NORTHWEST OHIO BUSINESS ALLIANCE MEWA

HMO

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

This Certificate of Coverage is not a Medicare supplement policy or certificate. If you are eligible for Medicare, review the "Guide to Health Insurance for People with Medicare" available from The Plan

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

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

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

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

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

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

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

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

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

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

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

Assyrian:

ܪܝܫܐ ܡܫܬܡܫܝܢ ܡܫܬܡܫ ܫܪܝܪ ܒܪ ܦܪ ܚܫܚ ܒܪ ܐܒ .ܡܬܬ ܪܝܫܐ ܡܫܬܡܫ ܫܪܝܪ ܒܪ ܦܪ ܚܫܚ ܒܪ ܐܒ ,ܡܝܐ ܚܫܚ ܒܪ ܐܒ :ܡܝܐ
ܫܝܫ ܒܪ ܚܫܚ ܐܒ (**TTY:711**) **1-800-462-3589** ,ܢܐ .ܡܫܡ ܡܝܬ ܫܝ ܡܫܬ ܫܝ ܡܫ ܫܪ ܒܪ ܚܫ ܐܒ ,ܡܫ ܫܪ ܒܪ ܚܫ ܐܒ

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 Nondiscrimination and Accessibility: Discrimination is Against the Law

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

The Plan provides:

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

If you need these services, contact The Plan Member Services at 1-800-462-3589, for TTY users, 1-888-740-5670, 8:00 a.m. to 5:00 p.m., Monday through Friday.

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

Member Services
300 Madison Avenue, Suite 270
Toledo, Ohio 43604

Alternate in Person Delivery Address:
650 Beaver Creek Circle, Suite 100
Maumee, Ohio 43537

Phone: 419-887-2525
Toll Free: 1-800-462-3589
TTY: 1-888-740-5670
Fax: 419-887-2047
Email: Paramount.MemberServices@MedMutual.com.

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

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

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

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

In Case of an Emergency Medical Condition

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

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

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

Your Primary Care Provider or PCP can be reached 24 hours a day, seven (7) days a week. If you need medical advice after hours, on weekends or holidays, call your doctor's office number. The answering service will take your call. Leave a message for the doctor or a nurse to return your call. A doctor or nurse will call you back with instructions.

List the names and numbers of the PCP for each family member.

Member Name_____
PCP (Name)_____
(Number)_____

Member Name_____
PCP (Name)_____
(Number)_____

Member Name_____
PCP (Name)_____
(Number)_____

Member Name_____
PCP (Name)_____
(Number)_____

Member Name_____
PCP (Name)_____
(Number)_____

Member Name_____
PCP (Name)_____
(Number)_____

Police_____**Fire**_____
Rescue_____ **Ambulance**_____
Hospital_____ **Poison Control**_____
Other_____

Dear Member:

Welcome.

This Certificate of Coverage will help you understand and use your benefits most effectively.

The PCP you chose when you joined will help you when you need medical care. ALWAYS CONTACT YOUR PCP FIRST unless there is an Emergency Medical Condition. He or she will help you coordinate all your medical care.

If you did not need to change doctors, be sure to call your PCP's office as soon as possible to let them know you are now covered by The Plan..

If you did change doctors, it is a good idea to get to know your doctor so you can feel comfortable asking questions, especially if an Emergency Medical Condition arises. If you are a new patient with your PCP, we encourage you to call the doctor's office for an appointment as soon as you can to discuss your medical history and get to know each other.

This Certificate of Coverage also explains who is covered under your Plan and how the Plan works. Please take a few minutes to read it. *If you have any questions or need help understanding your benefits, please call Member Services, Monday through Friday, 8:00 a.m. to 5:00 p.m.* at TEL: *(419) 887-2525 Toll-Free 1-800-462-3589.*

We look forward to serving you.

Member Services Department

The coverage described in the Certificate of Coverage is based upon the terms of the Group Medical and Hospital Service Agreement (Group Contract or Contract) issued to your Group, and the Plan that your Group choose for you. The Group Contract, this Certificate of Coverage and any endorsements, amendments or riders attached, form the entire legal contract under which Covered Services are available. All documents referenced above are on file with your Group.

This Certificate of Coverage contains a summary of your rights and obligations regarding your enrollment and health benefits.

If there are any inconsistencies between this Certificate of Coverage and the Group Contract, the Group Contract will control.

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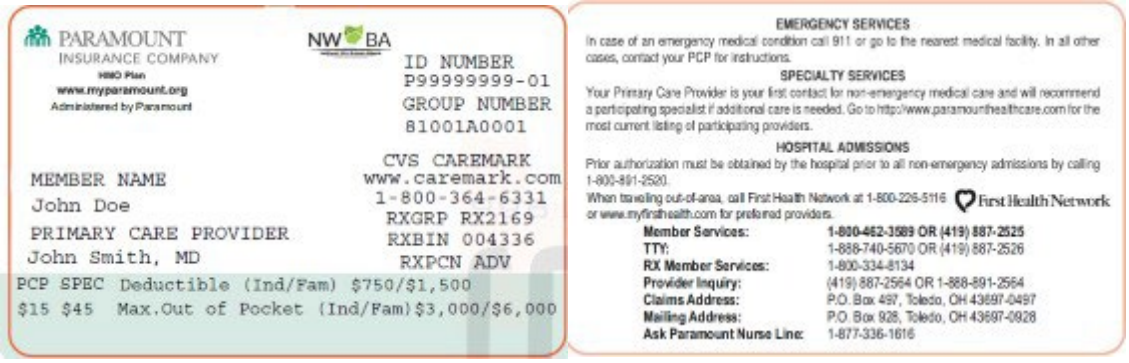
I. THE BASICS

HOW THE PLAN WORKS

Your PCP is your first contact when you need medical care. Your PCP will coordinate your medical care with other Participating Providers in The Plan network. Female Members may receive OB/GYN care from a obstetrics/gynecology Participating Specialist without Prior Authorization from the PCP. For children, you may designate a pediatrician as their PCP.

YOUR IDENTIFICATION ("I.D.") CARD



Every Member receives a I.D. Card with his or her name. The name of that person's PCP is on the card.

If your ID Card is lost or stolen or any information is incorrect, call Member Services immediately. A new card will be mailed to you promptly.

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

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

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

IS THERE A PRE-EXISTING CONDITION RESTRICTION?

The Plan does not have any restrictions on pre-existing conditions. In other words, if you were being treated for a condition before you became a member, The Plan will provide benefits for Covered Services related to that condition on or after your effective date with The Plan as long as you follow the procedures described in

Section II, GETTING A DOCTOR'S CARE.

WHAT ARE DEDUCTIBLES?

The amount you and your Dependents must pay for Covered Services within a Contract Year before any benefits will be paid by the Plan. The single Deductible is the amount each Member must pay. The family Deductible is the total amount any **two or more** covered family members must pay. The Deductible amount of one family member will not exceed that of an individual annual Deductible maximum amount. If your Plan is a High Deductible Health Plan (HDHP), all Covered Services except for Preventive Health Services are subject to the Deductible. An Embedded Deductible plan cannot be used as a High Deductible Health Plan (HDHP) with a Health Savings Account (HSA) if either the Deductible for the family as a whole or the Deductible for an individual family member is less than the minimum annual Deductible for family coverage.

See **Section VIII, TERMS AND DEFINITIONS**, in this Certificate of Coverage for more information regarding an HDHP and HSA. See **Section IV, COVERED SERVICES**/Preventive Health Services for a list of Preventive Health Services/Benefits.

WHAT ARE COPAYMENTS AND COINSURANCE?

The Plan Members pay Copayments (copays) or Coinsurance for services such as: office visits and services, inpatient services (services you receive while a patient in a hospital or other medical facility), outpatient medical services, emergency services, laboratory and radiology services, treatment for mental illness and substance abuse. Cost Sharing will not exceed 40% of the total annual cost to The Plan of providing all Covered Services. See your Schedule of Benefits for Copayments, Coinsurance and Deductibles on specific services. Copayments are payable at the time you receive services.

If you are required to pay for a health care service out-of-pocket, the amount you are required to pay shall not exceed the amount the applicable reimbursement rates negotiated with the provider or pharmacy. This provision does not preclude a person from reaching an agreement with a Health Care Provider or pharmacy on terms that are more favorable to the person than negotiated reimbursement rates that otherwise would apply as long as the claim submitted reflects the alternative amount negotiated.

The Out-of-Pocket Maximum is the maximum amount of Deductible, Copayments and Coinsurance you pay every Contract Year. Once the Out-of-Pocket Maximum is met, there will be no additional Cost Sharing during the remainder of the Contract Year for Covered Services**.** The Out-of-Pocket Maximum is stated in your Schedule of Benefits. 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 Plan will pay 100% of applicable charges for each family member who has reached the self-only Out-of-Pocket maximum, even if the family Out-of-Pocket Maximum has not been met.

WHO TO CALL FOR INFORMATION

The Plan values your comments and suggestions to improve our services. It is our goal to resolve any concerns as quickly and satisfactorily as possible. Our Member Services staff is available Monday through Friday, 8:00 A.M. to 5:00 P.M., at (419) 887-2525, or toll-free 1-800-462-3589, to answer your questions, and assist you with solving your problems. After hours, if you need information on how to access health care services, you may call the local or toll-free The Plan Member Services phone number and be connected with an after-hours information service.

Call, if you:

- Have any questions about your coverage
- Have questions about the Providers who participate with The Plan
- Have questions about how to obtain health care services
- Need help understanding how to use your benefits
- Need to change your PCP
- Are changing addresses, or need to add a new family member to your Plan
- Lose your I.D. Card
- Or have any other health care coverage concerns

If you have an administrative complaint or a complaint unrelated to a claim, you may direct these complaints to the Member Services Department by phone or mail to P.O. Box 928, Toledo, Ohio 43697-0928, Attention: Member Services, or email: Paramount.memberservices@promedica.org. TTY users may call 1-888-740-5670.

MEMBERS' RIGHTS

As a Member of The Plan, you have certain rights that you can expect from The Plan and Participating Providers. You have the right to:

- Receive information about The Plan, its services, providers and your rights and responsibilities.
- Participate with your Physicians in decision making regarding your health care.
- A candid discussion of appropriate or Medically Necessary treatment options for the conditions regardless of cost or benefit coverage.
- Be treated with respect, recognition of your dignity and the need for privacy.
- Make recommendations regarding The Plan's Member rights and responsibilities policies.
- Voice complaints or appeals about the health plan or care provided.

MEMBERS' RESPONSIBILITIES

As a Member of The Plan, you have certain responsibilities that The Plan and Participating Providers can expect from you. You have the responsibility to:

- Provide, to the extent possible, information that The Plan and the Participating Providers need to care for you. Help your PCP fill out current medical records by providing current prescriptions and your previous medical records.
- Engage in a healthy lifestyle, become involved in your health care and follow the plans and instructions for the care that you have agreed on with your PCP or specialists.
- Understand your health problems and participate in developing mutually agreed-upon treatment and goals to the degree possible.
- Notify The Plan if you suspect healthcare fraud, waste, or abuse against the company by using the following resources:

    - Contact Member Services 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 ProMedica Health System Compliance Hotline at 1-800-807-2693
    - Writing a letter to The Plan mailing address:
      The Plan Health Care
      Attn.: The Plan Compliance Fraud, Waste, and Abuse
      300 Madison Ave Suite 270Toledo, OH 43604
    - Email Address: Paramount.memberservices@MedMutual.com
    - Confidential fax number: 419-887-2037

    For more information, please visit The Plan's website at https://www.paramounthealthcare.com/legal-privacy-compliance/fraud-waste-and-abuse.

SURPRISE BILLING

Your Rights and Protections Against Surprise Medical Bills

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

Both the Ohio Revised Code (ORC 3902.50 to 3902.54), Ohio Administrative Code Section 3901-8-17 and the federal "No Surprises Act" (Public Law 116-260) establish patient protections against non-participating providers' surprise bills for Emergency Services or, in certain circumstances, for covered services rendered at in-network facilities by non-participating providers. The Plan will comply with state

and federal surprise billing requirements as they apply to health plans, including those which relate to the processing of claims from certain out-of-network providers.

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

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

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

You are protected from balance billing for:

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

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

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

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

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

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

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

network.

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

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

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

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

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

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

In addition, you may contact The Plan’s 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.

II. GETTING A DOCTOR'S CARE

START WITH YOUR PCP

Your PCP is the doctor you chose to handle your medical care through your Plan. The Plan requires the designation of a PCP for each Member. You have the right to designate any PCP who participates in The Plan’s network as a PCP and who is available to accept you or your family members. PCPs are family practitioners, internists and pediatricians participating in The Plan’s network. For children, you may designate a pediatrician as the PCP. Each family member can have a different PCP. For information on how to select or change a PCP, and a list of the Participating Providers who are PCPs, contact Member Services at (419) 887-2525 or toll-free 1-800-462-3589. A directory of Participating Providers is also available at: www.paramounthealthcare.com.

If you have chosen a doctor you have not seen before, make an appointment and get to know the doctor and staff. The more comfortable you are with your doctor - and the better your doctor knows you - the more effective your health care can be.

For doctor appointments, call your PCP's office.

The Plan maintains specific access standards to make sure you get the care you need on a timely basis. Access refers to both telephone access and the ability to schedule appointments. If you are having difficulty scheduling an appointment or reaching a provider's office, please contact the Member Service Department. They will assist you.

Please call as far in advance as possible for an appointment. Use the following table of access standards as a guide for the lead-time you should allow.

ACCESS STANDARDS for MEDICAL HEALTH CARE SERVICES	
TYPE OF CARE REQUIRED	**EXPECTED ACCESS STANDARDS**
Routine assessments, physicals or new visits	30 days
Routine follow-up visits (for recurring problems related to chronic ailments like high blood pressure, asthma, diabetes, etc.)	14 days
Symptomatic, non-urgent symptoms (cold, sore throat, rash, muscle pain, headache)	2 - 4 days
Urgent Medical Conditions (unexpected illnesses or injuries requiring prompt attention soon after they appear; Urgent Medial Conditions are not permanently disabling or life-threatening; an example would be a persistent high fever)	1 – 2 days
Emergency Medical Conditions (such as heart attack, stroke, poisoning, loss of consciousness, inability to breathe, uncontrolled bleeding and convulsions)	Immediately call 911 or seek medical treatment. Afterward, call your PCP for follow-up care.

ACCESS STANDARDS for BEHAVIORAL HEALTH CARE SERVICES	
TYPE OF CARE REQUIRED	**EXPECTED ACCESS STANDARDS**
Emergency care, immediate threat to self or others (acutely suicidal or homicidal)	Immediately call 911 or seek medical treatment. Then call your PCP for follow-up care
Urgent Care, may not be life-threatening, but requires urgent attention (complex or dual problems)	1 – 2 days
Routine Care/ Office Visit for new problems upon request of the Member or Provider	14 days
Routine Care/ Office Follow-Up Visits	30 days

If you are unable to keep an appointment, call your Physician as soon as possible so the time can be made available for other patients. The Plan will not cover claims associated with missed appointments.

Your PCP can be reached 24 hours a day, seven (7) days a week. If you need medical advice after hours, on weekends or holidays, call your doctor's office number. The answering service will take your call. Leave a message for the doctor to return your call.

When your doctor, the doctor who is covering for your PCP or a nurse calls you, explain the problem clearly. They will advise you on what to do.

When your doctor recommends a treatment or test, in most cases it will be covered. However, some treatments may not be covered or are covered only when authorized in advance by The Plan. Your doctor may be working with several plans; plans are often different from one company to the next. The service your doctor recommends for you may be covered under some similar plans, but not under your particular Plan.

If you are not sure, the best thing to do is ask Member Services. Don't be afraid to call.

IF YOU HAVE A QUESTION about whether a service is covered, you can find out by calling Member Services.

If another doctor is covering for your PCP during off-hours or vacation, you do not need The Plan Prior Authorization before you see that doctor. Be sure to tell the doctor you are a Member of The Plan.

You may change your PCP. You must notify The Plan first, before you see any new PCP. Call Member Services or email through The Plan web site at: www.paramountinsurancecompany.com. The change can be made effective the day you call. You will receive a new I.D. Card with your new Physician's name. If you need to see the doctor before your card arrives, your doctor can call Member Services to check your membership.

What to Consider When Selecting or being referred to a Physician or Hospital/Facility

If you need specific information about the qualifications of any Physicians, who are Participating Providers, you may call Member Services or you may use the on-line provider directory available through our web site at www.Paramountinsurancecompany.com with links to the Ohio State Medical Association.

The following qualifications are important to consider in selecting or being referred to a PCP or a specialist:

- Professional education – medical school/residency training,
- Current Board Certification status,
- Number of years in practice and
- Languages spoken
- Is the Physician a Participating Provider

The following qualifications are important when selecting a hospital/facility:

- The Joint Commission status (The Plan Participating Hospitals are required to have Joint Commission accreditation)
- Hospital experience/volume in performing certain procedures.
- Consumer satisfaction and comparable measures of quality on hospitals and outpatient surgical facilities.
- Is the hospital/facility a Participating Provider

If you need a current directory, you may request one by calling Member Services or you may use the on-line provider directory available through our web site at www.paramounthealthcare.com.

