PARAMOUNT INSURANCE COMPANY

SMALL GROUP

2 LEVEL PPO PLAN

CERTIFICATE OF COVERAGE

Preferred Choices

NOTICE CONCERNING COORDINATION OF BENEFITS (COB)

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

Notice of Availability of Language Assistance Services and Auxiliary Aids and 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 ܡܗܡܙܡܬ ܐܬܘܪܝܐ، ܒܫܒܩܐ ܐܝܬ ܗܡ ܐܢܐ ܐܝܬ ܩܛܘܥܝ ܡܫܡܫܢܘܬܐ ܕܥܘܕܪܢܐ ܠܫܢܢܐ. ܐܦ ܐܝܬ ܒܫܒܩܐ ܗܡ ܐܢܐ ܡܢܬܝܐ ܘܡܫܡܫܢܘܬܐ ܠܗܘܕܪܝܐ
ܠܝܗܒܐ ܡܢ ܡܥܠܘܡܬܐ ܕ ܡܘܢܝܐ ܠܡܛܠܬܐ ܐܝܟܐ ܕܗܘܝܐ ܡܦܫܛܐ. ܩܪܝ **1-800-462-3589** (**TTY:711**) ܐܘ ܡܡܠܠ ܥܡ ܡܦܪܢܣܢܐ ܕ ܡܫܡܫܢܘܬܐ

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 постачальни

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 Paramount 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.

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

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

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

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

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

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

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

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 the Employer electing to sponsor this Plan. 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 Employer has purchased.** Questions regarding your Plan can also be directed to the Paramount Member Services Departments at; (419)887-2531 or toll-free at 1-866-452-6128.

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

SECTION ONE: ELIGIBILITY AND EFFECTIVE DATE

1. **Eligibility**. No one who is eligible to enroll or renew as a Subscriber, Dependent or Dependent with disabilities will be refused enrollment by Paramount based on student status, health status related factor, pre-existing condition, genetic testing or the results of such testing, health care needs or age.

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

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

(2) Considered a bona fide employee employed on a permanent basis and working at least an average of 30 hours per week; or such other minimum average that is approved by Paramount;

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

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

(5) Eligibility for Plan attached to a Health Savings Account:

a. An employee must be enrolled in a high deductible Health Plan,

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

c. Not covered by any other Health Plan (except some limited coverage), and

d. Not eligible for Medicare.

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

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

(1) The employee's legal spouse; or

(2) Married or unmarried child, as defined in this section until your child reaches age 26

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

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

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

This disability must have started before the dependent age limit was reached and must be medically certified by a Physician. You must notify Paramount of the disabled dependents desire to continue coverage prior to or within 31 days of reaching the limiting age. You and your Physician must complete and sign a form that will provide Paramount with information that will be used to evaluate eligibility for such disabled dependent status. You may also be required to periodically provide current proof of intellectual disability or physical handicap and dependence,

but not more often than annually after the first two years. To obtain the form required to establish disabled dependent status, please contact a Paramount Member Services representative at (419)-887-2531 or toll-free at 1-866-452-6128.

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

A. **Initial Election Period**. An Election Period will be held prior to the Effective Date of this Plan. An eligible employee and his or her eligible dependents may choose between this Plan and any other health care benefit plans offered by the Employer during this time, and may enroll in the Plan.

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

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

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

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

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

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

D. **Special Enrollment Period.** If an eligible employee declines enrollment for themselves or their dependents (including their spouse), the employee may in the future be able to enroll themselves or their dependents in this plan, provided that the employee requests enrollment within 31 days after there is a loss of Minimum Essential Coverage as a result of legal separation, divorce, death of an employee, termination or reduction in hours of employment – voluntary or involuntary (with or without electing COBRA), exhaustion of COBRA, "aging out" under other parent's coverage, or moving out of an HMO's service area. Loss of eligibility for coverage does not include loss due to the individual's failure to pay premiums or termination of coverage for cause, such as fraud.

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

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

E. **Newly Eligible**. An eligible employee and his or her eligible dependents may enroll

within 31 calendar days of first becoming eligible because the employee is newly hired or newly in the class of employees to which coverage under this Plan is offered (e.g., union vs. non- union employee, employee living in a particular region, part-time employee vs. full-time employee).

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

G. **Court Ordered Coverage**. If a covered or eligible employee is required by a court or administrative order to provide health care coverage for his or her child and the child is an eligible dependent, the employee may enroll the child at any time after the order. If the employee is not already enrolled, he or she must enroll with the child.

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

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

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

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

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

(1) In the case of marriage, on the date of a legal marriage if a completed enrollment application is received by Paramount within 31 days of the marriage date.
(2) In the case of birth, as of the date of such birth if a completed enrollment application and any required additional premium payment is received by Paramount within 31 days of the birth date; or
(3) In the case of adoption or placement for adoption, the date of adoption or placement for adoption if a completed enrollment application is received by Paramount within 31 days of the date of adoption or placement for adoption.

C. **Special Enrollment Period -** If an eligible employee and/or eligible dependent(s) enroll due to a loss of minimum essential coverage as defined in this section, coverage is effective the day after the date on which prior medical benefits terminated. In the case of termination from Medicaid or Children's Health Insurance Program (CHIP) coverage or eligibility for Employment Assistance under Medicaid or CHIP, birth, adoption, or placement for adoption, coverage is effective on the date of the event.

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

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

4. **Terms**. Once enrolled as described in this section, an eligible employee is known as a "covered employee" and an eligible dependent is known as a "covered dependent." A "Covered Person" is a defined term

meaning a covered employee or covered dependent. Whenever used in this Certificate of Coverage, "You" or "Your" means a Covered Person.

5. **Pre-Existing Conditions**. Paramount Insurance Company does not have any restrictions on Pre-Existing conditions. In other words, if you were being treated for a condition before you became a Paramount member, Paramount will provide benefits for Covered Services related to that condition on or after your effective date with Paramount.

6. **Termination of Coverage**.

A. **Employee**. 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 this section.

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

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

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

(3) The last calendar day of the month preceding the first day of the next month for which any required contribution for employee coverage has not been made, unless the Employer's Contract with Paramount provides for a different termination date;

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

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

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

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

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

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

(4) The last calendar day of the month preceding the first calendar day of the next month for which the required payment for dependent coverage has not been made, unless the Employer's Contract with Paramount provides for a different termination date.

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

(1) Do not make any required premium contribution; or

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

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

b. Providing untrue, incorrect, or incomplete information on behalf of yourself or another Covered Person in the application for this Plan, which constitutes a material

misrepresentation. You will be responsible for paying charges for all Covered Services provided to you through Paramount that are related to such untrue, incorrect, or incomplete information.

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

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

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

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

(1) Failure to pay the required premiums on time;

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

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

(4) If the membership of the Employer in an Alliance (on the basis of which coverage is provided) ceases:

(5) When Paramount discontinues offering this Plan in the Small Group market, as applicable, in Ohio and:

a. Paramount provides notice to each Employer and Covered Person provided coverage under this Plan in the Small Group Market, as applicable, of such discontinuation at least 90 calendar days prior to the date of discontinuation of such coverage;

b. Paramount offers each Employer provided coverage in the Small Group Market, as applicable, under this Plan the option to purchase other coverage currently being offered by Paramount to an Employer or union sponsored health benefit plan in such market(s); and

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

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

SECTION TWO: CONTINUATION OF COVERAGE

1. **Continuation of Coverage Under COBRA.** For employer groups with more than 20 employees, if your coverage under the Employer's Contract with Paramount would otherwise end; you may be eligible for continuation of coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"),

as amended, or under other federal or state laws.

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

2. **Continuation of Coverage Under Ohio State Law (for Employers with fewer than 20 Employees)**. As an alternative to the continuation of coverage described in Paragraph 1 of this section, you may continue group coverage for a period of 12 months following the covered employee's termination of employment if the covered employee:

A. Has been covered under any coverage for at least 3 months preceding the date his or her employment was terminated.

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

C. Is not eligible for or covered by:

(1) Medicare; or

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

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

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

The continuation period will begin on the date coverage would have terminated because the reservist was call to active duty. Your contributions for the continued coverage will be the same as those paid by similarly situated active employees during the first 30 days of your absence. Thereafter, your contributions will be the same as those paid for COBRA continuation of coverage. Whether or not you continue coverage during military service, you may reinstate coverage under the Plan on your return to employment provided you continue to meet the Plan eligibility requirements.

