physician, supplier or pharmacy and are eligible under Medicare Part B guidelines and limits, with the exception of Outpatient prescription drugs covered by Medicare Part B. However, certain diabetic and asthmatic
supplies may be covered under a separate program administered through a pharmacy benefit. See Limited Medical Supply Rider for details.

Medical supplies are small and often disposable items that are part of medical treatment for an illness or injury. The supply must be compatible with the diagnosis and generally must not be useful in the absence of illness or injury for which it is used.

7. **Durable Medical Equipment (DME).** These items are covered when ordered by a Physician, supplied by a Physician, supplier or pharmacy and if such equipment would be considered Medically Necessary under Medicare Part B guidelines. However, certain diabetic and asthmatic equipment may be covered under a separate program administered through a pharmacy benefit. See Limited Medical Supply Rider for details.

**Benefits will be subject to the Coinsurance amount and/or Benefit Limit indicated in the Schedule of Benefits.**

Claims Administrator will determine whether the item should be purchased or rented. At all times the maximum benefit for an item of eligible DME is the purchase price of the equipment. The purchase of a duplicate DME item will be limited to once every 24 months. Certain equipment requires pre- authorization. See Section Three.

8. **Prosthetic Devices**. These items are covered when ordered by a Physician, supplied by a Physician, supplier or pharmacy and eligible under Medicare Part B guidelines. **Benefits will be subject to the Coinsurance amount and/or Benefit Limit indicated in the Schedule of Benefits.**

   Prosthetic devices are appliances which replace all or part of an absent body part, or replace all or part of the function of a permanently inoperable or malfunctioning body part. Repair and replacement of prosthetic devices is covered subject to Medicare Part B guidelines.

9. **Clinical Trial.** Coverage is provided to a qualified individual (as defined under PHS Act section 2709(b)) 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 another 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.

   With respect to a Clinical Trial, 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.

   For clinical trials, "life-threatening disease or condition" means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted. 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.

10. **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.

## SECTION FIVE: HOSPITAL CARE

The level of benefits for these services will depend on whether these services are obtained through In-Network or Out-of-Network Providers. ***Covered Services must be Medically Necessary (see the Definition Section).***

When You receive Inpatient Hospital Services (except for Emergency Services) You must obtain pre-authorization before the benefits will be made available. If You obtain pre-authorization, these services, procedures and equipment will be covered at the appropriate benefit level indicated in Your Schedule of Benefits. Pre-authorization is required to avoid a potential reduction in payment of benefits.

If You do not obtain the required pre-authorization, a Retrospective Review will be done to determine if Your care was Medically Necessary. You are responsible for all charges for services Claims Administrator determines are not Medically Necessary.

If You ***do not obtain pre-authorization*** and the services are Medically Necessary, any benefit payment for a ***facility fee (including Inpatient facility services under Section Three)*** 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 pre-authorization for care received In-Network will count toward Your Out-of-Pocket Maximum. Financial penalties for care received Out-of-Network will not count toward Your Out-of-Pocket Maximum.

1. **Acute Care General Hospital:** The Plan will pay for Covered Services at the most common charge for semi-private accommodations in an acute care general Hospital. An acute care general Hospital is a licensed institution primarily engaged in providing: Inpatient diagnostic and treatment services for surgical and medical patients; treatment and care of injured and sick persons by or under the supervision of Physicians; and 24 hour nursing service by or under the supervision of registered nurses.

2. **Inpatient Care in a Hospital:** The Plan will pay for services customarily furnished by an acute care general Hospital when You are a registered Inpatient in such Hospital. Your share of the cost will vary depending on whether care is obtained from an In-Network or Out-of-Network Hospital.

3. **Hospital Services:** The Plan will pay for services customarily furnished in an acute care general Hospital such as room and board, nursing care, medical social work, pharmacy services and supplies, diagnostic laboratory tests, operating room charges, and labor and delivery room charges.

   As a general rule, services are not covered Hospital services unless the following conditions are met: The service is provided by an employee of the Hospital, the Hospital bills for the service, and Hospital retains the payment collected for the service.

4. **Visits to the Emergency Room:** An emergency room Copayment and Coinsurance must be paid as indicated in the Schedule of Benefits for each visit to a Hospital emergency room. If You are admitted to the Hospital from the emergency room, the emergency room Copayment will be waived. If You have an Emergency Medical Condition, dial 911 for assistance or go to the nearest Hospital emergency room. Refer to Section Five: Hospital Care for information regarding Ambulance Services.

5. **Outpatient Care in a Hospital:** The Plan will pay for the Covered Services provided to You

in the Outpatient department of a Hospital if equivalent services would also be covered on an Inpatient basis.

The Plan will also pay the facility's charges for Covered Services provided in a health center, diagnostic center, or treatment center which is licensed under appropriate state law. These facilities are sometimes called birthing centers, ambulatory surgical centers or hemodialysis centers. However, regardless of the name of the facility, payments will be made only if the facility possesses all licenses, permits, certifications and approvals required by applicable state, local, and federal law. Your share of the cost will vary depending on whether care is obtained from an In-Network or Out-of-Network Provider.

6. **Care in a Skilled Nursing Facility or Rehabilitation or Residential Facility:** Covered Services include care in a Skilled Nursing Facility or rehabilitation or residential facility subject to the maximum benefit indicated in the Schedule of Benefits. Your share of the cost will vary depending on whether care is obtained from an In-Network or Out-of-Network Facility.

7. **Receiving Care from Hospital-Based Providers:** Hospitals employ many Physicians and other Providers, such as emergency room Physicians, radiologists, pathologists and anesthesiologists, who only serve patients in the Hospital. The PPO Network has Contracts with a vast majority of Hospital-based Physicians. These Contracts mean the services will be paid under In-Network benefits and protects the Covered Person from being balanced billed. Protection against balance billing means the Covered Person will not receive a bill for the difference between the Provider's charge and the fee that the In-Network pays for that service. However, there are cases where the Network has been unable to secure a Contract with a Hospital-based Physician or Provider. The following would only apply if the insured selects care from an out-of-network Hospital. If the care is provided by an out-of-network provider at an in-nerwork hospital, the patient cannot be balance billed.

8. **Ambulance Service:** Covered Services include the use of a licensed motor vehicle or air ambulance which charges a fee for its service if:

   A. Because of an accident or sudden Emergency Medical Condition, it is necessary to transport You in an ambulance to the closest Hospital that is medically equipped to provide treatment for Your condition;
   B. It is necessary to transport You from a Hospital where You are an Inpatient to another Hospital because;

      1. The first Hospital lacks the equipment or expertise necessary to care for You properly and You are admitted as an Inpatient to the other Hospital; or
      2. You are taken to another Hospital to receive a test or service which is not available at the Hospital where You have been admitted, and You return after the test or service is completed; or
      3. The first Hospital is not an In-Network Hospital, and You are taken to an In-Network Hospital after Your condition has stabilized.

   C. You are transported directly from a Hospital where You were an Inpatient to a Skilled Nursing Facility where You are then admitted as a patient.

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.

## SECTION SIX: MENTAL HEALTH / SUBSTANCE USE DISORDER

Treatment of mental health and substance use disorder benefits provided under Your Plan must comply with section 2726 of Public Health Service Act, as amended, and any applicable implementing regulations.

**Mental Health/Substance Use Disorder.** Inpatient and Outpatient services and emergency care for the treatment of mental health and substance abuse disorders are covered subject to the same terms, Deductible**,** Copayments and/or Coinsurance, plan standards and medical management processes to which those Covered Services would be subject if delivered as medical/surgical benefit. This includes intermediate levels of care such as residential treatment, partial hospitalization and intensive Outpatient services. Refer to Section Four: Covered Services and Section Five: Hospital Services. The level of benefits for these services will depend on whether these services are obtained through In-Network or Out-of-Network Providers.

**Determination of Appropriate Levels of Treatment.** In determining the appropriate levels of treatment, Claims Administrator considers:

A. The intensity and scope of care necessary to meet the standard of Medical Necessity through an appropriate treatment plan that supports problem-focused treatment; and

B. The least restrictive environment that will provide appropriate care for You and Your family and offers the opportunity for independent functioning.

**NOTE:** See Section Ten: EXCLUSIONS, Mental Illness*/Substance Abuse Services*.

**Opioid Utilization Management Citeria:** Our CDC-aligned opioid UM criteria helps maintain appropriate clinical access and supports limits on duration and dose:

7-Day Supply for Acute Pain
- Length of the first fill limited to seven days when appropriate, for new prescriptions for immediate-release (IR) opioids, for members without claims history of prior opioid use
- Higher day supply provided with prior authorization (PA) and/or when coverage conditions are met

Morphine Milligram Equivalent (MME) Based Quantity Limits
- New initial limits for obtaining opioids without PA up to 90 MME/day (based on 30-day supply)
- Includes those combined with acetaminophen (APAP), aspirin (ASA) or ibuprofen (IBU)
- PA can be requested for up to 200 MME/day for Immediate Release and Extended Release Opioids
- Quantities higher than initial limits or limits beyond 200 MME/day require an appeal
- Products containing opioids in combination with APAP or ASA limited to four grams of APAP or ASA per day
- Products containing opioids in combination with IBU limited to 3200 mg IBU/day

Step Therapy
- IR formulations required before prescribing extended-release (ER) formulations
- Requires PA if claim history has no prior use of an IR or if not already stable on an ER

Coverage Duration
- Post-limit PA approvals limited to one month for acute pain and 12 months for chronic pain
- Prescriber attests to reassessing patient response at least every three months
- Duration not limited for patients actively fighting cancer

Increase Access to Treat Opioid Addiction
- Remove PA (retain quantity limits) for buprenorphine-naloxone combination products
- PA with quantity limits in place for buprenorphine mono products

## SECTION SEVEN: HOSPICE CARE

Coverage for the following services is available when a Covered Person is diagnosed by their Physician as being terminally ill with a prognosis of six months or fewer to live. Your share of the cost for hospice care will depend on whether the care is obtained from an In-Network or Out-of-Network Provider.

