PARAMOUNT INSURANCE COMPANY

Short-Term, Limited-Duration Health Insurance
Preferred Provider Organization (PPO) Plan
Certificate of Coverage

IMPORTANT: This is a short-term, limited-duration policy, NOT comprehensive health coverage

This is a temporary limited policy that has fewer benefits and Federal protections than other types of health insurance options, like those on HealthCare.gov.

This policy	Insurance on HealthCare.gov
Might now cover you due to preexisting health conditions like diabetes, cancer, stroke, arthritis, heart disease, mental health & substance use disorders	Can't deny you coverage due to preexisting health conditions
Might not cover things like prescription drugs, preventive screenings, maternity care, emergency services, hospitalization, pediatric care, physical therapy & more	Covers all essential health benefits
Might have **no limit on what you pay** out-of-pocket for care	Protects you with limits on what you pay each year out-of-pocket for essential health benefits
You **won't qualify** for Federal financial help to pay premiums & out-of-pocket costs	Many people qualify for Federal financial help
Doesn't have to meet Federal standards for comprehensive health coverage	All plans must meet Federal standards

Looking for comprehensive health insurance?

- **Visit HealthCare.gov** or call **1-800-318-2596** (TTY: 1-855-889-4325) to find health coverage options.
- To find out if you can get health insurance through your job, or a family member's job, contact the employer.

Questions about this policy?

For questions or complaints about this policy, contact your State Department of Insurance. Find their number on the National Association of Insurance Commissioners' website (NAIC.org) under "Insurance Departments."

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 policy is not a Medicare supplement policy. If you are eligible for Medicare, review the "Guide to Health Insurance for People with Medicare" available from Paramount.

If for any reason you are not satisfied with this policy, you may return it to Paramount within 10 days after you receive it. Please see Right to Rescind under Section Two: Eligibility and Effective Date of this Certificate.

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:

ܙܘܗܪܐ: ܐܢ ܗܡܙܡܬ ܐܬܘܪܝܐ، ܟܡܢ ܐܝܬ ܠܟ ܦܬܚ ܐܝܬܐ ܡܢ ܡܓܢܐ ܕܦܠܚܢܘܬܐ ܕܗܝܪܬܐ ܠܫܢܢܝܐ. ܐܦ ܐܝܬ ܟܡܢ ܠܟ ܦܬܚ ܐܝܬܐ ܡܫܘܚܠܦܬܐ ܘܦܠܚܢܘܬܐ ܠܗܝܪܬܐ
ܠܡܘܬܝܒܐ ܡܢ ܡܘܕܥܢܘܬܐ ܕ ܡܘܬܒܐ ܠܡܬܠܐ ܐܝܟ ܡܓܢܐ. ܩܪܝ، **1-800-462-3589** (**TTY:711**) ܐܘ ܡܡܠܠ ܥܡ ܡܘܬܒܐ ܕ ܦܠܚܢܘܬܐ

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

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

Paramount 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 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 Paramount 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.

Paramount Member Services
300 Madison Ave. Suite 270
Toledo, Ohio 43604

Alternate in Person Delivery Address:
650 Beaver Creek Cr. 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.

PARAMOUNT INSURANCE COMPANY
P. O. Box 928
Toledo, Ohio 43697-0928
419-887-2500
Member Services: 419-887-2525

RATE PERIOD: 01-01-2025 THRU 12-31-2025
PREPAYMENT DUE IN ADVANCE OF THE FIRST DAY OF SAID COVERAGE PERIOD.

NOTE: This plan is non-renewable

Table of Contents

INTRODUCTION

You have enrolled in a comprehensive program of health care benefits ("Plan") with Paramount Insurance Company ("Paramount"), a licensed insurance company.

This booklet, referred to as a Certificate of Coverage, including the accompanying Schedule of Benefits is provided to describe the Plan. This Certificate of Coverage has been issued to You as part of the Contract between Paramount and You. To determine Your Paramount benefits for a specific service, You should refer to both this Certificate of Coverage and Your Schedule of Benefits. **You should check both sources for information about the Plan because this Certificate of Coverage presents information about the basic Plan, while the Schedule of Benefits explains the specific program that the You have purchased.** Questions regarding Your Plan can also be directed to the Paramount Member Services Departments at; 419-887-2525 or toll-free 1-800-462-3589.

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

SECTION ONE: SURPRISE BILLING

Your Rights and Protections Against Surprise Medical Bills

When you receive emergency care, unanticipated out-of-network care, or get treated by an out-of-network provider at an in-network facility, you are protected from surprise billing or balance billing.

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

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

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

"Surprise billing" is an unexpected balance bill. This can happen when you cannot 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.

<u>You are protected from balance billing for:</u>

Emergency services
Ohioans who get health insurance through plans regulated by the Ohio Department of Insurance are 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 <u>never</u> required to give up your protections from balance billing. You also aren't 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 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 Paramount'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.

SECTION TWO: ELIGIBILITY AND EFFECTIVE DATE

1. **Eligibility**. The following persons are eligible for coverage and are eligible for enrollment at any time within a calendar year. The Subscriber must list all potential enrollees on the enrollment application.

   Eligible dependents:

   - Spouse of Subscriber
   - 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 do not reside in the household of the parent are eligible to enroll in this plan.
     - Eligible Dependent children are covered through the last day of the benefit period in which they turn age twenty-six (26).
   - Subscriber or Subscriber's spouse who, by court order, must provide health care coverage
     - If the enrolled parent fails to make application to enroll the Child, Paramount will enroll the child upon application by the other parent or upon receipt of a child support order containing provisions in compliance with 3119.29 to 3119.56 of the Ohio Revised Code. Paramount will not terminate the Child's coverage without written evidence the court order is no longer in effect or the child is or will be enrolled under comparable health care coverage through another insurer with an effective date not later than the termination date of the current coverage.

   Children of Dependents 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.

   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 be covered 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 benefits beyond the thirty-one days following the birth.

   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.

   Divorce In the case of divorce, you must notify Paramount 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.

   Death of a Subscriber If there is a death of a subscriber, Dependents of a deceased Subscriber may be eligible for continuation coverage.

   Effective dates when a plan selection is approved: Between the first and the fifteenth day of any month, enrollee's coverage effective date is the fifteenth day of the following month; or Between the sixteenth and the last day of any month, enrollee's coverage effective date is the first day of the second following month. **Your account will be immediately charged

   Nondiscrimination No one who is eligible to enroll as a Subscriber, Dependent or Dependent with disabilities will be refused by Paramount based on genetic testing or the results of such testing, or the exercise of rights under Paramount's internal review procedures.

2. **Termination of Coverage:** During the course of the benefit contract period, either the enrollee or Paramount may need to terminate an enrollee's coverage in a plan.

The following events may trigger termination of coverage:

a. Loss of Eligibility – The enrollee is no longer eligible for coverage;
b. Non-payment – An individual fails to pay premiums and a grace period has been exhausted;
c. Fraud – The enrollee has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of coverage,
d. Termination of Product – The plan is withdrawn by Paramount and terminated.

