PARAMOUNT






Paramount Insurance Company
Certificate of Coverage - Michigan
2 Level Maximum Choice
Preferred Provider Organization (PPO) Plan

www.paramountinsurancecompany.com

Paramount is the health insurance option that offers a diverse line of products, a broad provider network, high quality and local, dependable service.

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PARAMOUNT

Insurance Company

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.

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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.

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SECTION ONE: ELIGIBILITY AND EFFECTIVE DATE

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

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

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

(2) An employee who works on a full-time basis with a normal workweek of 30 or more hours. Eligible employee includes an employee who works on a full-time basis with a normal workweek of 17.5 to 30 hours, if an Employer so chooses and if this eligibility criterion is applied uniformly among all of the Employer's employees without regard to health-status related factors;

(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.

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) Any child of the employee who is married or unmarried as defined in this section until age 26.

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

Coverage for a covered dependent child may be continued beyond age twenty-six (26), if the child is:

(1) incapable of self-support due to mental retardation or physical handicap; and
(2) 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 dependent's desire to continue coverage prior to or with in 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 retardation 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 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.

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. The newborn child must be enrolled within the 31-calendar day period in order for coverage to continue beyond such period.

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

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

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

D. Special Enrollment Period - If an eligible employee declines enrollment for themselves or their dependents (including their spouse) because of other health insurance coverage, the employee may in the future be able to enroll themselves or their dependents in this plan, provided that the employee requests enrollment within 31 days after other coverage ends because (1) there is a loss of eligibility for group health plan coverage or health insurance coverage and (2) termination of employer contributions toward group health plan coverage. Examples of reasons for loss of eligibility include: legal separation, divorce, death of an employee, termination or reduction in hours of employment – voluntary or involuntary (with or without electing COBRA), exhaustion of COBRA, "aging out" under other parent's coverage, moving out of an HMO's service area, and meeting or exceeding lifetime limit on all benefits. Loss of eligibility for cover age does not include loss due to the individual's failure to pay premiums or termination of coverage for cause, such as fraud.

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

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

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 in the case of a large group, 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. For Employers with fewer than 50 employees, the affiliation period cannot exceed 60 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 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 - Loss of Other Coverage. If an eligible employee and/or eligible dependent(s) enrolls because of loss of other coverage pursuant to Paragraph 2.D. of this section, coverage is effective on the day following the effective date of termination of other coverage if a completed enrollment application is received by Paramount within 31 days of the termination of other coverage.

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

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

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

5. Pre-Existing Conditions. You have a "Pre-Existing Condition" if You have a physical or mental condition, regardless of the cause, for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period ending on Your Effective Date. "Effective Date" means the first day You are covered.

If You have a Pre-Existing Condition, it is excluded from coverage for a period of 6 months after Your Effective Date. The period of exclusion for Your Pre-Existing Condition will be reduced by the total time You were covered by Creditable Coverage; however, if Your coverage otherwise eligible to be counted as Creditable Coverage was followed by a Significant break in Coverage, such coverage will not be counted in determining Creditable Coverage. "Significant Break in Coverage" means a continuous period of 63 calendar days or more without Creditable Coverage.

Creditable Coverage may be demonstrated by obtaining a certificate from Your prior plan. If necessary, Paramount will assist You in obtaining the certificate. If You are unable to obtain the certificate, Paramount will inform You upon Your request of alternative methods of demonstrating Creditable Coverage. Call a Paramount Member Services Representative (419-887-2531) or toll-free (1-866-452-6128.) for assistance.

The following are the only exceptions to the Pre-Existing Condition exclusion:

A. Covered Persons who are under 19 years of age. With respect to Covered Persons under 19 years of age, your Plan covers any condition that may have been previously excluded by name or specific description as a pre-existing condition. This also means a Covered Person under the age of 19 cannot be excluded from the plan if the exclusion is based on a preexisting condition.

B. Pregnancy will not be deemed to be a Pre-Existing Condition.

6. Termination of Coverage.

A. Employee. A covered employee's coverage and that of his or her covered dependents will end (subject to Section Two, Continuation/Conversion 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;

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

B. Dependent. Coverage for a covered dependent will end (subject to Section Two, Continuation/Conversion 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; or

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 or 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; and

c. 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, its agent or employees in connection with such coverage;
(3) Failure to comply with any contribution and participation requirements defined by Paramount;
(4) If there is no longer a Covered Person who lives, resides, or works in the state of Michigan;
(5) If the membership of the Employer in an association (on the basis of which coverage is provided) ceases;
(6) When Paramount discontinues offering this Plan in the Small or Large Group market, as applicable, in Michigan and:

a. Paramount provides notice to each Employer and Covered Person provided coverage under this Plan in the Small or Large 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 or Large 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

(7) When Paramount discontinues offering coverage in the Large or Small Group Market, or both, in Michigan and after Paramount provides notice to the Michigan 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/CONVERSION OF COVERAGE

1. Continuation of Coverage Under COBRA. 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 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 from the first day of absence or, if earlier, until the day after the date You are required to apply for or return to active employment. 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 provided You have at least 12 months of combined continuous medical coverage credit under the Plan and a military medical plan, and there has been no 63 day break in coverage. If You do not have a continuous 12 months of coverage credit on returning to active employment, the Plan's Pre-Existing Condition Exclusion provision will apply to the extent the 12-month period has not been satisfied. If You dropped coverage for Your dependents under the Plan, they may re-enter the Plan with You subject to this rule, and the Plan's Special Enrollment rules.

3. 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.

4. 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.

5. Conversion Privilege. If the Employer's Contract with Paramount is in effect, You will be eligible to purchase coverage under a Paramount conversion contract if You have been covered under the Employer's Contract with Paramount and Your coverage terminates for any of the following reasons:

A. The covered employee is no longer employed by the Employer;

B. The covered employee's death;

C. A covered dependent child attains the dependent age limit;

D. The covered employee and his or her spouse get a divorce, dissolution, annulment, or legal separation; or

E. The covered employee and his or her dependents have continuously received COBRA continuation coverage for the maximum time allowed and such coverage has expired.

The coverage may be different from the coverage provided under this Certificate of Coverage. You must apply in writing to and pay Paramount for such conversion coverage no later than 31 calendar days after the date You are notified Your coverage under the Employer's Contract with Paramount has terminated.

You must pay for conversion coverage from the date You stop being a Covered Person under the Employer's Contract with Paramount. If You pay from that date, Your coverage under the conversion contract will be effective on the date the coverage under the Employer's Contract with Paramount terminates. Federally Eligible Individuals are entitled to coverage. (See Definition Section for Federally Eligible Individual.)

Conversion is not permitted in the following situations:

A. The Employer's Contract with Paramount has been terminated or non-renewed, or notice of such termination or non-renewal has been provided and has been replaced by other group coverage;

B. Your coverage is being terminated by the Employer because You were not eligible to be enrolled in the Plan;

C. You are covered or eligible for coverage for Hospital, medical and surgical expenses under any comparable government program or other health benefit plan or policy; or

D. Your COBRA continuation coverage is terminated prior to the expiration of the maximum time allowed for such continuation.

NOTICE: If You elect COBRA continuation coverage, and the provisions of this Certificate of Coverage are changed or revised, Paramount will notify the Employer 31 calendar days before the changes become effective. It is the responsibility of the Employer to notify You. If payments continue to be made to Paramount, Paramount will assume that You have accepted the changes. If You do not consent to the changes, You may end Your coverage by notifying the Employer in writing. Any change in the premium, which resulted from a change or

revision to the provisions of this Certificate of Coverage, will be made in accordance with the Employer's Contract with Paramount.