Hospice care may be provided in the home or at a Hospice facility where medical, social and psychological

services are given to help treat patients with a terminal illness. Hospice Services include routine home care, continuous home care, Inpatient Hospice and Inpatient respite. To be eligible for Hospice benefits, the patient must have a life expectancy of six months or less, as confirmed by the attending Physician.

Covered Services will continue if the Member lives longer than six months. When approved by your Physician, Covered Services include the following:

- Skilled Nursing Services (by an R.N. or L.P.N.).
- Diagnostic Services.
- Physical, speech and inhalation therapies if part of a treatment plan.
- Medical supplies, equipment and appliances (benefits will not be covered for equipment when the Member is in a Facility that should provide such equipment).
- Counseling services.
- Inpatient confinement at a Hospice.
- Prescription Drugs given by the Hospice.
- Home health aide.

Non Covered Services include but are not limited to:

- Services provided by volunteers.
- Housekeeping services.

## SECTION EIGHT: TRANSPLANT BENEFITS

Benefit levels for transplants will depend on where Your care is obtained. Transplant services obtained at an In- Network Center of Excellence will be paid at the In-Network benefit level. Transplant services obtained at an Out- of-Network facility will be paid at the Out-of-Network benefit level and will be subject to a penalty outlined in paragraph 4 below. If You use an Out-of-Network Provider, You may receive a bill for the difference between the Provider's charge and the fee that the In-Network Provider pays for that service. A facility is a "Center of Excellence" when it appears on the Plan's list of centers for the specific transplant being performed. Pre-authorization for transplant services is required or a penalty will apply (see paragraph 4 below). The Plan will cover transplant services as follows:

1. **Transplant Procedures covered.** The Plan will pay for Covered Services for heart, lung, kidney, heart- lung, liver, pancreas, kidney-pancreas, bowel, bone marrow and cornea transplants. Benefits will not be provided for any organ or tissue transplant procedures not specifically covered under the Plan, or for any transplants that do not meet the established criteria determined by Claims Administrator.

2. **General Description of Transplant Covered Services.** Covered Services include any Hospital, medical- surgical, and other service related to the transplant, including blood and blood plasma. The Plan will pay for Covered Services for organ transplants, subject to Deductibles, Coinsurance, benefit maximums or other limits after pre-authorization is obtained. In order to be pre-authorized, the organ transplant must be Medically Necessary, medically appropriate, and not experimental or investigational for the medical condition for which the transplant is recommended. These determinations must be made by a Plan-approved external Independent Review Organization specializing in transplant services, such as the Ohio Solid Organ Transplant Consortium or the Ohio Bone Marrow Transplant Consortium.

3. **Specified Covered Services.**

   A. **Hospital Care:** All Inpatient and Outpatient care.

   B. **Organ Procurement:** The tissue typing, surgical procedure, storage expense, and transportation costs directly related to the donation of an organ or other human tissue used in Your pre- authorized transplant procedure will be covered as follows:

1. If the donor is covered under another health care benefit plan which includes coverage for donations used in the covered transplant procedure, then the donor's plan will be primary and this Plan will be secondary; and

2. If the donor is not covered by any health care benefit plan or is covered by a health care benefit plan which excludes from coverage donation benefits, this Plan will be primary.

C. **Operative Care and Post-Operative Care:** Benefits paid will vary depending on whether You obtain care through a Center of Excellence or other Provider. Pre-authorization is required (see paragraph 4 below).

Covered Services related to transplant surgery will be paid if the expense is incurred during the 5 calendar days prior to surgery and the 365 calendar days thereafter.

The following operative and post-operative care are Covered Services:

- Hospital room, board, and general nursing in semi-private rooms and/or special care units;
- Medically Necessary Hospital ancillaries while You are an Inpatient;
- Physician's services for surgery, surgical assistance, administration of anesthetics, and Inpatient Medical Care;
- Acquisition, preparation, transportation and storage of a human heart, lung, kidney, heart, lung, liver, pancreas, kidney-pancreas, bowel, bone marrow or;
- Diagnostic X-rays and other radiology services; laboratory and pathology services; and EKGs, EEGs and radioisotope tests.

With prior approval by Claims Administrator, benefits will be paid for other services (such as home health care and certain therapy services) when such services are directly related to a covered transplant and are ordered by Your Physician.

4. **Pre-authorization Required.** You, or someone doing so on Your behalf, must call Claims Administrator at (419)887-2549 or toll free 1-800-891-2549 to obtain pre-authorization for Inpatient Transplant Services (except for Emergency Services). If You obtain pre-authorization, these services, procedures and equipment for care at a Center of Excellence will be covered at the appropriate benefit level indicated in Your Schedule of Benefits. Pre-authorization is required to avoid a potential reduction in payment of benefits.

If You do not obtain the required pre-authorization, a Retrospective Review will be done to determine if your care was Medically Necessary. You are responsible for all charges for services Claims Administrator determines are not Medically Necessary.

If You ***do not obtain pre-authorization*** and the services are Medically Necessary, any benefit payment for a ***facility fee (including Inpatient facility services under Section Three)*** will be reduced by $500 the Allowable Amount. The services are then subject to the applicable Deductible, Copayment and/or Coinsurance. Financial penalties for failure to obtain pre-authorization for care received In-Network will count toward Your Out-of-Pocket Maximum. Financial penalties for care received Out-of-Network will not count toward the Out-of-Pocket Maximum.

5. **Transplant Benefit Penalty.** The transplant will be eligible for benefit payment only if it is determined to be a Medically Necessary Covered Service.

6. **Limitation.** In accordance with and to the extent permitted by applicable law, reimbursement to You under this Plan will be secondary to any and all governmental or institutional sources of funding that will offset the cost of Covered Services. No benefits are provided for an artificial organ.

## SECTION NINE: MOTHER AND NEWBORN CARE

The level of benefits for maternity and newborn care will depend on whether care is obtained through In-Network or Out-of-Network Providers. The Plan will cover such services as follows:

1. **Covered Services.** Covered Services include the full range of obstetrical services at a Physician's office, including prenatal visits and postnatal visits and all other services set forth in Section Four, Covered Services, with respect to pregnancy.

   During any period of covered hospitalization, Covered Services include obstetrical services for the termination of a pregnancy by delivery of a baby, or miscarriage, and the initial examination of a covered newborn child performed by a Physician other than the delivery Physician. Payment for maternity care includes payment for all the Medically Necessary care related to the pregnancy.

2. **Hospital Services.** Coverage for Inpatient care for a covered mother and her newborn pursuant to Section Five, Paragraph 2, Inpatient Care in a Hospital, shall extend for 48 hours following normal vaginal delivery or 96 hours following a cesarean delivery or until a Physician or nurse-midwife determines that an earlier discharge is warranted after conferring with the mother or person responsible for the mother or newborn (e.g. parent, guardian or other person with authority to make medical decision for the mother or newborn). You are not required to stay in the Hospital for the above specified period of time, and if Medically Necessary, longer stays will be covered by the Plan. Pre-authorization is required for Inpatient delivery services for stays that exceed 48 hours (following normal vaginal delivery) or 96 hours (following a cesarean delivery). See Section Five: Hospital Care.

3. **Follow-up Care.** The following Physician-directed services or advanced practice registered nurse- directed services provided after discharge from Inpatient care are covered as follow-up care:

   A. Physical assessment of the mother and newborn;
   B. Parent education, assistance, and training in breast and bottle feeding;
   C. Assessment of the home support system;
   D. Performance of any Medically Necessary clinical tests; and
   E. Performance of any other services that are consistent with the follow-up care recommended in the protocols and guidelines developed by national organizations that represent pediatric, obstetric, and nursing professionals.

   If the mother or newborn is discharged prior to the expiration of the applicable number of Inpatient hours specified in paragraph 2 of this section, all follow-up care provided within 72 hours after discharge is covered. If the mother or newborn receive at least the number of Inpatient hours specified in paragraph 2 of this section, all such care determined to be Medically Necessary by the Physician or nurse-midwife responsible for discharge is covered. Follow-up care may be provided in a Physician's office or during a home health visit if the Health Care Professional conducting the home visit is knowledgeable and experienced in maternity and newborn care.

## SECTION TEN: EXCLUSIONS

To help manage the funding rates, the Plan excludes from coverage certain services that are considered to be insufficiently effective, experimental, inappropriate or outside the practical scope of coverage. However, certain sections of this Certificate of Coverage may waive an exclusion or limitation or may list additional exclusions or limitations. Please be certain to check the specific provisions of this Certificate of Coverage. Services not listed as Covered Services are considered not covered. The exclusions and limitations listed below will not, under any circumstances, be covered by this Plan.

Benefits for the following will not be provided.

1. **Admission to a Hospital Before You Became Covered Under this Plan:** Services provided at a Hospital or Skilled Nursing Facility as a registered Inpatient before the Effective Date of this Plan.

2. **Bariatric Treatment/Surgery.** Medical services or supplies (such as weight loss or weight maintenance programs), dietary counseling programs and surgical procedures to treat morbid obesity are not covered.