In the case of termination for non-payment coverage ends on the last day of the month for which premium payment was received in full.

Paramount will provide notice upon termination of coverage.

3. **Non-Renewability:** Your Short-Term plan is not renewable. Short Term Medical is issued for a specific period of time.

4. **Benefits After Termination:** 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:

a. The effective date of any new coverage,
b. The date of discharge,
c. The attending physician certifies that inpatient care is no longer medically indicated,
d. The limit for contractual benefits has been reached.

5. **Refunds:** Paramount will process refunds for clerical or billing errors that are caused by Paramount. All premiums are paid before the month of coverage, and once paid, are non-refundable. The only exception to this rule is if the enrollee has elected to pay several months ahead in their premium payments. Any credit that is on an account after Paramount settles the account for the determined Effective Date of termination will be refunded to the subscriber.

6. **Right to Rescind:**
   - **a.** A policyholder has the right to rescind coverage until midnight of the tenth day after the date on which the policyholder receives the policy, by returning the policy to the insurer or an agent of the insurer. No reason will need to be stated for the return of rescission.
     - **i.** The policy will be enforced during any period prior to its return, and a pro-rated portion of the premium is chargeable for the coverage.
   - **b.** The policy will be deemed returned, if, within the period of time specified by the insurer, the policyholder mails the policy to the insurer or agent, or delivers, or causes the delivery of, the policy to the insurer or agent.

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

SECTION THREE: HOW THE SHORT-TERM LIMITED-DURATION PLAN WORKS

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

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

In-Network Option – You may seek care from any In-Network Provider. You must satisfy the Deductible under the In-Network option before any benefits will be paid and Your share of the cost for services will be

lower compared to obtaining service from Out-of-Network Providers. Pre- authorization from Paramount is required for certain services.

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

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

Special Note on Out-of-Network Providers. For Out-of- Network Hospitals, Physicians/Providers, Paramount pays for benefits based on the lesser of the Usual, Customary and Reasonable (UCR) Charge or the actual charge for the service. For Emergency Services provided by an Out-of-Network Provider, please see "Coverage for Emergency Services" in this section.

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

Example (assumes the Deductible has already been met):

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

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

Benefit Limits - Some benefits described in this Certificate of Coverage are limited, may vary, or require payment of additional amounts. Please refer to the Schedule of Benefits and to the specific conditions, limitations, exclusions, and/or payment levels that are set forth in the section which describes that benefit in detail and in Section Eight, Exclusions, for a description of services and supplies that are not covered under this Plan. Always call Paramount at 419-887-2525 or toll-free 1-800-462-3589 if You have any questions about specific conditions, limitations, exclusions, or payment levels.

2. **Pre-Authorization**

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

Pre-authorization is required for, but not limited to, the following list of services, procedures and equipment. A more comprehensive list can be found at www.paramounthealthcare.com/priorauth.

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

Pre-Authorization must be obtained by calling Paramount at 419-887-2549 or toll free 1-800-891-2549

(preferably two weeks in advance) before obtaining any of the following.

A. Services requiring pre-authorization (not an all-inclusive listing, refer to www.paramounthealthcare.com/priorauth):
   i. Inpatient admission to a Hospital, Intensive Outpatient Programs (IOP), partial hospitalizations (PHP), and Inpatient admissions at rehabilitation /residential facilities;
   ii. Home Health services; and
   iii. Organ/Bone Marrow Transplant services.

B. Procedures requiring pre-authorization (not an all-inclusive listing, refer to www.paramounthealthcare.com/priorauth):
   i. Cochlear implants;
   ii. MRI and CT Imaging;
   iii. New Technology (Medical, Diagnostics, Durable medical Equipment); and
   iv. Autism Treatment.

C. Equipment requiring pre-authorization (not an all-inclusive listing, refer to www.paramounthealthcare.com/priorauth):
   i. Air fluidized beds;
   ii. Bone stimulators and supplies;
   iii. Power operated vehicles, power wheelchairs and power wheelchair accessories;
   iv. Enteral nutrition;
   v. Speech generating devices;
   vi. Continuous Blood Glucose Monitoring services – Long Term;
   vii. Cranial orthotic remolding device; and
   viii. Hearing aids/Bone-Anchored Hearing Aids (BAHA).

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

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

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

Non-urgent non-electronic claim
When Pre-Notification is required in the case of a non-urgent non-electronic claim, Paramount will decide, and notify you of its decision, within fifteen (15) working days from Paramount's receipt of the claim that requires Pre-Authorization. If circumstances beyond Paramount's control require that this period be extended, Paramount may extend this period for up to fifteen (15) days. Paramount will notify you prior to the expiration of the initial 15-day period of the circumstances requiring the extension of time and the date by which Paramount expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and you will be afforded at least forty-five (45) days from receipt of the notice within which to provide the specified information.

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

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

Electronic claims
Paramount will accept health care provider requests when received electronically. Paramount'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 mean medical care or other service for a condition where application of the timeframe for making routine or non-life threatening care determinations is either of the following:

(a) Could seriously jeopardize the life, health, or safety of the patient or others due to the patient's psychological state;
(b) In the opinion of a practitioner with knowledge of the patient's medical or behavioral condition, would subject the patient to adverse health consequences without the care or treatment that is the subject of the request.

If the electronic request is incomplete, Paramount 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 Paramount acknowledging the request.

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

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

Concurrent Reviews
Concurrent reviews are requests to extend coverage that was previously approved for a specified length of time.
If Paramount 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. Paramount will notify the Insured (in cases where the Insured will have financial liability) and requesting Provider of the Adverse Benefit Determination, in writing or electronically, at a time sufficiently in advance of that reduction or termination to allow the claimant to utilize the internal and external appeals process explained in this certificate to request review of this decision.

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

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

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

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

Retrospective review
A retrospective review is a request for Paramount to evaluate whether a health care service that the Insured has already received was Medically Necessary. For all retrospective reviews, Paramount will decide, and will notify the provider and the Insured of its decision, within thirty (30) business days after receiving the request for retrospective review. This period may be extended one time by Paramount for as many as

fifteen (15) days, provided that Paramount determines such an extension is necessary due to matters beyond Paramount's control. If an extension is necessary, Paramount will notify the Insured, prior to the expiration of the initial 30-day period, of the circumstances requiring an extension and of the date by which Paramount expects to render a decision.

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

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

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

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

3. **The Preferred Provider Organization (PPO) Network**. The PPO Network Directory lists all Physicians and other Providers who are part of the PPO Network. The PPO Network Directory will be updated periodically and You may access the PPO Network Directory at; www.paramounthealthcare.com. Or by calling the Member Service Department at 419-887-2525 or toll-free 1-800-462-3589.