SECTION THREE: HOW THE MAXIMUM CHOICE PLAN WORKS

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

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

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

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 Hospital Providers in Lucas County, Paramount pays for benefits based on the lesser of the Non-Contracting Amount (NCA) that is determined payable by Paramount or the actual charge for the service. For all other Out-of-Network Hospitals, Physicians/Providers, Paramount pays for benefits based on the lesser of the Usual, Customary and Reasonable (UCR) Charge or the actual charge for the service.

If the charge billed is greater than the NCA or Usual, Customary and Reasonable (UCR) Charge, **You must pay the excess portion.** For Covered Services rendered Out-of-Network, Deductibles, Coinsurance and benefit maximums are based on the lesser of the NCA, the UCR Charge or the actual charge for the service.

Example (assumes the Deductible has already been met):

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

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

Benefit Limits - Some benefits described in this Certificate of Coverage are limited, may vary, or require payment of additional amounts. Please refer to the Schedule of Benefits and to the specific conditions, limitations, exclusions, and/or payment levels that are set forth in the section which describes that benefit in detail and in Section Ten, Exclusions, for a description of services and supplies that are not covered under this Plan. Always call 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.

2. Pre-Authorization

You must obtain pre-authorization by calling Paramount at 419-887-2549 or toll free 1-800-891-2549 before (preferable two weeks in advance) obtaining any of the following:

A. Services requiring pre-authorization:

i. Inpatient admission to a Hospital, including Inpatient admissions for Mental Illness, drug abuse or alcohol abuse treatment and Inpatient admissions at rehabilitation facilities; or
ii. Inpatient admission to a Skilled Nursing Facility; or
iii. Hospice or Home Health services; or
iv. Organ/Bone Marrow Transplant services.

B. Procedures requiring pre-authorization:

i. Enhanced External Counterpulsation (EECP);
ii. Prophylactic Mastectomy;
iii. BRCA Testing;
iv. Orthognathic and maxillofacial surgery;
v. Eyelid surgery/lifts (blepharoplasty); and
vi. Cochlear implants.

C. Equipment requiring pre-authorization:

i. Bone stimulators and supplies;
ii. Power operated vehicles, power wheelchairs and power wheelchair accessories over $5,000;
iii. Chest wall oscillation vest (ThAIRapy Vest System);
iv. Enteral nutrition, and
v. Speech generating devices.

Even if You obtain a referral from an In-Network Physician or an Out-of-Network Physician, **pre-authorization is always required before obtaining the above services, procedures and equipment.** If You obtain pre-authorization, these services, procedures and equipment will be covered at the appropriate benefit level indicated in Your Schedule of Benefits. Pre-authorization is required to avoid a potential denial or reduction in payment of benefits.

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 that are not Medically Necessary.

If You ***do not obtain pre-authorization*** and the services are Medically Necessary, any benefit payment for a *facility fee (including inpatient facility services under Section Three, 2,A and outpatient facility services under Section Three, 2,B)* will be reduced by 50% up to a maximum of $500 of the Allowable Amount. The services are then subject to the applicable Deductible, Copayment and/or Coinsurance. The 50% penalty does not count toward the Out-of-Pocket Maximum.

Notification of Pre-Authorization Decision. Paramount will make its decision regarding coverage and notify You within two (2) business days of receiving all necessary information.

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.

If You disagree with Paramount's determinations, You may appeal Paramount's decision by following the appeal procedure set forth in Section Thirteen, Questions, Problems or Grievances.

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

3. **The Preferred Provider Organization (PPO) Network.** The PPO Network Directory lists all Physicians and other Providers who are part of the PPO Network. The PPO Network Directory will be updated periodically and You may access the PPO Network Directory at; www.paramount insurancecompany.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.

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

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

   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.

   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 at 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).

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

A. Deductible. The amount You and Your Dependents must pay for Covered Services within a 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. The single Deductible is the amount each Covered Person must pay, but the family Deductible is the total amount any two or more covered family members must pay. Covered Services requiring a Copayment and Preventive Health Services are not subject to the Deductible.

The expenses incurred for Covered Services received from In-Network Providers apply towards satisfying the In-Network PPO Deductibles. However, the expenses incurred for Covered Services received from Out-of-Network Providers apply only towards satisfying the Out-of-Network Deductible.

B. Copayment. The fixed dollar amount You must pay each time You receive certain Covered Services. See Your Schedule of Benefits for Copayments that apply to You and Your Dependents. ***Copayments for office visits and other fixed dollar Copayments do not count toward the Out-of-Pocket Maximum.***

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

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

D. Out-of-Pocket Maximum. Your Out-of-Pocket Maximum is stated in Your Schedule of Benefits. After that amount has been paid, there will be no additional payments required for Coinsurance during the remainder of that calendar year. The Out-of-Pocket Maximum includes a Deductible and Coinsurance incurred by a Covered Person in a calendar year. The following do not apply to the Out-of-Pocket Maximum:

- Financial penalties imposed for failure to obtain required pre-authorization;
- Fixed dollar Copayments;
- Coinsurance for durable medical equipment;
- Coinsurance for prosthetic devices;
- Coinsurance for benefits under a Prescription Drug Rider; and
- Non-Network charges in excess of NCA or UCR.

The single Out-of-Pocket Maximum is the amount each Covered Person must pay, but the family Out-of-Pocket Maximum is the total amount any two or more covered family members must pay.

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

E. Maximum Lifetime Benefit. Benefits under the Plan are limited to the amount shown on the Schedule of Benefits per Covered Person. The Maximum Lifetime Benefit is the maximum dollar amount Paramount will pay for Covered Services during Your lifetime. The benefits paid for Covered Services received from In-Network and Out-of-Network Providers will be counted toward Your Maximum Lifetime Benefit. No additional Covered Services will be provided to You after You have received Your Maximum Lifetime Benefit.

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 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.

F. Annual Dollar Limits. Your Plan may have annual dollar limits on the claims the Plan will pay each year for Essential Health Benefits. Your Plan may include other benefits not defined as Essential Health Benefits, and those other benefits may have annual dollar limits. If your Plan has annual dollar limits on Essential Health Benefits they are subject to the following:

- For a plan year beginning on or after September 23, 2010, but before September 23, 2011, the limit can be no less than $750,000.
- For a plan year beginning on or after September 23, 2011, but before September 23, 2012, the limit can be no less than $1.25 million.
- For a plan year beginning on or after September 23, 2012, but before December 31, 2013, the limit can be no less than $2 million.
- For a plan year beginning on or after January 1, 2014, there is no dollar limit for Essential Health Benefits under your Plan.

6. Medically Necessary. Covered Services must be Medically Necessary (see the Definition Section). The fact that Your Provider prescribed the care or service does not automatically mean that the care is Medically Necessary or that it qualifies for coverage.

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

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

7. Coverage for Emergency Services. Usually, services obtained from Out-of-Network Providers are covered at the Out-of-Network benefit level. However, if You have an accident, unforeseen illness, or injury that requires immediate care, You may seek Emergency Services (see the Definition Section) 24 hours a day and 7 days a week at the nearest health care facility, and You will receive the In-Network benefit level based on the lesser of the Usual, Customary and Reasonable (UCR) Charge or the actual charge for the service. 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. In-Network benefits for care received from Out-of-Network Providers are limited to Emergency Services required before You can, without medically harmful results, return to the care of In-Network Providers.

SECTION FOUR: MEDICAL SERVICES

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

Plan provisions may be modified, if a Medically Necessary and less costly alternative course of treatment is available.

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

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

   A. **Diagnosis and Treatment:** Services of Physicians and other medical personnel for diagnosis and treatment of disease, injury, or other conditions; and Urgent Care Services and Emergency Services provided 24 hours a day and 7 days a week. This includes surgical procedures performed in a Physician's office and consultations with specialists.