   Coverage will be provided for certain dietary counseling programs under Preventive Health Services as mandated under federal law (PPACA). Surgical procedures to treat morbid obesity (including but not limited to Roux-en-Y (RNY), gastric bypass surgery and Gastroplasty) may be covered if the Covered Person meets medical necessity criteria established by the Plan. ***Pre-authorization must be obtained before coverage will be provided for these services and procedures.*** The level of benefits will depend on whether care is obtained through In-Network or Out-of-Network Providers. If You use an Out-of-Network Provider, You may be responsible for additional charges up to and including the balance of the amount billed as outlined in SECTION THREE: HOW THE MAXIMUM CHOICE PLAN WORKS. For a comprehensive list of preventive services, please visit www.hhs.gov/healthcare/prevention/index.html.

3. **Clinical Trial Services.** A Health Care Service, item or drug that is**:**

   a. The subject of a clinical trial;
   b. A Health Care Service, item, or drug provided solely to satisfy data collection and analysis needs for the cancer clinical trial that is not used in the direct clinical management of the patient;
   c. An investigational or experimental drug or device that has not been approved for market by the United States food and drug administration;
   d. Transportation, lodging, food, or other expenses for the patient, or a family member or companion of the patient, that are associated with the travel to or from a facility providing the clinical trial;
   e. An item or drug provided by the clinical trial sponsors free of charge for any patient;
   f. A service, item, or drug that is eligible for reimbursement by a person other than the insurer, including the sponsor of the clinical trial.

   This exclusion does not apply to routine patient care of a Covered Person in an Eligible Clinical Trial.

4. **Cardiac Rehab:** Services provided as part of Cardiac Rehabilitation, Phase III and Phase IV.

5. **Care Provided by a Family Member:** Care provided by an individual who normally resides in Your household or is a member of Your immediate family or the family of Your spouse. Immediate family is defined as parents, siblings, spouses, children, grandparents, aunts, uncles, nieces, and nephews.

6. **Care Rendered in Certain Non-Hospital Institutions:** Care or supplies in convalescent homes or similar institutions, facilities providing primarily custodial or rest care or domiciles, care or supplies in health resorts, spas, sanitariums, tuberculosis Hospitals, or infirmaries at schools, colleges or camps.

7. **Charges in Excess of Annual Maximums:** Any service, supply or treatment in excess of the annual maximums shown in the Schedule of Benefits.

8. **Charges in Excess of NCA or UCR:** Charges for Out-of-Network services that are in excess of the Non-Contracting Amount (NCA) for Out-of-Network Hospital Providers in Lucas, Defiance, Sandusky County(ies) or in excess of] the Usual, Customary and Reasonable (UCR) charges for Out- of-Network Physicians and Providers.

9. **Complementary Treatments:** Acupuncture, Acupressure, Hypnotherapy, Massotherapy, Aroma Therapy, Chelation therapy, Rolfing, Biofeedback training, neurofeedback training and related diagnostic tests and other forms of alternative treatments including but not limited to non-

prescription drugs or medicines, vitamins, nutrients and food supplements are not Covered Services. This limitation applies even if the service or item is prescribed by or administered by a Physician. Certain benefits are mandated as preventive services under federal law (PPACA). The level of benefits will depend on whether care is obtained through In- Network or Out-of-Network Providers. If You use an Out-of-Network Provider, You may be responsible for additional charges up to and including the balance of the amount billed as outlined in SECTION THREE: HOW THE MAXIMUM CHOICE PLAN WORKS. For a comprehensive list of preventive services, please visit www.hhs.gov/healthcare/prevention/index.html.

10. **Convenience Items:** Items that are primarily for Your convenience and personal comfort. These are items that are not directly related to the provision of Covered Services. Such items include, but are not limited to, telephone, television, barber or beauty service, guest service, private rooms (except as Medically Necessary) in a Hospital or Skilled Nursing Facility, housekeeping services and meal services as part of Home Health care, travel, transportation, or living expenses, rest cures, recreational or diversional therapy.

11. **Cosmetic or Plastic Surgery:** This limitation applies to any procedures, services, equipment, or supplies provided in connection with cosmetic or plastic surgery which is intended primarily to improve appearance or to treat a mental or emotional condition through a change in body form. In addition, the Plan will not cover procedures, services, equipment or supplies for any disease or condition resulting from a cosmetic or plastic surgery excluded under this Section. This limitation does not apply to the repair of anatomical impairment to improve or correct functional disability, breast reconstruction following a covered mastectomy or plastic surgery after an accidental injury.

12. **Custodial or Convalescent Care:** Services for Hospital care, nursing home or Skilled Nursing Facility care, home care, respite care or any other setting which is determined to be custodial. Custodial Care means
(1) non-health related services, such as assistance in activities of daily living, or (2) health-related services which do not seek to cure or which are provided during periods when the medical condition of the patient is not changing, or (3) services which do not require continued administration by trained medical personnel. Custodial Care includes, but is not limited to, help in eating, getting out of bed, bathing, dressing, toileting and supervision in taking medications.

13. **Dental Care:** Dental work, treatment, supplies or x-rays including but not limited to, treatment of cavities and extractions; bridges, crowns, root canals; replacement or restoration of the teeth; care of gums or bones supporting the teeth; treatment of periodontal abscess; removal of impacted teeth; orthodontia (including braces, retainers and bite plates); false teeth; treatment of temporomandibular joint syndrome (TMJ) and orthognathic surgery; or any other dental service.

    This exclusion does not apply to the following procedures performed by a dentist or oral surgeon and when benefits are not available under a separate dental plan. These procedures are:
    a. treatment for tumors and cysts (including pathological examination) of the jaws, cheeks, lips, tongue, roof and floor of the mouth; or
    b. repair of fractures and dislocations.
    c. initial first aid treatment received within 72 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

14. **Designated Blood Donation.** If You choose to designate another person to be a blood donor so that You may receive the designated blood at a future time, the Plan will not cover storage of such donated blood or any extra charges associated with designated blood donation.

15. **Diabetic and Asthmatic Equipment and Supplies.** The following Diabetic and Asthmatic equipment and supplies are not covered under this Plan:

    - Needles and syringes (1cc or less)
    - Tubing for insulin pumps
    - Blood glucose monitor, test strips, batteries and control solutions

- Lancing devices, lancets
- Peak expiratory flow rate meter (hand-held)
- Spacers for metered dose inhaler
- Masks and tubing for nebulizers
- Limited ostomy supplies
- Diaphragms

The above may be covered under a under a separate program administered through a pharmacy benefit.

16. **Donor Searches:** Searches for organ and tissue transplants, including compatibility testing of potential donors who are not immediate, blood related family members (parent, child, sibling).

17. **Elective Abortion**. Only an abortion necessary to save the life of the mother will be covered under this Plan.

18. **Enteral Nutrition.** All services and supplies associated with enteral nutrition. However, the Plan will cover these services and supplies if You have a disease or malfunction of the structures that normally permit food to reach the gastrointestinal tract. In this case, coverage will be provided when it is required to maintain Your weight and/or prevent clinical deterioration.

19. **Equipment.** Items not eligible under Medicare Part B guidelines including but not limited to: hypoallergenic pillows, central or unit air conditioners, humidifiers, dehumidifiers, air purifiers, water purifiers, mattresses, waterbeds, commodes, exercise equipment, common first aid supplies, adhesive removers, cleansers, underpads or ice bags. Charges relating to the purchase or rental of household fixtures, including but not limited to, escalators, elevators, handrails, ramps, stair glides, adjustments to a vehicle and swimming pools are also not covered.

20. **Experimental/Investigational** 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 Claims Administrator determines in its discretion to be Experimental/Investigative is not covered under the Plan.

Claims Administrator will deem any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental/Investigative if it determines that one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought. The Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply:

- cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA), or other licensing or regulatory agency, and such final approval has not been granted;

- has been determined by the FDA to be contraindicated for the specific use; or
- is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or

- is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function; or

- is provided pursuant to informed consent documents that describe the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental/Investigative, or otherwise indicate that the safety, toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.

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

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

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

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

Claims Administrator has the authority and discretion to identify and weigh all information and determine all questions pertaining to whether a Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative. See Internal Claims And Appeals Procedures and External Review section in this certificate.

21. **First Aid Supplies.** Common first aid supplies.

22. **Foot Orthotic Devices:** Heel cups, arch supports, lifts, wedges, shoe inserts, corrective shoes, foot orthotics used solely for sports and devices not eligible under Medicare Part B guidelines.

23. **Fraudulent or Misrepresented Claims:** Services related to intentional fraudulent or misrepresented claims.

24. **Free Care.** Care furnished without charge or care that would normally be furnished without charge. This exclusion also applies if the care would have been furnished without charge if You were not covered under this Plan or under any other health care benefit plan or other insurance.

25. **Genetic Testing:** Genetic testing services other than fetal screenings. Services for potential illnesses that may result from genetic predisposition or family history are not covered in the absence of signs or symptoms.

26. **Government Expense and Programs:** Services where care is provided at the Government's expense. This includes charges for Covered Services that are payable under Medicare or any other federal, state or local government program. The Plan will not cover treatment of disabilities from diseases Contracted or injuries sustained as a result of military service or war, declared or undeclared, or any act of war. This exclusion does not apply if You are legally obligated to pay for such treatment or service in the absence of insurance or where the law prohibits it.

27. **Growth Hormone Therapy.** All services, drugs, and procedures associated with growth hormone therapy.

28. **Hair Loss Treatment.** Services and supplies for the treatment of hair loss.