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

   Please note that Paramount's Contracting and credentialing with In-Network Providers should not, in any case, be understood as a guarantee or a warranty of the appropriateness and/or adequacy of the Medical Care rendered by such Provider. In-Network Providers are independent Contractors and are not employees or agents of Paramount. The selection of an In-Network Provider or any other Provider, and the decision to receive or decline to receive Health Care Services is **Your responsibility**. Health care decisions are made solely by You in consultation with Your Health Care Providers. Health Care Providers are solely responsible for patient care and related clinical decisions once You make Your health care decision.

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

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

   Claim forms: Upon receipt of a notice of claim, Paramount will furnish to You the necessary forms for filing proof of loss. If such forms are not furnished within fifteen days after receiving notice, You shall be deemed to have complied with the requirements of this policy as to proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

   Proofs of loss: Written proof of loss must be furnished to the insurer at its office in case of claim for loss for which this policy provides any periodic contingent upon continuing loss within ninety days after the termination of the period for which the insurer is liable and in case of claim for any other loss within ninety days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

Payment of claims: Paramount will make payment immediately upon, or within thirty days after, receipt of due written proof of loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid within thirty days and any balance remaining unpaid immediately upon receipt of due written proof.

In most cases, reimbursement for Covered Services will be sent directly to the Provider, but in some cases, Paramount may choose to send reimbursement to You. If You pay for the Covered Services You may request reimbursement from Paramount. Claim forms are available by calling the Paramount Member Services Department at 419-887-2525 or toll-free 1-800-462-3589**.**

Explanation of Benefits (EOB): After a claim has been filed with Paramount, You will receive an Explanation of Benefits (EOB). The EOB is a summary of the coverage for that claim. The EOB is not a bill, but a statement from Paramount to help You understand the coverage You are receiving. The EOB shows:

- Total amount charged for services/supplies received;
- The amount of the charges paid by Your coverage; and
- The amount for which You are responsible (if any).

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

A. **Deductible.** The amount You and Your Dependents must pay for Covered Services within a contract period, before any benefits will be paid by the Plan. See Your Schedule of Benefits for the Deductible amount that applies to You and Your Dependents. If You have single coverage (self only), the single Deductible is the amount You must pay. If You have family coverage (two or more covered family members), the family Deductible is the total amount any **two** or more covered family members must pay. The Deductible amount of one family member will not exceed that of an individual annual Deductible maximum amount. A plan will only be used as a High Deductible Health Plan (HDHP) with a Health Savings Account (HSA) when it follows the minimum and maximum limits for a HDHP. See Definitions section of this certificate for more information regarding an HDHP and HSA. The expenses incurred for Covered Services received from In-Network Providers apply towards satisfying the In-Network PPO Deductibles. The expenses incurred for Covered Services received from Out-of-Network Providers apply only towards satisfying the Out-of-Network Deductible.

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

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

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

D. **Out-of-Pocket Maximum**. Your Out-of-Pocket Maximum is stated in Your Schedule of Benefits. After that amount has been paid, there will be no additional cost sharing during the remainder of that contract period. The Out-of-Pocket Maximum is the maximum amount of Copayments and Coinsurance including medical Deductibles (if any) paid by a Covered Person in a contract period. 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. If the Out-of-Pocket Maximum stated in Your Schedule of Benefits is unlimited, You are responsible for all additional Cost Sharing.

The following ***do not*** apply to the Out- of-Pocket Maximum:

- Financial penalties imposed for failure to obtain required pre-authorization for care received

Out-of-Network;
- Non-Network charges in excess of NCA or UCR.

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

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

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

   Paramount will not make any payment for care which is not Medically Necessary.

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

Usually, services obtained from Out-of-Network Providers are covered at the Out-of-Network benefit level. However, in the case of Medically Necessary Emergency Services, at a minimum, Paramount will cover charges from Out-of-Network facilities (hospitals) and Providers based on the greatest of the median In-Network coverage rate, the Usual, Customary Rate, and the Medicare rate for those Covered Services; appropriate Copayments/Coinsurance will be applicable. Paramount must be notified within 48 hours of an Emergency admission, or as soon as possible, so Your benefits can be verified for the Provider.

Please see Surprise Billing under Section One: Surprise Billing.

SECTION FOUR: MEDICAL SERVICES

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

Paramount, at its discretion, may modify some Plan provisions, if a Medically Necessary and less costly alternative course of treatment is available.

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

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

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

   B. **Dental Services**: The following procedures performed by a dentist or oral surgeon are covered when benefits are not available under a separate dental plan. These procedures are:
      - initial first aid treatment received within 72 hours of an accidental Injury to sound natural teeth, the jaw bones, or surrounding issues, to the extent of extraction of teeth and repair

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

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

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

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

1. Out-Patient Physical Rehabilitation services including:
   - Speech and Language therapy and/or Occupational therapy, performed by a licensed therapist twenty (20) visits per year of each service; and
   - Clinical Therapeutic Intervention under the supervision of a professional who is licensed, certified, or registered by an appropriate agency of this state to perform the services in accordance with a health treatment plan, twenty (20) hours per week;

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

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

E. **Mammography:**
Coverage for mammography includes:
- Screening mammography to detect the presence of breast cancer in adult women. One screening mammography every year, including digital tomosynthesis.
- Supplemental breast cancer screening to detect the presence of breast cancer in adult women meeting either of the following conditions:
  - The women'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 women 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 women'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%).

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

G. **Online Clinic Visit:** When available, Your coverage will include Online Clinic Visit Services with your physician or Specialist Physician. Covered Services will include Medically Necessary consultations regarding diagnosis and treatment of injuries and sickness using the internet via a webcam, chat and voice. Services will be payable under the Physician Office Visit benefit as outlined in Your Schedule of Benefits.

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

I. **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 services is consulting regarding the patient.

This plan will cover Telehealth Services on the same basis and to the same extent that the plan provides coverage for in-person Health Care Services. Please reference exclusion 69(e) for additional information.

J. **ProMedica OnDemand Visit:** ProMedica OnDemand allows You and Your Dependents to have a live video visit with a board-certified Provider 24 hours a day, 7 days a week, and 365 days a year. This telemedicine service is ideal for conditions such as allergies, cold and flu, pinkeye, and rash. ProMedica OnDemand is covered with no Deductible, Copayments or Coinsurance. To sign up or download the mobile device application, please visit https://www.paramounthealthcare.com/members/member-perks/promedica-ondemand.

K. **Radiation Therapy and Chemotherapy.**

L. **Screenings and Immunizations:** Screenings and immunizations for children, adolescents, and adults when Medically Necessary. Please refer to Child Health Supervision Services provision for additional information.

M. **Second Surgical Opinion.**

N. **Speech Therapy:** Speech and speech therapy services for habilitative services only. This does not include non-medical conditions such as stuttering, lisping, articulation disorders, tongue thrust and delayed onset of speech.

