Paramount Insurance Company

Patient Protection and Affordable Care Act Market Reforms of 2014
And the 130th General Assembly of the State of Ohio amended Senate Bill Number 99

TRADITIONAL GROUP AMENDMENT

This Amendment amends your health benefit plan (Plan), becomes a part of your Plan, and revokes/replaces the Amendment issued January 1, 2012 under form name, *PIC: Group Trad PPACA NGF Amdmt1.1.2012*. All provisions of this Amendment are effective for plans new/renewing on or after January 1, 2015. Please place this Amendment with your Certificate of Coverage for future reference.

On the Effective Date of this **Amendment**, certain benefits, terms, conditions, limitations, and exclusions in your Plan will be amended to comply with the requirements of the federal health care reform legislation, the Patient Protection and Affordable Care Act of 2010, in light of the transitional policy communicated by the President on November 14, 2013 and further clarified by the Center for Consumer Information and Oversight (CCIIO). Pursuant to the transitional policy, your Plan may not comply with all of the 2014 ACA market reforms.

In the event that there is an inconsistency between any state or federal law and the language of this Amendment, or any other wording attached to this Amendment, then to the extent permitted by law, the Insurer will resolve the inconsistency by applying the terms, conditions or limitations that are more favorable to the Insured under the applicable law.

Regardless of the terms and conditions of any other provisions of your Plan, this Amendment will control.

The following Definition is added to your Plan:

"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. Your plan may contain some or all of these types of benefits prior to 2014 when they become mandatory. If your plan contains any of these benefits, there are certain requirements that may apply to those benefits, as provided in this **Amendment**.

Emergency Services

"*Stabilize*" means, to provide such medical treatment of an Emergency Medical Condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

Lifetime Dollar Limits

The Essential Health Benefits that may be provided by your Plan are not subject to a lifetime dollar limit. Plan benefits that are not defined as Essential Health Benefits may have a lifetime dollar limit. If you have reached a lifetime dollar limit under your Plan before the federal regulation prohibiting lifetime dollar limits for Essential Health Benefits became effective, and you are still eligible under your Plan's terms, and that Plan is still in effect, you will receive a notice that the lifetime dollar limit no longer applies and that you will have an opportunity to enroll or be reinstated under your Plan. If you are eligible for this enrollment opportunity, you will be treated as a special enrollee.

Annual Dollar Limits

For a plan year beginning on or after January 1, 2014, there is no dollar limit for Essential Health Benefits under your Plan and your plan must comply with section 2711 of the Public Health Act, as amended, and any applicable implementing regulations.

Rescission of Coverage

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

Preventive Health Benefits

Under Ohio law, the following preventive health benefits are required to be provided in your Plan:

- Initial Mammography starting at age 35
- Annual screening for cervical cancer
- Child Health Supervision

Your Plan provides additional coverage for selected preventive services without a copayment, coinsurance or deductible. Depending upon your age, services may include:

- Screenings and tests for diseases
- Mental Health screenings, including substance abuse
- Healthy lifestyle counseling

- Vaccines and immunizations
- Pregnancy counseling and screenings
- Well baby and well child visits through age 21
- Periodic physical exams

Eligible services have been determined by recommendations and comprehensive guidelines of governmental scientific committees and organizations. 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.

Please contact us at www.paramountinsurancecompany.com **or (419)-887-2525,** if you have any questions or need to determine whether a service is eligible for coverage as a preventive service. For a comprehensive list of recommended preventive services, please visit www.healthcare.gov/center/regulations/prevention.html.

Dependent Coverage

This Plan will cover your married or unmarried child as defined in **the Eligibility, Effective Date and Termination Date section** of this Plan until your child reaches age 26.

Your Plan will provide coverage, or offer you the opportunity to purchase coverage, for your unmarried natural child, stepchild, or adopted child until your child reaches age 28 if your child is (1) a resident of Ohio or a full-time student at an accredited public or private institution of higher education; and (2) not employed by an employer who offers any health benefit plan under which your child is eligible for coverage; and (3) not eligible for Medicaid or Medicare.

The section titled "OHIO EXTERNAL AND EXPEDITED REVIEW PROCESS, CLAIM DISPUTE AND REVIEW REQUEST TO THE OHIO DEPARTMNET OF INSURANCE" is deleted and replaced with the following:

CLAIM PROVISIONS, CLAIMS REVIEW PROCEDURE and APPEALS:

ASSIGNMENT: The Insured Person may authorize the Company to pay benefits under the Group Policy directly to the provider on whose charges a claim is based.