29. **Home Monitoring Equipment:** Charges for services and supplies used for home monitoring, including but not limited to blood pressure equipment, hydrospray jet injectors, bed wetting alarms, home pregnancy, ovulation, HIV and any other home testing kits.

30. **Illegal Occupation.** The Plan will not be liable for any loss to which a contributing cause was the insured'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.

31. **Infertility Services.** Any procedure intended to induce pregnancy, such as artificial insemination, in vitro fertilization, infertility drugs, embryo or ovum transplant or transfer services, gamete intrafallopian transfer (GIFT) procedures, zygote intrafallopian transfer (ZIFT) procedures, experimental and investigational infertility services, donor ovum, and semen related costs, including collection and preparation, storage of eggs and sperm, cryogenics, sperm banking, reversal of voluntary sterilization and any related procedures, and associated counseling. (If the Employer purchased an optional rider, additional benefits may be available. See the Schedule of Benefits.)

32. **Injuries During Riots:** Services for injuries sustained while You participated in an insurrection or riot.

33. **Insulin.** Insulin, insulin injections, or other insulin therapy.

34. **Mandated or Court Ordered Care.** Any medical, psychological, alcohol and drug abuse, or psychiatric care which is solely the result of court order or otherwise mandated by a third party (such as an Employer or licensing board). These services would be covered if deemed Medically Necessary.

35. **Marriage-related Services:** Marriage relationship counseling and charges relating to premarital laboratory work required by any state or local law.

36. **Medical Reports.** Special medical reports not directly related to treatment; appearances at hearings and court proceedings.

37. **Mental Illness /.** Covered Services do not include the following treatments for mental illness, drug abuse and alcohol abuse*:

    a. Structured sexual therapy programs;

b. Vocational and recreational activities or coma stimulation therapy;
c. Treatment in a specialized facility or program for a patient who has not been or would not be responsive to therapeutic management;
d. Inpatient treatment for codependency or environmental changes;
e. Services or care provided or billed by a school, halfway house, custodial care center, or outward bound programs, even if psychotherapy is included;
f. Cognitive rehabilitation therapy;
g. Family counseling or marriage counseling;
h. Social skills classes;
i. Treatments for sleep disorders.

*** Note –**Mental Illness and Substance Use Disorder is covered the same as any medical/surgical benefit within the same classification or sub classification.
*Note: This exclusion is not applicable with respect to Covered Services available for the treatment of Autism Spectrum Disorder as set forth in this certificate.

38. **Natural Disaster or Uncontrolled Event:** Benefit coverage may be limited due to the extent that a natural disaster, war, riot, civil uprising or any other Emergency or similar event not within the control of NWOBA, results in the inability to provide Health Care Services in accordance with the Plan. NWOBA will make a good faith effort to continue operations, taking into account the severity of the event.

39. **Not Medically Necessary Services:** Services and supplies which, as determined by the Plan, are not Medically Necessary. The exclusion of coverage in such cases is solely a benefit determination and not a medical treatment determination or recommendation. You or Your Provider may elect to proceed with the Planned treatment, at Your expense, and appeal the denial of claim for such services in accordance with the Plan's appeal procedure.

40. **Nutrition Counseling:** Nutrition counseling and related services, except when provided as part of diabetes education. Certain benefits are mandated as preventive services under federal law (PPACA). The level of benefits will depend on whether care is obtained through In-Network or Out-of-Network Providers. If You use an Out-of-Network Provider, You may be responsible for additional charges up to and including the balance of the amount billed as outlined in SECTION THREE: HOW THE MAXIMUM CHOICE PLAN WORKS. For a comprehensive list of preventive services, please visit www.hhs.gov/healthcare/prevention/index.html.

41. **Organ Donation Services:** Organ transplant services related to donation of an organ by a Covered Person; artificial organs and services related to the implantation thereof, and other related services, except as specified in Section Eight, Transplant Benefits.

42. **Orthopedic Devices:** Orthopedic devices not eligible under Medicare Part B guidelines.

43. **Paternity Testing:** Testing to establish paternity is not covered.

44. **Penile Implants:** Penile implants for the treatment of impotence of a psychological origin.

45. **Prescription Drugs and Non-Prescription Drugs:** Outpatient Prescription Drugs are not covered whether self- administered or administered by a Provider, with the exception of drugs covered under Preventive Health Services as mandated under federal law, infused chemotherapy and short-term medications (e.g., antibiotics, steroids, etc.). Outpatient Drug coverage may be available if the
Employer's Application and Participation Agreement provides coverage under a separate Prescription Drug Program. Refer to the Schedule of Benefits and Section Fifteen, Prescription Drug Program, if applicable.

46. **Private Duty Nursing:** Private duty nursing services.

47. **Private Room:** If You occupy a private room, You will have to pay the difference between the Hospital's charges for a private room and the Hospital's most common charge for semi-private

accommodations, unless Claims Administrator determines that it was Medically Necessary for You to have a private room or if the Hospital only provides private rooms.

48. **Prosthetic Devices:** Prosthetic devices including repair and replacement of prosthetic devices.

49. **Reports:** Services relating to telephone consultations, care plan oversight in the absence of the patient, missed appointments, completion of claim forms, copies of medical records or special medical reports not directly related to treatment; appearances at hearings and court proceedings.

50. **Required Examinations:** Examinations specifically for the purpose of obtaining or maintaining employment, obtaining insurance and/or professional or other licenses; examinations precedent to engaging in athletic or recreational activities or attending camp, school or other program, unless obtained in the context of the periodic examination described in Section Four, paragraph 2.k, Preventive Health Services and services for other than therapeutic purposes such as custody evaluations, adoption, research and judicial proceedings.

51. **Reversal of Sterilization:** Any procedures or related care to reverse previous voluntary sterilization.

52. **Routine Foot Care:** Any services, supplies, or devices used to improve comfort or appearance including but not limited to trimming and/or scraping of calluses, bunions (except capsular and bone surgery), toenails, subluxations, fallen arches, weak feet, chronic foot strain, or sympathetic complaints of the feet.

53. **Self-Inflicted Injuries:** Charges for the diagnosis, care, or treatment of any condition arising from self- inflicted injuries or attempted suicide, unless the result of an underlying medical condition such as depression.

54. **Services After Termination of Coverage:** Services after Your coverage under this Plan ends.

55. **Services Not Chargeable for Individuals Without Health Care Benefit:** Services for which no charge would be made if the individual had no health care benefit.

56. **Services Not Recommended by a Physician.** Services not recommended and approved by a Physician. Also excluded are services not completed in accordance with the attending Physician's orders.

57. **Services Not Specified as Covered:** Any services not specifically described as covered in this Certificate of Coverage.

58. **Sex-related Disorders:** Unless Medically Necessary, surgical procedures or related care to alter sex from one gender to the other or treatment related to sexual dysfunction. Evidence based and nondiscriminatory criteria will be used to determine Medical Necessity.

59. **Skilled Nursing Facility:** Stays for the treatment of psychiatric conditions and senile deterioration, or facility services during a temporary leave of absence from the facility.

60. **Stand-by Charges:** Physician stand-by charges.

61. **Surrogate and/or Gestational Pregnancy:** 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).

62. **Therapy Services**: Group speech therapy, group physical therapy or recreational therapy which includes but is not limited to sleep, dance, arts, crafts, aquatic, gambling, horseback riding (equestrian therapy) and nature therapy.

63. **Topical Anesthetics:** Topical anesthetics are not covered.

64. **Transplant Services:** The transportation and/or lodging costs of the transplant recipient or individuals traveling with him or her are not covered. Transplants using artificial organs or non-human donors, or any transplant that is not specifically listed in Section Eight, Transplant Benefits are not covered.

65. **Vision Care:** Routine eye examinations for refractory treatment, Orthoptic training, eyeglasses, contact lenses, contact lens evaluation and fittings, sunglasses of any type, and surgery including but not limited to: eye surgery to correct refractory errors, LASIK surgery, Keratomileusis, excimer laser, photo refractory keratectomy (interwave technology), radial keratotomy, and other vision care services and supplies, except Covered Services required for the diagnosis and treatment of diseases of, or injury to, the eyes. (If the Employer has purchased an optional Vision Hardware Rebate Rider, additional benefits may be available. See the Schedule of Benefits.) IMPORTANT: If You opt to receive vision care services or vision care materials that are not covered benefits under this plan, a participating vision care Provider may charge You his or her normal fee for such services or materials. Prior to providing You with vision care services or vision care materials that are not covered benefits, the vision care Provider will provide You with an estimated cost for each service or material upon Your request.

66. **Work-Related Injuries:** Care for treatment of a work or occupational related injury or illness. This includes charges for injury or illness 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.

67. **X-Rays:** Diagnostic x-rays performed in connection with a research project are not covered.

## SECTION ELEVEN: 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 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 reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses.