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

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

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

A. **Surgery** includes:

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

The Plan will also cover medical and surgical procedures for:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Home health care includes any of the following:

1. Part-time or intermittent home nursing care by or under the supervision of a registered nurse;
2. Part-time or intermittent home health aide services which consist primarily of caring for You under the supervision of a registered nurse; and
3. Skilled treatments performed by licensed or certified home health agency personnel, including the non-prescription medical supplies and drugs used or furnished during a visit by home health agency personnel. Non-prescription medical supplies and drugs may include surgical dressings and saline solutions, but do not include prescription drugs, certain intravenous solutions, or insulin.

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

4. Nutrition counseling and related services when provided as part of diabetes education or part of nutritional guidance in relation to home care services. The level of benefits will depend on whether care is obtained through In-Network or Out-of-Network Providers. If You use an Out-of-Network Provider, You may be responsible for additional charges up to and including the balance of the amount billed as outlined in SECTION THREE: HOW THE SHORT-TERM LIMITED-DURATION PLAN WORKS.

C. **Oxygen and Oxygen Related Equipment:** These items are covered when ordered by a Physician and rented, not bought.

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

   Medical supplies are small and often disposable items that are part of medical treatment for an illness or injury. The supply must be compatible with the diagnosis and generally must not be useful in the absence of illness or injury for which it is used. This plan does not provide benefits for procedures, equipment, services, supplies or charges for pre-existing conditions.

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

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

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

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

   Prosthetic devices are appliances which replace all or part of an absent body part or replace all or part of the function of a permanently inoperable or malfunctioning body part.

   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 Member Services number on the back of your Identification Card.

9. **New Technology and Medical Procedures.** The Paramount Technology Assessment Working Group (TAWG) regularly monitors the medical literature concerning new technology and medical procedures for which coverage is not currently provided for under the Plan. The working group evaluates data on safety and efficacy of new technology, new applications of existing technology and medical procedures from a variety of sources. These include medical journals, recommendations of medical specialty societies, local medical experts, and government agencies. After considerable study and discussion of information from these sources, the Physicians on the TAWG develop recommendations regarding coverage of the new technology and medical procedures under review. You and Your Physician may request the working group to review particular new technology or medical procedures.

10. **Clinical Trial.** Coverage is provided to a qualified individual (as defined under PHS Act section 2709(b)) for routine patient care rendered as part of a clinical trial if the services are otherwise Covered Services under this certificate. A qualified individual is generally a participant or beneficiary who is eligible to participate in an approved clinical trial according to the trial protocol with respect to the treatment of cancer or another life-threatening disease or condition; and either: (1) the referring Health Care Professional is a participating Provider and has concluded that the individual's participation in such trial would be appropriate; or (2) the participant or beneficiary provides medical and scientific information establishing that the individual's participation in such trial would be appropriate.

    Paramount:

    (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.

SECTION FIVE: HOSPITAL CARE

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

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

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

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

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

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

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

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

4. **Visits to the Emergency Room:** Covered for Emergency Services for Emergency Medical Conditions as described below. 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 Summary of Benefits. If you receive Emergency Services at an Out-of-Network facility or Provider, the most the facility or Provider may bill you is your plans in-network cost-sharing amount (such as copayment or 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 balance billed for these post-stabilization services.

   Charges for Medically Necessary continuation of care, including for facility (hospital) services and physician and professional services, beyond those needed to evaluate or Stabilize your condition in an emergency, will be covered according to your Schedule of Benefits and subject to the provisions of this certificate.

5. **Outpatient Care in a Hospital:** The Plan will pay for the Covered Services provided to You in the Outpatient department of a Hospital if equivalent services would also be covered on an Inpatient basis.

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

care is obtained from an In-Network or Out-of-Network Provider.

6. **Receiving Care from Hospital-Based Providers:** Hospitals employ many Physicians and other Providers, such as emergency room Physicians, radiologists, pathologists and anesthesiologists, who only serve patients in the Hospital. The PPO Network has Contracts with a vast majority of Hospital-based Physicians. These Contracts mean the services will be paid under In-Network benefits and protects the Covered Person from being balanced billed. Protection against balance billing means the Covered Person will not receive a bill for the difference between the Provider's charge and the fee that the In-Network pays for that service. However, there are cases where the Paramount Network has been unable to secure a Contract with a Hospital-based Physician or Provider. Please note that services from Out-of-Network Hospital-based Providers even though rendered in an In-Network Hospital will be paid under Out-of-Network benefits. Additionally, Out-of-Network Providers may not accept the UCR payment as payment in full and You may be responsible for additional charges.

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

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

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

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

SECTION SIX: ALCOHOL ABUSE

Alcohol Abuse. Inpatient and Outpatient services, intermediate primary care benefits and emergency care for the treatment of alcohol abuse disorders are covered subject to the same terms, Deductible**,** Copayments and/or Coinsurance, and plan standards to which those Covered Services would be subject if delivered as medical/surgical benefit or primary care physician benefit, up to five hundred fifty dollars per contract period. Refer to Section Four: Medical Services and Section Five: Hospital Services.

These services shall be legally performed by or under the clinical supervision of any of the following:

- A physician authorized to practice medicine and surgery or osteopathic medicine and surgery;
- A psychologist
- A licensed professional clinical counselor, licensed professional counselor, independent social worker, or independent marriage and family therapist whose practice includes chemical dependency counseling;
- An independent chemical dependency counselor;
- A clinical nurse specialist or certified nurse practitioner whose nursing specialty is mental health.

The services may be performed in an office, in a hospital, in a community mental health facility, or in an alcoholism treatment facility so long as the hospital, community mental health facility, or alcoholism treatment facility is approved by the joint commission, the council on accreditation, or the commission on accreditation of rehabilitation facilities or certified by the department of mental health and addiction services.

For an eligible person, who received treatment for alcoholism from an approved or certified alcoholism treatment facility, to remain eligible for benefits under this section, a Health Care Professional identified above, shall every three months certify that such person needs to continue utilizing such treatment.

SECTION SEVEN: TRANSPLANT BENEFITS

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

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

2. **General Description of Transplant Covered Services.** Covered Services include any Hospital, medical-surgical, and other service related to the transplant, including blood and blood plasma.

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

3. **Specified Covered Services.**

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

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

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

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

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

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

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

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

      With prior approval by Paramount, benefits will be paid for other services (such as home health

care and certain therapy services) when such services are directly related to a covered transplant and are ordered by Your Physician.

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

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

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

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

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

SECTION EIGHT:
EXCLUSIONS

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

Benefits for the following will not be provided.

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

2. **Allergy Testing**: Allergy tests which are performed and related to a specific diagnosis as well as desensitization treatments are not covered.

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

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

5. **Charges in Excess of Annual Maximums:** Any service, supply or treatment in excess of the annual maximums shown in the Schedule of Benefits. Not applicable for products with unlimited Out-Of-Pocket Maximums.

6. **Charges in Excess of NCA or UCR:** Charges for Out-of-Network services that are in excess of amount

defined in Section Two.