Your reinstatement under the Plan will be without any Pre-Existing Condition Exclusion. If you dropped coverage for your dependents under the Plan, they may re-enter the Plan with you subject to the Plan's Special Enrollment rules.

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

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

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

respect to such provider or facility. If this situation occurs, you should contact Paramount Member Services.

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

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

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

SECTION THREE: HOW THE PREFERRED CHOICES PLAN WORKS

1. **Surprise Billing.**

Your Rights and Protections Against Surprise Medical Bills

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

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

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

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

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

You are protected from balance billing for:

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

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

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

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

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

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

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

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

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

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

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

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

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

In addition, you may contact 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.

2. **Health Care Reimbursement Choices**. Paramount's Preferred Choices 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. You are also required to obtain Pre-authorization from Paramount 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.**

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

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, 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
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 Five, Non-Covered Services/Exclusions, for a description of services and supplies that are not covered under this Plan. Always call Paramount at 419-887-2531 or toll-free 1-866-452-6128 if you have any questions about specific conditions, limitations, exclusions, or payment levels.

3. **Pre-Authorization/ Pre-Certification (Also known as Authorization, Certification, or Prior 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 decisions. These guidelines reflect the standards of practice and medical interventions identified as appropriate medical practice. We reserve the right to review and update these clinical coverage guidelines periodically. Your Certificate and the employer Contract take precedence over these guidelines.

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 following 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; or
ii. Inpatient admission to a Skilled Nursing Facility; or
iii. Home Health services; or
iv. Organ/Bone Marrow Transplant services.

B. Procedures requiring Pre-Authorization not an all-inclusive listing, refer to www.paramounthealthcare.com/priorauth):

i. Enhanced External Counterpulsation (EECP);
ii. Prophylactic Mastectomy;
iii Genetic, molecular diagnostic, and drug testing as identified in the above referenced list
iv. Orthognathic and maxillofacial surgery
v. All potentially cosmetic procedures including but not limited to eyelid surgery/lifts (bleparoplasty)
vi. Cochlear implants
vii. MRI and CT Imaging
viii. New Technology (Medical & Behavioral Health Procedures, Diagnostics, Durable Medical Equipment);

C. Equipment requiring Pre-Authorization not an all-inclusive listing, refer to www.paramounthealthcare.com/priorauth):

i. Air fluidized beds;
ii. Bone stimulators and supplies;
iii. Power operated vehicles, power wheelchairs and power wheelchair accessories;
iv. Chest wall oscillation vest (ThAIRapy Vest System);
v. Enteral nutrition;
vi. Speech generating devices
vii. Continuous Blood Glucose Monitoring services – Long Term
viii. Cranial orthotic remolding device.

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 services under Section Four)*** 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-Authorization is required in the case of a non-urgent non-electronic claim, Paramount will make a decision, and notify you of its decision, within fifteen (15) 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 make a decision, and advise the claimant of its decision, as soon as possible, but not later than seventy-two (72) hours after receipt of the claim. If insufficient information is received, Paramount will notify the claimant not later than twenty-four (24) hours after receipt of the claim, 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 means a medical care or other service for a condition where application of the timeframe for making routine or non-life threatening care determinations is either of the following:

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

If the Pre-Authorization 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 to the health care provider will indicate whether the request is approved or denied. If the Pre-Authorization is denied, Paramount will provide the specific reason for the denial. You have the right to appeal through the appeals process outlined in **Section Eight, Internal Claims and Appeals**

Procedures and External Review of this Handbook.

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 Member (in cases where the Member 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 Handbook 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 of the decision 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.

For 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*.

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

You have the right to appeal through the appeals process outlined in Section Eight, **Internal Claims and Appeals Procedures and External Review** of this Handbook.

Retrospective review

A retrospective review is a request for Paramount to evaluate whether a health care service that a Member has already received was Medically Necessary. For all retrospective reviews, Paramount will make a decision, and will notify the provider and the Member 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 you, 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:

a) The service is directly related to another service for which pre-approval has already been obtained and that has already been performed.
b) The new service was not known to be needed at the time the original Pre-Authorized service was performed.
c) 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 is received. Paramount will not deny a claim for such a new service based solely on the fact that a Pre-Authorization approval was not received for the new service in question.

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

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

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

   Please note that 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.

5. **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.

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

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

   In most cases, reimbursement for Covered Services will be sent directly to the provider, but in some cases, 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 from the Employer's personnel or benefits office or by calling the Paramount Member Services Department at (419) 887-2531 or toll-free 1-866-452-6128**.**

   Explanation of Benefits (EOB): After a claim has been filed with 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).

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

   A. Deductible. The amount you and your Dependents must pay for Covered Services including Prescription Drugs within a calendar year, before any benefits will be paid by the Plan. The single Deductible is the amount each Covered Person must pay. The family Deductible is the total amount

any **two** or more covered family members must pay. The deductible amount of one family member will not exceed that of an individual annual deductible maximum amount. All Covered Services except for Preventive Health Services are subject to the Deductible. A plan will only be used as a High Deductible Health Plan (HDHP) with a Health Savings Account (HSA) when it follows the minimum and maximum limits for a HDHP. See Definitions section of this certificate for more information regarding an HDHP and HSA.

See your Schedule of Benefits for the type of Deductible and Deductible amount under your Plan. The expenses incurred for Covered Services received from In-Network and Out-of-Network Providers including Prescription Drugs apply to the Deductible.

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

C. **Coinsurance.** The fixed percentage of charges you must pay toward the cost of certain Covered Services. See your Schedule of Benefits to determine whether a service requires a Coinsurance payment and the amount for that service. Coinsurance on benefits received from In-Network Providers is a percentage of the contract charge negotiated between the PPO Network and the Provider. This means that you receive the benefit of any discount. Coinsurance on benefits received from Out-of- Network Providers is a percentage of the Non-Contracting Amount (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 for Essential Health Benefits during the remainder of that calendar year. The Out-of-Pocket Maximum is the maximum amount of Coinsurance and Copayments including medical and prescription drug Deductibles (if any) paid by a Covered Person in a calendar year. The single Out-of-Pocket Maximum is the amount each Member must pay, and the family Out-of-Pocket Maximum is the total amount any two or more covered family members must pay. The Out-of-Pocket Maximum of one family member will not exceed that of an individual annual Out-of-Pocket Maximum amount. Paramount will pay 100% of applicable charges for each family member who has reached the self-only out of pocket maximum, even if the family Out-of-Pocket Maximum has not been met.

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 UCR.

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

If you ***do not obtain Pre-Authorization*** and the services are Medically Necessary, any benefit payment for a ***facility fee (including inpatient services under Section Four)*** 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.

7. **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 <u>not</u> Medically Necessary include without limitation: Inpatient Hospital admission

for care that could have been provided safely either in a doctor's office or on an Outpatient basis; a Hospital stay longer than is Medically Necessary to treat your condition; or a surgical procedure performed instead of a medical treatment which could have achieved equally satisfactory management of your condition.

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

8. **Coverage for Emergency Services**. If you have an Emergency Medical Condition (see the Definition Section), 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 THREE: HOW THE PREFERRED CHOICE PLAN WORKS and Emergency Services under SECTION FOUR: COVERED SERVICES in this handbook.

SECTION FOUR: COVERED SERVICES

This section describes the Covered Services available under your Health Plan benefits. All Covered Services and benefits are subject to the conditions, exclusions, limitations, terms and provisions of this Certificate, including any attachments, riders and endorsements. Covered Services must be Medically Necessary and not Experimental/Investigative. The fact that a Provider may prescribe, order, recommend or approve a service, treatment or supply does not make it Medically Necessary or a Covered Service and does not guarantee payment. To receive maximum benefits for Covered Services, you must follow the terms of the Certificate, including receipt of care from an In-Network Provider, and obtain any required Pre-Authorization. Our payment for Covered Services will be limited by any applicable Coinsurance, Copayment, Deductible, or Calendar Year Limit/Maximum in this Certificate.

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

Ambulance Services

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

- From your home, scene of accident or medical Emergency to a Hospital;
- Between Hospitals;
- Between a Hospital and Skilled Nursing Facility; or
- From a Hospital or Skilled Nursing Facility to your home.

Treatment of a sickness or injury by medical professionals from an Ambulance Service when you are not transported will be covered if Medically Necessary. Other vehicles which do not meet this definition, including but not limited to ambulettes, are not Covered Services.