WHEN YOU NEED OB/GYN CARE

You do not need an out-of-plan Prior Authorization from The Plan or from any other person (including your PCP)

in order to obtain access to obstetrical or gynecological care from a Health Care Professional in The Plan network who specializes in obstetrics or gynecology. The Health Care Professional, however, may be required to comply with certain procedures, including obtaining Prior Authorization for certain services or following a pre-approved treatment plan. See **Prior Authorization** in this Certificate of Coverage for more information. For a list of participating Health Care Professionals who specialize in obstetrics or gynecology, contact Member Services at (419) 887-2525 or toll-free 1-800-462-3589. A directory of Participating Providers is also available at: www.paramounthealthcare.com.

If you need more specialized OB/GYN care, the gynecologist may recommend another Participating Specialist.

WHEN YOU ARE REFERRED TO A SPECIALIST

Most of your health care needs can and should be handled by your PCP. If your PCP believes you need to see a specialist - a cardiologist, orthopedist or others - your PCP will recommend a Participating Specialist, or you may choose the Participating Specialist you wish to see from those listed in the *Participating Physicians and Facilities* directory (also available on the website) and make an appointment. You will be held financially responsible if your selected specialist (and/or hospital/facility where services are rendered) is Non-Participating and an out-of-plan Prior Authorization was not obtained. See **Prior Authorization** in this Certificate of Coverage for more information.

Newly enrolled Members of The Plan who are already seeing a specialist should verify that the specialist is participating with The Plan as a Participating Specialist.

IF YOU HAVE A QUESTION about whether a service, facility or provider is covered and is participating, you can find out by calling Member Services.

PRIOR AUTHORIZATION

Prior Authorization is required for certain procedures or services. It is the responsibility of the Participating Provider to obtain Prior Authorization from The Plan in advance of these procedures or services. However, it is the Member's responsibility to make sure procedures and services are provided by a Participating Provider or that an out-of-plan Prior Authorization is obtained.

Participating Providers are listed in your Directory of Participating Physicians and Facilities or at The Plan's website www.paramountinsurancecompany.com.

If a Medically Necessary Covered Service is not available from any Participating Providers, The Plan will make arrangements for an "out of plan Prior Authorization". Your Primary Care Provider must request an "out of plan Prior Authorization" in advance. Consultations with Participating Providers may be required before an "out of plan Prior Authorization" can be approved. If The Plan approves the "out of plan Prior Authorization", written confirmation will be sent to you, your PCP and the non-Participating Provider. All eligible authorized services will be covered at no greater cost to you than if you had obtained the service or procedure from a Participating Provider.

UTILIZATION MANAGEMENT

Participating Providers have direct access to The Plan's Utilization Management Department to authorize specific procedures and certain other services based on Medical Necessity. If you experience an Emergency Medical Condition after normal office hours, you should call 911, an ambulance or rescue squad or go to the nearest medical facility. You do not need to obtain Prior Authorization from your PCP or The Plan. Afterward, you should notify your PCP that you were treated.

Utilization management decisions are not subject to incentives to restrict or deny care and services. In fact, The Plan monitors under-utilization of important preventive services, health screening services (immunizations, pap

tests, etc.), medications and other services to care for chronic conditions, such as asthma and diabetes. The Plan will send reminder cards to the Member and Physician if a claims review suggests that important services were missed.

If you need to discuss the status of a Prior Authorization, you should contact your PCP. You may also call Member Services at (419) 887-2525 or toll-free 1-800-462-3589.

INITIAL DETERMINATIONS

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

In the case of an urgent non-electronic request for services, The Plan will make a decision as soon as possible, but not later than forty-eight (48) hours after receipt of the request. If insufficient information is received, The Plan will notify the Member and/or your provider not later than twenty-four (24) hours after receipt, of the specific information needed. The Member will be afforded not less than forty-eight (48) hours to provide the specified information. The Plan will provide a decision no later than forty-eight (48) hours after the earlier of:

a) The Plan's receipt of the specified information

b) The end of the period afforded the Member to provide the specified information.

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

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

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

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

The Plan's response will indicate whether the request is approved or denied. If the Prior Authorization is denied, The Plan will provide the specific reason for the denial. You have the right to appeal through the appeals process outlined in **Section VI, Internal Claims and Appeals Procedures and External Review** of this Certificate of Coverage.

CONCURRENT REVIEWS

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

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

Any request that involves both urgent care and the extension of a course of treatment previously approved by The Plan must be decided as soon as possible, and notification must be provided within twenty-four (24) hours after receipt of the request, provided the request to The Plan 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 The Plan, the request may be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim, e.g., as a *pre-service claim* or a *post-service claim*.

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 48 hours after receipt.

In the event of a denial, in whole or in part, by The Plan, you have the right to appeal through the appeals process outlined in **Section VI, Internal Claims and Appeals Procedures and External Review** of this Certificate of Coverage.

RETROACTIVE DENIALS

If The Plan authorizes a proposed admission, treatment, or health care service by a Participating Provider based upon the complete and accurate submission of all necessary information The Plan will not retroactively deny this authorization if the Participating Provider renders the care in good faith and pursuant to the authorization and all of the terms and conditions of the provider's contract with The Plan.

RETROSPECTIVE REVIEWS

A Retrospective Review is a request for The Plan to evaluate whether a health care service that a Member has already received was Medically Necessary. For all Retrospective Reviews, The Plan will make a decision within thirty (30) business days after receiving all necessary information. The Plan will notify the provider and the Member of its decision in writing. If The Plan makes an adverse determination, The Plan will notify the provider and the Member of its decision in writing five (5) business days after receiving the request.

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

- The service is directly related to another service for which Prior Authorization has already been obtained and that has already been performed.
- The new service was not known to be needed at the time the original prior authorized service was performed.
- The need for the new service was revealed at the time the original authorized service was performed.

If the claim meets all three of these conditions, The Plan will review the claim for coverage and Medical Necessity once the written request for Retrospective Review and all necessary information are received. The Plan will not deny a claim for such a new service based solely on the fact that a Prior Authorization approval was not received for the new service in question. The Plan will make a decision regarding the claim within thirty (30) business days after receiving all necessary information. The Plan will notify the provider and the Member of its decision in writing. If The Plan makes an adverse determination, The Plan will notify the provider and the Member of its decision in writing five (5) business days after receiving the request.

ADVERSE BENEFIT DETERMINATIONS AND REQUESTS FOR RECONSIDERATION

The Plan's written notification will include the principal reason/s for the decision including specific utilization review criteria or benefit provision used in making the determination. The Plan will also include instructions for requesting a written statement of the clinical rationale used to make the decision. The Plan will provide a written statement of the clinical rationale to any Authorized Person making the request and following the instructions.

When an adverse determination has been made in response to an initial determination or concurrent review request, the provider may, in writing and on the Member's behalf, request that The Plan reconsider the adverse determination. No reconsideration may occur without the prior consent of the Member. The Plan will reconsider the adverse determination within three (3) business days after The Plan's receipt of the written request. The reconsideration shall be conducted between the provider or facility rendering the service and the reviewer who made the Adverse Benefit Determination, unless that reviewer is unavailable. If that reviewer cannot be available within three business days, the reviewer may designate another reviewer. If the reconsideration does not resolve the difference of opinion, you or your provider acting with your prior consent may request an internal review through the appeals process outlined in **Section VI, Internal Claims and Appeals Procedures and External Review** of this Certificate of Coverage.

OBTAINING NECESSARY INFORMATION

If a provider or Member will not release the necessary information needed to make a decision, The Plan may deny approval.

ENTERING THE HOSPITAL

Your PCP or Participating Specialist will make the arrangements when you need hospital care. The Plan Participating Hospitals are listed in your *Participating Physicians and Facilities* directory or The Plan web site at www.paramounthealthcare.com. Show your I.D. Card when you are admitted.

If you are in the hospital when this Plan becomes effective, your The Plan coverage will begin on your effective date. (The Plan you had when you were admitted should cover your hospital stay up to your effective date with this Plan.)

An emergency admission to a non-Participating Hospital must be called in to The Plan within 24 hours (or as soon as reasonably possible). If and when your medical condition allows, your PCP and The Plan may arrange for you to be transferred to a Participating Hospital.

CHANGE IN BENEFITS

The Plan will notify you in writing if any benefits described in this Certificate of Coverage and Schedule of Benefits change.

IF A PROVIDER LEAVES THE PLAN

The Plan will notify affected Members of the termination of a contract for the provision of health care services between The Plan and a provider or facility by mail within fifteen (15) business days of The Plan receiving notification of the termination. Notice will be given to Members who have received health care services from the provider or facility or if the insured has selected the physician as their primary care physician within the previous twelve months. Additionally, if a member has received health care services within the last twelve months, The Plan will pay, in accordance with this Certificate of Coverage, all Covered Services rendered to a Member by the PCP or hospital between the date of the termination of the contract and five days after the notification of the termination is mailed to the Member's last known address.

IF A PARTICIPATING SPECIALIST LEAVES THE PLAN

If you are being seen regularly by a Participating Specialist or a specialty group whose agreement with The Plan ends, you and your PCP will be notified by mail within 15 days of The Plan receiving notification of the termination. You may then contact a new Participating Specialist for an appointment.

CONTINUITY OF CARE

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

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

PROVIDER REIMBURSEMENT/FILING A CLAIM

You should always show your I.D. Card to all providers. You are responsible for paying any office visit Copayments at the time you receive services. Participating Providers must notify The Plan of the services they have rendered within 90 days from the date of service.

If you have received services from a non-Participating Provider, it is your responsibility to submit a claim for consideration. You must obtain a standard claim form from the provider and send the claim to The Plan at the address below *within 120 days from the date of the service*. Be sure to include your I.D. Card number and a brief explanation of the circumstances related to the service.

Paramount Insurance Company
P.O. Box 928
Toledo, Oh 43697-0928

The Plan will send reimbursement directly to Participating Providers for Covered Services. In most cases, reimbursement for Covered Services will be sent directly to a non-Participating Provider, but instead may be paid directly to you. Claims are processed within 30 days from receipt of a fully completed claim. If any claim is denied, The Plan will send you an "Explanation of Benefits" with the reason for the denial. If you receive a denial on a claim and need further explanation or wish to appeal the denial, you may call Member Services for assistance. The appeal process is also described in **Section VI Internal Claims and Appeals Procedures and External Review** of this Certificate of Coverage.

NON-COVERED SERVICES

If you receive services that are not covered under your Plan, you are responsible for full payment to the provider of those services.

IF YOU RECEIVE A BILL

Copays are due at time of service. For Covered Services, you may be billed for Deductibles and Coinsurance by Participating Providers. Providers may bill you for non-Covered Services. If you have any questions about any amount(s) shown on the bill or statement, please contact Member Services.

NEW TECHNOLOGY ASSESSMENT

The Plan investigates all requests for coverage of new technology using the *HAYES Medical Technology Directory*® and current evidenced-based medical/scientific publications. If further information is needed, The Plan utilizes additional sources including Medicare and Medicaid policy and Food and Drug Administration (FDA)

releases. This information is evaluated by The Plan's Medical Director and other Physician advisors.

PRIVACY AND CONFIDENTIALITY

The Plan will keep all documented Member medical and personal information, whether obtained in writing or verbally, in the strictest confidence. The Plan will provide Members the opportunity to approve or deny the release of personal health information, except when such release is required by law. See The Plan's Notice of Privacy Practice for more information.

OWNERSHIP AND PHYSICIAN COMPENSATION

Paramount Insurance Company is a wholly owned subsidiary of the ProMedica Health System – one of the largest integrated delivery systems in the country. The ProMedica Health System operates acute care hospitals, ancillary facilities and primary care and specialist Physician practices in northwest Ohio and southeast Michigan. ProMedica facilities and providers are participating in The Plan network.

The Plan contracts with Participating Providers for health care services on an economically competitive basis, while taking steps to ensure that The Plan Members receive quality health care. The Plan reimburses Participating Providers through "fee-for-service". Fee-for-service is the payment of a specific amount for each specific service provided by the Physician. The amount is determined by The Plan, based on the procedure performed, and The Plan allowed amount for that procedure. Participating Providers agree to accept The Plan allowed amount (from a contractual fee schedule) as payment in full. Participating Providers, who are PCPs, are not subject to any risk or financial incentives for hospitalization or referring their patients for specialized services.

Through The Plan fee schedule, The Plan obtains discounts. When Coinsurance is charged as a percentage of eligible expenses, the amount a Member pays is determined as a percentage of the allowed amount (fee schedule) between The Plan and the Participating Provider, rather than a percentage of the provider's billed charge. The Plan's allowed amount is ordinarily lower than the Participating Provider's billed charge. Therefore, the benefit of the discount is passed on to you.

PATIENT SAFETY

The Plan is working with other hospitals, Physicians and health plans to educate our Members about patient safety. Here is what you can do to improve the safety of your medical care:

- Provide your doctors with a complete health history.
- Be an active member of your health care team. Take part in every decision about your health care. Speak up – ask questions.
- Make sure that all of your doctors know about everything that you are taking, including over the counter medications and herbal/dietary supplements.
- Make sure that your doctors know about any allergies and reactions to medications that you have had.
- Ask for test results. Don't assume that no news is good news.
- Advise your doctor of any changes in your health.
- Follow your doctors' advice and the instructions for care that you and your doctor have agreed on.
- Make sure that you can read the prescriptions you get from your doctor.
- Ask your doctor and pharmacist questions about your medications.
  - What is the medication for?
  - What are the brand and generic names of the medication?
  - What does the medication look like?
  - How should it be taken and for how long?
  - What should you do if you miss a dose?

- How should you store the medication?
- Does the medication have side effects? What are they? What should you do if they occur?

- When you pick up the medication, ask the pharmacist if this is the medication that was prescribed.
  - Make sure that you understand the instructions on the label.
  - Ask the pharmacist about the best device to measure liquid medications.
  - Read the information that is provided by the pharmacy.

It is always important that you play an active role in decisions about your health and your health care. Take responsibility – you can make a difference**!**

If you ever find yourself in the hospital, you'll likely have many health care workers taking care of you. While they make every effort to provide appropriate care, sometimes errors can happen. By taking an active role in your care and asking questions, you can help make sure the care you receive is right for you.

Should you find yourself needing hospital care, be sure to:

- Do your homework. Make sure that the hospital you're being treated in has experience in treating your condition. If you need help getting this information, ask your doctor or call the Plan's Member Service Department.
- See that health care workers wash their hands before caring for you. This is one way to prevent the spread of germs at home and infections in a hospital. Studies have shown that when patients checked whether health care staff had washed their hands, the workers washed their hands more often and used more soap.
- Ask about services or tests. Make sure to ask what test or x-ray is being done to make sure you are getting the right test. In the example of a knee surgery, be sure that the correct knee is prepped for surgery. A tip from the American Academy of Orthopedic Surgeons urges their Physicians to sign their initials on the site to be operated on before surgery.
- Ask about what to do when you get home. Before leaving the hospital, be sure the doctor talks to you about any medicines you need to take. Make sure you know how often, what dose to take, and any side effects to expect from the medicine. Also ask when you can return to your regular activities. See if the doctor has advice on things you can do to help your recovery.

If you have any questions or if things just don't seem right after you come home, be sure to call your doctor right away.

III. WHAT TO DO FOR URGENT CARE OR EMERGENCY MEDICAL CONDITIONS

URGENT CARE SERVICES

URGENT CARE SERVICES means Covered Services provided for an Urgent Medical Condition. An Urgent Medical Condition is an unforeseen condition of a kind that usually requires medical attention without delay but that does not pose a threat to the life, limb or permanent health of the injured or ill person. Urgent Medical Conditions include but are not limited to:

- Colds and cough, sore throat, flu
- Earache
- Persistent high fever
- Minor cuts where bleeding is controlled
- Sprains
- Sunburn or minor burn
- Skin rash

Urgent Medical Conditions should be treated by your PCP or, in the event your PCP is not available, in a participating urgent care facility. You should not go to a hospital emergency room for Urgent Medical Conditions.

Services received in a hospital emergency room for an Urgent Medical Condition without prior direction from your PCP, a participating plan Physician or The Plan are not covered.

What to do:

During office hours: Call your PCP's office as soon as symptoms persist or worsen. In most cases, your PCP will be able to treat you the same day or the next day. If the office cannot schedule you within a reasonable time, you may seek treatment at a participating urgent care facility or Physician's office. The service will be subject to an urgent care facility or office visit Copayment/Coinsurance, depending on where you receive treatment. Your Copayment/Coinsurance may be found in your Schedule of Benefits.

Participating Providers are listed in your Directory of Participating Physicians and Facilities or The Plan web site at www.paramountinsurancecompany.com.

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

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

Follow-up care within the Service Area: Your PCP will coordinate what care you need after your urgent care services.

Follow-up care outside the Service Area: Follow-up services outside The Plan Service Area will not be covered unless authorized by your PCP and The Plan in advance.