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

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

**Right to Receive and Release Needed Information**

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This plan and other Plans. This 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. This plan need not tell, or get consent of any person to do this. Each person claiming benefits under This plan must provide any facts This plan 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, This 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. This 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 payment made by This 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 This plan has not paid a claim properly, You should first attempt to resolve the problem by contacting the Claims Administrator at (419) 887-2525 or refer to Section Thirteen: Internal Claims and Appeals Procedures and External Review. If You are still not satisfied, You may call the Ohio Department of Insurance for instructions on filing a consumer complaint. Call 1-800-686-1526, or visit the Department's website at http://insurance.ohio.gov

## SECTION TWELVE: MEDICARE AND YOUR COVERAGE

You may have coverage under the Plan and under Medicare. Medicare means the benefits offered under Title XVIII of the Social Security Act, and includes all of the benefits provided by Parts A and B of Medicare. In general, when You have coverage under both the Plan and Medicare, the Plan will pay primary benefits for:

1. An active employee who is age 65 and over (if the Employer has 20 or more employees or if the Employer has fewer than 20 employees and the Employer has not received an exception from CMS);

2. An active employee's spouse age 65 or over;

3. An active employee under age 65 entitled to Medicare because of disability (only if the Employer has 100 or more employees);

4. An active employee's covered dependent(s) under age 65 entitled to Medicare because of disability (only if the Employer has 100 or more employees); or

5. Up to 30 months after Your treatment for end stage renal disease begins.

If You do not fall into any of the categories 1 through 5 above, the Plan will pay benefits secondary to Medicare. If You do not elect Part B coverage, the payment to be made by the Plan will be made as if You had elected Part B. When the Plan is secondary, You must first submit the claim to Medicare. After Medicare makes payment, You may submit the claim to the Plan for payment.

These rules are based on regulations issued by the Centers for Medicare and Medicaid Services (CMS), and may be amended or changed at any time. It is the intent of the Plan to abide by the Medicare Secondary Payer Rules. If the Plan in any way conflicts with regulations issued by CMS, the Plan will pay benefits in accordance with CMS regulations.

## SECTION THIRTEEN:
## 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 Claims Administrator at the Member Services Department, P.O. Box 928, Toledo, Ohio 46397-0928, Attention: Member Services, 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 (*Concurrent* or Pre-*Service Claim* denial), this denial is called an Adverse Benefit Determination. The plan is required to notify You when it makes an Adverse Benefit Determination in response to your claim for plan benefits, and You, or someone You have authorized to speak on Your behalf (an *Authorized Representative*), can request an appeal of the plan's decision. When the plan receives Your appeal, it is required to review its own decision. If the plan rescinds Your coverage or denies Your application for coverage, You may also appeal this decision. 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.
- Please note that different timeframes apply for appeals of denied electronic pre-service claims. See Electronic Pre-service Non-urgent and Urgent Care Claim Denial in this section.

**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 **Definitions** section of this certificate.

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

Paramount Insurance Company, P.O. Box 928, Toledo, Ohio 43697-0928, Attn: Member Services Department Appeals, by telephone at 1-800-462-3589 or email: PHCMbrSvcAppeals@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 a *Rescission* of coverage is a cancellation or discontinuance of coverage that has retroactive effects, if the plan's decision to rescind is upheld, You will be responsible for payment of all claims for Your Health Care Services.

**Time Limits for filing an internal claim or appeal:** You must file the internal appeal within 180 days of the receipt of the notice of claim denial (an *Adverse Benefit Determination*). Failure to file within this time limit may result in Claims Administrator 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 Affairs Division at The Ohio Department of Insurance (800) 686-1526.

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

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

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

## INTERNAL CLAIMS AND APPEALS

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 determined, and You will be notified of Claims Administrator's decision, within forty-eight (48) hours after Claims Administrator's receipt of the request for appeal. Electronic pre-service appeals for non-urgent care services will be determined, and You will be notified of Claims Administrator's decision, within ten (10) calendar days of Claims Administrator's receipt of the request for appeal.

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 Claims Administrator's decision has already been upheld through an external review by an IRO.

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

Paramount Insurance Company, P.O. Box 928, Toledo, Ohio 43697-0928, Attn: Member Services Department Appeals, by telephone at 1-800-462-3589 or email: PHCMbrSvcAppeals@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, within 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 Claims Administrator'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 the date of Claims Administrator's receipt of a request for 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 Claims Administrator's receipt of the expedited review 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 Claims Administrator. 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.

## SECTION FOURTEEN: REIMBURSEMENT/SUBROGATION

1. **Reimbursement and Subrogation**. Subject to ORC 2323.44, to the extent applicable:

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

2. **Workers' Compensation/Non-Duplication**. The benefits which You are entitled to receive under the Plan 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 Covered Person pursuant to Workers' Compensation are deemed to be assigned to the Plan.

3. **Cooperation by Covered 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.

4. **Cooperation by Employer**. By executing the Group Policy, the Employer agrees to assist the Plan 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 Plan or its nominee under this Section.

## SECTION FIFTEEN: PRESCRIPTION DRUG PROGRAMS

**Prescription Drug Benefits**. You may be enrolled in one or more of the following programs – Retail Pharmacy Program, Mail Order Pharmacy Program, Maintenance Drugs, Limited Medical Supplies, Specialty Drugs. Refer to Your Schedule of Benefits for more details.

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

The P&T Working Group reviews and approves the Plan's Formulary annually. However, formulary management may be delegated to the Pharmacy Benefit Manager (PBM). When formulary management is delegated, the initial formulary is approved by the P&T Working Group, but ongoing formulary changes throughout the year are reviewed and approved by the PBM's P&T committee or other clinical working group that handles the delegated function of formulary management.

**Pharmacy Benefits Management**. The pharmacy benefits available to you under this Certificate are administered by the Pharmacy Benefits Manager (PBM). The PBM is a company with which the Plan contracts to administer your pharmacy benefits. The PBM has a nationwide network of retail pharmacies and a Mail Service pharmacy.

Example services that the PBM provides include managing a network of retail pharmacies, operating a Mail Service pharmacy and prescription drug claims processing. The PBM, in consultation with the Plan, also provides services to promote and enforce the appropriate use of pharmacy benefits. These services can include reviews for possible excessive use, recognized and recommended dosage regimens, and Drug interaction screenings.

**Covered Prescription Drug Benefits**. A valid prescription is required to obtain all prescription

drug benefits. Prescription Drugs, unless otherwise stated, must be Medically Necessary and not Experimental/Investigative, in order to be Covered Services. For certain Prescription Drugs, the prescribing Physician may be asked to provide additional information before the Health Plan can determine Medical Necessity. The Plan may establish quantity and/or age limits for specific Prescription Drugs which the PBM will administer. Covered Services will be limited based on Medical Necessity, quantity and/or age limits established by the Health Plan, or utilization guidelines.

- FDA approved Prescription Legend Drugs.
- FDA approved Specialty Drugs.
- Injectable insulin and syringes used for administration of insulin.
- Contraceptive devices, oral immunizations, and biologicals, although they are legend drugs may be payable as medical supplies based on where the service is performed or the item is obtained. If such items are over-the-counter drugs, devices or products, they are not Covered Services unless prescribed by a physician and covered as a preventive service, as required by federal and state law.
- Certain supplies and equipment obtained by Mail Service or from a Network Pharmacy (such as those for diabetes) are covered under Prescription Drug Benefits. Refer to your Schedule of Benefits and formulary list or contact RxBenefits Member Services at 1-800-334-8134 to determine approved covered supplies. Other supplies, equipment or appliances may be covered as Medical Supplies, Equipment and Appliances instead of under Prescription Drug benefits.
- Off label use of FDA approved drugs as defined in ORC 3923.60. The Plan shall not limit or exclude coverage for any drug approved by the United States food and drug administration on the basis that the drug has not been approved by the United States food and drug administration for the treatment of the particular indication for which the drug has been prescribed, provided the drug has been recognized as safe and effective for treatment of that indication in one or more of the standard medical reference compendia adopted by the United States department of health and human services.

**Non Covered Prescription Drug Benefits:**

The following exclusions apply:

1. Unless otherwise specified in your summary of benefits, durable medical equipment, therapeutic devices, support garments; and other supplies or substances which may be obtained without a prescription;
2. Prescription Drugs or Refills in excess of either the quantity or days supply indicated on the prescription. For any prescription that is filled before the designated days supply on the previous fill has been exhausted, the member will be responsible for full cost of the prescription.
3. Dietary supplements and some prescription vitamins (other than prenatal vitamins or those mandated by PPACA guidelines);
4. Prescription Drugs used for cosmetic purposes such as: drugs used to decrease wrinkles, drugs to promote hair growth, and drugs to control perspiration;
5. Drugs for weight loss including diet pills and appetite suppressants;
6. Drugs that do not require a prescription for dispensing known as “Over-the-Counter” drugs unless approved by the Plan;
7. Any prescription products that are not FDA approved medications or are labeled as experimental or investigational. This includes prescription devices;
8. Prescription Drugs used to enhance athletic or sexual performance;
9. For compound drugs to be covered, they must satisfy certain requirements. In addition to being medically necessary and not experimental or investigative, compound drugs must not contain any ingredient on a list of excluded ingredients. Any denial of coverage of a compound drug may be appealed in the same manner as any other drug claim denial under this coverage. Compounded medications equal to or exceeding $300 per script will require prior authorization.

10. Any Prescription Drug which is determined to have been abused or otherwise misused by a Covered Person;
11. Any claim for Prescription Drug(s) submitted to the Plan or the PBM for reimbursement more than one (1) year from the date the Prescription Drug was dispensed will not be eligible for reimbursement;
12. Prescription Drugs for which the cost is recoverable under any workers' compensation or occupations disease law or any federal or state agency or any drug for which no or substantially discounted charge is made;
13. Prescription Drugs that are prescribed, dispensed or intended for use during a hospital inpatient or skilled nursing facility stay;
14. Non-Formulary Prescription Drugs, unless determined to be medically necessary through the Non-formulary Exceptions process
15. Growth hormones for growth and development unless medically necessary and covered according to your summary of benefits;
16. Any drugs or devices used for treatment of male/female sexual dysfunction including but not limited to erectile dysfunction, delayed ejaculation, anorgasmia and decreased libido;
17. Fertility drugs unless otherwise stated in your summary of benefits.