7. **Chiropractic Services:** Chiropractic services including spinal manipulation and visits to an outpatient chiropractic location are not included in this plan

8. **Complementary Treatments:** Acupuncture, Acupressure, Hypnotherapy, Massotherapy, Aroma Therapy, Chelation therapy, Rolfing, Biofeedback training, neurofeedback training and related diagnostic tests and other forms of alternative treatments including but not limited to non-prescription drugs or medicines, vitamins, nutrients and food supplements are not Covered Services. This limitation applies even if the service or item is prescribed by or administered by a Physician. The level of benefits will depend on whether care is obtained through In-Network or Out-of-Network Providers. If You use an Out-of-Network Provider, You may be responsible for additional charges up to and including the balance of the amount billed as outlined in SECTION THREE: HOW THE SHORT-TERM LIMITED-DURATION PLAN WORKS.

9. **Contraceptives:** Devices or drugs serving to prevent pregnancy are not covered under this plan.

10. **Convenience Items:** Items that are primarily for Your convenience and personal comfort. These are items that are not directly related to the provision of Covered Services. Such items include, but are not limited to, telephone, television, barber or beauty service, guest service, housekeeping services and meal services as part of Home Health care, travel, transportation, or living expenses, rest cures, recreation or diversional therapy.

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

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

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

    This exclusion does not apply to the following procedures performed by a dentist or oral surgeon and when benefits are not available under a separate dental plan. These procedures are:
    a. treatment for tumors and cysts (including pathological examination) of the jaws, cheeks, lips, tongue, roof and floor of the mouth; or
    b. repair of fractures and dislocations.
    c. initial first aid treatment received within 72 hours of an accidental Injury to sound natural teeth, the jaw bones, or surrounding issues, to the extent of extraction of teeth and repair of soft tissue

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

15. **Diabetic and Asthmatic Equipment and Supplies.** The following Diabetic and Asthmatic equipment and supplies are not covered under this Plan:
    a. Needles and syringes (1cc or less)
    b. Tubing for insulin pumps
    c. Blood glucose monitor, test strips, batteries and control solutions
    d. Lancing devices, lancets
    e. Peak expiratory flow rate meter (hand-held)

f. Spacers for metered dose inhaler
g. Masks and tubing for nebulizers
h. Limited ostomy supplies
i. Diaphragms

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

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

17. **Drug Abuse Services.** All medications and services used to treat drug abuse.

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

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

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

21. **Experimental/Investigational** Any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which we determine in our discretion 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:

a. 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;
b. has been determined by the FDA to be contraindicated for the specific use; or
c. 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
d. is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function; or
e. is provided pursuant to informed consent documents that describe the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental/Investigative, or otherwise indicate that the safety, toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.

Any service not deemed Experimental/Investigative based on the criteria above may still be deemed Experimental/Investigative by Paramount. 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 Paramount 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.

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

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

23. **Foot Orthotic Devices:** Heel cups, arch supports, lifts, wedges, shoe inserts, corrective shoes, foot orthotics used solely for sports and devices.

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

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

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

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

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

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

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

31. **Hospice:** Services, care, and equipment at a Hospice will not be covered under this plan.

32. **Illegal Occupation.** Paramount will not be liable for any loss to which a contributing cause was the insured's commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal occupation.

33. **Infertility Services.** Any procedure intended to induce pregnancy, such as artificial insemination, in vitro fertilization, infertility drugs, embryo or ovum transplant or transfer services, gamete intrafallopian transfer (GIFT) procedures, zygote intrafallopian transfer (ZIFT) procedures, experimental and investigational infertility services, donor ovum, and semen related costs, including collection and preparation, storage of eggs and sperm, cryogenics, sperm banking, reversal of voluntary sterilization and any related procedures, and associated counseling. Does not include 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.

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

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

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

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

38. **Maternity Services:** Coverage for Maternity services (pre-natal visits, post-natal visits, inpatient hospital, physician delivery) will be excluded under this plan.

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

40. **Biologically-Based and Non-Biologically Based Mental Illness Services.** All medication and services used to treat mental illness.

41. **Morbid Obesity Surgery:** Surgical procedures to treat Morbid Obesity are not covered under this Plan.

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

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

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

45. **Orthopedic Devices:** Orthopedic devices not eligible under guidelines.

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

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

48. **Prescription Drugs and Non-Prescription Drugs:** Outpatient Prescription Drugs are not covered whether self-administered or administered by a Provider. All prescription and non-prescription drugs are excluded from coverage. This exclusion does not apply to Medically Necessary screenings and immunizations, Children's Health Supervision Services and Mammography Services as described in Section FOUR: Medical Services.

49. **Preventive Health Services**: Any service or benefit intended to treat an existing illness, injury or

condition (including medications) does not qualify. This exclusion does not apply to Medically Necessary screenings and immunizations, Children's Health Supervision Services and Mammography Services as described in Section FOUR: Medical Services.

50. **Private Duty Nursing:** Private duty nursing services, except in the case of home care nursing services.

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

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

53. **Required Examinations:** Examinations specifically for the purpose of obtaining or maintaining employment, obtaining insurance and/or professional or other licenses; examinations precedent to engaging in athletic or recreational activities or attending camp, school or other program. This exclusion does not apply to Medically Necessary screenings and immunizations, Children's Health Supervision Services and Mammography Services as described in Section Four: Medical Services.

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

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

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

57. **Services After Termination of Coverage:** Services after Your coverage under this Plan ends. Refer to **Benefits After Termination** listed in Section Two: Eligibility and Effective Date.

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

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

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

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

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

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

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

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

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

67. **Vision Care:** Routine eye examinations for refractory treatment, orthoptic training, eyeglasses, contact lenses, contact lens evaluation and fittings, sunglasses of any type, and surgery including but not limited to: eye surgery to correct refractory errors, LASIK surgery, Keratomileusis, excimer laser, photo refractory keratectomy (Interwave Technology), radial keratotomy, and other vision care services and supplies, except Covered Services required for the diagnosis and treatment of diseases of, or injury to, the eyes.

68. **Work-Related Injuries:** Care for treatment of a work or occupational related injury or illness. This includes charges for injury or illness arising out of or in the course of past or current work for pay, profit, or gain, unless workers' compensation or benefits under similar law are not required or available.

69. For the following:
    a. Surcharges for furnishing and/or receiving medical records and reports.
    b. Charges for doing research with providers not directly responsible for your care.
    c. Charges that are not documented in provider records.
    d. 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.
    e. 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.

SECTION NINE: COORDINATION OF BENEFITS

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

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

Definitions

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

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

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

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

B. "This plan" means, in a COB provision, the part of the Contract providing the health care benefits to which the COB provision applies, and which may be reduced because of the benefits of the other

plans. Any other part of the Contract providing health care benefits is separate from This plan. A Contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only similar benefits, and may apply another COB provision to coordinate other benefits.

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

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

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

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

(1) The difference between the cost of a standard Hospital room and a private Hospital room is not an Allowable Expense, unless one of the Plans provides coverage for private Hospital room expenses.

(2) If a person is covered by 2 or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.

(3) If a person is covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.