ANY TIME AN URGENT CARE PHYSICIAN RECOMMENDS ADDITIONAL CARE, such as a return visit, seeing a specialist, additional testing or X-rays, etc., call The Plan Member Services **BEFORE** you get the services. The Plan Member Services can tell you if the service will be covered, or if you need to contact your PCP.

EMERGENCY SERVICES

If you are experiencing an emergency, call 9-1-1 or go to the nearest hospital. Services which The Plan determines to meet the definition of Emergency Services will be covered, whether the care is rendered by a Participating Provider or Non-Participating Provider. Emergency Services rendered by a Non-Participating Provider will be covered as Covered Services, however the Member will be responsible for any applicable Coinsurance, Copayment or Deductible.

Hospitals are open to treat an emergency 24 hours a day, 7 days a week. **Follow-up care is not considered an Emergency Service**. Benefits are provided for treatment of Emergency Medical Conditions and emergency screening and Stabilization services without Prior Authorization for conditions that reasonably appear to a prudent layperson to constitute an Emergency Medical Condition based upon the patient's presenting symptoms and conditions. Benefits for Emergency Services include but are not limited to facility costs and physician services, and supplies and prescription drugs charged by that facility. Whenever you are admitted as an Inpatient directly from a hospital emergency room, the emergency room services Copayment for that emergency room visit will be waived.

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

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

An Emergency Medical Condition also includes a behavioral health emergency where the Member is acutely suicidal or homicidal.

Emergency Services means the following:

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

Stabilize/Stabilized 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.

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

What to do:

Inside the Service Area: In the event of an Emergency Medical Condition, call 911, an ambulance or rescue squad or go directly to the nearest medical facility. In the event you are unsure about whether a condition is an Emergency Medical Condition, you may contact your PCP for instructions. Medical care is available through The Plan Physicians seven (7) days a week, 24 hours a day. The Plan will cover Emergency Services from non-Participating Providers inside the Service Area for Emergency Medical Conditions meeting the definition in Section VIII of 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 Member Services if you receive a balance bill for services for Emergency Medical Conditions when treated or transported by Non-Participating Providers.

Afterward, you should contact your PCP for advice on follow-up care.

Outside the Service Area: Call 911, an ambulance or rescue squad or go to the nearest emergency facility for treatment. Show your I.D. Card. In some cases, you may be required to make payment and seek reimbursement from The Plan. The Plan will cover Emergency Services from non-Participating Providers outside the Service Area for Emergency Medical Conditions meeting the definition in Section VIII of 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 The Plan Member Services if you receive a balance bill for services for Emergency Medical Conditions when treated or transported by Non-Participating Providers.

Follow-up care within the Service Area: Follow-up medical care must be arranged by your PCP with Participating Providers.

Follow-up care outside the Service Area: Only initial care for an **Emergency Medical Condition** is covered. Any follow-up care outside the Service Area is not covered unless authorized by your PCP and The Plan BEFORE the care begins.

If you are admitted to a hospital outside The Plan Service Area, you must call The Plan within 24 hours or as soon as reasonably possible. Follow-up care must be coordinated through your PCP.

THE PLAN SERVICE AREA

The Plan Service Area includes all of Ashland, Crawford, Defiance, Erie, Fulton, Hancock, Henry, Huron, Lucas, Marion, Morrow, Ottawa, Putnam, Richland, Sandusky, Seneca, Williams, Wood, and Wyandot counties, and portions of Allen, Delaware, Hardin, Knox, Lorain and Paulding counties.

IV. YOUR PLAN COVERED SERVICES

This section describes the Covered Services available under your Health Plan benefits when provided and billed by Participating Providers. To receive maximum benefits for Covered Services, care must be received from a PCP, Participating Specialist or another Participating Provider, except for Emergency Services. Services which are not received from a Participating Provider or approved with a Prior Authorization will be considered a non-Covered Service, the amount payable for Covered Services varies depending on the type of Participating Provider providing care.

All Covered Services and benefits are subject to the conditions, exclusions, limitations, terms and provisions of this Certificate of Coverage, including any attachments, riders and endorsements. Covered Services must be Medically Necessary and not Experimental/Investigative. The fact that a provider prescribes, orders, recommends, or approves a service, treatment or supply does not make it Medically Necessary or a Covered Service and does not guarantee payment. To receive maximum benefits for Covered Services, you must follow the terms of the Certificate of Coverage, including receipt of care from a Participating Provider, and ensuring your Participating Provider has obtained any required Prior Authorization. Our payment for Covered Services will be limited by any applicable Coinsurance, Copayment, Deductible, or Calendar Year Limit/Maximum in this Certificate of Coverage.

If you are required to pay for a health care service out-of-pocket, the amount you are required to pay shall not exceed the amount the applicable reimbursement rates negotiated with the provider or pharmacy. This provision does not preclude a person from reaching an agreement with a health care provider or pharmacy on terms that are more favorable to the person than negotiated reimbursement rates that otherwise would apply as long as the claim submitted reflects the alternative amount negotiated.

See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information

1. Ambulance Services

Ambulance Services are transportation by a vehicle (including ground, water, fixed wing and rotary wing air transportation) designed, equipped and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals:

- From your home, scene of accident or medical emergency to a Hospital;
- Between Hospitals;
- Between a Hospital and skilled nursing facility; or
- From a Hospital or skilled nursing facility to your home.

Treatment of a sickness or injury by medical professionals from an Ambulance Service when you are not transported will be covered if Medically Necessary. Other vehicles which do not meet this definition, including but not limited to ambulettes, are not Covered Services. The Plan will cover Emergency Services from Non-Participating Providers for Emergency Medical Conditions meeting the definition in Section VIII of this Certificate of Coverage. Members will not be balance billed for services for Emergency Medical Conditions when treated or transported by Non-Participating Providers.

Ambulance services are a Covered Service only when Medically Necessary, except:

- When ordered by an employer, school, fire or public safety official and the Member is not in a position to refuse; or
- When a Member is required by The Plan to move from a Non-Participating Provider to a Participating Provider.

Ambulance trips must be made to the closest local facility that can give Covered Services appropriate for your condition. If none of these facilities are in your local area, you are covered for trips to the closest facility outside your local area.

The Plan will cover Emergency Services from Non-Participating Providers for Emergency Medical Conditions meeting the definition in this Certificate of Coverage. Members will not be responsible for a balance bill from Non-Participating Providers for services for Emergency Medical Conditions when treated or transported by Participating Providers. Please contact Member Services if you receive a balance bill for services for Emergency Medical Conditions when treated or transported by Non-Participating Providers.

Ambulance usage is not covered when another type of transportation can be used without endangering the Member's health. Any ambulance usage for the convenience of the Member, family or Physician is not a Covered Service.

Non Covered Services for Ambulance include but are not limited to, trips to:

- a Physician's office or clinic;
- a morgue or funeral home.

2. **Behavioral Health Services (Mental Illness/Substance Abuse)**

Behavioral Health Services (Mental Illness/Substance Abuse Services) are covered for care of mental health and substance use disorders, including Biologically Based and non-Biologically Based Mental Illness. Coverage includes inpatient and outpatient care, emergency care and prescription drugs subject to the same Deductible, Copayments and/or Coinsurance, Plan standards and medical management processes to which those Covered Services would be subject if delivered as medical/surgical benefits. This includes intermediate levels of care such as residential treatment, partial hospitalization and intensive outpatient services. Outpatient office visits are subject to the Primary Care Physician Copayment/Coinsurance.

NOTE: Opioid Utilization Management Criteria

The 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 to 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

Non-Covered Services (please also see Non-Covered Services/Exclusions of this Certificate of Coverage)

Custodial or Domiciliary Care
- Supervised living or halfway houses.
- Room and board charges unless the treatment provided meets our Medical Necessity criteria for Inpatient admission.
- Services or care provided or billed by a school, halfway house, Custodial Care center for the developmentally disabled, or outward bound programs, even if psychotherapy is included.

NOTE: The Plan is intended to comply with the federal Mental Health Parity and Addictions Equity Act.

3. **Clinical Trials**

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 of Coverage. 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. 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.

4. Dental Services

Related to Accidental Injury - Outpatient Services, Physician Home Visits and Office Services, emergency care and Urgent Care Services for dental work and oral surgery are covered if they are for the initial repair of an injury to the jaw, sound natural teeth, mouth or face which are required as a result of an accident and are not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment without adversely affecting the patient's condition. Injury as a result of chewing or biting is not considered an accidental injury. "Initial" dental work to repair injuries due to an accident means performed within 12 months from the injury, or as reasonably soon thereafter as possible and includes all examinations and treatment to complete the repair. For a Child requiring facial reconstruction due to dental related injury, there may be several years between the accident and the final repair.

See the Schedule of Benefits for Benefit Limitation information. The benefit limit will not apply to outpatient facility charges, anesthesia billed by a provider other than the Physician performing the service, or to Covered Services required by law.

Covered Services for accidental dental include, but are not limited to:

- oral examinations;
- x-rays;
- tests and laboratory examinations;
- restorations;
- prosthetic services;
- oral surgery;
- mandibular/maxillary reconstruction; and
- anesthesia.

Other Dental Services

The only other dental expenses that are Covered Services are facility charges for Outpatient Services. Benefits are payable for the removal of teeth or for other dental processes only if the patient's medical condition or the dental procedure requires a hospital setting to ensure the safety of the patient.

Dental x rays, supplies & appliances and all associated expenses, including hospitalization and anesthesia for transplant preparation, initiation of immunosuppresives, and direct treatment of cancer or cleft palate are Covered Services.

NOTE: Pediatric stand-alone dental plans are available. Contact The Plan Marketing Department for information.

Non-Covered Dental Services

For dental treatment, regardless of origin or cause, except as specified elsewhere in this Certificate of Coverage. "Dental treatment" includes but is not limited to: Preventive care, diagnosis, treatment of or related to the teeth, jawbones (except that TMJ is a Covered Service) or gums, including but not limited to:

- extraction, restoration and replacement of teeth.
- medical or surgical treatments of dental conditions.
- services to improve dental clinical outcomes.
- Dental braces

- Dental x-rays, supplies & appliances and all associated expenses, including hospitalization and anesthesia, except as required by law. The only exceptions to this are for transplant preparation, initiation of immunosuppresives, direct treatment of acute traumatic injury, cancer or cleft palate.
- For treatment of the teeth, jawbone or gums that is required as a result of a medical condition except as expressly required by law or specifically stated as a Covered Service.
- Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly.

If general dental care services have been added to your coverage, it is stated in your Schedule of Benefits.

5. Diabetic Equipment, Education and Supplies

Diabetes Self-Management Training for an individual with insulin dependent diabetes, non-insulin dependent diabetes, or elevated blood glucose levels induced by pregnancy or another medical condition when:

- Medically Necessary;
- Ordered in writing by a Physician or a podiatrist; and
- Provided by a Health Care Professional who is licensed, registered, or certified under state law.

For the purposes of this provision, a "Health Care Professional" means the Physician or podiatrist ordering the training or a provider who has obtained certification in diabetes education by the American Diabetes Association.

Covered Services also include all Physician prescribed Medically Necessary equipment and supplies used for the management and treatment of diabetes. See “Medical Supplies, Durable Medical equipment and Appliances” and “Preventive Health Services” “Physician Home Visits and Office services”.

6. Diagnostic Services

Diagnostic services are tests or procedures performed when you have specific symptoms, to detect or monitor your condition. Coverage for Diagnostic Services, including when provided as part of Physician Home Visits and Office Services, Inpatient Services, Outpatient Services, Home Care Services, and Hospice Services includes but is not limited to:

- X-ray and other radiology services, including mammograms for any person diagnosed with breast disease
- Magnetic Resonance Angiography (MRA)
- Magnetic Resonance Imaging (MRI)
- CAT scans
- Laboratory and pathology services
- Cardiographic, encephalographic, and radioisotope tests
- Nuclear cardiology imaging studies
- Ultrasound services
- Allergy tests
- Electrocardiograms (EKG)
- Electromyograms (EMG) except that surface EMG’s are not Covered Services
- Echocardiograms
- Bone density studies

- Positron emission tomography (PET scanning)
- Diagnostic Tests as an evaluation to determine the need for a Covered Transplant Procedure
- Echographies
- Doppler studies
- Brainstem evoked potentials (BAER)
- Somatosensory evoked potentials (SSEP)
- Visual evoked potentials (VEP)
- Nerve conduction studies
- Muscle testing
- Electrocorticograms

Central supply (IV tubing) or pharmacy (dye) necessary to perform tests are covered as part of the test, whether performed in a hospital or Physician's office.

When Diagnostic radiology is performed in a Participating Physician's Office, no Copayment/Coinsurance is required.

7. Emergency Services

Covered for Emergency Services for Emergency Medical Conditions as described in Section III. WHAT TO DO FOR URGENT CARE OR EMERGENCY MEDICAL CONDITIONS of this Certificate of Coverage. Benefits for Emergency Services include but are not limited to facility costs and Physician services, and supplies and prescription drugs charged by that facility. The facility (hospital) charge will be subject to the appropriate Copayment/Coinsurance. If there is a Copayment it will be waived if the Member is admitted as a hospital inpatient. All other Physician and professional services charges will be subject to the appropriate Coinsurance as described in the Covered Services section of your Schedule of Benefits. If you receive Emergency Services at an Out-of-Network facility or Provider, 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 services. This includes services you may receive after you're in stable condition, unless you provide written consent and give up your protections not to be billed for these post-stabilization services.

Continuation of care from a Non-Participating Provider beyond that needed to evaluate or Stabilize your condition in an emergency will be covered if we authorize the continuation of care and it is Medically Necessary.

8. Urgent Care Center Services

Covered ONLY for initial treatment of an Urgent Medical Condition in a participating urgent care facility or Physician office. Follow-up treatment in or outside The Plan Service Area must be authorized in advance by the PCP in order to be covered.

Not covered:

Services received in a hospital emergency room for an Urgent Medical Condition without prior direction from your PCP, a participating plan Physician or The Plan.

9. Home Care Services

Covered Services are those performed by a Home Health Care Agency or other provider in your residence. Home Health Care includes professional, technical, health aide services, supplies, and medical equipment. The Member must be confined to the home for medical reasons and be physically unable to obtain needed medical services on an Outpatient basis.

Covered Services include but are not limited to:

- Intermittent Skilled Nursing Services (by an R.N. or L.P.N.)
- Medical/Social Services
- Diagnostic Services
- Nutritional Guidance
- Home Health Aide Services. The Member must be receiving skilled nursing or therapy. Services must be furnished by appropriately trained personnel employed by the Home Health Care provider. Other organizations may provide services only when approved by The Plan, and their duties must be assigned and supervised by a professional nurse on the staff of the Home Health Care provider.
- Therapy Services (except for Manipulation Therapy which will not be covered when rendered in the home). Home Care Visit limits specified in the Schedule of Benefits for Home Care Services apply when Therapy Services are rendered in the home.
- Medical/Surgical Supplies
- Durable Medical Equipment
- Prescription Drugs (only if provided and billed by a Home Health Care Agency)

Non-Covered Services include but are not limited to:

- Private Duty Nursing, unless listed in the Schedule of Benefits.
- Food, housing, homemaker services and home delivered meals
- Home or Outpatient hemodialysis services (these are covered under Therapy Services)
- Physician charges
- Helpful environmental materials (hand rails, ramps, telephones, air conditioners, and similar services, appliances and devices.)
- Services provided by registered nurses and other health workers who are not acting as employees or under approved arrangements with a contracting Home Health Care provider.
- Services provided by a member of the patient's immediate family.
- Services provided by volunteer ambulance associations for which patient is not obligated to pay, visiting teachers, vocational guidance and other counselors, and services related to outside, occupational and social activities.

Home infusion therapy

Benefits for home infusion therapy include a combination of nursing, durable medical equipment and pharmaceutical services which are delivered and administered intravenously in the home. Home IV therapy includes but is not limited to: injections (intra-muscular, subcutaneous, continuous subcutaneous), Total Parenteral Nutrition (TPN), Enteral nutrition therapy, Antibiotic therapy, pain management and chemotherapy.

10. Hospice Services

Hospice care can 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.

11. Infertility Services

Covered for the Medically Necessary diagnosis and exploratory procedures to determine infertility including surgical procedures to correct the medically diagnosed disease or condition of the reproductive organs including but not limited to endometriosis, collapsed/clogged fallopian tubes, or testicular failure.

If infertility drug coverage has been added to your coverage, it is stated in your Schedule of Benefits. Refer to Prescription Drug Programs in this Certificate for additional details.

Non Covered Services include but are not limited to procedures not essential for the protection of a Member's health.

12. Inpatient Services

Inpatient Services include:

- Charges from a Hospital, skilled nursing facility or other provider for room, board and general nursing services.
- Ancillary (related) services.
- Professional services from a Physician while an Inpatient.