CLAIMS REVIEW PROCEDURE:

The timeframe within which an initial claim determination will be made depends upon the type of claim involved. If the claim is for urgent care, you will receive notice of Paramount's benefit determination as soon as possible, but not later than 72 hours after receipt of the claim by Paramount. The initial notification may be provided to you orally, if a written notification is provided to you not later than three (3) days after the oral notification. A claim involving "urgent care" is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations (a) could seriously jeopardize your

life or health or your ability to regain maximum function; or (b) in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

In the case of a concurrent care decision, you will receive notice of Paramount's benefit determination:

(1) To reduce or terminate an ongoing course of treatment (other than by Plan amendment or termination) before the end of a previously approved period of time or number of treatments, at a time sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination or review of the Adverse Benefit Determination before the benefit is reduced or terminated; and

(2) With respect to a request to extend a course of treatment involving urgent care beyond the previously approved period of time or number of treatments, within 24 hours after receipt of the claim by Paramount, provided that such claim is made to Paramount at least 24 hours before the expiration of the previously approved period of time or number of treatments.

In the case of a pre-service claim, Paramount shall notify the claimant of Paramount's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the Paramount. This period may be extended one time by Paramount for up to 15 days, provided that Paramount both determines that such an extension is necessary due to matters beyond the control of the plan and notifies the claimant, 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 a failure of the claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information. A "pre-service" claim means any claim for a benefit with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

In the case of a post-service claim, you will receive notice of Paramount's benefit determination no later than 30 days after receipt of the claim by Paramount. This period may be extended one time by Paramount for up to 15 days, provided Paramount determines that such an extension is necessary due to matters beyond the control of Paramount and notifies you, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which Paramount expects to render a decision. A "post-service" claim means any claim for a benefit under the Plan that is not a pre-service claim.

If a claim is denied, in whole or in part, the claimant and the provider will be notified in writing. The written denial will give the specific reason or reasons for the denial. In order to obtain information regarding a claim, an Insured Person may call the Company at 1-800-462-3589 or

write to Paramount Insurance Company, 1901 Indian Wood Circle, Maumee, OH 43537, Attention: Member Services, or email: Paramount.memberservices@promedica.org.

Paramount's Member Services Department is available to assist you with any questions from 8:00 A.M. to 5:00 P.M., Monday through Friday.

If you call the Member Services Department after hours, you may leave a message and we will call you back on the next working day. You may also Email at:

PHCMbrSvcAppeals@ProMedica.org.

The Member Services Department's goal is to help you with any questions about procedures, benefits, participating providers, payment for services, enrollment, etc. We encourage you to call us with any questions. Paramount provides a TTY number for Insured Persons who are hearing impaired. Paramount will also provide translation services for those who don't speak English. If an Insured Person needs foreign language translation services, they should call the Member Services Department. If you have any suggestions for improving our service or if you wish to recommend changes in procedures or benefits, please write us or call us. We also encourage you to develop a good relationship with your physician so that you fully understand the diagnosis and treatment prescribed.

Should you have any questions you may contact the Ohio Department of Insurance at:

Department of Insurance
50 W. Town Street,
Third Floor--Suite 300
Columbus, Ohio 43215
Telephone: (614) 644-2673
Toll Free: (800) 686-1526

How to Handle a Complaint

All Member complaints will be resolved informally whenever possible. You are encouraged to initially attempt to resolve complaints about medical treatment through your Primary Care Provider. If the complaint cannot be satisfactorily resolved in this manner, or if the complaint is not a medical treatment issue, you may telephone Paramount's Member Services Department. A Member Services Representative will be available to receive the call and seek informal resolution of the complaint. If your complaint is not resolved satisfactorily on an informal basis, the Member Services Representative will inform you of your right to seek formal resolution of the complaint through the internal appeals procedures described below.

Appeal to Paramount

An Adverse Benefit Determination eligible for internal appeal is a decision by Paramount to do any of the following:

(1) Deny, reduce or terminate requested health care service or payment in whole or part;
(2) Not issue health insurance coverage to an applicant in the individual and non-employer group markets; or
(3) Rescind coverage under a health benefit plan.