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

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

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

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

   F. **Radiation Therapy and Chemotherapy:** A Food and Drug Administration (FDA) approved drug used in antineoplastic therapy and the reasonable cost of its administration are covered regardless of whether the specific neoplasm for which the drug is being used as treatment is the specific neoplasm for which the drug has received approval by the FDA if all of the following conditions are met:
      1. The drug is ordered by a physician for the treatment of a specific type of neoplasm.
      2. The drug is approved by the FDA for use in antineoplastic therapy.
      3. The drug is used as part of an antineoplastic drug regimen.
      4. Current medical literature substantiates its efficacy and recognized oncology organizations generally accept the treatment.
      5. The physician obtained informed consent from the patient for the treatment regimen which includes FDA approved drugs for off-label indications.

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

H. Second Surgical Opinion.

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

J. Preventive Health Services: Your Plan provides additional coverage for selected Preventive Health Services without a Copayment, Coinsurance, or Deductible when these services are delivered by an In-Network Provider. Please refer to Your Schedule of Benefits for coverage levels. 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.

Preventive Health Services include, as an example, the following:
1. Well-baby and well-child care visits through age 21;
2. Periodic Physical examinations;
3. Screenings and tests for diseases;
4. Mental Health screenings, including substance abuse;
5. Healthy lifestyle counseling;
6. Vaccines and immunizations;
7. Pregnancy counseling and screenings.

Please contact us at **www.paramountinsurancecompany.com or (419)-887-2531; toll-free 1-866-452-6128,** 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.

K. Routine Vision Exam: An annual routine vision exam for refractory disorders of the eye.

L. Contraceptive Services: Contraceptive (birth control) services, devices and supplies, including but not limited to, voluntary sterilization (including tubal ligations and vasectomies), implantable contraceptive drugs, IUDs, or diaphragms.

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

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

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

The Plan will also cover medical and surgical procedures for:

1. Correction of functional defect or functional impairment which results from an acquired and/or con genital disease or injury; and

2. Reconstructive surgery to correct congenital malformations or anomalies resulting in a functional defect or functional impairment of a covered child 19 or Younger; and

3. Breast reconstruction following a covered mastectomy including:
   a. Reconstruction of the breast on which the mastectomy was performed;
   b. Surgery and construction of the other breast to produce a symmetrical appearance; and
   c. Prostheses and physical complication during all stages of the mastectomy, including lyphedemas.

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

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

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

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

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

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

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

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

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

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

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

5. Services at Home: These services include:

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

B. Home Health Care by Home Health Agency Personnel: Visits by home health agency personnel in Your home or other place of residence, up to a maximum indicated in the Schedule of Benefits. If home health

care is recommended, Paramount must approve benefits for such care in advance. If You obtain pre-authorization, these services, procedures and equipment will be covered at the appropriate benefit level indicated in Your Schedule of Benefits. Pre-authorization is required to avoid a potential reduction or denial of benefits.

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

Home health care includes any of the following:

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

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

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

6. Medical Supplies. These items are covered when ordered by a Physician, supplied by a Physician, supplier or pharmacy and are eligible under Medicare Part B guidelines and limits, with the exception of Outpatient prescription drugs covered by Medicare Part B.

A. Asthmatic Supplies: Certain asthmatic supplies may be covered under a separate program administered through a pharmacy benefit. See Limited Medical Supply Rider for details.

B. Diabetic Equipment, Supplies and Education: These items are covered when ordered by a Physician. The following diabetic equipment and supplies are available from Network Pharmacies, even if You are not enrolled in Paramount's Prescription Drug Program:

1. Blood glucose monitors;
2. test strips for glucose monitors, visual reading and urine testing strips, lancets, and spring powered lancet devices;
3. needles and syringes (1cc or less); and
4. medical supplies required for the use of an insulin pump

Medical supplies are small and often disposable items that are part of medical treatment for an illness or injury. The supply must be compatible with the diagnosis and generally must not be useful in the absence of illness or injury for which it is used. Coinsurance for medical supplies, except diabetic supplies, is not counted toward the Out-of-Pocket Maximum.

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

Benefits will be subject to the Coinsurance amount and/or Benefit Limit indicated in the Schedule of Benefits. Coinsurance for Durable Medical Equipment (DME) is not counted toward the Out-of-Pocket Maximum.

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

8. **Prosthetic Devices.** These items are covered when ordered by a Physician, supplied by a Physician, supplier or pharmacy and eligible under Medicare Part B guidelines. **Benefits will be subject to the Coinsurance amount and/or Benefit Limit indicated in the Schedule of Benefits.** Coinsurance for Prosthetic Devices is not counted toward the Out-of-Pocket Maximum.

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

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

10. **Cancer Clinical Trial.** Routine patient care for Covered Persons enrolled in an Eligible Cancer Clinical Trial is covered. Routine patient care means all health care services consistent with the coverage under this Plan for the treatment of cancer, including the type and frequency of any diagnostic modality, that is typically covered for a cancer patient who is not enrolled in a cancer clinical trial, and that is not necessitated solely because of the trial.

SECTION FIVE: HOSPITAL CARE

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

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

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

If You ***do not obtain pre-authorization*** and the services are Medically Necessary, any benefit payment for a ***facility fee (including inpatient facility services under Section Three, 2,A)*** will be reduced by 50% up to a maximum of $500 of the Allowable Amount. The services are then subject to the applicable Deductible, Copayment and/or Coinsurance. The 50% penalty does not count toward the Out-of-Pocket Maximum.

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

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

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

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

4. **Visits to the Emergency Room:** An emergency room Copayment and Coinsurance must be paid as indicated in the Schedule of Benefits for each visit to a Hospital emergency room. Your Plan covers Emergency Services for an Emergency Medical Condition treated in any hospital emergency department. If you are admitted to the Hospital from the emergency room, the emergency room Copayment will be waived. If You have an Emergency Medical Condition, dial 911 for assistance or go to the nearest hospital emergency room. Your Plan will not require prior authorization or impose any other administrative requirements or benefit limitations that are more restrictive if you receive Emergency Services from an Out-of-Network Provider. However, an Out-of-Network Provider of Emergency Services may send you a bill for any charges remaining after your Plan has paid (this is called "balance billing").

   Except where your Plan provides a better benefit, your Plan will apply the same Copayments and Coinsurance for Out-of-Network Emergency Services as it generally requires for In-Network Emergency Services. A Deductible may be imposed for Out-of-Network Emergency Services, only as part of the Deductible that generally applies to Out-of-Network benefits. Similarly, any Out-of-Pocket Maximum that generally applies to Out-of-Network benefits will apply to Out-of-Network Emergency Services.

   Your Plan will calculate the amount to be paid for Out-of-Network Emergency Services in three different ways and pay the greatest of the three amounts: 1) the amount your Plan pays to In-Network Providers for the Emergency Services furnished (this calculation is not required if your Plan does not have negotiated per service amounts with In-Network Providers for the services furnished); 2) the amount that would be paid using the same method your Plan generally uses to determine payment for Out-of-Network services (such as the usual, customary and reasonable charges), but substituting In-Network Copayments and Coinsurance amounts; and 3) the amount that would be paid under Medicare for the services provided. All three of these amounts are calculated before application of any In-Network Copayments or Coinsurance.

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

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

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

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

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

A. Because of an accident or sudden Emergency Medical Condition, it is necessary to transport You in an ambulance to the closest Hospital that is medically equipped to provide treatment for Your condition;

B. It is necessary to transport You from a Hospital where You are an Inpatient to another Hospital because;

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

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

SECTION SIX: MENTAL HEALTH / DRUG ABUSE AND ALCOHOL ABUSE

Mental Health Services include treatment for Biologically and Non-Biologically Based Mental Illness.