(4) If a person is covered by one Plan that calculates its benefits or services on the basis of usual or customary fees or relative value schedule reimbursement methodology or similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fee or payment amount is different than the Primary Plan's payment arrangement and if the Provider's Contract permits, the negotiated fee or payment shall be the Allowable expense used by the Secondary plan to determine its benefits.

(5) The amount of any benefit reduction by the Primary plan because a Covered Person has failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of plan provisions include precertification of admissions and preferred Provider arrangements.

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

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

Order of Benefit Determination Rules

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

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

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

provisions of both Plans state that the complying plan is primary.

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

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

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

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

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

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

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

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

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

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

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

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

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

- The Plan covering the spouse of the non-custodial parent.

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

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

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

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

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

Effect on the Benefits of this Plan

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

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

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This plan and other Plans. Paramount 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. Paramount need not tell, or get consent of any person to do this. Each person claiming benefits under This plan must give Paramount 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, Paramount 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. Paramount will not have to pay that amount again. The term "payment

made" includes providing benefits in the form of services, in which care "payments made" means the reasonable cash value of the benefits provided in the form of services.

Right of Recovery

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

Coordination Disputes

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

SECTION TEN:
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 Paramount Insurance Company at the Member Services Department, P.O. Box 928, Toledo, Ohio 46397-0928, Attention: Member Services, or by telephone at, 1-800-462-3589 or email: Paramount.memberservices@medmutual.com. TTY users may call 1-888-740-5670.

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

Notification of an *Adverse Benefit Determination* must include:

- The reasons for the plan's decision;
- Your right to appeal the claim decision
- Your right to request an external review; and
- The availability of a Consumer Assistance Program at The Ohio Department of Insurance.

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

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

- 72 hours after receiving Your request when You are appealing the denial of a claim for urgent care. (If Your appeal concerns urgent care, You may be able to have the internal appeal and external reviews take place at the same time.)
- 30 days after receipt of the request for appeals of denials of non-urgent care You have not yet received.

- 60 days after receipt of the request for appeals of denials of services You have already received (post-service denials).
- No extensions of the maximum time limits are permitted unless You consent.
- Please note that different timeframes apply for appeals of denied electronic pre-service claims. See Electronic Pre-service Non-urgent and Urgent Care Claim Denial in this section.

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

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

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

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

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

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

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

Rescission of coverage: If the plan rescinds Your coverage, You may file an appeal according to the following procedures. The plan cannot terminate Your benefits until all of the appeals have been exhausted. Since a *Rescission* of coverage is a cancellation or discontinuance of coverage that has retroactive effects, if the plan's decision to rescind is upheld, You will be responsible for payment of all claims for Your Health Care Services.

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

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

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

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

rationale, You must be provided, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal *Adverse Benefit Determination* is required to be provided to give You a reasonable opportunity to respond prior to that date.

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

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

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

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

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

Other Resources to help You

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

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

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

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

INTERNAL CLAIMS AND APPEALS

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

Non-urgent, *Pre-Service Claim* denial

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

Urgent Pre-service Care claim denial

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

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

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

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

In the case of a *Claim Involving Urgent Care*, You or Your Authorized Representative may also request an expedited internal review. A request for expedited internal review may be submitted orally or in writing by You or Your

Authorized Representative; and all necessary information, including the plan's benefit determination on review, shall be transmitted between the plan and the claimant by telephone, facsimile, or other expeditious method.

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

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

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

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

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

Post-service appeal of a claim denial (retrospective)

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

EXTERNAL REVIEW

Right to External Review

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

If the covered person has requested an internal appeal and the health plan issuer has not issued a written decision to the covered person within thirty days following the date the covered person files the request, and the covered person has not requested or agreed to a delay, the covered person may file a request for external review pursuant to section 3922.08 of the Revised Code and may be considered to have exhausted the health plan issuer's internal appeals process for purposes of section 3922.04 of the Revised Code.

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

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

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

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

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

- Standard *Health Care Services* have not been effective in improving the condition of the *Covered Person*
- Standard *Health Care Services* are not medically appropriate for the *Covered Person*

- No available standard Health Care Service covered by Paramount is more beneficial than the requested Health Care Service

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

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

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

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

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

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

Non-urgent request for an external review

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

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

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

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

If the plan denies Your request for an external review on the basis that the *adverse benefit determination* is not eligible for an external review, the plan will notify You, in writing, the reasons for the denial and that You have a right to appeal the decision to the Superintendent of insurance.

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

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

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

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

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

The request may be made orally or electronically by You or Your *Health Care Provider*.

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

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

(1) Standard *Health Care Services* have not been effective in improving Your condition;

(2) Standard *Health Care Services* are not medically appropriate for You; or

(3) There is no available standard Health Care Service covered by the *Health Plan Issuer* that is more beneficial than requested Health Care Service.

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

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

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

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

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

The IRO written notice must include the following information:

- A general description of the reason for the request for external review
- The date the *Independent Review Organization* was assigned by the Ohio Department of Insurance to conduct the external review
- The dates over which the external review was conducted
- The date on which the *Independent Review Organization*'s decision was made
- The rationale for its decision

- References to the evidence or documentation, including any evidence-based standards, that was used or considered in reaching its decision
- Decisions that involve a health care treatment or service that is stated to be experimental or investigational also includes the principle reason(s) for the IRO's decision and the written opinion of each clinical reviewer including their recommendation and their rationale for the recommendation

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

In addition to the information provided under division (D)(1)(b) of section 3922.05, division (B) of section 3922.08, division (C) of section 3922.09, and division (D) of section 3922.10 of the Revised Code, an assigned Independent Review Organization, to the extent that such documents are available and appropriate, shall consider all of the following when conducting its review:

- The covered person's medical records;
- The attending Health Care Professional's recommendation;
- Consulting reports from appropriate Health Care Professionals and other documents submitted by the health plan issuer, covered person, or covered person's treating provider;
- The terms of coverage under the covered person's health benefit plan to ensure that the Independent Review Organization's decision is not contrary to the terms of the plan;
- The most appropriate practice guidelines, including evidence-based standards, and practice guidelines developed by the federal government, and national or professional medical societies, boards, and associations;
- Any applicable clinical review criteria developed and used by the health plan issuer or its designated utilization review organization;
- The opinion of the Independent Review Organization's clinical reviewer or reviewers after considering the other sources described in this section.

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

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

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

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

Review by the *Superintendent* of Insurance: If the plan has made an *Adverse Benefit Determination* based on a contractual issue (e.g., whether a service or services are covered under Your Contract of insurance), You may request an external review by the Superintendent of Insurance. If the Superintendent of Insurance determines that the health service is a covered service, the health plan issuer shall cover the service. If the Superintendent of Insurance determines that the health care service is not a covered service, the health plan issuer is not required to cover the service or afford the covered person an external review by an Independent Review Organization.