Room, Board, and General Nursing Services

- A room with two or more beds.
- A private room. The private room allowance is the Hospital's average semi-private room rate unless it is Medically Necessary that you use a private room for isolation and no isolation facilities are available.
- A room in a special care unit approved by The Plan. The unit must have facilities, equipment and supportive services for intensive care of critically ill patients.

Ancillary (Related) Services

- Operating, delivery and treatment rooms and equipment.
- Prescribed Drugs.
- Anesthesia, anesthesia supplies and services given by an employee of the Hospital or other provider.
- Medical and surgical dressings, supplies, casts and splints.
- Diagnostic Services.

- Therapy Services.

Professional Services

- **Medical care** visits limited to one visit per day by any one Physician.
- **Intensive medical care** for constant attendance and treatment when your condition requires it for a prolonged time.
- **Concurrent care** for a medical condition by a Physician who is not your surgeon while you are in the Hospital for Surgery. Care by two or more Physicians during one Hospital stay when the nature or severity of your condition requires the skills of separate Physicians.
- **Consultation** which is a personal bedside examination by another Physician when requested by your Physician. Staff consultations required by Hospital rules; consultations requested by the patient; routine radiological or cardiographic consultations; telephone consultations;
- **Surgery and the administration of general anesthesia.**
- **Newborn exam.** A Physician other than the Physician who performed the obstetrical delivery must do the examination.

13. Maternity Services

Maternity services include Inpatient Services, Outpatient Services and Physician Home Visits and Office Services. These services are used for normal or complicated pregnancy, miscarriage, therapeutic abortion (abortion recommended by a provider), and ordinary routine nursery care for a healthy newborn. Abortion means the ending of a pregnancy before the birth of the infant. Miscarriage is a spontaneous abortion (occurs naturally and suddenly). A therapeutic abortion is one performed to save the life or health of the mother, or as a result of incest or rape.

NOTE: If a newborn Child is required to stay as an Inpatient past the mother's discharge date, the services for the newborn Child will then be considered a separate admission from the Maternity and an ordinary routine nursery admission, and will be subject to a separate Inpatient Coinsurance.

Coverage for the Inpatient postpartum stay for you and your newborn Child in a Hospital will be, at a minimum, 48 hours for a vaginal delivery and 96 hours for a cesarean section. Coverage will be for the length of stay recommended by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists in their Guidelines for Prenatal Care.

Physician-directed follow-up care after delivery is also covered by an advanced practice registered nurse. Services covered as follow-up care include physical assessment of the mother and newborn, parent education, assistance and training in breast or bottle feeding, assessment of the home support system, performance of any Medically Necessary and appropriate clinical tests, and 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. The coverage applies to services provided in a medical setting or through home health care visits. The coverage shall apply to a home health care visit only if the provider who conducts the visit is knowledgeable and experienced in maternity and newborn care.

Coverage for a length of stay shorter than the minimum period mentioned above is permitted if your attending Physician or certified nurse-midwife working in collaboration with a Physician determines further Inpatient postpartum care is not necessary for you or your newborn Child, provided the following are met and the mother concurs:

- In the opinion of your attending Physician, the newborn Child meets the criteria for medical stability in the Guidelines for Perinatal Care prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists that determine the appropriate length of stay based upon evaluation of:

1. the antepartum, intrapartum, and postpartum course of the mother and infant;
2. the gestational stage, birth weight, and clinical condition of the infant;
3. the demonstrated ability of the mother to care for the infant after discharge; and
4. the availability of post discharge follow-up to verify the condition of the infant after discharge.

- **Covered Services include at-home post-delivery care visits** at your residence by a Physician or Nurse performed no later than 72 hours following you and your newborn Child's discharge from the Hospital. Coverage for this visit includes, but is not limited to:

  1. parent education;
  2. assistance and training in breast or bottle feeding; and
  3. performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care for you or your newborn Child, including the collection of an adequate sample for the hereditary and metabolic newborn screening.

14. Medical Supplies, Durable Medical Equipment, and Appliances

The supplies, equipment and appliances described below are Covered Services under this benefit. If the supplies, equipment and appliances include comfort, luxury, or convenience items or features which exceed what is Medically Necessary in your situation or needed to treat your condition, reimbursement will be based on the Maximum Allowable Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowable Amount for the standard item which is a Covered Service is your responsibility. For example, the reimbursement for a motorized wheelchair will be limited to the reimbursement for a standard wheelchair, when a standard wheelchair adequately accommodates your condition.

Repair, adjustment and replacement of purchased equipment, supplies or appliances as set forth below are covered, as approved by The Plan. The repair, adjustment or replacement of the purchased equipment, supply or appliance is covered if:

- The equipment, supply or appliance is a Covered Service;
- The continued use of the item is Medically Necessary;
- There is reasonable justification for the repair, adjustment, or replacement (warranty expiration is not reasonable justification).

In addition, replacement of purchased equipment, supplies or appliance are covered if:

1. The equipment, supply or appliance is worn out or no longer functions.
2. Repair is not possible or would equal or exceed the cost of replacement. An assessment by a rehabilitation equipment specialist or vendor should be done to estimate the cost of repair.
3. Individual's needs have changed and the current equipment is no longer usable due to weight gain, rapid growth, or deterioration of function, etc.
4. The equipment, supply or appliance is damaged and cannot be repaired.

Benefits for repairs and replacement do not include the following:

- Repair and replacement due to misuse, malicious breakage or gross neglect.
- Replacement of lost or stolen items.

We may establish reasonable quantity limits for certain supplies, equipment or appliance described below.

Covered Services include, but are not limited to:

- **Medical and surgical supplies -** Covered Services provided under medical benefits may include, but are not limited to:

  1. Allergy serum extracts
  2. Chem strips, Glucometer, Lancets
  3. Clinitest
  4. Needles/syringes
  5. Ostomy bags and supplies except charges such as those made by a Pharmacy for purposes of a fitting are not Covered Services.
  6. Contraceptive devices including diaphragms, intra uterine devices (IUDs), and implants. These may also be covered under prescription benefits depending on where the service is performed or the item is obtained.

  Non-Covered Services include but are not limited to:

  1. Adhesive tape, band aids, cotton tipped applicators
  2. Arch supports
  3. Doughnut cushions
  4. Hot packs, ice bags
  5. Vitamins
  6. Medijectors

  Covered Services do not include items usually stocked in the home for general use like Band Aids, thermometers and petroleum jelly. If you have any questions regarding whether a specific medical or surgical supply is covered call the Member Services number on the back of your I.D. Card.

- **Durable medical equipment -** The rental (or, at our option, the purchase) of durable medical equipment prescribed by a Physician or other provider. Durable medical equipment is equipment which can withstand repeated use; i.e., could normally be rented, and used by successive patients; is primarily and customarily used to serve a medical purpose; is not useful to a person in the absence of illness or injury; and is appropriate for use in a patient's home. Examples include but are not limited to wheelchairs, crutches, hospital beds, and oxygen equipment. Rental costs must not be more than the purchase price. Health Plan will not pay for rental for a longer period of time than it would cost to purchase equipment. The cost for delivering and installing the equipment are Covered Services. Payment for related supplies is a Covered Service only when the equipment is a rental, and medically fitting supplies are included in the rental; or the equipment is owned by the Member; medically fitting supplies may be paid separately. Equipment should be purchased when it costs more to rent it than to buy it. Repair of medical equipment is covered.

  Covered Services include, but are not limited to:

  1. Hemodialysis equipment
  2. Crutches and replacement of pads and tips
  3. Pressure machines
  4. Infusion pump for IV fluids and medicine
  5. Glucometer
  6. Tracheotomy tube
  7. Cardiac, neonatal and sleep apnea monitors
  8. Augmentive communication devices are covered when we approve based on medical necessity.

  Non-covered items include but are not limited to:

  1. Air conditioners
  2. Ice bags/coldpack pump

3. Raised toilet seats
4. Rental of equipment if the Member is in a Facility that is expected to provide such equipment
5. Translift chairs
6. Treadmill exerciser
7. Tub chair used in shower.
8. Hearing aids - If a hearing aid benefit has been added to your coverage, it is stated in your Schedule of Benefits.

If you have any questions regarding whether a specific durable medical equipment is covered call the Member Services number on the back of your Identification Card.

- **Prosthetics** – Artificial substitutes for body parts and tissues and materials inserted into tissue for functional or therapeutic purposes. Covered Services include purchase, fitting, needed adjustment, repairs, and replacements of prosthetic devices and supplies that:

  1. Replace all or part of a missing body part and its adjoining tissues; or
  2. Replace all or part of the function of a permanently useless or malfunctioning body part.

  Prosthetic devices should be purchased not rented, and must be Medically Necessary. Applicable taxes, shipping and handling are also covered.

  Covered Services include, but are not limited to:

  1. Aids and supports for defective parts of the body including but not limited to internal heart valves, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograft vascular replacements, fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction.
  2. Left Ventricular Artificial Devices (LVAD) (only when used as a bridge to a heart transplant).
  3. Breast prosthesis whether internal or external, following a mastectomy, and four surgical bras per Calendar Year, as required by the Women's Health and Cancer Rights Act. Maximums for Prosthetic devices, if any, do not apply.
  4. Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc.
  5. Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or glasses are often prescribed following lens implantation and are Covered Services. (If cataract extraction is performed, intraocular lenses are usually inserted during the same operative session). Eyeglasses (for example bifocals) including frames or contact lenses are covered when they replace the function of the human lens for conditions caused by cataract surgery or injury; the first pair of contact lenses or eyeglasses are covered. The donor lens inserted at the time of surgery are not considered contact lenses, and are not considered the first lens following surgery. If the injury is to one eye or if cataracts are removed from only one eye and the Member selects eyeglasses and frames, then reimbursement for both lenses and frames will be covered.
  6. Cochlear implant.
  7. Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
  8. Restoration prosthesis (composite facial prosthesis)
  9. Wigs (the first one following cancer treatment, not to exceed one per Calendar Year).

  Non-covered Prosthetic appliances include but are not limited to:

  1. Dentures, replacing teeth or structures directly supporting teeth.
  2. Dental appliances.
  3. Such non-rigid appliances as elastic stockings, garter belts, arch supports and corsets.
  4. Artificial heart implants.

5. Wigs (except as described above following cancer treatment).
6. Penile prosthesis in men suffering impotency resulting from disease or injury.

If you have any questions regarding whether a specific prosthetic is covered call The Plan Member Services number on the back of your Identification Card.

- **Orthotic devices -** Covered Services are the initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part. The cost of casting, molding, fittings, and adjustments are included. Applicable tax, shipping, postage and handling charges are also covered. The casting is covered when an orthotic appliance is billed with it, but not if billed separately.

  Covered orthotic devices include, but are not limited to, the following:

  1. Cervical collars.
  2. Ankle foot orthosis.
  3. Corsets (back and special surgical).
  4. Splints (extremity).
  5. Trusses and supports.
  6. Slings.
  7. Wristlets.
  8. Built-up shoe.
  9. Custom made shoe inserts.

  Orthotic appliances can be replaced once per year per Member when Medically Necessary in the Member's situation. However, additional replacements will be allowed for Members under age 18 due to rapid growth, or for any Member when an appliance is damaged and cannot be repaired.

  Non-Covered Services include but are not limited to:

  1. Orthopedic shoes (except therapeutic shoes for diabetics).
  2. Foot support devices, such as arch supports and corrective shoes, unless they are an integral part of a leg brace.
  3. Standard elastic stockings, garter belts, and other supplies not specially made and fitted (except as specified under Medical Supplies).
  4. Garter belts or similar devices.

  If you have any questions regarding whether a specific orthotic is covered call the Member Services number on the back of your Identification Card.

15. Outpatient Services

Outpatient Services include facility, ancillary, facility use, and professional charges when given as an Outpatient at a Hospital, Alternative Care Facility, Retail Health Clinic, or other provider as determined by the Health Plan. These facilities include a non-Hospital site providing Diagnostic and therapy services, surgery, or rehabilitation, or other provider facility as determined by The Plan. Professional charges only include services billed by a Physician or other professional.
When Diagnostic Services or Other Therapy Services (chemotherapy, radiation, dialysis, inhalation, or cardiac rehabilitation) is the only Outpatient Services charge, no Copayment is required if received as part of an Outpatient surgery. Any Coinsurance will still apply to these services.

For Emergency Accident or Medical Care refer to **Section III, What To Do For Urgent Care Or Emergency Medical Conditions** of this Certificate of Coverage.

16. Physician Home Visits and Office Services

Covered Services include care provided by a Physician in their office or your home. Refer to the sections titled "Preventive Health Services", "Maternity Care", "Home Care Services" and "Behavioral Health Services for services covered by the Health Plan. For emergency care refer to **Section III, What To Do For Urgent Care Or Emergency Medical Conditions** of this Certificate of Coverage.

Office visits for medical care and consultations to examine, diagnose, and treat an illness or injury performed in the Physician's office. Office visits also include allergy testing, injections and serum. When allergy serum is the only charge from a Physician's office, no Copayment is required. Coinsurance is not waived. Please reference exclusion 8(e) for additional information.

Home Visits for medical care and consultations to examine, diagnose, and treat an illness or injury performed in your home.

Diagnostic Services when required to diagnose or monitor a symptom, disease or condition.

Surgery and Surgical Services (including anesthesia and supplies). The surgical fee includes normal post-operative care.

Therapy Services for physical medicine therapies and other therapy services when given in the office of a Physician or other professional provider.

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;

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

ProMedica OnDemand Visit: ProMedica OnDemand allows you and your Dependents to have a live video visit via webpage or mobile device with a board-certified Provider 24 hours a day, 7 days a week, and 365 days a year. This service is ideal for conditions such as allergies, cold and flu, pinkeye, and rash. Refer to your Schedule of Benefits for an explanation of how this benefit is covered. To sign up or download the mobile device application, please visit https://www.paramounthealthcare.com/members/member-perks/promedica-ondemand.

17. Prescription Drug Benefits

See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Pharmacy and Therapeutics (P&T) Committee

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 Plan's P&T 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 Plan's P&T, 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 Manager

The pharmacy benefits available to you under this Certificate of Coverage are administered by the ~~our~~ 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 Health 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 Health Plan can 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.
- Off label use of FDA approved drugs as defined in ORC 1751.66. 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 (please also see NON-COVERED SERVICES AND EXCLUSIONS in this Certificate of Coverage):

The following exclusions apply:

1. Unless otherwise specified in your Schedule 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/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 Member;
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. Prescription Drugs obtained from Non-Participating Pharmacies.
16. Growth hormones for growth and development unless Medically Necessary and covered according to your Schedule of Benefits;
17. 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;
18. Fertility drugs unless otherwise stated in your Schedule of Benefits.

How to Obtain Prescription Drug Benefits

Participating Pharmacy – Present your written Prescription Order from your Physician, and your Identification Card to the pharmacist at a Participating Pharmacy. The Pharmacy will file your claim for you. You will be charged at the point of purchase for applicable Deductible and/or Copayment/Coinsurance amounts. If you do not present your Identification Card, you will have to pay the full retail price of the prescription. If you do pay the full charge, ask your pharmacist for an itemized receipt and submit it to The Plan with a written request for refund. Prior Authorization and limitations to coverage will still apply prior to refunds.

CVS Mail Order Pharmacy – Refer to your Schedule of Benefits for Mail Service coverage. If you have Mail Service coverage, you will need to complete a patient profile with the appropriate pharmacy. You may mail written prescriptions from your Physician, or have your Physician fax the prescription to the Mail Service. You will need to pay the applicable Deductible, Coinsurance and/or Copayment amounts to the Mail Service when you request a prescription or refill. Not all drugs are covered through the Mail Service pharmacy. Some drugs, such as controlled substances or specialty medications, are limited by the Plan. For information about limitations and availability of coverage, you may contact RxBenefits Member Services at 1-800-334-8134.

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 Members Services at 1-800-334-8134.

Specialty Pharmacy Network

The Plan's specialty pharmacy network is available to Members who use Specialty Drugs. Members may obtain a printed list of the specialty Participating Pharmacies, and covered Specialty Drugs, by calling RxBenefits Member Services at 1-800-334-8134.

Days Supply

The number of days supply of a Drug which you receive can be limited based upon the type of pharmacy and specific medication. The days supply limit applicable to Prescription Drug coverage is shown in the Schedule of Benefits.

Payment of Benefits

The amount of benefits paid by The Plan is based upon the type of pharmacy from which you receive the Covered Services. It is also based upon which Tier we have classified the Prescription Drug or Specialty Drug, days supply, covered Additional Benefits and Programs, and Special Promotions.

The amounts for which you are responsible and the applicable number of days supply are shown in the Schedule of Benefits. Your Copayment(s), Coinsurance and/or Deductible amounts will not be reduced by any discounts, rebates or other funds received by the PBM and/or the Health Plan from Drug manufacturers or similar vendors.

No payment will be made by The Plan for any Covered Service unless the negotiated rate exceeds any applicable Deductible and/or Copayment/Coinsurance for which you are responsible.