Biologically and Non-Biologically Based Mental Illness. Inpatient and outpatient services for the treatment of Biologically and Non-Biologically Based Mental Illnesses are covered subject to the same terms, Deductible, Copayments and/or Coinsurance as any other physical disease or condition. Refer to Section Four: Medical Services and Section Five: Hospital Care. The level of benefits for these services will depend on whether these services are obtained through In-Network or Out-of-Network Providers. The inpatient and outpatient benefits for Biologically and Non-Biologically Based Mental Illness are listed in Your Schedule of Benefits.

Drug and Alcohol Abuse. Inpatient and outpatient services for the treatment of Drug and Alcohol Abuse are covered subject to the same terms, Deductible, Copayments and/or Coinsurance as any other physical disease or condition. Refer to Section Four: Medical Services and Section Five: Hospital Care. The level of benefits for these services will depend on whether these services are obtained through In-Network or Out-of-Network Providers. The inpatient and outpatient benefits for Drug and Alcohol Abuse are listed in Your Schedule of Benefits.

1. Levels of Treatment

A. Outpatient Services: The Outpatient benefit are listed in Your Schedule of Benefits. Outpatient services include the following:

- Diagnostic evaluation,
- Individual psychotherapy;
- Group psychotherapy; and
- Convulsive therapy.

B. Inpatient Services: The Inpatient benefit are listed in Your Schedule of Benefits.

1. Hospitalization Services: Services provided while You are confined in a Hospital on a 24 hour a day basis to treat Mental Illness, drug abuse or alcohol abuse, including room and board, Physician services, nursing care, pharmacy services, diagnostic tests, and the following:
   - Diagnostic evaluation;
   - Individual psychotherapy;
   - Group psychotherapy; and
   - Convulsive therapy.

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

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

   If You ***do not obtain pre-authorization*** and the services are Medically Necessary, any benefit payment for a ***facility fee (including inpatient facility services under Section Three, 2,A)*** will be reduced by 50% up to a maximum of $500 of the Allowable Amount. The services are then subject to the applicable Deductible, Copayment and/or Coinsurance. The 50% penalty does not count toward the Out-of-Pocket Maximum.

   Call Paramount at (419) 887-2549 or toll free 1-800-891-2549 for pre-authorization.

C. Partial Hospitalization Services: The same services covered under hospitalization services described above in this section (except room and board). However, partial hospitalization services are provided only for a duration of six to eight hours a day and do not require an overnight stay in the Hospital.

D. Intensive Outpatient Program (IOP) Services: The same services covered under hospitalization services described above in this section (except room and board, nursing and pharmacy). However, intensive Outpatient program (IOP) services are structured ambulatory behavioral health services with a duration of two to four hours per day, at least three days per week.

2. Determination of Appropriate Levels of Treatment: In determining the appropriate levels of treatment, Paramount considers:

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

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

SECTION SEVEN: HOSPICE CARE

Coverage for the following services is available when a Covered Person is diagnosed by their Physician as being terminally ill with a prognosis of six months or less to live. Your share of the cost for hospice care will depend on whether the care is obtained from an In-Network or Out-of-Network Provider. Pre-authorization for hospice care is required or a significant penalty will apply (see paragraph 3 below).

1. **Hospices.** In order to receive coverage, You must obtain care from a Medicare certified hospice with all licenses, certifications, permits, and approvals required by applicable state and local law.

2. **Hospice Care Covered.** Covered Services include hospice care authorized by Your Physician during the period when hospice has admitted You to its program. Covered Services include the following services provided by the hospice:

A. Inpatient palliative care, excluding room and board, in a free standing hospice, hospice unit within a Hospital or Skilled Nursing Facility, or regular Hospital bed; and

B. Home care services provided by the hospice either directly or under arrangements with other licensed Providers.

3. **Pre-Authorization Required.** You, or someone doing so on Your behalf, must call Paramount at (419) 887-2549 or toll-free at 1-800-891-2549 to obtain pre-authorization for Inpatient hospice services (except for Emergency Services). Pre-authorization is required to avoid a potential reduction or denial in payment of benefits. 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 You do not obtain the required pre-authorization, a retrospective review will be done to determine if your care was Medically Necessary. You are responsible for all charges for services that are not Medically Necessary.

If You ***do not obtain pre-authorization*** and the services are Medically Necessary, any benefit payment for a ***facility fee (including inpatient facility services under Section Three, 2,A)*** will be reduced by 50% up to a maximum of $500 of the Allowable Amount. The services are then subject to the applicable Deductible, Copayment and/or Coinsurance. The 50% penalty does not count toward the Out-of-Pocket Maximum.

SECTION EIGHT: TRANSPLANT BENEFITS

Benefit levels for transplants will depend on where Your care is obtained. Transplant services obtained at a Center of Excellence will be paid at the In-Network benefit level. Transplant services not obtained at a Center of Excellence will be subject to a significant penalty outlined in paragraph 5 below. A facility is a "Center of Excellence" when it appears on Paramount's list of centers for the specific transplant being performed. Pre-authorization for transplant services is required or a significant penalty will apply (see paragraph 4 below). Paramount will cover transplant services as follows:

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

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

The Plan will pay for Covered Services for organ transplants, subject to Deductibles, Coinsurance, benefit maximums or other limits after pre-authorization is obtained. In order to be pre-authorized, the organ transplant must be Medically Necessary, medically appropriate, and not experimental or investigational for the medical condition for which the transplant is recommended. These determinations must be made by a Plan-approved external independent review organization specializing in transplant services.

3. Specified Covered Services.

A. Hospital Care: All Inpatient and Outpatient care.

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

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

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

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

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

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

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

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

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

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

If You ***do not obtain pre-authorization*** and the services are Medically Necessary, any benefit payment for a ***facility fee (including inpatient facility services under Section Three, 2,A)*** will be reduced by 50% up to a maximum of $500 of the Allowable Amount. The services are then subject to the applicable Deductible, Copayment and/or Coinsurance. The 50% penalty does not count toward the Out-of-Pocket Maximum.

5. **Transplant Benefit Penalty.** Transplant services received at a non-Center of Excellence (Out-of-Network facility) will be subject to a reduction of benefit payment for all services of 50% of the Allowable Amount. The penalty does not count toward any out-of-pocket maximum. The transplant will be eligible for benefit payment only if it is a Medically Necessary Covered Service.

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

SECTION NINE: MOTHER AND NEWBORN CARE

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

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

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

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

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

   A. Physical assessment of the mother and newborn;

   B. Parent education, assistance, and training in breast and bottle feeding;

   C. Assessment of the home support system;

   D. Performance of any Medically Necessary clinical tests; and

   E. Performance of any other services that are consistent with the follow-up care recommended in the protocols and guidelines developed by national organizations that represent pediatric, obstetric, and nursing professionals.

   If the mother or newborn is discharged prior to the expiration of the applicable number of Inpatient hours specified in paragraph 2 of this section, all follow-up care provided within 72 hours after discharge is covered. If the mother or newborn receive at least the number of Inpatient hours specified in paragraph 2 of this section,

all such care determined to be Medically Necessary by the Physician or nurse-midwife responsible for discharge is covered. Follow-up care may be provided in a Physician's office or during a home health visit if the health care professional conducting the home visit is knowledgeable and experienced in maternity and newborn care.

SECTION TEN: EXCLUSIONS

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

Benefits for the following will not be provided.

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

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

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

   The above may be covered under a under a separate program administered through a pharmacy benefit. See Limited Medical Supply Rider for details.

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

4. **Cancer Clinical Trial Services.** A health care service, item or drug that is:

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

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

5. **Cardiac Rehab:** Services provided as part of Cardiac Rehabilitation, Phase III.