**How to Obtain Prescription Drug Benefits**

If You have the Retail Pharmacy Program, show Your identification card to the pharmacist when purchasing Prescription Drugs and certain over-the- counter medications approved by the PBM. If You use a Network Pharmacy, You will be responsible for Your Drug Copay and the pharmacist will submit Your claim electronically to the PBM.

If You use a Non-Network Pharmacy, You will have to pay the full price of the Prescription Drug to the Non-Network Pharmacy. You will have to submit Your itemized receipt to Claims Administrator for reimbursement. Claims Administrator or the PBM will reimburse You **50% of the benefit available, less the applicable Drug Deductible and Copay**. You must send an original, itemized pharmacy receipt to Claims Administrator within ninety (90) days to receive reimbursement. Refer to Section Three, Filing Claims, for additional information.

**Mail Order Pharmacy Program**. If You have the Mail-Order Pharmacy Program, it is stated on Your Schedule of Benefits. A convenient network mail order service is beneficial for those who take medications regularly for chronic conditions. If Your Physician prescribes this type of medication, You may want to use the Mail Order Pharmacy Program. Certain medications are required to be obtained through a Mail Order Pharmacy. Your medication will be mailed directly to Your home.

**CVS Maintenance Choice (90-day) Pharmacy Program** - The Maintenance Choice program is for prescription drugs taken continuously to manage chronic or long-term conditions, such as high blood pressure, asthma, diabetes, or high cholesterol. After two 30-day fills of a prescription medication that is on the CVS Maintenance Choice list, the prescription must be filled for a 90-day supply at either CVS Caremark mail order or a CVS retail store. Members may obtain a list of the CVS Maintenance Choice medications by calling RxBenefits Member Services at 1-800-334-8134.

**Additional Coverage Options. A**dditional coverage options, are stated on Your Schedule of Benefits.

A. **Limited Medical Supplies -** Diabetic, asthma and other supplies as determined by the Plan's P & T subject to Copay or Coinsurance when covered under Your benefit are stated in the Schedule of Benefits. The supplies covered under the Limited Medical Supplies benefit include:

- Needles and syringes (1cc or less)
- Tubing for insulin pumps
- Blood glucose monitor, test strips and control solutions
- Lancing devices, lancets
- Peak expiratory flow rate meter (hand-held)
- Spacers for metered dose inhaler

- Masks and tubing for nebulizers
- Limited ostomy supplies
- Diaphragms

B. **Specialty Drugs -** Specialty Drugs are complex Prescription Drugs, as determined by the Plan's P & T, used to treat chronic conditions. These drugs are self-administered as injectable/infused or oral drugs and often require special handling and monitoring**.** When covered under your benefit, Specialty Drugs are subject to a Specialty Drug Copay or Coinsurance as stated in the Schedule of Benefits. The Prescription Drugs under the Specialty Drug option are subject to prior authorization.

C. **Orally Administered Cancer Medication** – The Plan will not provide coverage or impose Cost Sharing for a prescribed, orally administered cancer medication on a less favorable basis than the coverage it provides or Cost Sharing it imposes for intravenously administered or injected cancer medications.

**Drug Formulary.** A list of Federal Drug Administration (FDA) approved Prescription Drugs and supplies developed by a Pharmacy and Therapeutics Committee, and/or customized by CVS Caremark or RxBenefits. This list reflects the current clinical judgment of practicing health care practitioners based on a review of current data, medical journals, and research information. In your prescription drug coverage, the Formulary Drug list is used as a guide for determining your costs for each prescription. Drugs not listed on the Formulary may not be covered.

Questions regarding Your specific Drug Formulary may be answered by calling RxBenefits Member Services at 1-800-334-8134.

**Generic Drugs**. To get the greatest savings on Prescription Drugs, it's important to request a Generic Drug when available, instead of a Brand Name Drug. Your Prescription Drug Program may have Generic
Mandate or Generic Substitution. Refer to Your Prescription Drug formulary and Your Schedule of Benefits to determine if certain Brand Name Drugs are covered.

Generic Policy – Dispense As Written (DAW)

If your doctor writes a prescription stating that a Generic may be dispensed, we will only pay for the Generic drug. If you choose to buy the Brand name drug in this situation, you will be required to pay the Generic copay/coinsurance plus the difference in cost between the Generic and Brand name drug. The Generic Policy does not apply if your doctor requires a brand name medication.

Preferred drugs are a list of commonly prescribed Brand Name Drugs selected by the Plan based on clinical and cost-effectiveness. You can save money by asking Your doctor to prescribe preferred drugs.

**Drug Deductible and Drug Coinsurance**. The Prescription Drug Program may require that You meet a Deductible and or Coinsurance. The expenses incurred for Covered Services from In-Network, and Out-of-Network Providers including Prescription Drugs may apply to a Deductible. The Deductible for Your Plan is stated on Your Schedule of Benefits.

The Drug Copay is a fixed dollar amount of the Prescription Drug cost for which You are responsible. The Drug Copay for Your Plan is stated on Your Schedule of Benefits.

The amount You pay for Drug Copays, Coinsurance under any benefit of a Prescription Drug Program counts toward the Out-of-Pocket Maximum.

**Smoking Cessation Drugs -** Prescription Drugs and over-the-counter medications for smoking cessation are mandated as preventive services under federal law (PPACA). The level of benefits will depend on whether care is obtained through In-Network or Out-of-Network Providers. If You use an Out-of-Network Provider, You may be responsible for additional charges up to and including

the balance of the amount billed as outlined in SECTION THREE: HOW THE MAXIMUM CHOICE PLAN WORKS. For a comprehensive list of preventive services, please visit www.hhs.gov/healthcare/prevention/index.html.

**Contraceptive/Birth Control Drugs -** All FDA Contraceptive Services for women are covered under Preventive Health Services as mandated under federal law (PPACA).

**Days Supply, Quantity Limits, and Prior Authorization**. The number of days supply of a Prescription Drug that You receive is limited. Some Prescription Drugs have quantity limits and may require prior authorization before Your prescription can be filled. Refer to Your Schedule of Benefits for days supply.

Prior Authorization and Appeals: If a prescription drug claim is wholly or partially denied, you or your authorized representative has the right to appeal the decision. You or your authorized representative may appeal the denial no later than 180 days after receiving notice of an adverse claim decision. Appeals of prescription drug claims are handled by RxBenefits and are decided in accordance with the terms of the plan document. Following a clinical review, one of four actions will occur: the medication is approved, the medication claim is denied, the doctor may decide to withdraw and prescribe a different medication, or the reviewer can dismiss the claim due to lack of communication for the prescriber. If denied, the appeal process is available. Your prior authorizations are handled by the PBM.

The following medication may require a prior authorization under your plan:

- Acne Topical Agents
- ADHD Medications
- Opioid Analgesics
- Anti-Infective Agents
- Anti-Ulcer Medications
- Antiviral Agents
- Anti-Fungals
- Diabetic Agents
- Migraine Agents
- Narcolepsy Medications
- Specialty Medications
- Testosterone
- Topical Antihistamines
- Topical Anti-Inflammatories

The Appeal Process: If denied, the member may appeal the decision. Upon appeal, a second pharmacist reviewer will evaluate the prior authorization and make a decision (approved/denied). If denied a second time, a final appeal may be made, which is forwarded to an outside medical reviewer. If denied, there are no further appeals. Your doctor may initiate the Prior Authorization, quantity limit, high dollar claim review or any other rejection process by calling RxBenefits at 1-800-334-8134.

Quantity Limits: Quantity limits are limits on the amount of a drug that may be covered for reasons of safety and/or dose optimization. Quantity limits may apply when medical literature, clinical best practice and/or the FDA has established a maximum dosage as a safe limit. Quantities that exceed these safe limits are not a covered benefit. Dose optimization is limits on the quantity of a certain dose of medication in order to promote using the recommended quantity of drug per dosages available.

**Questions:** Contact RxBenefits Member Services for information regarding the prescription drug program at 1-800-334-8134.

See DEFINITIONS for additional information on Exigent Circumstances.

## SECTION SIXTEEN: MISCELLANEOUS PROVISIONS

1. **No Assignment**. You may not assign any benefits or monies under this Plan to any person, corporation, organization, or other entity. Any such assignment will be void and have no effect. Assignment means the transfer to another person, corporation, organization, or other entity of a right to the benefits provided under this Plan. The Plan will not prevent a Provider from receiving payment for eligible charges for Covered Services rendered under a valid assignment. The Plan will determine whether an assignment of benefits to a Provider is a valid assignment.

2. **Notice**. Any notice which the Employer or its designee gives to You will be in writing and mailed to You at the address as it appears on the records. If You have to give the Employer or Claims Administrator any notice, it should be in writing and mailed to the address set forth in the Introduction section of this Certificate of Coverage.

3. **Medical Records**. The Plan is a covered entity under HIPAA and is permitted to use, obtain and disclose protected health information to perform the Plan's operations in accordance with the Plan's Notice of Privacy Practices. The Plan or its designee may obtain Your medical records and information relating to Your care from Physicians, Hospitals, Skilled Nursing Facilities, pharmacies, or other treating Providers in order to pay claims or carry out other health care operations as explained in the Plan's Notice of Privacy Practices. The Plan will not use or disclose Your protected health information other than for the purposes allowed by HIPAA without Your authorization.

4. **Genetic Testing**. The Plan will not seek or use genetic screening or test results for the purpose of determining group health care plan rates or eligibility for enrollment.