Deductible/Coinsurance/Copayment

Each Prescription Order may be subject to a Deductible and Coinsurance/Copayment. The Coinsurance/Copayment may be dependent on the Covered Drug's Formulary placement and days supply of medication. If the Prescription Order includes more than one covered Drug, a separate Coinsurance/Copayment will apply to each covered Drug. Your Prescription Drug Coinsurance/Copayment will be the lesser of your Copayment/Coinsurance amount or the cost of the Drug. Please see the Schedule of Benefits for any applicable Deductible and Coinsurance/Copayment.

Formulary

A Formulary is a list of drugs that are covered by the Plan under a Member's prescription drug benefits. Members can obtain a copy of the Plan's Formulary by calling RxBenefits Member Services at 1-800-334-8134. The Formulary list is subject to periodic review and amendment. Inclusion of a Drug or related item on the covered Prescription Drug list is not a guarantee of coverage.

Tier and Formulary Assignment Process

Your Copayment/Coinsurance amount varies based on how the Prescription Drug, including covered Specialty Drugs, has been classified by the Plan's formulary and the type of Copayment/Coinsurance tier structure per the Schedule of Benefits.

The determination of tiers and formulary assignment is made by a P&T Committee based upon clinical information, treatment options, and Drug costs relative to other Drugs used to treat the same or similar condition.

We retain the right at our discretion to determine coverage for dosage formulations in terms of covered dosage administration methods (for example, by mouth, injections, topical, or inhaled) and may cover one form of administration and exclusion or place other forms of administration in another tier.

6-Tier Copayment

Refer to the Schedule of Benefits for exceptions that apply to drugs subject to Additional Benefits and Programs.

- **Tier 1** Preferred Generic Prescription Drugs have the lowest Coinsurance or Copayment.
- **Tier 2** Non-Preferred Generic Prescription Drugs will have a higher Coinsurance or Copayment than those in Tier 1.
- **Tier 3** Preferred Brand Prescription Drugs will have a higher Coinsurance or Copayment than those in Tier 2.
- **Tier 4** Non-Preferred Brand Prescription Drugs will have a higher Coinsurance or Copayment than those in Tier 3.
- **Tier 5** Preferred Specialty Prescription Drugs will have a higher Coinsurance or Copayment than those in Tier 4.
- **Tier 6** Non-Preferred Specialty Prescription Drugs will have the highest Coinsurance or Copayment.

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.

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 from the prescriber. If denied, the appeal process is available. Your prior authorizations are handled by the PBM.

The following medications 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.

Specialty Drug Program

Specialty Drugs are reviewed and designated through the Plan's P&T Committee. They will have the highest Coinsurance or Copayment and will contain Specialty and Injectable medications. Characteristics of Specialty Drugs are:

- Generally high-cost drugs prescribed for rare or complex, ongoing medical conditions.
- May be injectable, infused, oral, or inhaled drugs which typically are not stocked at traditional pharmacies due to unique storage, shipment, or dispensing requirements.
- Often they require close supervision and monitoring by a Physician or another trained healthcare professional.

Members may obtain a list of the specialty network pharmacies, and covered Specialty Drugs, by calling RxBenefits Member Services at 1-888-334-8134.

Oral Chemotherapy
This Plan shall not provide coverage or impose Cost Sharing for a prescribed, orally administered cancer medication on a less favorable basis than the coverage it provides or Cost Sharing it imposes for intravenously administered or injected cancer medications.

QUESTIONS

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

See Section VIII, **TERMS AND DEFINITIONS** for additional information on Exigent Circumstances.

Special Promotions

From time to time, we initiate various programs to encourage the use of more cost-effective or clinically

effective Prescription Drugs including, but not limited to, Generic Drugs, Mail Service Drugs, over the counter or preferred products. Such programs can involve reducing or waiving Copayments or Coinsurance for certain Drugs or preferred products for a limited period of time.

18. Preventive Health Services (More information available in **Terms and Definitions** section of this Certificate of Coverage)

Preventive Health services include Outpatient services and Office Services. Screenings and other services are covered as preventive care for adults and children with no current symptoms or prior history of a medical condition associated with that screening or service.

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

Preventive Health Services in this section shall meet requirements as determined by federal and state law. Preventive Health Services are covered by this Certificate of Coverage with no Deductible, Copayments or Coinsurance from the Member when provided by a Participating Provider. That means we pay 100% of the Maximum Allowed Amount. These services fall under four broad categories as shown below:

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 all women with reproductive capacity. Prescription coverage includes at least one product for each of the following contraceptive methods: Barrier (diaphragm), implanted devices (IUD), Hormonal (generic orals), and emergency Contraception. (Refer to the Standard and Expedited Review for Prior Authorization, Step Therapy Exceptions, and Non-formulary Exceptions in the prescription drug section for more details.)

   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 I.D. 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:

- Routine hearing screenings
- Routine children's vision screenings

For those who use tobacco products, at least two tobacco cessation attempts per year. For this purpose, covering a cessation attempt includes coverage for:

1. Four tobacco cessation counseling sessions of at least 10 minutes each (including telephone counseling, group counseling and individual counseling) without Prior Authorization; and
2. All Food and Drug Administration (FDA) approved tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a health care provider without Prior Authorization.
3. Tobacco Cessation Programs are offered to Members over the age of twenty-one (21) at in-plan hospitals or ancillary providers and are covered as a preventive service.
4. Call Member Services for complete details on enrolling in a program. See also Preventive Health Services for additional information.

Mammography

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%).

Premium Rates for Tobacco Users

A tobacco user is someone who is age 21 or older who has regularly used tobacco (smoking or chewing) at least four or more times per week in the past six months. Religious or ceremonial uses of tobacco, for example, by American Indians and Alaskan Natives are specifically exempt.

Your Plan has different premium rates for tobacco users and non-tobacco users. If you are a tobacco user, currently paying tobacco user rates, by participating in a Tobacco Cessation Program you may have your premium rates reduced to the non-tobacco user rate. You may decide at any time during your coverage period to participate.

How the premium rate reduction works

If you are a tobacco user paying the tobacco user rate and enroll in a program, your premium rate will be adjusted to the non-tobacco user rate. If you are a tobacco user and you do not participate in a program, your premium rate will remain at the tobacco-user premium rate.

To have the tobacco-user rate adjusted you will be required to submit a signed attestation to The Plan certifying your enrollment in a tobacco cessation program. You can obtain a copy of the attestation form by contacting The Plan or visiting our website.

19. Reconstructive Services

Benefits include reconstructive surgery to correct significant deformities caused by congenital or developmental abnormalities, illness, injury or an earlier treatment in order to create a more normal appearance. Benefits include surgery performed to restore symmetry after a mastectomy. Reconstructive services needed as a result of an earlier treatment are covered only if the first treatment would have been a Covered Service under this Plan.

Mastectomy Notice

A Member who is receiving benefits for a covered mastectomy or for follow-up care in connection with a covered mastectomy, and who elects breast reconstruction, will also receive coverage for:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the patient and the patient's attending Physician and will be subject to the same annual Deductible, Coinsurance, Copayment provisions otherwise applicable under the Health Plan.

20. Surgical Services

Coverage for Surgical Services when provided as part of Physician Home Visits and Office Services, Inpatient Services, or Outpatient Services includes but are not limited to:

- Performance of accepted operative and other invasive procedures;
- The correction of fractures and dislocations;
- Anesthesia and surgical assistance when Medically Necessary;
- Usual and related pre-operative and post-operative care;
- Other procedures as approved by The Plan;
- Operative and cutting procedures;
- Endoscopic examinations, such as arthroscopy, bronchoscopy, colonoscopy, laparoscopy;
- Other invasive procedures such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine.

The surgical fee includes normal post-operative care. We may combine the reimbursement when more than one surgery is performed during the same operative session. Contact The Plan for more information.

21. Sterilization

Sterilization benefits for men and women include sterilization services and services to reverse a non-elective sterilization that resulted from an illness or injury. Reversals of elective sterilizations are not covered. Sterilizations for women are covered under the "Preventive Health Services" benefit.

22. Temporomandibular or Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder (TMJ)

Benefits are provided for medical treatment of temporomandibular (joint connecting the lower jaw to the temporal bone at the side of the head) and craniomandibular (head and neck muscle) disorders.

Treatment is covered if provided within our guidelines and with Prior Authorization.

23. Therapy Services

When Therapy Services are given as part of Physician Home Visits and Office Services, Inpatient Services, Outpatient Services, or Home Care Services, coverage for these Therapy Services is limited to the following:

Physical Medicine Therapy Services

The expectation must exist that the therapy will result in a practical improvement in the level of functioning within a reasonable period of time.

- **Physical therapy** including treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles and devices. Such therapy is given to relieve pain, restore function, and to prevent disability following illness, injury, or loss of a body part. Non Covered Services include but are not limited to: maintenance therapy to delay or minimize muscular deterioration in patients suffering from a chronic disease or illness; repetitive exercise to improve movement, maintain strength and increase endurance (including assistance with walking for weak or unstable patients); range of motion and passive exercises that are not related to restoration of a specific loss of function, but are for maintaining a range of motion in paralyzed extremities; general exercise programs; diathermy, ultrasound and heat treatments for pulmonary conditions; diapulse; work hardening.

- **Speech therapy** for the correction of a speech impairment.

- **Occupational therapy** for the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the person's particular occupational role. Occupational therapy does not include diversional, recreational, vocational therapies (e.g. hobbies, arts and crafts). Non Covered Services include but are not limited to: supplies (looms, ceramic tiles, leather, utensils); therapy to improve or restore functions that could be expected to improve as the patient resumes normal activities again; general exercises to promote overall fitness and flexibility; therapy to improve motivation; suction therapy for newborns (feeding machines); soft tissue mobilization (visceral manipulation or visceral soft tissue manipulation), augmented soft tissue mobilization, myofascial; adaptions to the home such as rampways, door widening, automobile adaptors, kitchen adaptation and other types of similar equipment.

- **Manipulation Therapy** is not covered unless listed in the Schedule of Benefits. It includes Osteopathic/Chiropractic Manipulation Therapy used for treating problems associated with bones, joints and the back. The two therapies are similar, but chiropractic therapy focuses on the joints of the spine and the nervous system, while osteopathic therapy includes equal emphasis

on the joints and surrounding muscles, tendons and ligaments. Manipulations whether performed and billed as the only procedure or manipulations performed in conjunction with an exam and billed as an office visit will be counted toward any maximum for Manipulation Therapy services as specified in the Schedule of Benefits. Manipulation Therapy services rendered by Non-Participating Providers, or rendered in the home as part of Home Care Services, are not covered.

Other Therapy Services

- **Cardiac rehabilitation** to restore an individual's functional status after a cardiac event. It is a program of medical evaluation, education, supervised exercise training, and psychosocial support. Home programs, on-going conditioning and maintenance are not covered.
- **Chemotherapy** for the treatment of a disease by chemical or biological antineoplastic agents, including the cost of such agents.
- **Dialysis treatments** of an acute or chronic kidney ailment which can include the supportive use of an artificial kidney machine.
- **Radiation therapy** for the treatment of disease by X-ray, radium, or radioactive isotopes. Includes treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources); materials and supplies used in therapy; treatment planning.
- **Inhalation therapy** for the treatment of a condition by the administration of medicines, water vapors, gases, or anesthetics by inhalation. Covered Services include but are not limited to, introduction of dry or moist gases into the lungs; nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication; continuous positive airway pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.
- **Pulmonary rehabilitation** to restore an individual's functional status after an illness or injury. Covered Services include but are not limited to Outpatient short-term respiratory services for conditions which are expected to show significant improvement through short-term therapy. Also covered is inhalation therapy administered in Physician's office including but are not limited to breathing exercise, exercise not elsewhere classified, and other counseling. Pulmonary rehabilitation in the acute Inpatient rehabilitation setting is not a Covered Service.

Physical Medicine and Rehabilitation and Habilitative services

A structured therapeutic program of an intensity that requires a multidisciplinary coordinated team approach to upgrade the patient's ability to function as independently as possible; including skilled rehabilitative nursing care, physical therapy, occupational therapy, speech therapy, services of a social worker or psychologist, and habilitative services. The goal is to obtain practical improvement in a reasonable length of time in the appropriate setting.

Physical medicine and rehabilitation involves several types of therapy, not just physical therapy, and a coordinated team approach. The variety and intensity of treatments required is the major differentiation from an admission primarily for physical therapy.

Non-Covered Services for physical medicine and rehabilitation
Include, but are not limited to:

- admission to a Hospital mainly for physical therapy;
- long-term rehabilitation in an Inpatient setting.

Day Rehabilitation Program services provided through a Day Hospital for physical medicine and rehabilitation are Covered Services. A Day Rehabilitation Program is for those patients who do not require Inpatient care but still require a rehabilitation therapy program four to eight hours a day, 2 or more days a week at a Day Hospital. Day rehabilitation program services may consist of Physical

Therapy, Occupational Therapy, Speech Therapy, nursing services, and neuro psychological services. A minimum of two Therapy Services must be provided for this program to be a Covered Service.

Habilitative services

Habilitative services cover health care services and devices that help a person keep, learn, or improve skills and functioning for daily living. This includes but is not limited to **habilitative** services for Members with a medical diagnosis of autism spectrum disorder, which at a minimum includes:

1. Out-Patient Physical Rehabilitation services including:
   a. Speech and Language therapy and/or Occupational therapy, performed by a licensed therapist 20 visits per year of each service; and
   b. Clinical Therapeutic intervention defined as therapies supported by empirical evidence, which include but are not limited to Applied Behavioral Analysis, provided by or 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 treatment plan, 20 hours per week;

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

24. Vision Services

Benefits are available for medical and surgical treatment of injuries and/or diseases affecting the eye.

Childhood vision screenings are covered under the "Preventive Health Services" benefit. Benefits for other Covered Services are based on the setting in which services are received.

Benefits are not available to Members **age 19 and up** for glasses and contact lenses except as described in the "Prosthetics" benefit.

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.

Additional Covered Services for all Members include:

- Determination of refraction,
- Routine Ophthalmological examination including refraction for new and established patients, and
- A visual functional screening for visual acuity.

Medically Necessary Contact Lenses: Contact lenses may be determined to be Medically Necessary and appropriate in the treatment of patients affected by certain conditions. In general, contact lenses may be Medically Necessary and appropriate when the use of contact lenses, in lieu of eyeglasses, will result in significantly better visual and/or improved binocular function, including avoidance of diplopia or suppression. Contact lenses may be determined to be Medically Necessary in the treatment of the following conditions:

Keratoconus, Pathological Myopia, Aphakia, Anisometropia, Aniseikonia, Aniridia, Corneal Disorders, Post-traumatic Disorders, Irregular Astigmatism.

Medically Necessary contact lenses are dispensed in lieu of other eyewear. Participating Providers will

obtain the necessary Prior Authorization for these services.

25. Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services

The human organ and tissue transplant (bone marrow/stem cell) services benefits or requirements described below do not apply to the following:

- Cornea and kidney transplants; and
- Any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. Please note that the initial evaluation and any necessary additional testing to determine your eligibility as a candidate for transplant by your provider and the harvest and storage of bone marrow / stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

The above services are covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the service is performed subject to Member cost shares.

Covered Transplant Procedure

Any Medically Necessary human organ and stem cell / bone marrow transplants and transfusions as determined by The Plan including necessary acquisition procedures, harvest and storage, and including Medically Necessary preparatory myeloablative therapy.

Transplant Benefit Period

Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate / global time period. The number of days will vary depending on the type of transplant received and the network transplant provider agreement. Contact the Case Manager for specific network transplant provider information for services received at or coordinated by a network transplant provider Facility or starts one day prior to a Covered Transplant Procedure and continues to the date of discharge at a Non-Participating Provider transplant provider Facility.

Transportation and Lodging

The Plan will provide assistance with reasonable and necessary travel expenses as determined by The Plan when you obtain Prior Authorization and are required to travel more than 75 miles from your residence to reach the facility where your Covered Transplant Procedure will be performed. Our assistance with travel expenses includes transportation to and from the facility and lodging for the patient and one companion. If the Member receiving treatment is a minor, then reasonable and necessary expenses for transportation and lodging may be allowed for two companions. The Member must submit itemized receipts for transportation and lodging expenses in a form satisfactory to The Plan when claims are filed.

Contact us for detailed information.

For lodging and ground transportation benefits, We will provide a maximum benefit up to a $10,000 benefit limit.

Non-Covered Services for transportation and lodging include, but are not limited to:

- Child care,
- Mileage within the medical transplant facility city,
- Rental cars, buses, taxis, or shuttle service, except as specifically approved by The Plan,
- Frequent Flyer miles,
- Coupons, Vouchers, or Travel tickets,
- Prepayments or deposits,

- Services for a condition that is not directly related, or a direct result, of the transplant,
- Telephone calls,
- Laundry,
- Postage,
- Entertainment,
- Interim visits to a medical care facility while waiting for the actual transplant procedure,
- Travel expenses for donor companion/caregiver,
- Return visits for the donor for a treatment of a condition found during the evaluation.

Unrelated Donor Search
The Plan will cover searches for bone marrow/stem cell transplants for a covered transplant procedure as approved by the Plan up to a $30,000 per transplant limit.