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

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

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

9. **Charges in Excess of NCA or UCR:** Charges for Out-of-Network services that are in excess of the Non-Contracting Amount (NCA) or in excess of Usual, Customary and Reasonable (UCR) charges.

10. **Complementary Treatments:** Acupuncture, Acupressure, Hypnotherapy, Massotherapy, Aroma Therapy, Chelation therapy, Rolfing, Biofeedback training, neurofeedback training and related diagnostic tests and other forms of alternative treatments including but not limited to non-prescription drugs or medicines, vitamins, nutrients and food supplements are not Covered Services. This limitation applies even if the service or item is prescribed by or administered by a Physician.

11. **Contraceptive Devices, Supplies or Drugs:** Contraceptive drugs, including birth control pills. Over-the-counter contraceptive condoms, sponges, foams, jellies and ointments. However, benefits for such birth control pills may be available if the Employer's Contract with Paramount provides coverage under a separate Prescription Drug Program. Refer to the Schedule of Benefits and Section Fifteen, Prescription Drug Program, if applicable.

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

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

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

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

This exclusion does not apply to the following procedures performed by a dentist or oral surgeon and when benefits are not available under a separate dental plan. These procedures are:

a. initial first aid treatment received within 72 hours of an accidental Injury to sound natural teeth, the jaw bones, or surrounding issues, to the extent of extraction of teeth and repair of soft tissue;
b. treatment for tumors and cysts (including pathological examination) of the jaws, cheeks, lips, tongue, roof and floor of the mouth; or
c. repair of fractures and dislocations.

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

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

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

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

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

21. Experimental and Investigational Procedures, Treatments, Drugs or Medicines: Treatments, procedures, drugs or medicines that are determined to be experimental or investigational. This means that one or more of the following is true:

a. the device, drug or medicine cannot be lawfully marketed without approval of the U. S. Food and Drug Administration and approval for marketing has not been given at the time the device, drug or medicine is furnished.

b. reliable evidence shows that the treatment, procedure, device, drug or medicine is the subject of ongoing phase, I, II, or III clinical trials or is under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis.

c. reliable evidence shows that the consensus of opinion among experts regarding the treatment, procedure, device, drug or medicine is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis. Reliable evidence means only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same treatment, procedure, device, drug or medicine; or the written informed consent used by the treating facility or by another facility studying substantially the same treatment, procedure, device, drug or medicine.

d. A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational or for research purposes.

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

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

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

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

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

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

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

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

30. **Hearing Care.** Hearing examinations, hearing aid evaluations, hearing aids and other hearing care services and supplies except Covered Services required for newborn hearing screening and the diagnosis and treatment of diseases of, or injury to, the ears. (If the Employer has purchased an optional hearing aid rider, additional benefits may be available. See the Schedule of Benefits.)

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

32. **Illegal Activities.** Charges for the diagnosis, care, or treatment of any condition arising from or occurring while engaged in any illegal activity, including but not limited to an illegal occupation, an assault, an attempted assault or felonious act.

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

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

35. **Insulin. Insulin, insulin injections, or other insulin therapy.** (If the Employer has purchased a prescription drug rider, additional benefits may be available. See the Schedule of Benefits.)

36. **Mandated or Court Ordered Care.** Any medical, psychological, alcohol and drug abuse, or psychiatric care which is solely the result of court order or otherwise mandated by a third party (such as an Employer or licensing board).

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

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

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

a. Special or remedial education, including testing and services for learning and behavioral disabilities, social skills classes, behavioral modification and other training programs including but not limited to Applied Behavioral Analysis (ABA) programs. This limitation applies whether or not associated with manifest Mental Illness or other disturbances.
b. Services which are extended beyond the period necessary for the evaluation and diagnosis of mental retardation, or pervasive developmental disorders, including but not limited to Autism, hyperkinetic syndrome, mental retardation, Rett's, Asperger's Disorder, Childhood Disintegrative Disorder, Atypical Autism or Pervasive Developmental Disorder Not Otherwise Specified;
c. Structured sexual therapy programs;
d. Services for narcotic maintenance therapy in which an agonist, antagonist, or agonist/antagonist drug is used for chronic administration, as well as detoxification services related to such chronic drug maintenance use;
e. Testing for ability, aptitude, intelligence or interest;
f. Vocational and recreational activities or coma stimulation therapy;
g. Treatment in a specialized facility or program for a patient who has not been or would not be responsive to therapeutic management or who has not been or is not motivated;
h. Continuation in a course of treatment for patients who are disruptive, unruly, abusive or non-cooperative;
i. Inpatient treatment for codependency or environmental changes;
j. Halfway houses and residential treatment programs;
k. Cognitive rehabilitation therapy;
l. Family counseling or marriage counseling;
m. Social skills classes;
n. Sleep disorders; or
o. Positron Emission Tomography (PET scans) for Mental Illness.

*** Note** – Biologically and Non-Biologically Based Mental Illness and Drug and Alcohol Abuse is covered the same as any physical condition.

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

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

42. **Nutrition Counseling:** Nutrition counseling and related services, except when provided as part of diabetes education.

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

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

45. Paternity Testing: Testing to establish paternity is not covered.

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

47. Pre-Existing Condition Exclusion: Pre-Existing Conditions are excluded as specified in Section One, paragraph 5, Pre-Existing Conditions.

48. Prescription Drugs and Non-Prescription Drugs: Outpatient Prescription Drugs whether self-administered or administered by a Provider, with the exception of infused chemotherapy and short-term medications (e.g., antibiotics, steroids, etc.). Benefits are not available for vitamins, nutrients, infant formula and food supplements even if prescribed by a Physician. However, benefits for such Prescription Drugs may be available if the Employer's Contract with Paramount provides coverage under a separate Prescription Drug Program. Refer to the Schedule of Benefits and Section Fifteen, Prescription Drug Program, if applicable.

49. Private Duty Nursing: Private duty nursing services.

50. Private Room: If You occupy a private room, You will have to pay the difference between the Hospital's charges for a private room and the Hospital's most common charge for semi-private accommodations, unless it was Medically Necessary for You to have a private room or if the Hospital only provides private rooms.

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

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

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

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

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

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

57. Services Normally Considered Non-Covered: Services and supplies which are normally considered non-covered when another health care benefit plan has the primary Coordination of Benefits obligation, and/or services for which no charge would be made if the individual had no health care benefit.

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

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

60. Services Not Within Providers Scope: Services and supplies that are not performed or provided within the scope of the Provider's license.

61. Sex-related Disorders: Surgical procedures or related care to alter sex from one gender to the other or treatment related to sexual dysfunction.

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

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

64. Surrogate and/or Gestational Pregnancy: Surrogate and/or gestational pregnancy and any related procedures.

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

66. Topical Anesthetics: Topical anesthetics are not covered.

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

68. Travel Related Immunizations and Services: Immunizations for the purpose of fulfilling requirements for international travel. Charges for confinement, treatment, services or supplies received outside the United States, unless required for an emergency medical Condition.

69. Vision Care: Orthoptic training, eyeglasses, contact lenses, contact lens evaluation and fittings, sunglasses of any type, and surgery including but not limited to: eye surgery to correct refractory errors, LASIK surgery, Keratomileusis, excimer laser, photo refractory keratectomy (interwave technology), radial keratotomy, and other vision care services and supplies, except Covered Services required for the diagnosis and treatment of diseases of, or injury to, the eyes. (If the Employer has purchased an optional Vision Hardware Rebate Rider, additional benefits may be available. See the Schedule of Benefits.)

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

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

SECTION ELEVEN: COORDINATION OF BENEFITS

Coordination of benefits is the procedure used to pay health care expenses when a person is covered by more than one plan. Paramount follows rules established by Michigan law to decide which plan pays first and how much the other plan must pay. The objective is to make sure the combined payments of all plans are no more than your actual bills.