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

- When ordered by an employer, school, fire or public safety official and the Member is not in a position to refuse; or
- When a Member is required by Paramount to move from an Out-of-Network Provider to an In-Network Provider.

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

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

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

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

Behavioral Health Services/Mental Illness/Substance Abuse

Behavioral Health Services also includes coverage for Biologically Based Mental Illness services. Biologically Based Mental Illness means schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, and panic disorder, as these terms are defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

Mental Illness/Substance Abuse Services are covered for care of mental health and substance use disorders. Coverage includes inpatient and outpatient care, Emergency Services, and prescription drugs subject to the same Deductible, Copayments and/or Coinsurance, plan standards and medical management processes to which those Covered Services would be subject if delivered as medical/surgical benefits. This includes intermediate levels of care such as residential treatment, partial hospitalization and intensive outpatient services.

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

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

Providers will treat opioid-use disorder with a monitored drug and therapy protocol called medication assisted treatment. To facilitate prompt treatment of opioid-use disorder assisted treatment does not require Prior Authorization. Paramount's limits on medication assisted treatment are related only to quantity or duration or to potentially disqualifying conditions.

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

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

Custodial or Domiciliary Care.

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

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

Clinical Trials

Coverage is provided to a qualified individual (as defined under PHS Act section 2709(b)) for routine patient care rendered as part of a clinical trial if the services are otherwise covered services under this certificate. 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.

Dental Services

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

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

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

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

Other Dental Services

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

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

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

Non-Covered Dental Services

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

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

Diabetic Equipment, Education and Supplies

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

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

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

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

Diagnostic Services

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

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

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

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

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

Emergency Services

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 your 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 Handbook.

Emergency Medical Condition is a medical condition that manifests itself by such acute symptoms of sufficient severity, including severe pain, that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following: (1) placing the health of the individual or, with respect to a pregnant 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 is a medical screening examination, as required by federal law, that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department, to evaluate an Emergency Medical Condition; such further medical examination and treatment that are required by federal law to stabilize an Emergency Medical Condition and are within the capabilities of the staff and facilities available at the Hospital, including any trauma and 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.

If you have an Emergency Medical Condition, dial 911 for assistance or go to the nearest hospital emergency room.

Urgent Care Center Services

Covered ONLY for initial treatment of an Urgent Medical Condition in an urgent care facility or physician office. Follow-up treatment in or outside the Paramount Service Area must be authorized in advance in order to be covered.

Home Care Services

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

Covered Services include but are not limited to:

- Intermittent Skilled Nursing Services (by an R.N. or L.P.N.)
- Medical/Social Services
- Diagnostic Services
- Nutritional Guidance
- Home Health Aide Services. The Member must be receiving skilled nursing or therapy. Services must be furnished by appropriately trained personnel employed by the Home Health Care Provider. Other organizations may provide services only when approved by Paramount, and their duties must be assigned and supervised by a professional nurse on the staff of the Home Health Care Provider.
- Therapy Services (except for Manipulation Therapy which will not be covered when rendered in the home). Home Care Visit limits specified in the Schedule of Benefits for Home Care Services apply when Therapy Services are rendered in the home.
- Medical/Surgical Supplies
- Durable Medical Equipment
- Prescription Drugs (only if provided and billed by a Home Health Care Agency)
- Private Duty Nursing is covered only when provided through the Home Care Services benefit. There is no visit limit and private duty nursing visits are not combined with the home health care visits which are limited to 100 visits per Benefit Period.

Non Covered Services include but are not limited to:

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

Home infusion therapy

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

Hospice Services

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

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

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

Non Covered Services include but are not limited to:

- Services provided by volunteers.
- Housekeeping services.

Infertility Services

Covered for the Medically Necessary diagnosis and treatment of infertility conditions.

Inpatient Services

Inpatient Services include:

- Charges from a Hospital, Skilled Nursing Facility (SNF) or other Provider for room, board and general nursing services.
- Ancillary (related) services.
- Professional services from a Physician while an Inpatient.

  Room, Board, and General Nursing Services

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

- **Ancillary (Related) Services**

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

- **Professional Services**

  - **Medical care** visits limited to one visit per day by any one Physician.
  - **Intensive medical care** for constant attendance and treatment when your condition requires it for a prolonged time.
  - **Concurrent care** for a medical condition by a Physician who is not your surgeon while you are in the Hospital for Surgery. Care by two or more Physicians during one Hospital stay when the nature or severity of your condition requires the skills of separate Physicians.
  - **Consultation** which is a personal bedside examination by another Physician when requested by

your Physician. Staff consultations required by Hospital rules; consultations requested by the patient; routine radiological or cardiographic consultations; telephone consultations are excluded.

- **Surgery and the administration of general anesthesia.**
- **Newborn exam.** A Physician other than the Physician who performed the obstetrical delivery must do the examination.

Maternity Services

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

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

Coverage for the Inpatient postpartum stay for you and your newborn Child in a Hospital will be, at a minimum, 48 hours for a vaginal delivery and 96 hours for a cesarean section. Prior Authorization is not required for Inpatient postpartum stays for you and your newborn except when the stays exceed these timeframes. Coverage will be for the length of stay recommended by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists in their Guidelines for Prenatal Care

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

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

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

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

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

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

Mammography

Coverage for mammography includes:

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

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

Medical Supplies, Durable Medical Equipment, and Appliances

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

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

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

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

1. The equipment, supply or appliance is worn out or no longer functions.
2. Repair is not possible or would equal or exceed the cost of replacement. An assessment by a rehabilitation equipment specialist or vendor should be done to estimate the cost of repair.

3. Individual's needs have changed and the current equipment is no longer usable due to weight gain, rapid growth, or deterioration of function, etc.

4. The equipment, supply or appliance is damaged and cannot be repaired.

Benefits for repairs and replacement do not include the following:

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

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

Covered Services include, but are not limited to:

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

    1. Allergy serum extracts
    2. Chem strips, Glucometer, Lancets

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

Non Covered Services include but are not limited to:

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

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

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

  Covered Services include, but are not limited to:

  1. Hemodialysis equipment
  2. Crutches and replacement of pads and tips
  3. Pressure machines
  4 Infusion pump for IV fluids and medicine
  5. Glucometer
  6. Tracheotomy tube
  7. Cardiac, neonatal and sleep apnea monitors
  8. Augmentive communication devices are covered with Paramount approval.

  Non-covered items include but are not limited to:

  1. Air conditioners
  2. Ice bags/coldpack pump
  3. Raised toilet seats
  4. Rental of equipment if the Member is in a Facility that is expected to provide such equipment
  5. Translift chairs
  6. Treadmill exerciser
  7. Tub chair used in shower.

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

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

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

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

Covered Services include, but are not limited to:

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

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

1. Dentures, replacing teeth or structures directly supporting teeth.
2. Dental appliances.
3. Such non-rigid appliances as elastic stockings, garter belts, arch supports and corsets.
4. Artificial heart implants.
5. Wigs (except as described above following cancer treatment).
6. Penile prosthesis in men suffering impotency resulting from disease or injury.

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

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

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

  1. Cervical collars.
  2. Ankle foot orthosis.
  3. Corsets (back and special surgical).
  4. Splints (extremity).
  5. Trusses and supports.

6. Slings.
7. Wristlets.
8. Built-up shoe.
9. Custom made shoe inserts.

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

Non-Covered Services include but are not limited to:

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

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

Outpatient Services

Outpatient Services include both facility, ancillary, facility use, and professional charges when given as an Outpatient at a Hospital, Alternative Care Facility, Retail Health Clinic, or other Provider as determined by the Health Plan. These facilities include a non-Hospital site providing Diagnostic and therapy services, surgery, or rehabilitation, or other Provider facility as determined by Paramount. Professional charges only include services billed by a Physician or other professional.

When Diagnostic Services or Other Therapy Services (chemotherapy, radiation, dialysis, inhalation, or cardiac rehabilitation) is the only Outpatient Services charge, no Copayment is required if received as part of an Outpatient surgery. Any Coinsurance will still apply to these services.

Physician Home Visits and Office Services

Covered Services include care provided by a Physician in their office or your home. Refer to the sections titled "Preventive Health Services", "Maternity Services", "Home Care Services" and "Behavioral Health Services for services covered by the Health Plan.