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

SECTION ELEVEN: REIMBURSEMENT/SUBROGATION

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

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

   Subrogation. Where a Covered Person has benefits paid by Plan as a result of sickness or injury caused by a

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

Notwithstanding any contract or statutory provision to the contrary, the rights of a subrogee or any other person or entity that asserts a contractual, statutory, or common law subrogation claim against a third party or an injured party in a Tort Action shall be subject to both of the following:

- If less than the full value of the Tort Action is recovered for comparative negligence, diminishment due to a party's liability under sections 2307.22 to 2307.28 of the Ohio Revised Code, 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.
- If a dispute regarding the distribution of the recovery in the Tort Action arises, either party may file an action under Chapter 2721. of the Ohio Revised Code to resolve the issue of the distribution of the recovery.

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

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

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

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

2. **Workers' Compensation/Non-Duplication**. If you or your Dependents receive Health Care Services due to an injury which may be covered by Workers' Compensation, you must notify Paramount Member Services as soon as possible. If you filed a claim for Workers' 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 Workers' Compensation, you are expected to reimburse the Plan for the amounts paid.

3. **Cooperation by Covered Persons**. By enrolling in this Plan, You and Your covered dependents agree to execute and deliver all assignments or other documents as may be required and do whatever is necessary to effectuate and protect fully the rights of the Plan or its nominee. You may not do anything which might limit, waive or release the Plan's subrogation or reimbursement rights. The Covered

Person shall give the Plan written notice of any claim against a third-party as soon as the Covered Person becomes aware that the Covered Person may recover damages from a third-party. The Covered Person will be deemed to be aware that the Covered Person may recover damages from a third-party upon the date the Covered Person retains an attorney or the date written notice of the claim is presented to the third-party or the third-party's insurer by Covered Person, Covered Person's insurer or Covered Person's attorney, whichever is earlier. The Covered Person will not compromise or settle a claim without prior written consent of the Plan. If Covered Person fails to provide the Plan with written notice of a claim as required or if Covered Person compromises or settles a claim without prior written consent, the Plan will deem the Covered Person to have committed fraud or misrepresentation in a claim for benefits and will terminate the Covered Person's participation in the Plan.

SECTION TWELVE: MISCELLANEOUS PROVISIONS

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

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

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

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

5. **Recovery of Overpayments**. On occasion, a payment may be made to or for You when You are not covered, for a service which is not covered, or which is more than is appropriate for that service. When this happens, Paramount will explain the problem, and You must return to Paramount within 60 calendar days the amount of the mistaken payment, or provide Paramount with written notice stating the reasons why You may be entitled to such payment. In accordance with and to the extent permitted by applicable law, Paramount may reduce future payments to You in order to recover any mistaken payment. Overpayments and mistaken payments made to Providers will be recovered directly from them.
    - A payment made by a third-party payer to a provider in accordance with ORC 3901.381 and ORC 3901.386 shall be considered final two years after payment is made. After that date the amount of the payment is not subject to adjustment, except in the case of fraud by the provider.

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

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

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

9. **Limitation on Benefits of This Plan**. No person or entity other than Paramount, and Covered Persons hereunder is or shall be entitled to bring any action to enforce any provision of the Plan against Paramount or Covered Persons hereunder, and the covenants, undertakings and agreements set forth in the Contract with Paramount and this Certificate of Coverage shall be solely for the benefit of, and shall be enforceable only by Paramount and the Covered Persons covered under this Plan.

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

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

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

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

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

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

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

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

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

    Contact Paramount's Member Services Department for a confidential discussion at 419-887-2525
    a. or toll free at 1-800-462-3589.
    b. TTY services for the hearing-impaired are available at 1-888-740-5670 or 419-887-2526.
    c. You can contact the Paramount Compliance Hotline at 1-800-807-2693.
    d. Writing a letter to Paramount Mailing address:
       Paramount Health Care
       Attn: Paramount Compliance Fraud, Waste, and Abuse

       300 Madison Ave. Suite 270, Toledo, Ohio 43604
       Email Address: paramount.memberservices@medmutual.com
       Confidential fax number:419-887-2037
       For more information, please visit Paramount's website at
       https://www.paramounthealthcare.com/legal-privacy-compliance/fraud-waste-and-abuse/

19. **Entire Contract:** This policy, including the indorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be indorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.

No statement made by an applicant for a policy of sickness and accident insurance not included therein shall avoid the policy or be used to deny any claim thereunder or be used in any legal proceeding thereunder.

20. **Time limit on certain defenses:** (1) After two years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for this policy shall be used to void this policy or to deny a claim for loss incurred or disability (as defined in this policy) commencing after the expiration of such two year period.

    A policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums until at least age fifty, or a policy issued after the insured has attained age forty-four and which the insured has the right to continue in force subject to its terms by the timely payment of premiums for at least five years from its date of issue, may contain, in lieu of the foregoing policy provision in division (1) of this section, a provision, from which the clause in parentheses may be omitted at the insurer's option, under the caption Incontestable, as follows: After this policy has been in force for a period of two years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application.

    (2) No claim for loss incurred or disability (as defined in this policy) commencing after two years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this policy.
21. **Grace Period:** Unless not less than five days prior to the premium due date the insurer has delivered to the insured or has mailed to his last address as shown by the records of the insurer written notice of its intention not to renew this policy beyond the period for which the premium has been accepted.

    A grace period of 30 days will be granted for the payment of each premium falling due after the first premium, during which grace period this policy shall continue in force. Paramount requires a notice of late payment by day 15. If payment is not received after 30 days, the policy will be terminated.

22. **Reinstatement:** If any renewal premium be not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any agent duly authorized by the insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate this policy. If the insurer or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, this policy will be reinstated upon approval of such application by the insurer or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten days after such date. In all other respects the insured and insurer shall have the same rights thereunder as they had under this policy immediately before the due date of the defaulted premium, subject to any provisions indorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than sixty days prior to the date of reinstatement.

23. **Notice of Claim:** Written notice of claim must be given to the insurer within twenty days after the occurrence or commencement of any loss covered by this policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the insurer at 300 Madison Ave. Suite 270, Toledo, Ohio 43604 or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer.

24. **Payment of Claims:** Paramount will make payment immediately upon, or within thirty days after, receipt of due written proof of loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid within thirty days and any balance remaining unpaid immediately upon receipt of due written proof.

    Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at the option of the insurer, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the insured.

25. **Physical Examination and Autopsy:** The insurer at its own expense shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a

claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

26. **Change of Beneficiary:** The right to change of beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy or to any change of beneficiary or beneficiaries, or to any other changes in this policy.

27. **Cancellation by the Insured. Non-cancellation by the Insurer.** The insured may cancel this policy at any time by written notice delivered or mailed to the insurer, effective upon receipt or on such later date as specified in such notice. In the event of cancellation, the insurer will return promptly the unearned portion of any premium paid. The earned premium shall be computed by the use of the short-rate table last filed with the state official having supervision of insurance in the state where the insured resided when this policy was issued. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation. The insurer may not cancel this policy. This provision nullifies any other provision, contained in this policy or in any indorsement hereon or in any rider attached hereto, which provides for cancellation of this policy by the insurer or by the insured.