When you or your family members are covered by another group plan in addition to this one, we will follow Michigan coordination of benefit rules to determine which plan is primary and which is secondary. You must submit all bills first to the primary plan. The primary plan must pay its full benefits, as if you had no other coverage. If the primary plan denies the claim or does not pay the full bill, you may then submit the balance to the secondary plan.

Paramount pays for health care only when you follow our rules and procedures. If our rules conflict with those of another plan, it may be impossible to receive benefits from both plans, and you will be forced to choose which plan to use.

Plans That Do Not Coordinate
Paramount will pay benefits without regard to benefits paid by the following kinds of coverage:

- Individual (not group) policies or contracts, except where Paramount may have subrogation rights against your rights to recover under certain individual policies.
- Medicaid
- Group hospital indemnity plans which pay less than $100 per day
- School accident coverage
- Some supplemental sickness and accident policies

Paramount as Primary Plan
When we are primary, we will pay the full benefit allowed by your contract as if you had no other coverage.

Paramount as Secondary Plan
- Our payments will be based on the balance left after the primary plan has paid. We will pay no more than that balance. In no event will we pay more than we would have paid had we been primary.
- We will pay only for health care expenses that are covered by Paramount.
- We will pay only if you have followed all of our procedural requirements, including care obtained from or arranged by your Primary Care Provider, Participating Specialists, pre-authorizations, etc.
- We will pay no more than the "allowable expenses" for the health care involved. If our allowable expense is lower than the primary plan's, we will use our allowable expense. That may be less than the actual bill.

Determining Which Plan Is Primary
To decide which plan is primary, we have to consider both the coordination provisions of the other plan and which member of your family is involved in a claim. The primary plan will be determined by the first of the following factors which applies:

1. **Employee** The plan which covers you as an employee (neither laid off nor retired) is always primary.

2. **Children** (parents divorced or separated) If the court decree makes one parent responsible for health care expenses, that parent's plan is primary. If the court decree gives joint custody and does not mention health care, we follow the birthday rule. (See point 4 below.)

   If neither of those rules applies, the order will be determined in accordance with the Michigan Compiled Laws Section 550.253 and any regulations issued there under.

3. **Children (parents not divorced or separated) and the birthday rule** When your children's health care expenses are involved, we follow the "birthday rule". The plan of the parent with the first birthday is always primary for the children. For example, if your birthday is in January and your spouse's birthday is in March, your plan will be primary for all of your children.

However, if your spouse's plan is issued in another state and has some other coordination rule (for example, a "gender rule" which says the father's plan is always primary), we will follow the rules of that plan.

4. **Other situations** For all other situations not described above, the order of benefits will be determined in accordance with the Michigan Compiled Laws Section 550.253 and any regulation issued there under.

Coordination Disputes
If the 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 Thirteen: Questions, Problems or Grievances.

SECTION TWELVE: MEDICARE AND YOUR COVERAGE

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

1. An active employee who is age 65 and over (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. If You do not elect Part B coverage, the payment to be made by the Plan will be made as if You had elected Part B. When the Plan is secondary, You must first submit the claim to Medicare. After Medicare makes payment, You may submit the claim to the Plan for payment.

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

SECTION THIRTEEN: QUESTIONS, PROBLEMS OR GRIEVANCES

Paramount's Member Service Department welcomes your questions from 8:00 A.M. to 5:00 P.M., Monday through Friday. The Member Service staff can be reached by calling 419-887-2531 or use our toll-free number 1-866-452-6128. You can contact us by e-mail at: member.services@promedica.org

If you call the Member Service Department after hours, you may leave a message and you will receive a return call on the next working day. You may also email us through the Paramount website at www.paramountinsurancecompany.com

The Member Service Department's goal is to help you with any questions about procedures, benefits, payment for services, enrollment, etc. We encourage you to call us with any questions. Paramount provides a TTY number for members who are hearing impaired. Paramount will also provide translation services for members who do not speak English. If a member needs foreign language translation services, he/she should call the Member Service 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.

1. How to Handle a Problem. If you have a problem or you are dissatisfied with any aspect of Paramount service, call or write the Member Services Department. (If you have a problem with one of Paramount's providers, we encourage you to first discuss the issue with the provider.) A Member Services Representative will attempt to resolve the problem informally. If we are not able to resolve the problem to your satisfaction, you may file a grievance.

2. Filing a Grievance.
Under Michigan Public Act 252 of 2000, a "grievance" means a complaint by the member concerning any of the following:

a) The availability, delivery, or quality of health care services, including a complaint regarding an adverse determination (denial) made by utilization review,

b) Benefits or claims payment, handling, or reimbursement for health care services,

c) Matters concerning the contractual relationship between a member and Paramount.

An **"adverse benefit determination"** eligible for internal grievance includes a denial, reduction, or termination of, or a failure to provide or make a payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make a payment that is based on:

- A determination of an individual's eligibility for coverage;
- A determination that a benefit is not a covered benefit;
- The imposition of a preexisting condition exclusion, source-of-injury exclusion, network exclusion, or other limitation on otherwise covered benefits;
- A determination that a benefit is experimental, investigational, or not medically necessary or appropriate; or
- Any rescission of coverage, whether or not there is an adverse effect on any particular benefit at that time.

As a member of Paramount, you have the right to file a grievance concerning adverse benefit determinations. You must file a grievance ***within 180 days*** of receiving notification of the adverse benefit determination. Paramount will conduct a review and will issue a written decision within:

Post Service Claims:	35 calendar days from receipt of the grievance
Pre-Service Claims:	30 calendar days from receipt of the grievance
Urgent Care Claims:	24 hours from receipt of the grievance

Paramount will notify you of a benefit determination, whether adverse or not, with respect to an urgent care claim as soon as possible, but not later than 24 hours from receipt of the grievance, unless you fail to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under your benefit plan. In addition, concurrent internal grievance and external review is allowed for claims involving urgent care or an ongoing course of treatment.

For grievances, you should follow the steps outlined below:

Internal Grievance – Level 1

If you have a problem, call or write the Member Services Department. A Member Services representative will try to resolve the problem or grievance within two (2) working days for urgent clinical issues and seven (7) calendar days for other problems. You will be advised of the disposition of your problem by telephone call or in writing. If the first level problem is not resolved to your satisfaction, you may appeal to Paramount orally or in writing.

Internal Grievance – Level 2

If the first level problem is not resolved to your satisfaction, you will be informed of your right to file an oral or written second level grievance with Paramount. A written grievance should be sent to the address below.

Paramount Insurance Company
Attention: Complaint/Appeals Department
1901 Indian Wood Circle
Maumee, Ohio 43537

You will receive an acknowledgement from Paramount within five (5) working days from receipt of your request. You will also be advised that you have the right to attend an informal hearing to present your appeal in person to the Internal Grievance Committee. The member may authorize in writing that any person, including but not limited to a physician, may act on his or her behalf at any stage in the grievance review. You may request free of charge from Paramount reasonable access to and copies of all pertinent documents, records and other information regarding your appeal.

If the service is being denied, reduced or terminated because of contract benefit limits, because the service is not covered under the contract or the case involves a membership or enrollment issue, the review will be conducted by the Internal Grievance Committee. Paramount will consult a clinical peer for this review, if it involves a clinical issue. A clinical peer is a physician or provider who has the same license as the provider who will perform the service. The clinical peer will review your medical records and determine if the service is medically necessary. The Internal Grievance Committee will base their decision on the clinical peer's determination.

If your medical condition requires a faster review (called an expedited grievance), Paramount must provide you with a response ***within 24 hours***. An expedited grievance applies if a grievance is submitted and a physician orally or in writing verifies that the time frame for a standard grievance would seriously jeopardize the life and health of the member or would jeopardize the member's ability to regain maximum functioning. In addition, concurrent expedited grievance and external review is allowed for claims involving urgent care or an ongoing course of treatment. If you wish to request an expedited grievance, you may call the Paramount office at 1-888-887-5101 or fax, 1-888-740-0222.