Live Donor Health Services
The Plan will cover Medically Necessary charges for the procurement of an organ from a live donor including complications from the donor procedure for up to six weeks from the date of procurement. Donor benefits are limited to benefits not available to the donor from any other source.

26. Morbid Obesity Surgery
Not covered, including, gastric reservoir reduction, gastric stapling, or diversion for weight loss.

Surgery for the purpose of weight reduction or control is not covered except when specifically approved in advance by The Plan as Medically Necessary for severely obese Members with documented high-risk co-morbidities. Prior Authorization from The Plan must be obtained, and the surgery must be performed by Participating Providers authorized by The Plan to perform morbid obesity surgery. To obtain Prior Authorization, the Member must qualify under The Plan's Morbid Obesity Surgery medical policy. If approved for coverage, the Member will be responsible for the Copayment/Coinsurance stated in the Schedule of Benefits on services related to the surgery and related post-surgical services. The Copayment/Coinsurance on Covered Services related to morbid obesity surgery and post-surgical services will not apply to the Out-of-Pocket Copayment Limit.

Not covered:

- Surgery for the treatment of morbid obesity that does not meet the criteria in The Plan's Morbid Obesity Surgery medical policy and/or was not prior authorized by The Plan
- Morbid Obesity Surgery, and related services, that are not performed by Participating Providers authorized by The Plan to perform morbid obesity surgery.
- Cosmetic procedures, including but not limited to tummy tuck or panniculectomy following morbid obesity surgery.

NON-COVERED SERVICES/EXCLUSIONS

The following section indicates items which are excluded from benefit consideration and are not considered Covered Services. Excluded items will not be covered even if the service, supply, or equipment would otherwise be considered Medically Necessary. Basic health care services will not be excluded because they were the result of a complication from a non-Covered Service. This information is provided as an aid to identify certain common items which may be misconstrued as Covered Services. The Plan has the discretionary authority to determine Medical Necessity under the Plan.

We do not provide benefits for procedures, equipment, services, supplies or charges:

1. Which we determine are not Medically Necessary or do not meet our medical policy, clinical coverage guidelines, or benefit policy guidelines. See **Internal Claims and Appeals Procedures and External Review** section of this Certificate of Coverage.

2. Received from an individual or entity that is not a Participating Provider, as defined in this Certificate of Coverage, or recognized by The Plan.
3. Which are Experimental/Investigative or related to such, whether incurred prior to, in connection with, or subsequent to the Experimental/Investigative service or supply, as determined by The Plan. The fact that a service is the only available treatment for a condition will not make it eligible for coverage if we deem it to be Experimental/Investigative. See the **Internal Claims and Appeals Procedures and External Review** and **Experimental/Investigative Services Exclusion** sections of this Certificate of Coverage.
4. For any condition, disease, defect, ailment, or injury arising out of and in the course of employment if benefits are available under any Workers' Compensation Act or other similar law. If Workers' Compensation Act benefits are not available to you, then this Exclusion does not apply. This exclusion applies if you receive the benefits in whole or in part. This exclusion also applies whether or not you claim the benefits or compensation. It also applies whether or not you recover from any third party.
5. To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
6. For court ordered testing or care unless Medically Necessary.
7. For which you have no legal obligation to pay in the absence of this or like coverage.
8. For the following:
   - Surcharges for furnishing and/or receiving medical records and reports.
   - Charges for doing research with providers not directly responsible for your care.
   - Charges that are not documented in provider records.
   - Charges from an outside laboratory or shop for services in connection with an order involving devices (e.g., prosthetics, orthotics) which are manufactured by that laboratory or shop, but which are designed to be fitted and adjusted by the attending Physician.
   - For membership, administrative, or access fees charged by Physicians or other providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results.
9. Received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group.
10. Prescribed, ordered or referred by or received from a member of your immediate family, including your spouse, Child, brother, sister, parent, in-law, or self.
11. For completion of claim forms or charges for medical records or reports unless otherwise required by law.
12. For missed or canceled appointments.
13. For mileage, lodging and meals costs, and other Member travel related expenses, except as authorized by The Plan or specifically stated as a Covered Service.
14. For which benefits are payable under Medicare Parts A and/or B or would have been payable if a Member had applied for Parts A and/or B, except, as specified elsewhere in this Certificate of Coverage or as otherwise prohibited by federal law. For the purposes of the calculation of benefits, if the Member has not enrolled in Medicare Part B, we will calculate benefits as if they had enrolled.
15. Incurred prior to your Effective Date.
16. Incurred after the termination date of this coverage except as specified elsewhere in this Certificate of Coverage.
17. For any procedures, services, equipment or supplies provided in connection with cosmetic services. Cosmetic services are primarily intended to preserve, change or improve your appearance or are furnished for psychiatric or psychological reasons. No benefits are available for surgery or treatments to change the texture or appearance of your skin or to change the size, shape or appearance of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts). Medically necessary services due to complications of a non-covered procedure are covered.
18. For maintenance therapy, which is treatment given when no additional progress is apparent or expected to occur. Maintenance therapy includes treatment that preserves your present level of

functioning and prevents loss of that functioning, but which does not result in any additional improvement.

19. For the following:
    - Custodial Care, convalescent care or rest cures.
    - Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
    - Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
    - Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, or outward bound programs, even if psychotherapy is included.
    - Wilderness camps.
20. For routine foot care (including the cutting or removal of corns and calluses); Nail trimming, cutting or debriding; Hygienic and preventive maintenance foot care, including but not limited to:
    - cleaning and soaking the feet.
    - applying skin creams in order to maintain skin tone.
    - other services that are performed when there is not a localized illness, injury or symptom involving the foot.
21. For surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.
22. Weight loss programs, whether or not they are pursued under medical or Physician supervision, unless specifically listed as covered in this Certificate of Coverage. This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.
23. For bariatric surgery, regardless of the purpose it is proposed or performed, unless otherwise stated in the Schedule of Benefits. This includes but is not limited to Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgical procedures that reduce stomach capacity and divert partially digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastroplasty, (surgical procedures that decrease the size of the stomach), or gastric banding procedures.
24. For marital counseling.
25. For prescription, fitting, or purchase of eyeglasses or contact lenses except as otherwise specifically stated as a Covered Service. This Exclusion does not apply for initial prosthetic lenses or sclera shells following intraocular surgery, or for soft contact lenses due to a medical condition.
26. For vision orthoptic training.
27. For hearing aids or examinations to prescribe/fit them, unless otherwise specified within this Certificate of Coverage.
28. For services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein.
29. For services to reverse voluntarily induced sterility.
30. Assisted reproductive technology (ART) such as artificial insemination, in vitro fertilization, embryo transplant services, GIFT, ZIFT, zygote transfer, reversal of voluntary sterilization, ovarian tissue transplant and related services, cost of donor sperm or donor egg, and services and supplies related to ART procedures.
31. For personal hygiene, environmental control, or convenience items including but not limited to:
    - Air conditioners, humidifiers, air purifiers;
    - Personal comfort and convenience items during an Inpatient stay, including but not limited to daily television rental, telephone services, cots or visitor's meals;
    - Charges for non-medical self-care except as otherwise stated;
    - Purchase or rental of supplies for common household use, such as water purifiers;

- Allergenic pillows, cervical neck pillows, special mattresses, or waterbeds; Infant helmets to treat positional plagiocephaly;
- Safety helmets for Members with neuromuscular diseases; or
- Sports helmets.

32. Health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. This exclusion also applies to health spas.
33. For consultations other than those performed in-person, except as required by law, authorized by The Plan, or as otherwise described in this Certificate of Coverage (see, e.g., "Telehealth Services" and "ProMedica OnDemand" in the Covered Services section).
34. For care received in an emergency room which is not emergency care, except as specified in this Certificate of Coverage. This includes, but is not limited to suture removal in an emergency room.
35. For eye surgery to correct errors of refraction, such as near-sightedness, including without limitation LASIK, radial keratotomy or keratomileusis or excimer laser refractive keratectomy.
36. For self-help training and other forms of non-medical self-care, except as otherwise provided in this Certificate of Coverage.
37. For examinations relating to research screenings.
38. For stand-by charges of a Physician.
39. Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes, except as required by state or federal law.
40. For Private Duty Nursing Services unless specifically stated in the **COVERED SERVICES** section.
41. For Manipulation Therapy services rendered in the home as part of Home Care Services.
42. Unless Medically Necessary, services and supplies related to sex transformation and/or the reversal thereof, or male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This Exclusion includes sexual therapy and counseling. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, Prescription Drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related Diagnostic Testing. Evidence based and nondiscriminatory criteria will be used to determine Medical Necessity.
43. For (services or supplies related to) alternative or complementary medicine. Services in this category include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage and massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST), iridology-study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy, electromagnetic therapy, and neurofeedback.
44. For any services or supplies provided to a person not covered under the Certificate of Coverage in connection with a surrogate pregnancy (including, but not limited to, the bearing of a Child by another woman for an infertile couple).
45. For surgical treatment of gynecomastia.
46. For treatment of hyperhidrosis (excessive sweating).
47. For any service for which you are responsible under the terms of this Certificate of Coverage to pay a Copayment, Coinsurance or Deductible, and the Copayment, Coinsurance or Deductible is waived by a Non-Participating Provider.
48. Human Growth Hormone for children born small for gestational age. It is only a Covered Service in other situations when allowed by The Plan through Prior Authorization.
49. For Drugs, devices, products, or supplies with over the counter equivalents and any Drugs, devices, products, or supplies that are therapeutically comparable to an over the counter Drug, device, product, or supply. This exclusion does not apply to over-the-counter products the Plan must cover under federal law with a prescription.

50. Sclerotherapy for the treatment of varicose veins of the lower extremities including ultrasonic guidance for needle and/or catheter placement and subsequent sequential ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy.
51. Treatment of telangiectatic dermal veins (spider veins) by any method.
52. Reconstructive services except as specifically stated in the **COVERED SERVICES** section of this Certificate of Coverage, or as required by law.
53. Nutritional and/or dietary supplements, except as provided in this Certificate of Coverage or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written Prescription or dispensing by a licensed Pharmacist.
54. Abortion is not covered, unless Medically Necessary (i.e., to save the life or protect the health of the mother).
55. Dental x rays, supplies & appliances and all associated expenses, including hospitalization and anesthesia except as required by law. The only exceptions to this are for any of the following:
    - transplant preparation
    - initiation of immunosuppressives
    - direct treatment of cancer or cleft palate.

EXPERIMENTAL/INVESTIGATIVE SERVICES EXCLUSION

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 under the Health Plan.

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

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

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

- the scientific evidence is conclusory concerning the effect of the service on health outcomes;

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

The information considered or evaluated by The Plan 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.

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

WHO IS ELIGIBLE

The following persons are eligible for coverage. They must meet the requirements below and the Subscriber must list them on the enrollment application.

Subscriber
To be eligible to enroll as a Subscriber, the individual must:
- Be an employee of the Group, and:
- Be entitled to participate in the Plan purchased or arranged by the Group;
- Have satisfied any probationary or waiting period established by the Group and perform the duties of your principal occupation for the Group; and
- Reside or work in the Service Area.

Spouse The legal spouse of the Subscriber.

Dependent Children This Plan will cover the married or unmarried Dependent Children, stepchildren, legally adopted children and children placed for adoption of the Subscriber or the Subscriber's spouse under the age of twenty-six (26) regardless of student status, and who meet the eligibility requirements. Dependent Children who reside outside The Plan Service Area and/or do not reside in the household of the parent are eligible to enroll in this Plan.

If a Subscriber or Subscriber's spouse has been court-ordered to maintain health care coverage on a Dependent

Child, the Child is eligible to enroll without any enrollment period restrictions even if the Child resides outside The Plan Service Area. Coverage for service rendered outside the Service Area by Non-Participating Providers will be limited to Emergency Medical Conditions unless Prior Authorized by The Plan. If the enrolled parent fails to make application to enroll the Child, The Plan 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 Plan 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.

Children of Dependents (grandchildren) are not covered. If a covered Dependent Child becomes pregnant, the newborn will not be covered under the grandparents' contract. Separate coverage may be available for the mother and newborn. **Parents, grandparents, sisters or brothers of the Subscriber or Subscriber's spouse are not eligible Dependents.**

Dependents with disabilities If covered children meet the requirements of Dependents with disabilities because of physical handicap or intellectual disability (they are unable to earn their own living and rely primarily on the subscriber for support), coverage may continue past age 26. Proof of disability must be provided to The Plan prior to or within thirty-one (31) days of the Dependent's 26th birthday or within thirty-one days of new eligibility and may be requested annually.

Dependent students Dependent students are covered up to age 26.

The Plan, through its **Dependent Child Coverage Program**, provides coverage for emergency, urgent and follow-up care as well as care provided by student health centers while your Dependent student is away at school outside of The Plan Service Area. If your Dependent student needs medical care away from home that is not available from the student health center and it is not an emergency or urgent condition, before seeking services you or your Dependent student should contact our Utilization Management Department to obtain Prior Authorization. In the event of an Emergency Medical Condition, call 911, an ambulance or rescue squad or go directly to the nearest medical facility.

Urgent Care Visits at a Physician Office – covered when Prior Authorized by The Plan; Subject to applicable Physician office visit.

Urgent Care Facility Visits – Covered for unexpected illness or injury requiring medical attention soon after it appears that is not permanently disabling or life-threatening; No Prior Authorization Required; Subject to urgent care facility cost share.

Follow up Care – Covered when Prior Authorized by The Plan; Subject to applicable cost share.

For information on how to file a claim, follow the procedures outlined in the section titled Provider Reimbursement/Filing a Claim. Member liability will be limited to the cost-sharing for services rendered and the Member will not be responsible for the balance of billed charges.

The Plan's Utilization Management Department is also available to assist you and/or your Dependent student in locating providers outside of The Plan Service Area; contact Utilization Management at (419) 887-2520 or 1-800-891-2520.

Not eligible: Grandchildren and parents of Subscriber and/or Subscriber's spouse.

Newborn children A newborn Child of a Subscriber (or the Subscriber's spouse) is covered for the first thirty-one (31) days following birth. To continue coverage for a newborn Child beyond the 31-day period, a completed enrollment application and any required additional premium payment must be received within the first thirty-one (31) days following the birth. If the application and appropriate payment is not received, the newborn Child will not be eligible for any further benefits after the thirty-one days following the birth.

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

enrollment period.

Adoption or placement for adoption A completed enrollment application and any required additional premium payment must be received within the first thirty-one (31) days following adoption or placement for adoption. Coverage will become effective from the date of adoptive placement. Adoptive placement means the assumption and retention by a person of a legal obligation for total or partial support of a Child in anticipation of the adoption of the Child. The Child's placement with a person terminates upon termination of the legal obligation.

The only other time you may enroll adopted children, children placed for adoption or stepchildren is during your employer's open enrollment period, or a special enrollment period.

Marriage When a completed enrollment application is received by The Plan within thirty-one (31) days from the date of marriage, coverage of new spouses becomes effective on the date of marriage.

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

Divorce You must notify The Plan that you are removing your ex-Spouse and any other ineligible Dependents from the Plan at the time the annulment, dissolution or divorce decree is final. Coverage will end at the end of the month in which the decree is final.

Any ineligible Dependents may be eligible for continuation coverage under the employer group's health benefits plan. See your benefits office for details.

Death of a subscriber Dependents of a deceased Subscriber may be eligible for continuation coverage under the employer group's health benefits plan. See your benefits office for details.

ADDING AND REMOVING MEMBERS

When you need to change the number of Members covered under your Plan, it is your responsibility to notify your employer and The Plan promptly. YOU MUST COMPLETE AN ENROLLMENT APPLICATION WHEN YOU NEED TO **ADD A MEMBER TO OR REMOVE A MEMBER FROM YOUR PLAN.** Contact your benefits office.

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

Group Annual Open Enrollment 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. If you have a new Dependent due to marriage, adoption (including placement) or birth of a baby, they may be added to this Plan if the Subscriber completes and submits an application to the employer within thirty-one (31) days from the event. If you do not enroll eligible Dependents for coverage during the first employer enrollment period or within thirty-one (31) days of eligibility, you must wait until your employer's next annual open enrollment period to add them. See your benefits office for details.

SPECIAL ENROLLMENT PERIOD If an eligible employee declines enrollment for themselves or their Dependents (including their spouse), 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 there is a loss of Minimum Essential Coverage as a result of 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, or moving out of an HMO's service area. 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 within 31 days after the marriage, birth, adoption, or placement for adoption.

SPECIAL ENROLLMENT PERIOD EFFECTIVE DATES

If an eligible employee and/or eligible Dependent(s) enroll due to a loss of Minimum Essential Coverage as defined in this section, coverage is effective the day after the date on which prior medical benefits terminated. In the case of termination from Medicaid or Children's Health Insurance Program (CHIP) coverage or eligibility for Employment Assistance under Medicaid or CHIP, birth, adoption, placement for adoption, or a court order, coverage is effective on the date of the event.