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

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

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

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

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

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

- The patient receiving the services;

- Another Health Care Professional with whom the provider of the 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 8(e) for additional information

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

Prescription Drug Benefits

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

Pharmacy and Therapeutics (P&T) Working Group

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

Paramount's P&T reviews and approves Paramount's Formulary annually. However, formulary management may be delegated to the Pharmacy Benefit Manager (PBM). When formulary management is delegated, the initial formulary is approved by Paramount's P&T, but ongoing formulary changes throughout the year are reviewed and approved by the PBM's P&T committee or other clinical working group that handles the delegated function of formulary management. Should there be formulary changes throughout the year, you will be notified no less than 30 days before implementation of the change.

Pharmacy Benefits Manager

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

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

Covered Prescription Drug Benefits

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

- FDA approved Prescription Legend Drugs.
- FDA approved Specialty Drugs.
- Injectable insulin and syringes used for administration of insulin.
- Contraceptive devices, oral immunizations, and biologicals, although they are legend drugs may be payable as medical supplies based on where the service is performed or the item is obtained. If such items are over-the-counter drugs, devices or products, they are not Covered Services unless prescribed by a physician and covered as a preventive service, as required by federal and state law.

- Certain supplies and equipment (such as those for diabetes and asthma) obtained by Mail Service or from a Network or Non-Network Pharmacy are covered. Contact Paramount to determine approved covered supplies. If certain supplies, equipment or appliances are not obtained by Mail Service or from a Network or Non-Network Pharmacy then they are covered as Medical Supplies, Equipment and Appliances, instead of under Prescription Drug benefits. For any supply not covered by Paramount, you may follow the exceptions process. Please refer to the Standard and Expedited Exceptions Process in this section. If approved by Paramount, any cost sharing will be applied to the Out-of-Pocket Maximum.
- Off label use of FDA approved drugs as defined in ORC 3923.60. Paramount shall not limit or exclude coverage for any drug approved by the United States food and drug administration on the basis that the drug has not been approved by the United States food and drug administration for the treatment of the particular indication for which the drug has been prescribed, provided the drug has been recognized as safe and effective for treatment of that indication in one or more of the standard medical reference compendia adopted by the United States department of health and human services.

Non Covered Prescription Drug Benefits:

The following exclusions apply:

1. Unless otherwise specified in your summary of benefits, durable medical equipment, therapeutic devices, support garments; and other supplies or substances which may be obtained without a prescription;
2. Prescription Drugs or Refills in excess of either the quantity or days supply indicated on the prescription. For any prescription that is filled before the designated days supply on the previous fill has been exhausted, the member will be responsible for full cost of the prescription.
3. Dietary supplements and some prescription vitamins (other than prenatal vitamins or those mandated by PPACA guidelines);
4. Prescription Drugs used for cosmetic purposes such as: drugs used to decrease wrinkles, drugs to promote hair growth, and drugs to control perspiration;
5. Drugs for weight loss including diet pills and appetite suppressants;
6. Drugs that do not require a prescription for dispensing known as “Over-the-Counter” drugs unless approved by the Plan;
7. Any prescription products that are not FDA approved medications or are labeled as experimental or investigational. This includes prescription devices;
8. Prescription Drugs used to enhance athletic or sexual performance;
9. Compounded medications are not covered when a similarly equivalent product is available commercially, when the active ingredients do not require a Prescription, or there is insufficient evidence to prove the specific formulation is safe and effective. The Plan will not pay any preparation fee for compounded medications;
10. Any claim for Prescription Drug(s) submitted to the Plan or the PBM for reimbursement more than one (1) year from the date the Prescription Drug was dispensed will not be eligible for reimbursement;
11. Prescription Drugs for which the cost is recoverable under any workers’ compensation or occupations disease law or any federal or state agency or any drug for which no or substantially discounted charge is made;
12. Prescription Drugs that are prescribed, dispensed or intended for use during a hospital inpatient or skilled nursing facility stay;
13. Non-Formulary Prescription Drugs, unless determined to be medically necessary through the Non-formulary Exceptions process
14. Growth hormones for growth and development unless medically necessary and covered according to your summary of benefits;
15. Any drugs or devices used for treatment of male/female sexual dysfunction including but not limited to erectile dysfunction, delayed ejaculation, anorgasmia and decreased libido;
16. Fertility drugs unless otherwise stated in your summary of benefits.

How to Obtain Prescription Drug Benefits

Network Pharmacy – Present your written Prescription Order from your Physician, and your Identification Card to the pharmacist at a Network Pharmacy. The Pharmacy will file your claim for you. You will be charged

at the point of purchase for applicable Deductible and/or Copayment/Coinsurance amounts. If you do not present your Identification Card, you will have to pay the full retail price of the prescription. If you do pay the full charge, ask your pharmacist for an itemized receipt and submit it to Paramount with a written request for refund. Prior Authorizations and limitations to coverage will still apply prior to refunds.

Out-of-Network Pharmacy - You may use an out-of-network pharmacy, but you will be charged the full retail price of the prescription at the point of purchase, and any applicable Deductible and/or Copayment/Coinsurance amount is refunded to you. Refer to your Schedule of Benefits for applicable Deductible and/or Copayment/Coinsurance amounts, and ask your out-of-network pharmacist for an itemized receipt and submit it to Paramount with a written request for refund. Prior Authorizations and limitations to coverage will still apply prior to refunds.

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

CVS Maintenance Choice (90-day) Pharmacy Program - The Maintenance Choice program is for prescription drugs taken continuously to manage chronic or long-term conditions, such as high blood pressure, asthma, diabetes, or high cholesterol. After two 30-day fills of a prescription medication that is on the CVS Maintenance Choice list, the prescription must be filled for a 90-day supply at either CVS Caremark mail order or a CVS retail store. Members may obtain a list of the CVS Maintenance Choice medications by calling the Member Services telephone number on the back of their Identification Card, or by reviewing the list on the internet at www.paramounthealthcare.com.

Specialty Pharmacy Network

Paramount's Specialty Pharmacy Network is available to Members who use Specialty Drugs. Members may obtain a printed list of the Specialty Network Pharmacies, and covered Specialty Drugs, by calling the Member Services telephone number on the back of their Identification Card, or by reviewing the lists on the internet at www.paramounthealthcare.com.

Days Supply

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

Payment of Benefits

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

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

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

Deductible/Coinsurance/Copayment

Each Prescription Order may be subject to a Deductible and Coinsurance/Copayment. The Coinsurance/Copayment may be dependent on the Covered Drug's Formulary placement, the pharmacy network, and days supply of medication. Deductible and Coinsurance/Copayment may vary when drugs are purchased at Non-Network Pharmacies. If the Prescription Order includes more than one covered Drug, a

separate Coinsurance/Copayment will apply to each covered Drug. Your Prescription Drug Coinsurance/Copayment will be the lesser of your Copayment/Coinsurance amount or the cost of the Drug. Please see the Schedule of Benefits for any applicable Deductible and Coinsurance/Copayment.

Formulary

A Formulary is a list of drugs that are covered by the Plan under a member's prescription drug benefits. Members can obtain a copy of the Plan's Formulary by calling the Member Services telephone number on the back of their ID card, or by reviewing an electronic copy on the internet at www.paramounthealthcare.com. The Formulary list is subject to periodic review and amendment. Inclusion of a Drug or related item on the covered Prescription Drug list is not a guarantee of coverage.

Tier and Formulary Assignment Process

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

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

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

Value-Added Preventive Medications

In addition to federally mandated preventive medications, your benefit may include a list of Value-Added Preventive Medications. These are additional medications that the Paramount P&T committee has determined to help prevent the development of health conditions and their complications. These medications will be covered in full and will not be subject to Deductible. If a Member requests a brand-name medication on this list when a generic equivalent is available, applicable Deductible or Copay will apply. Refer to your Summary of Benefits to determine if you have this benefit. For a list of medications included, contact the Member Services or review the CDHP Preventive List on Paramount's website.

6-Tier Copayment

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

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

DAW Status

Dispense As Written (DAW) is a designation that you may request at the pharmacy or that your prescriber may make on your prescription. DAW requires the pharmacy to dispense the exact product that was written by the prescriber and no substitutions may be made. Refer to your Schedule of Benefits for an explanation of how these drugs are covered.

Prior Authorization for Prescription Drugs

Prior Authorization will be required for certain Prescription Drugs or for the prescribed quantity of a particular Drug. Prior Authorization helps promote appropriate use of medications and enforcement of guidelines for Prescription Drug benefit coverage. At the time you fill a prescription, the pharmacist is informed of the Prior Authorization requirement through the pharmacy's computer system. The PBM uses pre-approved edits, with criteria developed by a Pharmacy and Therapeutics (P&T) Committee which is reviewed and adopted by Paramount. Prescribers or pharmacies should contact Paramount with information to determine whether Prior Authorization should be granted. We communicate the results of the decision to your Provider.