Rights on Grievance

In connection with your right to file a grievance on an adverse determination, you:

- may submit written comments, documents, records, and other information relating to the claim for benefits;
- may request free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits;
- will receive a review of the determination that takes 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;
- will receive a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appeal representative of Paramount who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor his or her subordinate;

- will receive a review from the 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;
- will receive a review 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;
- 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;
- will receive no reduction or termination of an ongoing course of treatment without advance notice from Paramount or an opportunity for advance review;
- 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 your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and
- will be deemed to have exhausted the internal appeals process and may initiate an external review if Paramount has failed to strictly adhere to all the requirements of the internal appeals process, regardless of whether Paramount asserts that it substantially complied with all requirements or that any error it committed was de minimis.

3. Additional Appeals. If Paramount denies your internal grievance, Paramount will provide you with written or electronic notification of the determination. The notification will tell you the specific reason(s) for the adverse determination, the specific plan provisions on which the benefit 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 your claim for benefits and a statement of your right to request a review by the Superintendent of Insurance, and external review and/or bring an action under section 502(a) of ERISA.

If your claim involves urgent care, the notice may be provided orally to you within the time frames for urgent care claims described above. A written or electronic notice will be furnished to you within 3 days after the oral notice.

Forms required to request an external review will be made available to you by Paramount and are available at the Office of Financial and Insurance Regulation website at www.michigan.gov/cis.

Office of Financial and Insurance Regulation
Consumer Services
P.O.Box 30220
Lansing, Michigan 48909-7720
1-877-999-6442

A. Instructions for Requesting an External Independent Review

Not later than 60 days after the date you receive a notice of an adverse determination or final adverse determination, you or your authorized representative may file a request for an external review with OFIR. If you request an external review, you will be required to authorize the release of any medical records that may be required to be reviewed for the purpose of reaching a decision on the external review.

If OFIR accepts the request for an external independent review, you will receive an acknowledgement from OFIR. (If OFIR does not accept the request, OFIR will notify you of the reason.) OFIR will select a state-approved independent review organization (IRO) to conduct a review. The IRO will review all pertinent records available and notify OFIR of its recommendation. OFIR will then review the recommendation and notify the member and Paramount of the OFIR decision.

B. Expedited External Reviews

You or your authorized representative may make a request for an expedited external independent review with OFIR ***within 10 days*** after receiving an adverse determination if both of the following are met:

1. The adverse determination involves a medical condition in which the timeframe for completion of an expedited internal grievance would seriously jeopardize the life or health of the member or would jeopardize the member's ability to regain maximum function as substantiated by a physician either orally or in writing.

2. The member or member's authorized representative has filed a request for an expedited internal grievance.

Denials on services that have already been received do not qualify for an expedited external review. If OFIR accepts the request for an expedited external independent review you will receive an acknowledgement from OFIR. OFIR will select a state-approved independent review organization (IRO) to conduct the expedited external review. The IRO will review all pertinent records available and notify OFIR of its recommendation. You will receive a final decision from OFIR within 72 hours from receipt of our request for an expedited external review.

4. Limitation on Legal Actions. You may not bring action in court against Paramount until you have exhausted all the applicable procedures described above. In no event may you bring an action in court against Paramount more than three (3) years after the occurrence upon which the legal action is based. If the occurrence that is the basis for the legal action concerns a denial of a claim, the occurrence will be the date of service if the service was in fact received.

SECTION FOURTEEN: REIMBURSEMENT/SUBROGATION

1. Reimbursement and Subrogation. Where a Covered Person has benefits paid by Paramount for the treatment of sickness or injury caused by a third party or the Covered Person, these are conditional payments that must be reimbursed by the Covered Person if the Covered Person receives compensation, damages or other payment as a result of the sickness or injury from any person, organization or insurer, including the Covered Person's own insurer, medical payments coverage, excess umbrella, uninsured and/or underinsured motorist insurance, or any other source (including the party causing sickness or injury). As an alternative to reimbursement by the Covered Person, Paramount may subrogate to the Covered Person's rights of recovery and remedies by joining in Covered Person's lawsuit, assigning its rights to Covered Person to pursue on Paramount's behalf, or bringing suit in Covered Person's name as subrogee. Paramount has reimbursement and subrogation rights equal to the value of medical benefits paid for Covered Services provided to the Covered Person. Paramount subrogation rights are a first party claim against any recovery and must be paid before any other claims, including claims by the Covered Person for damages. This means the Covered Person must reimburse Paramount in full, 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 in attorney's fees, costs or other expenses incurred by Covered Person.

2. Workers' Compensation/Non-Duplication. The benefits which You are entitled to receive under Paramount's insured plans do not duplicate any benefit to which You are entitled under Workers' Compensation laws or similar Employer liability laws. All sums paid for services provided to any Covered Person pursuant to Workers' Compensation are deemed to be assigned to Paramount.

3. Cooperation by Covered Persons. By executing an enrollment application, 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 Paramount or its nominee under this Section. You may not do anything which might limit, waive or release Paramount's reimbursement or subrogation rights.

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 FIFTEEN: PRESCRIPTION DRUG PROGRAMS

1. **Prescription Drug Benefits.** You may be enrolled in one or more of the following programs – Retail Pharmacy Program, Mail Order Pharmacy Program, Maintenance Drugs, Limited Medical Supplies, Specialty Drugs, Infertility Drugs, Sexual Dysfunction Drugs, Smoking Cessation Drugs and Contraception/Birth Control Drugs. Refer to your Schedule of Benefits for more details.

2. **Pharmacy Benefits Management.** Paramount uses a pharmacy benefits manager (PBM) to manage the benefits under the Prescription Drug Program. If you have Prescription Drug coverage as part of your Plan, the PBM is indicated on your Paramount identification card. The PBM has a national network of participating pharmacies referred to as Network Pharmacies. Your Drug Copay will be lower if you use a Network Pharmacy. See #8, "How to Obtain Prescription Drug Benefits".

3. **Drug Formulary.** A Drug Formulary is a listing of Prescription Drugs established by Paramount's Pharmacy & Therapeutics Working Group (P & T). A Drug Formulary may be managed as "modified open" or "open" based upon the benefit design selected by the Employer. An open Drug Formulary provides benefits for all covered Prescription Drugs. A modified open Drug Formulary provides benefits only for specific Prescription Drugs on the closed Drug Formulary. Your specific Drug Formulary is indicated on your Schedule of Benefits.

   If it is Medically Necessary for you to take a Prescription Drug that is not on the closed formulary, your doctor must first have it approved through Paramount. Your Physician must document in Your medical record and certify that the Prescription Drug on the modified open formulary has been ineffective in the treatment for Your disease or condition. Or, Your Physician must document in Your medical record that he or she reasonably expects a Prescription Drug on the modified open formulary to cause You a harmful or adverse reaction. Your Physician must call (419) 887-2520 or toll-free 1-800-891-2520 for prior authorization. Questions regarding your specific Drug Formulary may be answered by calling the Paramount Member Services Department. Information on the Prescription Drug Program is also available on the Paramount website at: www.paramountinsurancecompany.com

4. **Generic Drugs.** To get the greatest savings on Prescription Drugs, it's important to request a Generic Drug, when available, instead of a Brand Name Drug.

5. **Drug Deductible and Drug Copayments/Coinsurance.** The Prescription Drug Program requires that you pay a Drug Deductible and Drug Copayments or Coinsurance. The Drug Deductible is the amount You are required to pay for covered Prescription Drugs in a calendar year before Paramount begins paying for Prescription Drugs. With the exception of Limited Medical Supplies and Specialty Drugs, all drug benefits are subject to the Drug Deductible. The Drug Deductible for your Plan is stated on Your Schedule of Benefits.