5. **Recovery of Overpayments**. On occasion, a payment may be made to or for You when You are not covered, for a service which is not covered, or which is more than is appropriate for that service. When this happens, the Plan will explain the problem, and You must return to the Plan within 60 calendar days the amount of the mistaken payment, or provide the Plan with written notice stating the reasons why You may be entitled to such payment. In accordance with and to the extent permitted by applicable law, the Plan may reduce future payments to You in order to recover any mistaken payment. Overpayments and mistaken payments made to Providers will be recovered directly from them. Overpayment can only be recovered if payment has been made within two years.

6. **Confidentiality**. Medical records, which the Plan receives from Providers, are confidential. The Plan will use Your individually identifiable personal health information only in performance of treatment, payment or health care operations in accordance with the Plan's Notice of Privacy Practices. See the Plan's Notice of Privacy Practices for further details.

7. **Right To Develop Guidelines**. The Plan reserves the right to develop or adopt criteria which set forth in more detail the instances and procedures when payments of benefits will be made under the Plan. Examples of the use of the criteria are: to determine whether care was Medically Necessary, whether Emergency Services in the Outpatient department of a Hospital were Medically Necessary, or whether certain services are skilled care. These criteria will be interpretive and illustrative only and will not be contrary to any term or provision of the Plan. If You have a question about the criteria which applies to a particular benefit, You may contact Claims Administrator for further information.

8. **Review**. If a claim for benefits is denied, a review of the denial may be obtained through the appeal procedure described in Section Thirteen, Internal Claims and Appeals Procedures and External Review.

9. **Limitation on Benefits of This Plan**. No person or entity other than the Employer, the Plan, NWOBA, and Covered Persons hereunder is or shall be entitled to bring any action to enforce any provision of the Plan against the Employer, the Plan, NWOBA or Covered Persons hereunder, and the covenants, undertakings and agreements set forth in the Employer's Application and Participation Agreement and this Certificate of Coverage shall be solely for the

benefit of, and shall be enforceable only by the Employer, the Plan, NWOBA and the Covered Persons covered under this Plan.

10. **Action at Law**. No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

11. **Certification**. Claims Administrator will automatically issue certification of Creditable Coverage under this Plan to You under certain conditions. A Claims Administrator Member Services Representative (419)-887-2525 or toll-free 1-800-462-3589 can assist You if You need to obtain certification of Creditable Coverage under this Plan.

12. **Applicable Law**. The Plan, the rights and responsibilities of the parties under the Plan, and any claims or disputes relating thereto, shall be governed by and construed and administered in accordance with the laws of the State of Ohio and any applicable federal law.

13. **Qualified Medical Child Support Orders**. The Plan will comply with all valid medical child support orders (QMCSOs) that are determined by the Plan to meet the requirements of the Employee Retirement Income Security Act of 1974, as amended.

14. **Facility of Payment:** If an insured person dies while benefits under the Plan remain unpaid, the Plan may, at its option, make direct payment to the Provider on whose charges the claim is based; or to the surviving spouse of the insured person; or if none, to his or her surviving child or children (including legally adopted child or children) share and share alike; or if none, to the executors or administrators of the insured person's estate.

15. **Time Effective:** The effective time for any dates used is 12:01 A.M. at the address of the insured person.

16. **Incontestability:** In the absence of fraud, any statement made by the insured person in applying for insurance under the Plan will be considered a representation and not a warranty. After the Plan 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.

17. **Misstatement of Age:** If the age of any person insured under the Plan 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).

18. **Fraud, Waste and Abuse**: Please notify Claims Administrator if you suspect healthcare fraud, waste or abuse against the company by using the following resources:

- Contact Claims Administrator's Member Services Department for a confidential discussion at 419-887-2525 or toll free at 1-800-462-3589.
- TTY services for the hearing-impaired are available at 1-888-740-5670 or 419-887-2526.
- You can contact the Paramount Compliance Hotline at 1-800-807-2693.
- Writing a letter to Claims Administrator's Mailing address:
- Paramount Health Care
    - Attn: Paramount Compliance Fraud, Waste, and Abuse
    - 300 Madison Ave, Suite 300, Toledo, OH 43604
- Email Address: paramount.memberservices@medmutual.com

**For more information, please visit Claims Administrator's website at https://www.paramounthealthcare.com/fraud-waste-and-abuse/**

## DEFINITIONS

When capitalized in this Certificate of Coverage or the Schedule of Benefits, the terms listed below will have these meanings:

**Adverse Benefit Determination** means a decision by Plan:

(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 Plan'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.

**Allowable Amount –** The maximum amount that Claims Administrator determines is reasonable for the Covered Services received.

**Authorized representative** means an individual who represents a covered person in an internal appeal or external review process of an *Adverse Benefit Determination* who is any of the following:

(1) A person to whom a covered individual has given express, written consent to represent that individual in an internal appeals process or external review process of an *Adverse Benefit Determination*;
(2) A person authorized by law to provide substituted consent for a covered individual;
(3) A family member but only when 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.

**Brand Name Drug** - A Prescription Drug that is dispensed under a proprietary name and classified as a brand by a national drug-pricing source.

**Certificate of Coverage -** This document, which includes the Schedule of Benefits.

**Child Health Supervision Services -** Periodic review of a child's physical and emotional status performed by a Physician or by a Health Care Professional under the supervision of a Physician. Periodic reviews are performed in accordance with the recommendations of the American Academy of Pediatrics and include a history, complete physical examination, developmental assessment, anticipatory guidance, appropriate immunizations, and laboratory tests.

**Claims Administrator** means Paramount Insurance Company**.**

**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.

**Coinsurance –** The fixed percentage of charges that You must pay toward the cost of certain Covered Services. See Your Schedule of Benefits to determine whether a service requires a Coinsurance payment and the amount for that service. Coinsurance on benefits received from In-Network Providers is a percentage of the Contract charge negotiated between the PPO Network and the Provider. This means that You receive the benefit of any discount. Coinsurance on benefits received from Out-of-Network Providers is a percentage of the NCA or UCR charge that the Plan will pay for the services rendered.

**Continuing Care Patient**- 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.

**Contract -** The agreement between the Employer and Paramount which consists of the following documents:

- The Large Group Policy.
- The Certificate of Coverage (Insurance).
- The Employer's application.
- The Employee's application, if any.
- Amendments or Endorsements to any of the above documents.
- Riders.

**Copayment -** The fixed dollar amount You must pay each time You receive certain Covered Services. See Your Schedule of Benefits for a list of those services that require Copayments.

**Cost Sharing** is any expenditure required by or on behalf of a Member with respect to Essential Health Benefits; the term includes Deductibles, Coinsurance, Copayments, or similar charges, but excludes premiums, balance billing amount for non-network Providers, spending for non-covered services and for cost-sharing for services obtained out- of-network.

**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.

**Covered Services -** The Health Care Services and items described in this Certificate of Coverage and updated in the Schedule of Benefits, for which the Plan provides benefits to You.

**Custodial Care** is treatment or services that could be learned and performed by a person not medically skilled, regardless of where they are to be provided. Custodial Care includes, but is not limited to:

1. personal care such as help in walking, getting in and out of bed, bathing, eating, tube or gastrectomy feeding, exercising, dressing, enema and using the toilet.

2. homemaking, such as preparing meals or special diets;
3. moving the patient;
4. suctioning;
5. catheter care;
6. acting as a companion or sitter;
7. supervising medication which is usually self-administered, and
8. preparation/supervision over medical supplies and/or medical equipment not requiring constant attention of trained medical personnel.

**Deductible -** The amount You and Your Dependents must pay for Covered Services, including Prescription Drug benefits, within a calendar year, before benefits will be paid by the Plan. See Your Schedule of Benefits for the Deductible amount that applies to You and Your dependents.

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

**Effective Date -** The first day You are covered under the Plan or the first day after the last day of the Employer's Waiting Period.

**Election Period -** The annual period of time during which an eligible employee and/or his or her dependents may select or turn down coverage under an Employer-sponsored health care benefit plan. An eligible employee and/or his or her eligible dependents may also change from one Employer sponsored health care benefit plan to another at this time.

**Elective -** Any activity pertaining to a condition that does not require immediate medical attention and for which reasonable delays will not adversely affect Your health or recovery. A foreseeable Hospital admission, such as the birth of a child, is also considered Elective.

**Emergency Medical Condition -** 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 individual or, with respect to a pregnant women, the health of the woman or her unborn child, in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

**Emergency Services -** means the following:

a) A medical screening examination, as required by federal law, that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department, to evaluate an Emergency Medical Condition;
b) Such further medical examination and treatment that are required by federal law to stabilize an Emergency Medical Condition and are within the capabilities of the staff and facilities available at the Hospital, including any trauma and the burn center of the Hospital.

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

a) Placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;
b) Serious impairment to bodily functions;
c) Serious dysfunction of any bodily organ or part. In the case of a woman having Contractions, "stabilize" means such medical treatment as may be necessary to deliver, including the placenta.

**Employer -** The Employer that elected to sponsor this Plan for its eligible employees/members and their eligible dependents.

**Essential Health Benefits** is defined under federal law (PPACA) as including benefits in at least the following categories: ambulatory patient services; Emergency Services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment;

prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. If Your plan contains any of these benefits, there are certain requirements that may apply to those benefits, as provided in this certificate.

**Exigent Circumstances** (Expedited Exception Request) exist when a member is suffering from a health condition that may seriously jeopardize the enrollee's life, health, or ability to regain maximum function or when a member is undergoing a current course of treatment using a non-formulary drug.