NONDISCRIMINATION

No one who is eligible to enroll or renew as a Subscriber, Dependent or Dependent with disabilities will be refused enrollment by The Plan based on student status, health status related factor, pre-existing condition, genetic testing or the results of such testing, health care needs or age. The Plan will not terminate coverage for you or your Dependents due to health status, health care needs or the exercise of rights under The Plan's internal review procedures. However, The Plan will not re-enroll anyone terminated for any of the reasons listed in the Termination of Coverage section.

RENEWAL OF COVERAGE

If all the conditions of group eligibility are met, the group coverage will be renewed. Renewal of coverage is not based on the Member's health condition and is not subject to any genetic testing or the results of such testing.

The Plan will renew coverage at the option of the employer group. The Plan will not renew group coverage only under the following conditions;

- Non-payment of premiums
- Fraud
- The group falls below minimum contribution or participation rules

TERMINATION OF MEMBER COVERAGE

A Member's coverage under The Plan may end for any of the following reasons:

- You fail to pay, or have paid for you, the required prepayments.
- You no longer meet the eligibility requirements.
- You have performed an act or practice that constitutes fraud or material misrepresentation of material fact under the terms of the coverage.

The termination may not be based, either directly or indirectly, on any health status-related factor concerning the Member. Do not use your ID card after your coverage ends.

RESCISSION OF COVERAGE

A rescission of your coverage means that the coverage may be legally voided all the way back to the day the

Plan began to provide you with coverage, just as if you never had coverage under the Plan. Your coverage can only be rescinded if you (or a person seeking coverage on your behalf), performs an act, practice, or omission that constitutes fraud; or unless you (or a person seeking coverage on your behalf) makes an intentional misrepresentation of material fact, as prohibited by the terms of your Plan. Your coverage can also be rescinded due to such an act, practice, omission or intentional misrepresentation by your employer.

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

BENEFITS AFTER CANCELLATION OF COVERAGE

If a Member is an Inpatient on the date coverage ends, the benefits of this coverage for hospital and professional services will continue for only that Member until the *earliest* of:

- The effective date of any new coverage.
- The date of discharge,
- The attending Physician certifies that inpatient care is no longer medically indicated,
- The maximum in benefits have been exceeded.

V. WHAT HAPPENS WITH YOUR PLAN -

WHEN YOU HAVE OTHER COVERAGE - HOW COORDINATION OF BENEFITS WORKS

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

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

Definitions

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

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

(2) Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; supplemental coverage as described in Revised 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 Member is not an Allowable expense.

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

(1) The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable Expense, unless one of the Plans provides coverage for private hospital room expenses.
(2) If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.
(3) If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.
(4) If a person is covered by one Plan that calculates its benefits or services on the basis of usual or customary fees or relative value schedule reimbursement methodology or similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fee or payment amount is different than the Primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable expense used by the Secondary plan to determine its benefits.
(5) The amount of any benefit reduction by the Primary plan because a Member 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 Members primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

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

Order of Benefit Determination Rules

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Effect on the Benefits of this Plan

A. When This plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, The Secondary plan will calculate the benefits it would have

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

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

Right to Receive and Release Needed Information

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

Facility of Payment

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

Right of Recovery

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

Coordination Disputes

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

WHEN YOU ARE ELIGIBLE FOR MEDICARE

If any enrolled Member is entitled to Medicare benefits, federal law will control whether The Plan or Medicare is primary. Contact your Group for current guidelines.

WHEN YOU QUALIFY FOR WORKER'S COMPENSATION

If you or your Dependents receive health care services due to an injury which may be covered by Worker's Compensation, you must notify The Plan as soon as possible.

If you filed a claim for Worker's Compensation, The Plan will withhold payment to your providers until the case is settled. If The Plan has made any payment to your provider and services are covered by Worker's

Compensation, you are expected to reimburse The Plan for the amounts paid. Please refer to the Group Contract filed with your Group for further details.

WHEN SOMEONE ELSE IS LIABLE (SUBROGATION AND REIMBURSEMENT)

Subject to ORC 2323.44, to the extent applicable:

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

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

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

Equitable Lien. The Plan's subrogation and reimbursement rights are a first party lien against any recovery and must be paid before any other claims, including claims by the Member for damages (with the exception of claims by the Member pursuant to the property damage provisions of any insurance policy). This lien is not offset or reduced in any way by the Member's attorney fees or costs incurred in obtaining the recovery. The "common fund doctrine", "made whole" rule, or similar common law doctrines do not reduce or affect The Plan's subrogation and reimbursement rights. This means the Member must reimburse The Plan, in an amount not to exceed the total recovery, even when the Member's settlement or judgment is for less than the Member's total damages and must be paid without any reductions for attorney fees. 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 The Plan has the right to obtain injunctive relief prohibiting the Member from accepting or receiving any settlement or other recovery relating to the expenses paid by The Plan until The Plan's right of subrogation and reimbursement are fully satisfied and Member consents to such injunctive relief.

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

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

The Plan with written notice of a claim as required or if Member compromises or settles a claim without prior written consent, The Plan will deem the Member to have committed fraud or misrepresentation in a claim for benefits and will terminate the Member's participation in The Plan.

WHEN YOU LEAVE YOUR JOB

Members who no longer meet eligibility requirements under **Section IV, YOUR PLAN/Who is Eligible** of this Certificate of Coverage may be eligible for continuation coverage under the Group's health benefits plan**.**

HOW YOU MAY CONTINUE GROUP COVERAGE

To get group continuation coverage when you are no longer eligible for the employer's group plan, you must live in The Plan Service Area, and you must pay the required monthly prepayment (the share your former employer used to pay) to the group plan, your former employer. How long you are allowed to continue your coverage depends on the circumstances and the conditions provided in your employer group's plan.

The following are conditions under which you may continue coverage under your current plan. See your benefits office for further information.

1. If your employer group has *20 or fewer* employees and your employment ends, you and your eligible Dependents may be able to continue your group coverage through that employer for up to twelve (12) months under state law. To be eligible for state group continuation coverage, you must also meet the guidelines below:

    - You must have been continuously covered under a group contract or under the contract and any prior similar group coverage replaced by the contract, during the entire three-month period preceding the termination of your employment
    - You did not voluntarily terminate your employment and the termination is not the result of your gross misconduct
    - You must not be or become eligible for Medicare coverage or any other group health coverage

2. If any of the following events occur and your employer group has *more than 20* employees*,* you or your Dependents may be able to continue your coverage under the federal Consolidated Omnibus Budget Reconciliation Act (COBRA):

    - Termination of your employment (for reasons other than gross misconduct) or reduction of hours of employment
    - Termination of your employment due to Chapter 11 Reorganization by your employer
    - Your death
    - Your divorce or legal separation
    - The end of a Child's status as a Dependent under the plan
    - Your eligibility for Medicare benefits

Group Coverage may be continued for a period up to eighteen months after the date on which the coverage would otherwise terminate, if a covered Subscriber (employee) is called to active duty in the Armed Forces of the United States including the Ohio National Guard and Ohio Air National Guard.

1. Covered Dependents may continue coverage for up to a thirty-six (36) month period, if any of the following events occurs during the eighteen (18) month period;

    a. The death of the reservist;
    b. The divorce or separation of a reservist from the reservist's spouse. The divorce or separate of a reservist from the reservist's spouse;
    c. The cessation of dependency of a child pursuant to the terms of the contract.

2. The thirty-six month period of continuation of coverage is deemed to begin on the date on which the coverage would otherwise terminate because the reservist is called or ordered to active duty.
3. The Subscriber and/or Dependent must complete and return to the employer an election form within thirty-one (31) days of the date coverage would terminate.
4. 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 contract with The Plan is terminated.

LIMITATION ON LEGAL ACTIONS

No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time
written proof of loss is required to be furnished.

VI. INTERNAL CLAIMS AND APPEALS PROCEDURES AND EXTERNAL REVIEW OVERVIEW

If *you* need help: If you do not understand your rights or if you need assistance understanding your rights or you do not understand some or all of the information in the following provisions, you may contact The Plan at Member Services, P.O. Box 928, Toledo, Ohio 43697-0928, 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 (pre-service claim denial), *you*, or someone *you* have authorized to speak on *your* behalf (an Authorized Representative), can request an appeal of The Plan's decision. If The Plan rescinds *your* coverage or denies *your* application for coverage, *you* may also appeal The Plan's decision. When The Plan receives *your appeal*, it is required to review its own decision. When The Plan makes a claim decision, it is required to notify *you* (provide notice of an *Adverse Benefit Determination*). See **Terms and 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 file appeal the claim decision
- *Your* right to request an *external review*; and
- The availability of a Consumer Assistance Program at The Ohio Department of Insurance.

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

When *you* request an *internal appeal*, The Plan must give *you* its decision as soon as possible, but no later than:

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

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

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

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

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: Paramount Member Services 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 Member;
- The Member's I.D. Card 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 The Plan's 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 Benefit Determination must be written in a manner understood by you, or if applicable, your *Authorized Representative* and must include all of the following:
  - The titles and qualifying credentials of the person or persons participating in the first level review process (the reviewers);
  - Information sufficient to identify the claim involved, including the date of service, the *Health Care Provider*;
  - A statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning.

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

Other Resources to help *you*

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

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

Language services are available from the Health 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 received is for non-electronic *Pre-service* 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 we will notify you within 48 hours after receipt. Electronic pre-service appeals for non-urgent care services will be determined and we will notify you within ten (10) calendar days of receipt.

Urgent appeal request and expedited internal review:

In the case of a *claim involving urgent care*, *you* or *your Authorized Representative* may also request an expedited internal review. A request for expedited internal review may be submitted orally or in writing by you or your *Authorized Representative*; and all necessary information, including The Plan's benefit determination on review, shall be transmitted between The Plan and the Member 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 according with the procedures of this Plan, and The Plan has denied or refused to change its decision, or if The Plan has failed, because of its actions or its failure to act, to provide *you* with a *final determination* of your appeal within the time permitted, or if The Plan waives, in writing, the requirement to exhaust the internal claims and appeals procedures, you may make a request for an external review of an *Adverse Benefit Determination*.

All requests for an *external review* must be made within 180 days of the date of the notice of The Plan's *Final Adverse Benefit Determination*. Standard requests for an external review must be provided in writing; requests for expedited external reviews, including E*xperimental/Investigational*, may be submitted orally or electronically.

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

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

The Adverse Benefit Determination indicates the requested service is Experimental/Investigational, the requested health care service is not explicitly excluded in the *Member's health benefit plan*, and the treating Physician certifies at least one of the following:

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

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

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

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

You may file the request for an _external review_ by contacting the Plan

Paramount Insurance Company, P.O. Box 928, Toledo, Ohio 43697-0928, Attn: Member Services Appeals, by telephone at 1-800-462-3589 or email: PHCMbrSvcAppeals@medmutual.com. TTY users may call 1-888-740-5670.

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

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

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

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

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

Expedited external review for Experimental/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/Investigational, except when the requested health care service is explicitly listed as an excluded benefit under the terms of the Plan.

To be eligible for an external review under this provision, you*r* 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 electronically. For Expedited/Urgent requests, your *health care provider* can orally make the request on *your* behalf.

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

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

Independent Review Organization: An *external review* is conducted by an *independent review organization* (IRO) selected on a random basis as determined in accordance with Ohio law. The IRO will provide *you* with a written notice of its decision to either uphold or reverse The Plan's *Adverse Benefit Determination* within 30 days from the date of The Plan'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 from The Plan'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/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 *Member*. A *Member* may not file a subsequent request for an external review involving the same *Adverse Benefit Determination* that was previously reviewed unless new medical or scientific evidence is submitted to The Plan. If the IRO reverses the Plan's decision, the Plan will immediately provide coverage for the health care service or services in question.

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

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

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

Emergency medical services: If The 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.

VII. GENERAL PROVISIONS

Entire Contract

Note: The laws of the state in which the Group Contract is issued will apply unless otherwise stated herein. This Certificate of Coverage, the Group Contract, the Group application, any riders, endorsements or attachments, and the individual applications of the Subscriber and Dependents constitute the entire Contract between the Group and us and as of the Effective Date, supersede all other agreements. Any and all statements made to us by the Group and any and all statements made to the Group by us are representations and not warranties. No such statement, unless it is contained in a written application for coverage under this Certificate of Coverage, shall be used in defense to a claim under this Certificate of Coverage or be used in any legal proceeding thereunder.

Legal Actions

No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

Inspection

The Group Contract, including this COC, together with any application in connection therewith shall be available for inspection at all reasonable times at the place of business or principal residence of the Group where the policy is on file, by any Member thereunder, or by an authorized representative of the Member.

Care Coordination

We pay Participating Providers in various ways to provide Covered Services to you. For example, sometimes we may pay Participating Providers a separate amount for each Covered Service they provide. We may also pay them one amount for all Covered Services related to treatment of a medical condition. Other times, we may pay a periodic, fixed pre-determined amount to cover the costs of Covered Services. In addition, we may pay Participating Providers financial incentives or other amounts to help improve quality of care and/or promote the delivery of health care services in a cost-efficient manner, or compensate Participating Providers for coordination of Member care. In some instances, Participating Providers may be required to make payment to us because they did not meet certain standards. You do not share in any payments made by Participating Providers to us under these programs.

Clerical Error

A clerical error will never disturb or affect your coverage, as long as your coverage is valid under the rules of The Plan. This rule applies to any clerical error, regardless of whether it was the fault of the Group or us.

Confidentiality and Release of Information

Applicable state and federal law requires us to undertake efforts to safeguard your medical information.

For informational purposes only, please be advised that a statement describing our policies and procedures regarding the protection, use and disclosure of your medical information is available on our website and can be furnished to you upon request by contacting Member Services.

Obligations that arise under state and federal law and policies and procedures relating to privacy that are referenced but not included in this Certificate of Coverage are not part of the contract between the parties and do not give rise to contractual obligations.

Conformity with Law

Any term of The Plan which is in conflict with the laws of the state in which the Group Contract is issued, or with federal law, will hereby be automatically amended to conform with the minimum requirements of such laws.

Contract with The Plan

The Group, on behalf of itself and its participants, hereby expressly acknowledges its understanding that this Plan constitutes a Contract solely between the Group and us, The Plan. The Group, on behalf of itself and Subscribers, further acknowledges and agrees that it has not entered into this Contract based upon representations by any person other than The Plan and that no person, entity, or organization other than The Plan shall be held accountable or liable to the Group for any of The Plan's obligations to the Group created under the Contract. This paragraph shall not create any additional obligations whatsoever on our part other than those obligations created under other terms of this agreement.

Form or Content of Certificate of Coverage

No agent or employee of ours is authorized to change the form or content of this Certificate of Coverage. Changes can only be made through a written authorization, signed by an officer of The Plan.

Government Programs

The benefits under this Plan shall not duplicate any benefits that you are entitled to, or eligible for, under any other governmental program. This does not apply if any particular laws require us to be the primary payer. If we have duplicated such benefits, all money paid by such programs to you for services you have or are receiving, shall be returned by or on your behalf to us.

Medicare

Any benefits covered under both this Plan and Medicare will be covered according to Medicare Secondary Payer legislation, regulations, and Centers for Medicare & Medicaid Services guidelines, subject to federal court decisions. Federal law controls whenever there is a conflict among state law, Certificate of Coverage terms, and federal law.

Except when federal law requires us to be the primary payer, the benefits under this Plan for Members age 65 and older, or Members otherwise eligible for Medicare, do not duplicate any benefit for which Members are entitled under Medicare, including Parts B and/or D. Where Medicare is the responsible payer, all sums payable by Medicare for services provided to you shall be reimbursed by or on your behalf to us, to the extent we have made payment for such services. For the purposes of the calculation of benefits, if you have not enrolled in Medicare Part B, we will calculate benefits as if you had enrolled.

You should enroll in Medicare Part B as soon as possible to avoid potential liability. If you do not enroll in Medicare Part B when you are eligible, you may have large out-of-pocket costs. Please refer to Medicare.gov for more details on when you should enroll, and when you are allowed to delay enrollment without penalties.

Modifications

This Certificate of Coverage allows the Group to make Plan coverage available to eligible Members. However, this Certificate of Coverage shall be subject to amendment, modification, and termination in accordance with any of its terms, the Group Contract, or by mutual agreement between the Group and us without the permission or involvement of any Member. Changes will not be effective until the date specified in the written notice we give to the Group about the change. By electing medical and Hospital coverage under the Plan or accepting Plan benefits, all Members who are legally capable of entering into a contract, and the legal representatives of all Members that are incapable of entering into a contract, agree to all terms and conditions in this Certificate of Coverage.

Not Liable for Provider Acts or Omissions

We are not responsible for the actual care you receive from any person. This Certificate of Coverage does not give anyone any claim, right, or cause of action against The Plan based on the actions of a Provider of health care, services, or supplies.

Payment Innovation Programs

We pay Participating Providers through various types of contractual arrangements. Some of these arrangements – Payment Innovation Programs (Program(s)) – may include financial incentives to help improve quality of care and promote the delivery of health care services in a cost-efficient manner.