If Paramount makes an Adverse Benefit Determination you will receive a written notification that includes:

(1) Information sufficient to identify the claim involved, including the date of service, the health care provider and the claim amount.
(2) The specific reasons for the adverse benefit determination;
(3) A reference to the specific Plan provision upon which the adverse benefit determination is based;
(4) A description of any additional material or information necessary for you to perfect your claim and an explanation of why such material or information is necessary;
(5) The contact information for any applicable office of health insurance consumer assistance established to assist with the internal appeal and external review process; and
(6) A description of the Plan's appeal procedures, the time limits applicable to such procedures, information on how to initiate an appeal and a statement of your right to bring a civil action under section 502(a) of ERISA;

You (the member), your Legal Representative, an Authorized Person, the provider, or the health care facility has the right to request an internal appeal of an Adverse Benefit Determination by contacting Paramount as set forth below in the section titled "Instructions for Requesting an Internal Appeal".

A provider or health care facility must have your authorization to request an appeal. You do not need the authorization of the provider. You may request an appeal of an Adverse Benefit Determination regardless of the actual or estimated cost of the health care service.

You will receive an acknowledgement from Paramount within five (5) days from receipt of your request for an internal appeal. You will be given the opportunity to attend a hearing before an administrative review panel. If you cannot attend the hearing, you may attend by teleconference or submit a written statement.

Instructions for Requesting an Internal Appeal

You may appeal an Adverse Benefit Determination at any time *within 180 days* of receiving notification of the Adverse Benefit Determination.

You must request an internal appeal in writing, unless the claim involves urgent care, in which case the appeal may also be requested orally. A claim involving "urgent care" is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations (a) could seriously jeopardize your life or health or your ability to regain maximum function; or (b) in the opinion of a physician with knowledge of the your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. If the claim involves urgent care, all necessary information, including Paramount's benefit determination on review, will be transmitted between you and Paramount by telephone, facsimile, or other available similarly expeditious method.

In connection with your written request for an internal appeal, you should submit comments, documents, records, and other information you believe is important to the claim for benefits that is the subject your request for an internal appeal.

Appeals to Paramount should be sent to the following address, or if a claim involves urgent care, you may contact Paramount by using the telephone, facsimile or e-mail below:

Paramount Insurance Company
Member Service Department-Appeals
P.O. Box 928
Toledo, Ohio 43697-0928
Telephone: (419) 887-2525
Toll Free: 1(800) 462-3589
Facsimile: (419-887-2037
E-mail: PHCMbrSvcAppeals@ProMedica.org

In connection with your right to an internal appeal of an Adverse Benefit Determination, you:

(1) may submit written comments, documents, records, and other information relating to the claim for benefits;
(2) may request free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits;
(3) will receive, free of charge, any new or additional evidence or rationale considered, relied upon, or generated by Paramount sufficiently in advance of the date on which the notice of benefit determination on review is required to be provided to allow you a reasonable opportunity to respond prior to that date; and
(4) will be provided, upon request, with the identification of the health care professional whose advice was obtained on behalf of the plan in connection with the Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination;

The appeal will be conducted by an appeal representative of Paramount who will issue a written decision within the time frames listed below:

Pre and Post Service Claims	30 calendar days from receipt of the appeal
Urgent Care Claims	Not later than 72 hours from receipt of the appeal

Full and Fair Review

To ensure you are provided with a full and fair review:

(1) The review will take into account all comments, documents, records, and other information that you submit relating to the claim, without regard to whether this information was submitted or considered in the initial benefit determination;

(2) The review will not afford deference to the initial adverse benefit determination and will be conducted by an appeal representative of Paramount and/or reviewed by a health care professional who is neither the individual who made or was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal, nor his or her subordinate;

(3) The review will be conducted by an appeal representative of Paramount in consultation with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate;

(4) The review will be conducted in a manner designed to avoid conflicts of interest by ensuring the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual will not be made based upon the likelihood that the individual will support the denial of benefits; and

(5) There will be no reduction or termination of an ongoing course of treatment without advance notice from Paramount or an opportunity for advance review.