Prior Authorization is required for coverage of an opioid analgesic prescription for chronic pain. Prior Authorization is not required for coverage of an opioid analgesic prescribed for chronic pain, when the drug is prescribed under one of the following circumstances: (a) To an individual who is a hospice patient in a hospice care program; (b) To an individual who has been diagnosed with a terminal condition but is not a hospice patient in a hospice care program; (c) To an individual who has cancer or another condition associated with the individual's cancer or history of cancer.

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

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

Providers will treat opioid-use disorder with a monitored drug and therapy protocol called medication assisted treatment. To facilitate prompt treatment of opioid-use disorder, most medication assisted treatment does not require Prior Authorization. Paramount's limits on medication assisted treatment are related only to quantity or duration or to potentially disqualifying conditions.

Prior Authorization for Prescription Drugs for treatment of opioid-use disorder will be expedited.

For a list of the current Drugs requiring Prior Authorization, please contact the Member Services telephone number on the back of your ID card or review the medication formulary on Paramount's website. This list is subject to periodic review and amendment. Inclusion of a Drug or related item on the list is not a guarantee of coverage under your Certificate. Refer to the Covered Prescription Drug benefit sections in this Certificate for information on coverage, limitations and exclusions. Your Provider or Pharmacist may check with Paramount to verify covered Prescription Drugs, any quantity and/or age limits, or applicable Brand or Generic Drugs recognized under the Health Plan.

Refer to "Standard and Expedited Review for Prior Authorizations, Step Therapy Exceptions, and Non-formulary Exceptions" in this section for details.

A rejected claim at the pharmacy does not constitute coverage denial. If a claim rejects at the pharmacy, you can initiate the prior authorization process by asking the pharmacist to initiate the prior authorization process electronically or by asking your provider to submit a prior authorization request to Paramount. If you pay for the prescription prior to review, Paramount will conduct a retrospective review to determine if the prescribed medication was Medically Necessary. Coverage will be approved if the following are determined to be true:

a. The patient was eligible under the plan at the time of dispensing;
b. The medication is covered under the plan;
c. The medication meets the standards for medical necessity and prior authorization criteria.

A request for coverage will not be denied based solely on the fact that a prior authorization was not obtained prior to dispensing. If you paid for the prescription and the review results in determining the above criteria are met for coverage, You can request the pharmacy reverse and reprocess the claim to be reimbursed or submit a receipt to Paramount for paper claim reimbursement. Reimbursed amount will be the difference between the total amount paid at the time of dispensing and any member cost share owed according to member benefits.

You are responsible for all charges for prescriptions Paramount determines are not Medically Necessary. The member or an authorized representative will have the right to submit an appeal if the prior authorization request is denied. Please see Internal Claims and Appeals Procedures and External Review section of this certificate.

Step Therapy

Step therapy is a protocol that requires a Member to use other medication(s) before a certain prescribed medication is authorized. Paramount monitors some Prescription Drugs to control utilization, to ensure that appropriate prescribing guidelines are followed, and to help Members access high quality yet cost effective Prescription Drugs. If a Physician decides that the prescribed medication is medically necessary, a step therapy exception request can be submitted. Refer to "Standard and Expedited Review for Prior Authorizations, Step Therapy Exceptions, and Non-formulary Exceptions" in this section for details.

Quantity Limits

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

Specialty Drug Program

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

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

Members may obtain a list of the Specialty Network Pharmacies, and covered Specialty Drugs, by calling the Member Services telephone number on the back of their Identification Card, or by reviewing the lists on the internet at www.paramounthealthcare.com.

Oral Chemotherapy

This plan shall not provide coverage or impose cost sharing for a prescribed, orally administered cancer medication on a less favorable basis than the coverage it provides or cost sharing it imposes for intravenously administered or injected cancer medications.

Standard and Expedited Review for Prior Authorizations, Step Therapy Exceptions, and Non-formulary Exceptions

A Covered Person or physician can request and gain access to clinically appropriate drugs, and Preventive Health Services items or services that are not on the formulary, are subject to a Step Therapy Protocol, or are subject to Prior Authorization. A rejected claim at the pharmacy does not constitute coverage denial. If a claim rejects at the pharmacy, you can initiate a coverage exception request in the same manner as a prior authorization request and Paramount will review for medical necessity. Refer to the Prior Authorization for Prescription Drug section for details. However, if your physician recommends a particular contraceptive service or FDA-approved contraceptive item based on medical necessity, Paramount will defer to the determination of the physician and

cover that particular service or item without cost sharing.

A standard Prior Authorization or exception request can be submitted in non-exigent circumstances and receive a decision within 72 hours of receipt of a request. For expedited requests based on Exigent Circumstances determination and notification will be provided no later than 24 hours following receipt of the request. If a medication is approved, it will be approved for a 12 month duration or until your benefit eligibility changes. Non-chronic medications, controlled substances, medications with a typical treatment duration of less than a year, or medications that require safety and efficacy monitoring may initially be given a shorter duration of approval. Medications that are approved through the Prior Authorization or exception request process will be treated as an Essential Health Benefit with insured's cost share applying to the Out-of-Pocket Maximum. If the request for coverage is denied, insured has the right to appeal through the appeals process outlined in Section Eight, INTERNAL CLAIMS AND APPEALS PROCESS AND EXTERNAL REVIEW of this Handbook.). The insured and physician will be notified of the IRO's decision no later than 24 hours following receipt of request for expedited exception request and 72 hours following receipt of a standard request. For more information or assistance, or to request coverage of a non-formulary drug or appeal a denial, contact the Paramount Member Services Department.

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

See **Section Eleven, DEFINITIONS** for additional information on Exigent Circumstances.

Special Promotions

From time to time we may initiate various programs to encourage the use of more cost-effective or clinically-effective Prescription Drugs including, but not limited to, Generic Drugs, Mail Service Drugs, over the counter or preferred products. Such programs may involve reducing or waiving Copayments or Coinsurance for certain Drugs or preferred products for a limited period of time.

Preventive Health Services

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

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

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

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

   Examples of these services are screenings for:

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

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

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

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

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

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

You may call Member Services using the number on your ID card for additional information about these services. (or view the federal government's web sites, http://www.healthcare.gov/center/regulations/prevention.html; or http://www.ahrq.gov/clinic/uspstfix.htm; http://www.cdc.gov/vaccines/recs/acip/.)

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

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

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

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

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

Premium Rates for Tobacco Users

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

Your plan has different premium rates for tobacco users and non-tobacco users. If you are a tobacco user, by participating in a Tobacco Cessation Program you may have your premium rates reduced to the non-tobacco user rate.

How the premium rate reduction works

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

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

Surgical Services

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

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

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

Reconstructive Services

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

Mastectomy Notice

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

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

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

Sterilization

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

Temporomandibular or Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder

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

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

Therapy Services

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

Physical Medicine Therapy Services

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

- **Physical therapy** including treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles and devices. Such therapy is given to relieve pain, restore function, and to prevent disability following illness, injury, or loss of a body part. Non Covered Services include but are not limited to: maintenance therapy to delay or minimize muscular deterioration in patients suffering from a chronic disease or illness; repetitive exercise to improve movement, maintain strength and increase endurance (including assistance with walking for weak or unstable patients); range of motion and passive exercises that are not related to restoration of a specific loss of function, but are for maintaining a range of motion in paralyzed extremities; general exercise programs; diathermy, ultrasound and heat treatments for pulmonary conditions; diapulse; work hardening.
- **Speech therapy** for the correction of a speech impairment.
- **Occupational therapy** for the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the person's particular occupational role. Occupational therapy does not include diversional, recreational, vocational therapies (e.g. hobbies, arts and crafts). Non Covered Services include but are not limited to: supplies (looms, ceramic tiles, leather, utensils); therapy to improve or restore functions that could be expected to improve as the patient resumes normal activities again; general exercises to promote overall fitness and flexibility; therapy to improve motivation; suction therapy for newborns (feeding machines); soft tissue mobilization (visceral manipulation or visceral soft tissue manipulation), augmented soft tissue mobilization, myofascial; adaptions to the home such as rampways, door widening, automobile adaptors, kitchen adaptation and other types of similar equipment.
- **Manipulation Therapy** includes Osteopathic/Chiropractic Manipulation Therapy used for treating problems associated with bones, joints and the back. The two therapies are similar, but chiropractic therapy focuses on the joints of the spine and the nervous system, while osteopathic therapy includes equal emphasis on the joints and surrounding muscles, tendons and ligaments. Manipulations whether performed and billed as the only procedure or manipulations performed in conjunction with an exam and billed as an office visit will be counted toward any maximum for Manipulation Therapy services as specified in the Schedule of Benefits. Manipulation Therapy services rendered in the home as part of Home Care Services are not covered.