DEFINITIONS

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

Adverse Benefit Determination means a decision by a Health Plan Issuer:

(1) To deny, reduce, or terminate a requested Health Care Service or payment in whole or in part, including all of the following:
(a) A determination that the Health Care Service does not meet the Health Plan Issuer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, including experimental or investigational treatments;
(b) A determination of an individual's eligibility for individual health insurance coverage, including coverage offered to individuals through a non-Employer group, to participate in a plan or health insurance coverage;
(c) A determination that a Health Care Service is not a covered benefit;
(d) The imposition of an exclusion, including exclusions for Pre-Existing Conditions, source of injury, network, or any other limitation on benefits that would otherwise be covered.
(2) Not to issue individual health insurance coverage to an applicant, including coverage offered to individuals through a non-Employer group;
(3) To rescind coverage on a Health Benefit Plan. See definition of Rescission in this section.

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

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:

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

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

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

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

Child Health Supervision Services - Periodic review of a child's physical and emotional status performed by a Physician or by a Health Care Professional under the supervision of a Physician. Periodic reviews are

performed in accordance with the recommendations of the American Academy of Pediatrics and include a history, complete physical examination, developmental assessment, anticipatory guidance, appropriate immunizations, and laboratory tests.

Claim Involving Urgent Care means any claim for Medical Care or treatment with respect to the application of the time periods for making non-urgent care determinations

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

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

The determination whether a claim is a "Claim Involving Urgent Care" will be determined by the plan; or, by a Physician with knowledge of the claimant's medical condition.

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

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

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

- The Certificate of Coverage (Insurance).
- The Enrollee's application, if any.
- Amendments or Endorsements to any of the above documents.

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

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

Covered Person means a policyholder, subscriber, enrollee, member, or individual covered by a Health Benefit Plan. "Covered Person" does include the Covered Person's Authorized Representative with regard to an internal appeal or external review.

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

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

1. personal care such as help in walking, getting in and out of bed, bathing, eating, tube or gastrectomy feeding, exercising, dressing, enema and using the toilet.
2. homemaking, such as preparing meals or special diets;
3. moving the patient;
4. suctioning;
5. catheter care;
6. acting as a companion or sitter;

7. supervising medication, which is usually self-administered, and
   preparation/supervision over medical supplies and/or medical equipment not requiring constant attention of trained medical personnel.

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

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

Effective Date - The first day You are covered under the Plan.

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

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

Emergency Medical Condition - A medical condition that manifests itself by such acute symptoms of sufficient severity, including severe pain, that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following: (1) placing the health of the individual or, with respect to a pregnant women, the health of the woman or her unborn child, in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

Emergency Services - means the following:

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

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

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

Essential Health Benefits is defined under federal law (PPACA) as including benefits in at least the following categories: ambulatory patient services; Emergency Services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. If Your plan contains any of these benefits, there are certain requirements that may apply to those benefits, as provided in this certificate.

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

Experimental/ Investigational - is Any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which we determine to be Experimental/Investigative is not covered. We will deem any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental/Investigative using

evidence-based criteria as defined in this certificate.

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

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

Health Benefit Plan means a policy, Contract, certificate, or agreement offered by a Health Plan Issuer to provide, deliver, arrange for, pay for, or reimburse any of the costs of Health Care Services.

Health Care Provider: Means a Health Care Professional or facility.

Health Care Professional: A physician, psychologist, nurse practitioner, physician assistant or other health care practitioner licensed, accredited, or certified to perform Health Care Services consistent with state law.

Health Care Services means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

Health Plan means Paramount.

Health Plan Issuer means an entity subject to the insurance laws and rules of this state, or subject to the jurisdiction of the Superintendent of insurance, that Contracts, or offers to Contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of Health Care Services under a Health Benefit Plan, including a sickness and accident insurance company, a health insuring corporation, a fraternal benefit society, a self-funded multiple employer welfare arrangement, or a nonfederal, government health plan. "Health Plan Issuer" includes a third party administrator to the extent that the benefits that such an entity is Contracted to administer under a Health Benefit Plan are subject to the insurance laws and rules of this state or subject to the jurisdiction of the Superintendent.

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

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

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

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

An HDHP provides Preventive Health Services without a Deductible.

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

The definition of Hospital may also include one or more of the following: (1) alcoholism or drug addiction treatment facility; (2) psychiatric Hospital; (3) ambulatory surgical facility; (4) freestanding birth center; and (5) hospice facility – provided the facility is licensed in the state in which the facility operates and is operating within the scope of its license.

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

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

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

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

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

Mail Order Pharmacy - A Mail Order Pharmacy that is Contracted with Paramount or PBM to provide mail order Prescription Drug benefits for Covered Persons.

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

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

Medically Necessary - means the service You receive must be:

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

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

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

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

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

Network Pharmacy - A retail pharmacy that is Contracted with Paramount or PBM to provide Prescription Drug benefits for Covered Persons.

Non-Contracting Amount (NCA)- The maximum amount determined as payable and allowed by Paramount for a Covered Service.

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

Online Clinic Visit – A virtual physician office visit with Your physician or Specialist Physician via webcam, chat and voice

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

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

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

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

Physician - means a Provider who holds a certificate under Ohio law authorizing the practice of medicine and surgery or osteopathic medicine and surgery or a comparable license or certificate from another state.

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

Post-service claim means any claim for a benefit under a health plan that is not a "Pre-Service Claim."

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

Preferred Brand Drug - A Prescription Drug that is approved for coverage as a "Preferred Brand Drug" by Paramount as determined by Paramount's P & T.

Prescription or Prescription Drug - A drug which has been approved by the U.S. Food and Drug Administration (FDA) and which may, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill

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

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

ProMedica OnDemand Visit - 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.

Provider - A person or organization responsible for furnishing Health Care Services, including a: Hospital, Skilled Nursing Facility, Physician, Doctor of Podiatry (D.P.M.), Licensed Psychologist, Certified Nurse Midwife acting within the scope of her or her license, under the direction and supervision of a licensed Physician; Licensed Physician Therapist (L.P.T.); Licensed Occupational Therapist (L.O.T.); Licensed Speech Therapist (L.S.T.); Licensed Optometrist; Certified Mechanotherapist acting within the scope of his

or her license, and performing services ordered by a Physician; Professional Clinical Counselor; Professional Counselor; or Independent Social Worker.

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

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

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

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

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

Superintendent means the superintendent of insurance.

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

Tort Action means a civil action for injury, death, or loss to person. Tory Action includes any claim for damages for injury, death, or loss to person, whether or not a lawsuit is pending, or claim in connection with uninsured or underinsured motorist coverage, but does not include a civil action for breach of contract or another agreement between persons.

Urgent Care Services means Covered Services provided for an Urgent Medical Condition and may include such Health Care Services for an Urgent Medical Condition provided out of network.

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

Usual, Customary and Reasonable (UCR) Charges - is the amount paid for a medical service in a geographic area based on what Providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

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