These Programs may vary in methodology and subject area of focus and may be modified by us from time to time, but they will be generally designed to tie a certain portion of an Participating Provider's total compensation to pre-defined quality, cost, efficiency or service standards or metrics. In some instances, Participating Providers may be required to make payment to us under the Program as a consequence of failing to meet these pre-defined standards.

The Programs are not intended to affect your access to health care. The Program payments are not made as payment for specific Covered Services provided to you, but instead, are based on the Participating Provider's achievement of these pre-defined standards. You are not responsible for any Copayment or Coinsurance amounts related to payments made by us or to us under the Program(s), and you do not share in any payments made by Participating network Providers to us under the Program(s).

Plan Information Practices Notice

The purpose of this information practices notice is to provide a notice to Members regarding our standards for the collection, use, and disclosure of information gathered in connection with our business activities. We may collect personal information about a Member from persons or entities other than the Member. We may disclose Member information to persons or entities outside of The Plan without Member authorization in certain circumstances. A Member has a right of access and correction with respect to all personal information collected by us. A more detailed notice will be furnished to you upon request.

Policies and Procedures

We are able to introduce new policies, procedures, rules and interpretations, as long as they are reasonable. Such changes are introduced to make the Plan more orderly and efficient. Members must follow and accept any new policies, procedures, rules, and interpretations.
Under the terms of the Group Contract, we have the authority, in our sole discretion, to introduce or terminate from time to time, pilot or test programs for disease management, care management or wellness initiatives which may result in the payment of benefits not otherwise specified in this Certificate of Coverage. We reserve the right to discontinue a pilot or test program at any time.

Program Incentives

We may offer incentives from time to time, at our discretion, in order to introduce you to covered programs and services available under this Plan. The purpose of these incentives include, but is not limited to, making you aware of cost effective benefit options or services, helping you achieve your best health, and encouraging you to update member-related information. These incentives may be offered in various forms such as monetary rewards, retailer coupons, gift cards, health related merchandise, and discounts on fees or Member cost shares. Acceptance of these incentives is voluntary as long as The Plan offers the incentives program. We may discontinue an incentive for a particular covered program or service at any time. If you have any questions

about whether receipt of an incentive or retailer coupon results in taxable income to you, we recommend that you consult your tax advisor.

Relationship of Parties (Group-Member-The Plan)

The Group is responsible for passing information to you. For example, if we give notice to the Group, it is the Group's responsibility to pass that information to you. The Group is also responsible for passing eligibility data to us in a timely manner. If the Group does not give us timely enrollment and termination information, we are not responsible for the payment of Covered Services for Members.

Relationship of Parties (The Plan and Participating Providers)

The relationship between The Plan and Participating Providers is an independent contractor relationship. Participating Providers are not agents or employees of ours, nor is The Plan, or any employee of The Plan, an employee or agent of Participating Providers. Your health care Provider is solely responsible for all decisions regarding your care and treatment, regardless of whether such care and treatment is a Covered Service under this Plan. We shall not be responsible for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by you while receiving care from any Participating Provider or in any Participating Provider's facilities.

Your Participating Provider's agreement for providing Covered Services may include financial incentives or risk sharing relationships related to the provision of services or referrals to other Providers, including Participating Providers, Non-Participating Providers, and disease management programs. If you have questions regarding such incentives or risk sharing relationships, please contact your Provider or us.

Reservation of Discretionary Authority

This section only applies when the interpretation of this Certificate of Coverage is governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. 1001 et seq. We, or anyone acting on our behalf, shall determine the administration of benefits and eligibility for participation in such a manner that has a rational relationship to the terms set forth herein. However, we, or anyone acting on our behalf, have complete discretion to determine the administration of your benefits. Our determination shall be final and conclusive and may include, without limitation, determination of whether the services, care, treatment, or supplies are Medically Necessary, Experimental / Investigational, whether surgery is cosmetic, and whether charges are consistent with the Maximum Allowable Amount. Our decision shall not be overturned unless determined to be arbitrary and capricious. However, a Member may utilize all applicable complaint and appeals procedures.

We, or anyone acting on our behalf, shall have all the powers necessary or appropriate to enable us to carry out the duties in connection with the operation and administration of The Plan. This includes, without limitation, the power to construe the Contract, to determine all questions arising under the Certificate of Coverage and to make, establish and amend the rules, regulations, and procedures with regard to the interpretation and administration of the provisions of this Plan. However, these powers shall be exercised in such a manner that has reasonable relationship to the provisions of the Contract, the Certificate of Coverage, Provider agreements, and applicable state or federal laws. A specific limitation or exclusion will override more general benefit language.

Right of Recovery and Adjustment

Whenever payment has been made in error, we will have the right to recover such payment from you or, if applicable, the Provider or otherwise make appropriate adjustment to claims. In most instances such recovery or adjustment activity shall be limited to the calendar year in which the error is discovered.

We have oversight responsibility for compliance with Provider and vendor contracts. We may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a Provider or vendor resulting from these audits if the return of the overpayment is not feasible. Additionally, we have established recovery and adjustment policies to determine which recoveries and adjustments are to be pursued, when to incur costs and expenses and settle or compromise recovery or adjustment amounts. We will

not pursue recoveries for overpayments or adjustments for underpayments if the cost of the activity exceeds the overpayment or underpayment amount.

Unauthorized Use of Identification Card

If you permit your Identification Card to be used by someone else or if you use the card before coverage is in effect or after coverage has ended, you will be liable for payment of any expenses incurred resulting from the unauthorized use. Fraudulent misuse could also result in termination of the coverage.

Value-Added Programs

We may offer health or fitness related programs to our members, through which you may access discounted rates from certain vendors for products and services available to the general public. Products and services available under this program are not Covered Services under your Plan but are in addition to Plan benefits. As such, program features are not guaranteed under your health Plan Contract and could be discontinued at any time. We do not endorse any vendor, product or service associated with this program. Program vendors are solely responsible for the products and services you receive.

Value of Covered Services

For purposes of subrogation, reimbursement of excess benefits, or reimbursement under any Workers' Compensation or Employer Liability Law, the value of Covered Services shall be the amount we paid for the Covered Services.

Voluntary Clinical Quality Programs
We may offer additional opportunities to assist you in obtaining certain covered preventive or other care (e.g., well child check-ups or certain laboratory screening tests) that you have not received in the recommended timeframe. These opportunities are called voluntary clinical quality programs. They are designed to encourage you to get certain care when you need it and are separate from Covered Services under your Plan. These programs are not guaranteed and could be discontinued at any time. We will give you the choice and if you choose to participate in one of these programs, and obtain the recommended care within the program's timeframe, you may receive incentives such as gift cards or retailer coupons, which we encourage you to use for health and wellness related activities or items. Under other clinical quality programs, you may receive a home test kit that allows you to collect the specimen for certain covered laboratory tests at home and mail it to the laboratory for processing. You may also be offered a home visit appointment to collect such specimens and complete biometric screenings. You may need to pay any cost shares that normally apply to such covered laboratory tests (e.g., those applicable to the laboratory processing fee) but will not need to pay for the home test kit or the home visit. If you have any questions about whether receipt of a gift card or retailer coupon results in taxable income to you, we recommend that you consult your tax advisor.

Voluntary Wellness Incentive Programs
We may offer health or fitness related program options for purchase by your Group. These programs are not Covered Services under your Plan, but are separate components, which are not guaranteed and could be discontinued at any time. If your Group has selected one of these options to make available to all employees, you may receive incentives such as gift cards by participating in or completing such voluntary wellness promotion programs as health assessments, weight management or tobacco cessation coaching. Under other options a Group may select, you may receive such incentives by achieving specified standards based on health factors under wellness programs that comply with applicable law. If you think you might be unable to meet the standard, you might qualify for an opportunity to earn the same reward by different means. You may contact us at The Plan Member Services number on your ID card, and we will work with you (and, if you wish, your Doctor) to find a wellness program with the same reward that is right for you in light of your health status. (If you receive a gift card as a wellness reward and use it for purposes other than for qualified medical expenses, this may result in taxable income to you. For additional guidance, please consult your tax advisor.)

Waiver

No agent or other person, except an authorized officer of The Plan, is able to disregard any conditions or restrictions contained in this Certificate of Coverage, to extend the amount of time for making a payment to us, or to bind us by making any promise or representation or by giving or receiving any information.

Workers' Compensation

The benefits under this Plan are not designed to duplicate benefits that you are eligible for under Workers' Compensation Law. All money paid or owed by Workers' Compensation for services provided to you shall be paid back by, or on your behalf of to us if we have made or makes payment for the services received. It is understood that coverage under this Plan does not replace or affect any Workers' Compensation coverage requirements.

VIII. TERMS AND DEFINITIONS

Active Course of Treatment means 1) an ongoing course of treatment for a life-threatening condition, defined as a disease or condition for which likelihood of death is probable unless the course of the disease or condition is interrupted; 2) an ongoing course of treatment for a serious acute condition, defined as a disease or condition requiring complex ongoing care which the Member is currently receiving, such as chemotherapy, radiation therapy, or post-operative visits; 3) the second or third trimester of pregnancy through the postpartum period; or 4) an ongoing course of treatment for a health condition for which a treating Physician or health care provider attests that discontinuing care by that Physician or health care provider would worsen the condition or interfere with anticipated outcomes. An ongoing course of treatment includes mental health and substance abuse disorder treatments.

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

1. To deny, reduce, or terminate a requested health care service or payment in whole or in part, including all of the following:
    a. A determination that the health care service does not meet the health plan issuer's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness, including Experimental/Investigational treatments;
    b. A determination of an individual's eligibility for individual health insurance coverage, including coverage offered to individuals through a nonemployer 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 nonemployer group;
3. To rescind coverage on a health benefit plan. See definition of rescission in this section.

Affiliation, Probationary or Waiting Period is the period between the date the individual files a substantially complete application for coverage and the first day of coverage.

Authorized Representative means an individual who represents *you* in an internal appeal or external review process of an Adverse Benefit Determination who is any of the following:

- 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;
- A person authorized by law to provide substituted consent for a covered individual;
- A family member but only when *you* are unable to provide consent.

Basic Health Care Services as defined by Section 1751.01 of the Ohio Revised Code are: Physician's services, inpatient hospital services, outpatient medical services, emergency health services, diagnostic laboratory

services and diagnostic and therapeutic radiology services, diagnostic and treatment services, other than prescription drug services, for biologically based mental illnesses; preventive health services including family planning, infertility services, periodic physical examinations, prenatal obstetrical care and well-child care; and routine patient care for patients enrolled in an eligible cancer clinical trial pursuant to section 3923.80 of the Ohio Revised Code.

Biologically Based Mental Illness as defined by ORC 1751.01, (D) means schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder and panic disorders as these terms are defined in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* published by the American Psychiatric Association.

Calendar Year means January 1 through December 31.

Child means the natural children, legally adopted children, stepchildren and children under legal custody (i.e., official court-appointed guardianship or custody) of the Subscriber or the Subscriber's spouse.

A 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.

Coinsurance is your share of the cost of some Covered Services (a percentage of the amount allowed).

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 Year is a Calendar Year or the term for which the employer group has an agreement with The Plan to provide Covered Services to eligible Subscribers and their Dependents.

Copayment is your share of the cost of some Covered Services. Copayment is a specific dollar amount, such as $5.00 or $10.00. Copayments for specific dollar amounts are due and payable at the time services are provided.

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

Covered Services are authorized services shown in our list of services covered and rendered by a provider for which The Plan will provide payment. A Covered Service may be subject to a Copayment/Coinsurance or other limitations.

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:

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

Deductible is the amount you and your Dependents must pay for Covered Services within each Contract 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. The single Deductible is the amount each Member must pay; the family Deductible is the total amount any two or more family members must pay. The Deductible of one family member will not exceed that of an individual annual Deductible maximum amount. Preventive Health Services are not subject to the Deductible.

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

Dependent means any member of a Subscriber's family who meets all the applicable eligibility requirements, has been enrolled in The Plan and for whom the payment required by the employer's group agreement has been received by The Plan.

Effective Date is the date your coverage begins**.**

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

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

An Emergency Medical Condition also includes a behavioral health emergency where the Member is acutely suicidal or homicidal.

Emergency Services means the following:

- A 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;
- 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.

Exigent Circumstances (Expedited Exception Request) exist when a Member is suffering from a health condition that may seriously jeopardize the Member'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/Investigative means 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 under the Health Plan. 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 the

Non-Covered Services/Exclusions section of this Certificate of Coverage.

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

Group means the employer or other organization (e.g., association), which has a Group Contract with us, The Plan.

Group Medical and Hospital Services Agreement (or Group Contract) means the contract between us, The Plan, and the Group. It includes this Certificate of Coverage, your application, any application or change form, your Identification Card, any endorsements, riders or amendments, and any legal terms added by us to the original Group Contract. The Group Contract is kept on file by the Group. If a conflict occurs between the Group Contract and this Certificate of Coverage, the Group Contract controls.

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 or Provider: Means a Health Care Professional, facility and other ancillary provider.

Health Plan means The Plan.

Health Savings Account (HSA) 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 not subject to a Deductible.

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

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

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.

Maximum Allowable Amount is the maximum amount the Health Plan will allow for Covered Services you receive**.**

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

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

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

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

Member means any Subscriber or Dependent as defined in **Section IV, YOUR PLAN/Who Is Eligible.**

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

Minimum Essential Coverage is the type of coverage an individual needs to have to meet the individual responsibility requirement under the Affordable Care Act. This includes individual market policies, job-based coverage, Medicare, Medicaid, CHIP, TRICARE and certain other coverage.

Non-Participating Provider means a Health Care Provider that does not have a contract with The Plan to provide Covered Services to Members.

Out-of-Pocket Maximum is the maximum amount of Deductible, Copayments and Coinsurance you and your Dependents pay every Contract Year. Once the Out-of-Pocket Maximum is met, there will be no additional Cost Sharing during the remainder of the Contract Year**.** The Out-of-Pocket Maximum is stated in your Schedule of Benefits. 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.

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

Service Area means all of Ashland, Crawford, Defiance, Erie, Fulton, Hancock, Henry, Huron, Lucas, Marion, Morrow, Ottawa, Putnam, Richland, Sandusky, Seneca, Williams, Wood, and Wyandot counties, and portions of Allen, Delaware, Hardin, Knox, Lorain and Paulding counties In Ohio and Lenawee and Monroe counties in Michigan.

Participating Hospital means any hospital with which The Plan has contracted or established arrangements for inpatient/outpatient hospital services and/or emergency services.

Participating Pharmacy means a pharmacy that has a contract with The Plan or its PBM to provide covered pharmacy services to Members.

Participating Provider means a Physician, hospital or other Health Care Professional or facility that has a contract with The Plan to provide Covered Services to Members.

Participating Specialist means a Physician who provides Covered Services to Members within the range of his or her medical specialty under an agreement with The Plan.

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 means the benefit plan your Group has purchased, which is described in this Certificate of Coverage.

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

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

Preventive Health Services/Benefits are those Covered Services that are being provided: 1) to a Member who has developed risk factors (including age and gender) for a disease for which the Member has not yet developed symptoms, and 2) as an immunization to prevent specific diseases. However, any service or benefit intended to treat an ***existing*** illness, injury or condition does not qualify as Preventive Health Services. More information is available in **Covered Services** section of this Certificate of Coverage #18 Preventive Health Services.

Primary Care Provider (PCP) means a Physician or other provider who specializes in family practice, internal medicine or pediatrics and is designated by The Plan as a Primary Care Provider. Female Members may receive OB/GYN care from a obstetrics/gynecology Participating Specialist without Prior Authorization.

Prior Authorization includes prospective, or utilization review procedures conducted prior to providing a health care service, device, or drug. Prior Authorization is required for certain procedures or services. It is the responsibility of the Participating Provider to obtain Prior Authorization from The Plan in advance of these procedures or services. It is the Member's responsibility to make sure procedures and services are provided by a Participating Provider or that an out-of-plan Prior Authorization is obtained. See **Prior Authorization** in this Certificate of Coverage for more information.

ProMedica OnDemand Visit is a live video consultation with a board-certified Provider scheduled by you or your Dependents via the webpage or downloadable mobile device application located at https://www.paramounthealthcare.com/members/member-perks/promedica-ondemand.

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 member.

Schedule of Benefits is the insert included with this Certificate of Coverage 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 program the Employer has purchased.

Specialty Drugs are complex Prescription Drugs as determined by The Plan's Pharmacy & Therapeutics Working Group (P & T) used to treat chronic conditions such as multiple sclerosis, cancer, hepatitis and rheumatoid arthritis. These drugs are self-administered as injectable or oral drugs and often require special handling and monitoring.

Stabilize/Stabilized 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:

- 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;
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part. In the case of a woman having contractions, "Stabilize" means such medical treatment as may be necessary to deliver, including the placenta.

Subscriber means an employee or member of the Group who is eligible for and has enrolled in The Plan.

Telehealth Services 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:

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

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

Urgent Care Services means health care services that are appropriately provided for 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, and may include such health care services provided out of The Plan's approved service area.