Other Therapy Services

- **Cardiac rehabilitation** to restore an individual's functional status after a cardiac event. It is a program of medical evaluation, education, supervised exercise training, and psychosocial support. Home programs, on-going conditioning and maintenance are not covered.
- **Chemotherapy** for the treatment of a disease by chemical or biological antineoplastic agents,

including the cost of such agents.

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

Physical Medicine and Rehabilitation and Habilitative Services

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

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

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

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

Day Rehabilitation Program services provided through a Day Hospital for physical medicine and rehabilitation are Covered Services. A Day Rehabilitation Program is for those patients who do not require Inpatient care but still require a rehabilitation therapy program four to eight hours a day, 2 or more days a week at a Day Hospital. Day rehabilitation program services consist of Physical Therapy, Occupational Therapy, Speech Therapy, nursing services, and neuro psychological services. A minimum of two Therapy Services must be provided for this program to be a Covered Service.

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

1. Out-Patient Physical Rehabilitation services including:

    a. Speech and Language therapy and/or Occupational therapy, performed by a licensed therapist 20 visits per year of each service; and
    b. Clinical Therapeutic intervention defined as therapies supported by empirical evidence, which include but are not limited to Applied Behavioral Analysis, provided by or under the supervision of a professional who is licensed, certified, or registered by an appropriate agency of this state to perform the services in accordance with a treatment plan, 20 hours per week;

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

Vision Services

Benefits are available for medical and surgical treatment of injuries and/or diseases affecting the eye. Childhood vision screenings are covered under the "Preventive Health Services" benefit. Benefits for other Covered Services are based on the setting in which services are received.

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

IMPORTANT: If you opt to receive vision care services or vision care materials that are not covered benefits under this plan, a participating vision care provider may charge you his or her normal fee for such services or materials. Prior to providing you with vision care services or vision care materials that are not covered benefits, the vision care provider will provide you with an estimated cost for each service or material upon your request.

Additional Covered Services for all Members include:

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

Pediatric Vision Services

Covered Services discussed below are covered in full for any Member or dependent to the end of the month they turn age 19.
One Exam with Dilation as Necessary including contact lenses fit/follow-up.
One pair of frames including plastic lenses (single, bifocal, trifocal, lenticular) or one set of contact lenses.
* Full version details can be found in the Summary of Benefits.

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

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

Medically necessary contact lenses are dispensed in lieu of other eyewear. Participating Providers will obtain the necessary Pre-Authorization for these services.

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

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

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

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

Covered Transplant Procedure

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

Transplant Benefit Period

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

Transportation and Lodging

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

Contact us for detailed information.

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

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

- Child care,
- Mileage within the medical transplant facility city,
- Rental cars, buses, taxis, or shuttle service, except as specifically approved by Paramount,
- Frequent Flyer miles,
- Coupons, Vouchers, or Travel tickets,
- Prepayments or deposits,
- Services for a condition that is not directly related, or a direct result, of the transplant,
- Telephone calls,
- Laundry,
- Postage,
- Entertainment,
- Interim visits to a medical care facility while waiting for the actual transplant procedure,
- Travel expenses for donor companion/caregiver,
- Return visits for the donor for a treatment of a condition found during the evaluation.

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

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

SECTION FIVE: NON-COVERED SERVICES/EXCLUSIONS

The following section indicates items which are excluded from benefit consideration, and are not considered Covered Services. Excluded items will not be covered even if the service, supply, or equipment would otherwise be considered Medically Necessary. This information is provided as an aid to identify certain common items which may be misconstrued as Covered Services. Paramount has the discretionary authority to determine Medical Necessity under the Plan.

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

1. Which we determine are not Medically Necessary or do not meet our medical policy, clinical coverage guidelines, or benefit policy guidelines. See appeal rights under Internal Claims And Appeals

Procedures And External Review section of this certificate.

2. Received from an individual or entity that is not a Provider, as defined in this Certificate, or recognized by Paramount.

3. Which are Experimental/Investigative or related to such, whether incurred prior to, in connection with, or subsequent to the Experimental/Investigative service or supply, as determined by Paramount. The fact that a service is the only available treatment for a condition will not make it eligible for coverage if we deem it to be Experimental/Investigative. See appeal rights under Internal Claims And Appeals Procedures And External Review section of this certificate, and Experimental/Investigative Services Exclusion in this section

4. For any condition, disease, defect, ailment, or injury arising out of and in the course of employment if benefits are available under any Workers' Compensation Act or other similar law. If Workers' Compensation Act benefits are not available to you, then this Exclusion does not apply. This exclusion applies if you receive the benefits in whole or in part. This exclusion also applies whether or not you claim the benefits or compensation. It also applies whether or not you recover from any third party.

5. To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.

6. For court ordered testing or care unless Medically Necessary.

7. For which you have no legal obligation to pay in the absence of this or like coverage.

8. For the following:
   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.

9. Received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group.

10. Prescribed, ordered or referred by or received from a member of your immediate family, including your spouse, Child, brother, sister, parent, in-law, or self.

11. For completion of claim forms or charges for medical records or reports unless otherwise required by law.

12. For missed or canceled appointments.

13. For mileage, lodging and meals costs, and other Member travel related expenses, except as authorized by Paramount or specifically stated as a Covered Service.

14. (redacted)

15. Incurred prior to your Effective Date.

16. Incurred after the termination date of this coverage except as specified elsewhere in this Certificate.

17. For any procedures, services, equipment or supplies provided in connection with cosmetic services. Cosmetic services are primarily intended to preserve, change or improve your appearance or are furnished for psychiatric or psychological reasons. No benefits are available for surgery or treatments to change the texture or appearance of your skin or to change the size, shape or appearance of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts). Complications directly

related to cosmetic services treatment or surgery, as determined by Health Plan, are not covered. This exclusion applies even if the original cosmetic services treatment or surgery was performed while the Covered Person was covered by another carrier/self-funded plan prior to coverage under this certificate. Directly related means that the treatment or surgery occurred as a direct result of the cosmetic services treatment or surgery and would not have taken place in the absence of the cosmetic services treatment or surgery. This exclusion does not apply to conditions including but not limited to: myocardial infarction; pulmonary embolism; thrombophlebitis; and exacerbation of co-morbid conditions.

18. For maintenance therapy, which is treatment given when no additional progress is apparent or expected to occur. Maintenance therapy includes treatment that preserves your present level of functioning and prevents loss of that functioning, but which does not result in any additional improvement.

19. For the following:
- Custodial Care, convalescent care or rest cures.
- Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
- Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
- Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, or outward bound programs, even if psychotherapy is included.
- Wilderness camps.

20. For routine foot care (including the cutting or removal of corns and calluses); Nail trimming, cutting or debriding; Hygienic and preventive maintenance foot care, including but not limited to:
- cleaning and soaking the feet.
- applying skin creams in order to maintain skin tone.
- other services that are performed when there is not a localized illness, injury or symptom involving the foot.

21. For surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.

22. Weight loss programs, whether or not they are pursued under medical or Physician supervision, unless specifically listed as covered in this Certificate. This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

23. For bariatric surgery, regardless of the purpose it is proposed or performed. This includes but is not limited to Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgical procedures that reduce stomach capacity and divert partially digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastroplasty, (surgical procedures that decrease the size of the stomach), or gastric banding procedures. Complications directly related to bariatric surgery that result in an Inpatient stay or an extended Inpatient stay for the bariatric surgery, as determined by Health Plan, are not covered. This exclusion applies when the bariatric surgery was not a Covered Service under this Plan or any previous Paramount plan, and it applies if the surgery was performed while the Member was covered by a previous carrier/self-funded plan prior to coverage under this certificate. Directly related means that the Inpatient stay or extended Inpatient stay occurred as a direct result of the bariatric procedure and would not have taken place in the absence of the bariatric procedure. This exclusion does not apply to conditions including but not limited to: myocardial infarction; excessive nausea/vomiting; pneumonia; and exacerbation of co-morbid medical conditions during the procedure or in the immediate post-operative time frame.