Concurrent Internal Appeal and External Review

If you are in the process of an internal appeal of an urgent care claim, you may also request that an expedited external review be conducted simultaneously in either of the following circumstances:

(1) Your treating physician certifies in writing that you have a medical condition where the time frame for completion of an expedited review of an internal appeal involving the Adverse Benefit Determination would seriously jeopardize your life or health or your ability to regain maximum

function ; or

(2) In the case of experimental or investigational treatment that otherwise meets the criteria for an external review, you may request an expedited review orally or by electronic means, if your treating physician also certifies in writing that the requested health care service would be significantly less effective if not promptly initiated.

If Your Appeal is Denied

If your appeal is denied, the appeal representative of Paramount will provide you with a written or electronic notification of the determination. The notification will be called a Final Adverse Benefit Determination.

The Final Adverse Benefit Determination will tell you the specific reason(s) for the denial, the specific plan provisions on which the determination is based, that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits and a statement of the right to bring an action under section 502(a) of ERISA. The Final Adverse Benefit Determination will also inform you of the right to pursue an external review, and explain the procedures for initiating the review including the time frames within which you must request external review.

If the claim involves urgent care, the notice may be provided to you orally within the time frames for urgent care claims described above. A written or electronic notice will be furnished to you within three days after the oral notice.

Your Right to an Additional Appeal

If Paramount issues a Final Adverse Benefit Determination for any of the reasons listed below, you, your Legal Representative or an Authorized Person has the right to ask for an external review:

(1) You are entitled to an external review by an Independent Review Organization (IRO) if:

a. the Adverse Benefit Determination involves a medical judgment or is based on any medical information (this includes a decision that a covered person sought services at an emergency room for a condition that did not meet the prudent layperson definition of an emergency); or

b. the Adverse Benefit Determination indicates the requested service is experimental or investigational, is not specifically listed as an excluded benefit, and the treating physician certifies one of the following:

i. Standard health care services have not been effective in

improving your condition;

ii. Standard health care services are not medically appropriate for you;

iii. No available standard health care service covered by Paramount is more beneficial than the requested health care service.

(2) You are entitled to an external review by the Department of Insurance if:

a. the Adverse Benefit Determination is based on a contractual issue that does not involve medical judgment or any medical information; or

b. the Adverse Benefit Determination indicates that emergency medical services did not meet the prudent layperson definition of emergency and Paramount's decision has already been upheld through an external review by an IRO.

Exhaustion Requirements

You must exhaust the internal appeals process prior to initiating an external review except in the following circumstances:

(1) Paramount agrees to waive the exhaustion requirement;

(2) You did not receive a written decision on your internal appeal within the required time frame;

(3) Paramount fails to meet all of the requirements of the internal appeal process unless the failure:

a. was de minimis;

b. does not cause or is not likely to cause you prejudice or harm;

c. was for good cause and beyond Paramount's control; and

d. is not reflective of a pattern or practice of non-compliance.

If Paramount denies your request for external review under subsection (3) above, you may request written explanation from Paramount, and Paramount shall provide explanation within ten (10) days, including a specific description of the reasons, if any, for asserting that the delay should not cause the internal appeals process to be considered exhausted. You may then request review by the Department of Insurance of the Paramount's explanation and if the Department affirms Paramount's explanation, you may, within ten (10) days of the Department's notice of decision, resubmit and pursue the internal appeals process. Time periods for re-filing the internal appeal shall begin to run upon your receipt of such notice.

You may not request an external review of an Adverse Benefit Determination involving a retrospective utilization review decision until Paramount's internal appeals process has been exhausted unless Paramount agrees to waive the exhaustion requirement.

Instructions for Requesting External Review

You may request an external review at any time *within 180 days* of the date of the Final Adverse Benefit Determination.

When filing a request for external review, you will be required to authorize the release of your medical records as necessary to conduct the review. An authorization for the release of your medical records will be provided to you with the Final Adverse Benefit Determination. The completed authorization form must be returned with your request for external review or confirmation of your request for an expedited external review.

All requests for external review shall be made in writing, except when making a request for an expedited review. Requests for an expedited external review may be requested orally or by electronic means. When an oral or electronic request for review is made, written confirmation of the request must be submitted to Paramount no later than five days after the initial request was made.

In connection with your written request for external review, you should submit comments, documents, records, and other information you believe is important to the claim for benefits that is the subject your request for external review.

Please be sure to reference the paragraphs titled **Expedited External Review and External Review of Experimental or Investigational Health Care Services** for additional requirements in connection with a request for an expedited external review or an external review that involves experimental or investigational treatment.