**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.

**Final Adverse Benefit Determination** means an *Adverse Benefit Determination* that is upheld at the completion of a Health Plan Issuer's internal appeals process.

**Generic Drug** - Any Prescription Drug that is dispensed under a non-proprietary name and classified as a generic by a national drug-pricing source.

**Health Benefit Plan** means a policy, certificate, or agreement offered by a Plan 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 Provider**: Means a Health Care Professional or facility.

**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.

**Health Savings Accounts (HSAs)** is a tax-exempt trust or custodial account You set up with a qualified HSA trustee to pay or reimburse certain medical expenses You incur. You must be an eligible individual to qualify for an HSA. To be an eligible individual and qualify for an HSA, You must meet the following requirements.

- You must be covered under a High Deductible Health Plan (HDHP)
- You have no other health coverage except as permitted and explained in IRS Publication 969.
- You are not enrolled in Medicare.
- You cannot be claimed as a dependent on someone else's tax return.

**High Deductible Health Plan (HDHP).** An HDHP has:

- A higher annual Deductible than typical health plans, and
- A maximum limit on the sum of the annual Deductible and out-of-pocket medical expenses that You must pay for covered expenses. Out-of-pocket expenses include Copayments and other amounts, but do not include premiums.

An HDHP provides Preventive Health Services without a Deductible.

**Hospital -** An institution that: (1) provides Medical Care and treatment of sick and injured persons on an Inpatient basis; (2) is properly licensed or permitted legally to operate as such; (3) has a Physician on call at all times; (4) has licensed graduate registered nurses on duty 24 hours a day; and (5) maintains facilities for the diagnosis and treatment of illness and for major surgery.

The definition of Hospital may also include one or more of the following: (1) alcoholism or drug addiction treatment facility; (2) psychiatric Hospital; (3) ambulatory surgical facility; (4) freestanding birth center; and

(5) hospice facility – provided the facility is licensed in the state in which the facility operates and is operating within the scope of its license.

The definition of Hospital does not include an institution or any part of one that is a convalescent/extended care facility, or any institution which is used primarily as: (1) a rest facility; (2) a nursing facility; (3) a facility for the aged; or (4) a place for Custodial Care.

**In-Network -** A group of Providers who participate in the Preferred Provider Organization (PPO) Network to provide Covered Services, as set forth in this Certificate of Coverage.

**In-Network Physician/Provider -** Any Physician, Hospital, or other health services Provider who has a Contract with the PPO Network to provide Covered Services to Covered Persons.

**Independent Review Organization (IRO)** means an entity that is accredited to conduct independent external reviews of *Adverse Benefit Determinations*.

**Inpatient -** You will be considered an Inpatient if You are treated in a Hospital as a registered bed patient incurring a charge for room and board, upon the recommendation of a Physician.

**Mail Order Pharmacy -** A Mail Order Pharmacy that has a contract with the Plan or a PBM to provide mail order Prescription Drug benefits for Covered Persons.

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

**Medical Director -** A duly licensed Physician or his or her designee who has been designated by the Plan or is designee to monitor the provision of Covered Services to Covered Persons.

**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 or its designee 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 or its designee utilizes additional sources including Medicare and Medicaid policy and Food and Drug Administration (FDA) releases. This information is evaluated by The Plan or its designee's Medical Director and other Physician advisors. See Internal Claims and Appeals Procedures and External Review Section in this certificate.

**Mental Disorder or Illness -** Any disorder or disability described in the most current edition of *Diagnostic and Statistical Manual of Mental Disorders,*(DSM*)*

**Multi Source Brand Drug** – A Multi Source Brand Drug includes:

- A Brand Drug that has a generic, over-the-counter or isomeric brand drug equivalent;
- A Brand Drug with An isomeric brand drug is a drug with a molecular structure similar to an existing drug already on the market (e.g. enantiomer having a mirror image relationship to a drug already on the market.). Examples include Clarinex (desloratadine) is an isomeric brand drug of Claritin (loratadine) and Xopenex (levalbuterol) is an isomeric brand drug of Proventil (albuterol).
- A Brand Drug representing a metabolite of an existing marketed drug; or
- A Brand Drug with an existing or substantially similar Brand or Generic Drug marketed by utilizing an oral, transdermal, inhaled, transscleral, etc. proprietary drug delivery system. Examples include OROS, Zydis, EnSolv, EnCirc, EnVel, CDT, or AdvaTab.

**Network Pharmacy** - A retail pharmacy that has a contract with Plan or PBM to provide Prescription Drug benefits for Covered Persons.

**Non-Contracting Amount (NCA)**- The maximum amount determined as payable and allowed by the Plan for a Covered Service provided by an Out-of-Network Hospital Provider in Lucas, Defiance, Sandusky County(ies).]

**Non-Preferred Brand Drug** – A Prescription Drug that is denoted as "Non-Preferred" by the Plan as determined by The Plan's P&T.

**Outpatient -** You will be considered to be an Outpatient if treated on a basis other than as an Inpatient in a Hospital or other covered facility. Outpatient care includes services and supplies provided and used at a Hospital or other covered facility under the direction of a Physician to treat a person not admitted as an Inpatient.

**Out-of-Network Physician/Provider -** Any Physician, Hospital or health services Provider who does not have a Contract with the Preferred Provider Organization (PPO) Network to provide Covered Services to Covered Persons.

**Out-of-Pocket Maximum -** Your Out-of-Pocket Maximum is stated in Your Schedule of Benefits. After that amount has been paid, there will be no additional Cost Sharing during the remainder of that calendar year. The Out-of-Pocket Maximum is the maximum amount of Copayments and Coinsurance including medical and prescription drug Deductibles (if any) paid by a Covered Person in a calendar year. The single Out-of-Pocket Maximum is the amount each Covered Person must pay. A family Embedded Out-of-Pocket Maximum is the total amount any **two or more** covered family members must pay. An Aggregate Out-of-Pocket Maximum is the total amount any **one or more** covered family member must pay. The Out-of-Pocket Maximum of one family member will not exceed the individual annual Cost Sharing limit as set by the Department of Health and Human Services.

**Pharmacy and Therapeutics Working Group (P & T)** - A committee comprised of Physicians and pharmacists that reviews medications for safety, efficacy and value. This committee continually monitors and updates the Formulary and Maintenance List and makes periodic revisions to plan guidelines regarding coverage for specific drugs and/or therapeutic categories.

**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.

**Plan -** The plan of health benefits described in this Certificate of Coverage and the Schedule of Benefits.

**Post-service claim** means any claim for a benefit under The Plan that is not a "Pre-Service Claim."

**Pre-existing Condition** - Any physical or mental condition, regardless of the cause, for which You have received medical advice, diagnosis or care, or have had treatment recommended within the 6-month period preceding Your Effective Date.

**Preferred Brand Drug** - A Prescription Drug that is approved for coverage as a "Preferred Brand

Drug".

**Prescription or Prescription Drug** - A drug which has been approved by the U.S. Food and Drug Administration (FDA) and which may, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. For the purpose of coverage under this Rider, this definition shall include insulin.

**Prescription Order or Refill** - An authorization for a Prescription Drug issued by a Physician who is duly licensed to make such an authorization in the ordinary course of his or her professional practice.

**Pre-Service Claim** means any claim for a benefit under The Plan, with respect to which the terms of the Plan condition receipt of the benefit, in completely or in part, on approval of the benefit in advance of obtaining Medical Care.

**Preventive Health Services** – Preventive Health Services are those Covered Services (including medications) that are being provided: 1) to a Covered Person who has developed risk factors (including age and gender) for a disease for which the Covered Person has not yet developed symptoms, and 2) as an immunization to prevent specific diseases. However, any service or benefit intended to treat an existing illness, injury or condition (including medications) does not qualify as Preventive Health Services. See Preventive Health Services in Section Four in this Certificate for details.

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

**Retrospective Review** means a review conducted after services have been provided to a Covered Person.

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

**Single Source Brand Drug** - A Brand Name Drug that is marketed under a registered trade name or trademark and is available from only one manufacturer. These drugs are generally patent protected for a period of time.

**Skilled Nursing Facility -** A specially qualified licensed facility which has staff and equipment to provide skilled nursing care or rehabilitation services and other related health services.

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

**Superintendent** means the superintendent of insurance.

**Telehealth** means 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 following is located:

a. the patient receiving the services;

b. another Health Care Professional with whom the provider of services is consulting regarding the patient.

**Urgent Care Services** means Covered Services provided for an Urgent Medical Condition. and may include such health care services for an Urgent Medical Condition provided out of the Plan's Service Area.

**Urgent Medical Condition** - An unforeseen condition of a kind that usually requires medical attention without delay but that does not pose a threat to the life, limb or permanent health of the injured or ill person.

**Usual, Customary and Reasonable (UCR) Charges -** is 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.

**Waiting Period -** A period of time that must pass before an employee or dependent's coverage is effective under the terms of an Employer or union sponsored Health Benefit Plan. If an employee or dependent enrolls under an enrollment period similar to one described in Section One, Paragraph 2.C., Marriage, Birth, Placement for Adoption, or Adoption or 2.D, Special Enrollment -Loss of Other Coverage, any period before such enrollment is not a Waiting Period. The Waiting Period will not exceed 90 days.

**You, Your, Yourself –** Refers to a policyholder, subscriber, enrollee, member, or individual covered by The Plan. "*You*" does include *Your* Authorized Representative with regard to an internal appeal or external review in accordance with of the provisions of this Certificate. "*You*" does not include *Your* representative in any other context.