24. For marital counseling.

25. For prescription, fitting, or purchase of eyeglasses or contact lenses except as otherwise specifically stated as a Covered Service. This Exclusion does not apply for initial prosthetic lenses or sclera shells following intraocular surgery, or for soft contact lenses due to a medical condition.

26. For vision orthoptic training.

27. For hearing aids or examinations to prescribe/fit them, unless otherwise specified within this Certificate.

28. For services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein.

29. For services to reverse voluntarily induced sterility.

30. Assisted reproductive technology (ART) such as artificial insemination, in vitro fertilization, embryo transplant services, GIFT, ZIFT, zygote transfer, reversal of voluntary sterilization, ovarian tissue transplant and related services, cost of donor sperm or donor egg, and services and supplies related to ART procedures.

31. For personal hygiene, environmental control, or convenience items including but not limited to:
    - Air conditioners, humidifiers, air purifiers;
    - Personal comfort and convenience items during an Inpatient stay, including but not limited to daily television rental, telephone services, cots or visitor's meals;
    - Charges for non-medical self-care except as otherwise stated;
    - Purchase or rental of supplies for common household use, such as water purifiers;
    - Allergenic pillows, cervical neck pillows, special mattresses, or waterbeds;
    - Infant helmets to treat positional plagiocephaly;
    - Safety helmets for Members with neuromuscular diseases; or
    - Sports helmets.

32. Health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. This exclusion also applies to health spas.

33. For consultations other than those performed in-person, except as required by law, authorized by Paramount, or as otherwise described in this Certificate (see, e.g., "Telehealth Services" and "ProMedica OnDemand" in the Covered Services section).

34. For care received in an emergency room which is not Emergency Services, except as specified in this Certificate. This includes, but is not limited to suture removal in an emergency room.

35. For eye surgery to correct errors of refraction, such as near-sightedness, including without limitation LASIK, radial keratotomy or keratomileusis or excimer laser refractive keratectomy.

36. For self-help training and other forms of non-medical self care, except as otherwise provided in this Certificate.

37. For examinations relating to research screenings.

38. For stand-by charges of a Physician.

39. Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes, except as required by state or federal law.

40. For Private Duty Nursing Services rendered in a Hospital or Skilled Nursing Facility; Private Duty Nursing Services are Covered Services only when provided through the Home Care Services benefit as specifically stated in the Covered Services section.

41. For Manipulation Therapy services rendered in the home as part of Home Care Services.

42. Unless Medically Necessary, services and supplies related to sex transformation and/or the reversal thereof, or male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This Exclusion includes sexual therapy and counseling. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, Prescription Drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related Diagnostic Testing. Evidence based and nondiscriminatory criteria will be used to determine Medical Necessity.

43. For (services or supplies related to) alternative or complementary medicine. Services in this category include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage and massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST), iridology-study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy, electromagnetic therapy, and neurofeedback.

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

45. For surgical treatment of gynecomastia.

46. For treatment of hyperhidrosis (excessive sweating).

47. For any service for which you are responsible under the terms of this Certificate to pay a Copayment, Coinsurance or Deductible, and the Copayment, Coinsurance or Deductible is waived by a Non-Participating Provider.

48. Human Growth Hormone for children born small for gestational age. It is only a Covered Service in other situations when allowed by Paramount through Pre-Authorization.

49. For Drugs, devices, products, or supplies not covered under Preventive with over the counter equivalents and any Drugs, devices, products, or supplies that are therapeutically comparable to an over the counter Drug, device, product, or supply. This exclusion does not apply to over-the-counter products the Plan must cover under federal law with a prescription.

50. Sclerotherapy for the treatment of varicose veins of the lower extremities including ultrasonic guidance for needle and/or catheter placement and subsequent sequential ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy.

51. Treatment of telangiectatic dermal veins (spider veins) by any method.

52. Reconstructive services except as specifically stated in the Covered Services section of this Certificate, or as required by law.

53. Nutritional and/or dietary supplements, except as provided in this Certificate or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written Prescription or dispensing by a licensed Pharmacist.

54. Abortion is not covered, unless medically necessary (i.e., a therapeutic abortion). Abortion means the ending of a pregnancy before the birth of the infant. Miscarriage is a spontaneous abortion (occurs naturally and suddenly). A therapeutic abortion is one performed to save the life or health of the mother, or as a result of incest or rape.

55. Dental x rays, supplies & appliances and all associated expenses, including hospitalization and anesthesia except as required by law. The only exceptions to this are for any of the following:
    - transplant preparation
    - initiation of immunosuppresives
    - direct treatment of cancer or cleft palate.

EXPERIMENTAL/INVESTIGATIVE SERVICES EXCLUSION

Any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which we determine in Our sole 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:

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

- has been determined by the FDA to be contraindicated for the specific use; or

- is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or

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

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

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

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

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

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

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

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

When This plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This plan is secondary, it determines its benefits

after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expenses.

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

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

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

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

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

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

(5) The amount of any benefit reduction by the Primary plan because a covered person has failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

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

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

Order of Benefit Determination Rules

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

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

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

(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder.

Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide out-of-network benefits.

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

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

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

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

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

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

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

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

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

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

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

- The Plan covering the Custodial parent;

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

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

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

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

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

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

Effect on the Benefits of this Plan

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

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

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This plan and other Plans. 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 Eight: 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 SEVEN: MEDICARE AND YOUR COVERAGE

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

1. An active employee who is age 65 and over (only if the Employer has 20 or more employees);
2. An active employee's spouse age 65 or over;
3. An active employee under age 65 entitled to Medicare because of disability (only if the Employer has 100 or more employees);
4. An active employee's covered dependent(s) under age 65 entitled to Medicare because of disability (only if the Employer has 100 or more employees); or
5. Up to 30 months after your treatment for end stage renal disease begins.

If you do not fall into any of the categories 1 through 5 above, the Plan will pay benefits secondary to Medicare. When the Plan is secondary, you must first submit the claim to Medicare. After Medicare makes payment, you may submit the claim to the Plan for payment.

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

SECTION EIGHT: 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 43697-0928, Attention: Member Services, or by telephone at, 1-800-462-3589 or email: Paramount.memberservices@medmutual.com. TTY users may call 1-888-740-5670.

Internal Claims and Appeals Procedures: When a health insurance plan denies a claim for a treatment or service (a claim for plan benefits), you have already received (post-service claim denial) or denies your request to authorize treatment or service (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. When the plan receives your appeal, it is required to review its own decision. See General Definitions section of this certificate for more information regarding an Adverse Benefit Determination and Rescission of coverage.

Notification of an *Adverse Benefit Determination* must include:

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

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

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

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

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 Covered Person;
- The Covered Person'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 Covered Person); and

- A copy of the notice of *adverse benefit determination.*

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

Time Limits for filing an internal claim or appeal: You must file the internal appeal within 180 days of the receipt of the notice of claim denial (an *adverse benefit determination*). Failure to file within this time limit may result in the company's declining to consider the appeal.

Time Limits for an External Appeal: You have 180 days to file for an *external review* after receipt of the plan's *final adverse benefit determination*.

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

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

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

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

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

Information sufficient to identify the claim involved, including the date of service, the *health care provider*;

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

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

Other Resources to help you

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

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

Language services are available from the health benefit plan and from The Ohio Department of Insurance.

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

INTERNAL CLAIMS AND APPEALS

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

Non-urgent, *Pre-service claim* denial

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

Urgent *Pre-service* Care claim denial

If your claim for benefits is urgent, you or your authorized representative, or your health care provider (physician) may contact us with the claim, orally or in writing.

If the request received is for non-electronic *Pre-service urgent care,* we will notify you of our decision as soon as possible, but no later than 72 hours after we receive your request.

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

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

Simultaneous Urgent appeal request and expedited internal review:

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

Additionally, you, or your *authorized representative*, may simultaneously request an expedited external review if both the following apply:

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

(2) After a *final adverse benefit determination*, if either of the following applies:
a) Your treating physician certifies that the *adverse benefit determination* involves a medical condition that could seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, if treated after the time frame of a standard external review;

b) The *final adverse benefit determination* concerns an admission, availability of care, continued stay, or health care service for which you received emergency services, but has not yet been discharged from a facility.