Requests for external review should be sent to the following address, or if a claim involves a request for expedited review, you may contact Paramount by using the telephone, facsimile or e-mail below:

Paramount Insurance Company
Member Service Department-Appeals
P.O. Box 928
Toledo, Ohio 43697-0928
Telephone: (419) 887-2525
Toll Free: 1-800-462-3589
Facsimile: (419) 887-2037
E-mail: PHCMbrSvcAppeals@ProMedica.org

Upon receipt of a request for an external review, Paramount will review it for completeness. If the request is complete, Paramount will initiate the external review and notify you, in writing, that the request is complete. If the request for external review is not complete, Paramount will inform you, in writing, of the information needed to make the request complete.

If Paramount denies a request for external review on the grounds that the Final Adverse Benefit Determination is not eligible for external review, you may appeal the denial to the Department of Insurance.

Expedited External Review

You may make a request for an expedited external review of a Final Adverse Benefit Determination under the following circumstances:

(1) 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; or

(2) The Final Adverse Benefit Determination concerns an admission, availability of care, continued stay, or heath care service for which you received emergency services but have not yet been discharged from the facility.

An expedited external review may not be provided for retrospective Final Adverse Benefit Determinations.

External Review of Experimental or Investigational Health Care Services

You may request an external review of a Final 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.

(1) To request an external review of a Final Adverse Benefit Determination based on the conclusion that a requested health care service is experimental or investigational, your treating physician must certify that one of the following situations is applicable:
   a. Standard health care services have not been effective in improving the condition of the covered person;
   b. Standard health care services are not medically appropriate for the covered person; or
   c. There is no available standard health care service covered by the Paramount that is more beneficial than the requested health care service.

External Review Determination:

An IRO assigned to review a Final Adverse Benefit Determination will provide you written notice of its decision to either uphold or reverse the determination within 30 days of receipt of a

request for standard review or a standard review involving experimental or investigational treatment, or within 72 hours of receipt of an expedited request.

If the IRO issues a decision to reverse the Final Adverse Benefit Determination, Paramount will immediately provide coverage for the service or services in question.

For appeals to the Department of Insurance, if the Department notifies Paramount that making a decision requires the resolution of a medical issue, Paramount will initiate an external review with an IRO. If the Department determines that the health service is a covered service, Paramount will cover the service. If the Department determines that the health care service is not a covered service, Paramount is not required to cover the service or afford you further external review.

An external review decision is binding on you and Paramount except to the extent you or Paramount have other remedies available under applicable federal or state law, or unless the Department of Insurance determines that, due to the facts and circumstances of an external review, a second external review is required.

CLAIM PROVISIONS, LEGAL ACTIONS:

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

Prohibition of Preexisting Condition Exclusions or Other Discrimination Based on Health Status

For a plan year beginning on or after January 1, 2014, preexisting condition exclusions with respect to such plan or coverage may not be imposed and your Plan must comply with section 2704 of the Public Health Service Act, as amended, and any applicable implementing regulations.

Prohibition of Discrimination Against Individual Participants and Beneficiaries Based on Health Status

For a plan year beginning on or after January 1, 2014, rules for eligibility under the terms of this plan or coverage may not be based on health status-related factors in relation to an individual or a dependent of an individual and your Plan must comply with section 2705 of the Public Health Service Act, as amended, and any applicable implementing regulations.

Mental Health Parity

For a plan year beginning on or after July 1, 2014, all financial requirements and treatment limitations imposed on any mental health and substance use disorder benefits provided under

your Plan cannot be more restrictive than the predominant financial requirements and treatment limitations that apply to substantially all medical/surgical benefits. Treatment of mental health and substance use disorder benefits provided under your Plan must comply with section 2726 of Public Health Service Act, as amended, and any applicable implementing regulations.

Orally Administered Cancer Medications

For a plan year beginning on or after January 1, 2015, the 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. Cost Sharing is any coverage limit, Copayments, Coinsurance, Deductible or other out-of-pocket requirement imposed.

This Amendment takes effect on the effective date of the Plan to which it is attached. This Amendment terminates concurrently with the Plan to which it is attached. It is subject to all the definitions, limitations, exclusions and conditions of the Plan except as stated.

IN WITNESS WHEREOF:
Paramount Insurance Company

John C. Randolph
President