Post-service appeal of a claim denial (retrospective)

If your appeal is for a *post-service claim denial*, we will notify you of our decision as soon as possible but no later than 30 days after we have received your appeal.

EXTERNAL REVIEW Right to External Review

Under certain circumstances, you have a right to request an external review of our adverse benefit decision by an *independent review organization* or by the superintendent of insurance, or both.

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

All requests for an external review must be made within 180 days of the date of the notice of the plan's *final adverse benefit determination*. Standard requests for an external review must be provided in writing; requests for expedited external reviews, including *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. TTY users may call 1-888-740-5670.

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

Non-urgent request for an external review

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

(a) The name and contact information for the assigned *independent review organization* or the superintendent of insurance, as applicable, for the purpose of submitting additional information; and

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

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

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

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

Request for external review to superintendent of insurance: If the plan denies your request for an external review, you may file a request for the superintendent of insurance to review the plan's decision by contacting Consumer Services

Division at 800-686-1526 between 8:00 a.m. and 5:00 p.m., eastern standard time or by sending a written request addressed to: Consumer Services, The Ohio Department of Insurance, 50 West Town St., Suite 300, Columbus, Ohio 43215. Information about external reviews is also available on the Department's website: www.insurance.ohio.gov. The Ohio Department of Insurance may determine the request is eligible for external review regardless of 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, including what is needed to make the request complete.

Independent Review Organization: An external review is conducted by an *independent review organization* (IRO) selected on a random basis as determined in accordance with Ohio law. The IRO will provide you with a written notice of its decision to either uphold or reverse the plan's adverse benefit determination within 30 days of 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.

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

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

After receipt of health care services: No expedited review is available for *adverse benefit determination*s made after receipt of the health care service or services in question.

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

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

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

SECTION NINE: REIMBURSEMENT/SUBROGATION

Subject to ORC 2323.44, to the extent applicable:

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

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

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

other source, including the Covered Person's own insurer and/or the party causing such sickness or injury.

Equitable Lien. The Plan's subrogation and reimbursement rights are a first party lien against any recovery and must be paid before any other claims, including claims by the Covered Person for damages (with the exception of claims by the Covered Person pursuant to the property damage provisions of any insurance policy). This lien is not offset or reduced in any way by the Covered Person's attorney fees or costs incurred in obtaining the recovery. The "common fund doctrine", "made whole" rule, or similar common law doctrines do not reduce or affect the Plan's subrogation and reimbursement rights. This means the Covered Person must reimburse the Plan, in an amount not to exceed the total recovery, even when the Covered Person's settlement or judgment is for less than the Covered Person's total damages and must be paid without any reductions for attorney fees. If less than the full value of the tort action is recovered for comparative negligence or by reason of the collectability of the full value of the claim for injury, death, or loss to person resulting from limited liability insurance or any other cause, the subrogee's or other person's or entity's claim shall be diminished in the same proportion as the injured party's interest is diminished. Covered Person agrees that Plan has the right to obtain injunctive relief prohibiting the Covered Person from accepting or receiving any settlement or other recovery relating to the expenses paid by the Plan until the Plan's right of subrogation and reimbursement are fully satisfied and Covered Person consents to such injunctive relief.

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

Plan Interpretation Clause: The Plan Sponsor has sole discretion to interpret the terms of the Subrogation and Reimbursement provision.

2. **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.

3. **When You Qualify for Workers' Compensation**

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.

4. **Cooperation by Employer**. By executing the Group Policy, the Employer agrees to assist Paramount in obtaining the necessary information from covered employees as may be required and to do whatever is

necessary to effectuate and protect fully the rights of Paramount or its nominee under this Section.

SECTION TEN: 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 the Employer or 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 the Employer or 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 group health care plan rates or eligibility for enrollment.

5. **Recovery of Overpayments**. On occasion, a payment may be made to or for you when you are not covered, for a service which is not covered, or which is more than is appropriate for that service. When this happens, 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. Paramount may recover the amount of any part of a payment determined to be an overpayment if the recovery process is initiated not later than two years after the payment was made to the provider. 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.

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 Eight, Internal Claims And Appeals Procedures And External Review.

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

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

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

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

18. **Fraud, Waste and Abuse:** Please notify 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 or toll free at 1-800-462-3589.
- TTY services for the hearing-impaired are available at 1-888-740-5670 or 419-887-2526.
- You can contact the Paramount Compliance Hotline at 1-800-807-2693.
- Writing a letter to Paramount Mailing address:
  Paramount Health Care
  Attn: Paramount Compliance Fraud, Waste, and Abuse
  300 Madison Ave. 3rd Floor
  Toledo, OH 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.

Claim Forms: Upon receipt of claim, Paramount will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within fifteen days after giving of such notice, the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in this policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

SECTION ELEVEN: DEFINITIONS

When capitalized in this Certificate of Coverage or the Schedule of Benefits or italicized in Section Eight, Internal Claims And Appeals Procedures And External Review, 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.

Ambulatory review means utilization review of health care services performed or provided in an outpatient setting.

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 but only when *you* are unable to provide consent.

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

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.

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.

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

Contract - The agreement between the Employer and Paramount which consists of the following documents (all of which are on file with your employer):

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

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

Cost Sharing is any expenditure required by or on behalf of a Member with respect to 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 - An eligible employee and/or his or her eligible dependents who elect coverage, become covered, and remain covered under this Plan, continuing to meet the Plan's eligibility requirements.

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, including Prescription Drug benefits, within a calendar year, before benefits will be paid by the Plan. See your Schedule of Benefits for the Deductible amount that applies to you and your dependents.

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

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

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

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

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

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

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

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

Essential Health Benefits is defined under federal law (PPACA) as including benefits in at least the following categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

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

Experimental 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 sole 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 using evidence-based criteria as defined in the Non-Covered Services/Exclusions section of this Member Certificate**.**

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

Group Policy provides coverage to a group of people which can be a professional group, such as an employer group.

Health Care Professional: Means a physician, psychologist, nurse practitioner, physician assistant or other health

care practitioner licensed, accredited, or certified to perform health care services consistent with state law.

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

Health Plan means Paramount.

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

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

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

- A higher annual deductible than typical Health Plans, and
- A maximum limit on the sum of the annual deductible and out-of-pocket medical expenses that you must pay for covered expenses. Out-of-pocket expenses include copayments and other amounts, but do not include premiums.

A HDHP provides Preventive Health Services not subject to 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.

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

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.

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.

Insured Person means an eligible employee whose insurance under the Group Policy: 1) became effective; and 2) has not terminated.

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.

Medical Necessity/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*)*

Mental Health Condition – A display of mental or nervous symptoms that are not a result of any physical or biological cause(s) or disorder(s).

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

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

Non-Contracting Amount – The maximum amount determined as payable and allowed by Paramount for a Covered Service provided by an Out-of-Network Hospital provider.

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

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

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

Out-of-Pocket Maximum - Your Out-of-Pocket Maximum is stated in your Schedule of Benefits. After that amount has been paid, there will be no additional Cost Sharing for Essential Health Benefits during the remainder of that calendar year. The Out-of-Pocket Maximum includes Deductible, Coinsurance and Copayments incurred by a Covered Person in a calendar year.

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 group Health Plan that is not a "pre-service claim."

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.

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

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

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

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

Preventive Health Services – Preventive Health Services are those Covered Services 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 does not qualify as Preventive Health Services. See Preventive Health Services in Section Four, Covered Services 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.promedicaondemand.org/landing.htm.

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.

Schedule of Benefits – The insert included with this Certificate of Coverage that provides information on the limits and maximums of the Plan and Deductible, Copayment, and Coinsurance amounts that you must pay and explains the specific program the Employer has purchased.

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

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

Substance Abuse – A condition that develops when an individual uses alcohol or other drug(s) in a way that damages their health and/or causes them to lose control of their actions.

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:

(a) The patient receiving the services;

(b) Another Health Care Professional with whom the provider of the services is consulting regarding the patient.

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 - Charges for hospital services, except for those located in Lucas County, professional, medical services and/or supplies that do not exceed the amount charged by most Providers of like and/or similar services and supplies in the locality where the services and/or supplies are received. Determination of whether or not a charge is UCR will be made by Paramount.

Urgent Care Services - Health care services that are appropriate and necessary for the diagnosis and treatment of an unforeseen condition that requires medical attention without delay, but does not pose a threat to the life, limb, or permanent health of the injured or ill person.

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