   The Drug Copayment is a fixed dollar amount and the Drug Coinsurance is a percentage of the Prescription Drug cost for which You are responsible. The Drug Copayment/Coinsurance for Your Plan is stated on Your Schedule of Benefits.

   The amount You pay for Drug Deductibles and Drug Copayments/Coinsurance under any benefit of a Prescription Drug Program does not count toward Your Maximum Choice Deductible, Coinsurance Out-of-Pocket Limit, or Maximum Lifetime Benefit.

   Your Drug Copayments/Coinsurance will not be reduced by any discounts or rebates received by Paramount or PBM.

6. **Maximum Drug Benefit.** The maximum amount Paramount will pay for Your Prescription Drugs in a calendar year. No additional benefits for Prescription Drugs will be provided after You have received the Maximum Drug Benefit and/or the Maximum Lifetime Benefit stated in the Schedule of Benefits. With the exception of Limited Medical Supplies and Specialty Drugs, all Prescription Drug benefits count toward Your Maximum Drug Benefit.

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

8. **How to Obtain Prescription Drug Benefits.** If you have the Retail Pharmacy Program, show your Paramount identification card to the pharmacist when purchasing Prescription Drugs and certain over-the-counter medications approved by Paramount. If you use a Network Pharmacy, you will be responsible for your Drug Copay and the pharmacist will submit your claim electronically to the PBM.

   If you use a Non-Network Pharmacy, you will have to pay the full price of the Prescription Drug to the Non-Network Pharmacy. You will have to submit your itemized receipt to Paramount for reimbursement. Paramount or the PBM will reimburse you **50% of the benefit available, less the applicable Drug Deductible and Copay.** You must send an original, itemized pharmacy receipt to Paramount within ninety (90) days to receive reimbursement. Refer to Section Three, #4, Filing Claims for additional information.

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

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

    A. **Limited Medical Supplies** - Asthma and other supplies subject to Copayment/Coinsurance stated in the Schedule of Benefits. The supplies covered under the Limited Medical Supplies benefit include:
       - Peak expiratory flow rate meter (hand-held)
       - Spacers for metered dose inhaler
       - Masks and tubing for nebulizers
       - Limited ostomy supplies
       - Diaphragms

    B. **Specialty Drugs** - Specialty Drugs are complex Prescription Drugs as determined by Paramount's P & T (refer to Specialty Drug List) used to treat chronic conditions. These drugs are self-administered as injectable/infused or oral drugs and often require special handling and monitoring. Specialty Drugs are subject to a Specialty Drug Deductible, Specialty Drug Copay/Coinsurance, Specialty Drug Out-of-Pocket Copay Limit and Specialty Drug Maximum Lifetime Benefit stated in the Schedule of Benefits. The Specialty Drug Deductible is the amount You are required to pay for covered Specialty Drugs in a calendar year before Paramount begins paying for Specialty Drugs. The Specialty Drug Copay Out-of-Pocket Limit is the maximum amount of Specialty Drug Copays You pay every calendar year. The Maximum Lifetime Specialty Drug Benefit is the maximum amount Paramount will pay for Your Specialty Drugs during Your lifetime. No additional benefits for Specialty Drugs will be provided after You have received the Specialty Drug Lifetime Maximum Benefit and/or the Maximum Lifetime Benefit stated in the Schedule of Benefits. The Prescription Drugs under the Specialty Drug option are subject to prior authorization.

    C. **Infertility Drugs** - Prescription Drugs for the treatment of infertility are subject to the Drug Deductible, Infertility Copay or Coinsurance, Infertility Drug Limit and Maximum Drug Benefit stated in the Schedule of Benefits.

D. Sexual Dysfunction Drugs - Prescription Drugs for the treatment of sexual dysfunction are subject to Drug Deductible, Drug Copay or Coinsurance, applicable quantity limits and Maximum Drug Benefit stated in the Schedule of Benefits.

E. Smoking Cessation Drugs - Prescription Drugs and over-the-counter medications for smoking cessation are subject to Drug Deductible, Drug Copay or Coinsurance, applicable limits and Maximum Drug Benefit stated in the Schedule of Benefits.

F. Contraceptive/Birth Control Drugs - Prescription Drugs for contraception and birth control are subject to Drug Deductible, Drug Copay or Coinsurance and Maximum Drug Benefit stated in the Schedule of Benefits.

11. Covered Drug Benefits:

- Federal Legend Drugs – medicinal substances, which bear the legend "Federal Law Prohibits Dispensing Without a Prescription."
- State Restricted Drugs – medicinal substances that may be dispensed only by prescription according to state law.
- Over-the-Counter drugs approved by Paramount.
- Compounded medications are covered when billed electronically to PBM by a Network Pharmacy. The compound must include at least one federal legend drug with a valid NDC number.

14. Prescription Drug Exclusions;

- Therapeutic devices, some prescription contraceptive devices (i.e., IUD); support garments; and other supplies or substances which may be obtained without a prescription.
- Prescriptions Drug or Refills either in excess of the number prescribed by the physician or those dispensed more than one (1) year after the physician's order.
- Dietary supplements and some Prescription vitamins (other than prenatal vitamins).
- Prescription Drugs used for cosmetic purposes such as: drugs used to decrease wrinkles, drugs to promote hair growth, drugs to control perspiration.
- Prescription Drugs for the amount dispensed (days supply or quantity limit) that exceeds the supply limit.
- Drugs that do not require a prescription for dispensing known as "Over-the-Counter" drugs unless approved by Paramount.
- Any drugs that are labeled as experimental, investigational or unproven.
- Prescription Drugs used to enhance athletic performance.
- Compounded medications in which the active ingredients do not require a Prescription Order or Refill. Paramount will not pay any preparation fee for compounded medications.
- Prescription Drugs requiring prior authorization that are dispensed without approval.
- Any Prescription Drug which is determined to have been abused or otherwise misused by a Covered Person.
- Any claim for Prescription Drug(s) submitted to Paramount or the PBM for reimbursement more than one (1) year from the date the Prescription Drug was dispensed will not be eligible for reimbursement.
- 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 charge is made.
- Prescription Drugs that are prescribed, dispensed or intended for use while you are an inpatient in a hospital or skilled nursing facility.
- Prescription Drugs related to in vitro fertilization, embryo transplant services, GIFT, ZIFT and zygote transfer.
- Prescription Drugs not approved under a modified open Formulary.

SECTION SIXTEEN: MISCELLANEOUS PROVISIONS

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

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 may be brought to recover under this Plan prior to the expiration of 60 calendar days after a claim for benefits has been filed as required by this Certificate of Coverage. Also, no such action may be brought after 3 years from the expiration of the time within which a claim for benefits is required by this Certificate of Coverage.

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

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

13. Qualified Medical Child Support Orders. Paramount will comply with all valid medical child support orders (QMCSOs) that 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 3 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 3 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).

DEFINITIONS

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

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

Biologically Based Mental Illness - Biologically Based Mental Illness as defined by ORC 3923.281, (A), (1) means schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder and panic disorders as these terms are defined in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders(DSM)* published by the American Psychiatric Association.

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

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

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

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

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

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

Copay/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 office visits and other fixed dollar Copayments do not count toward the Out-of-Pocket Maximum.

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.

Creditable Coverage - Coverage under one or more of the following: an Employer or union sponsored health benefit plan, a health insurer, a health maintenance organization, Medicare, Medicaid, a medical and dental plan for members (and certain former members) of the uniformed services, a medical program of the Indian Health Service or a tribal organization, a state health benefits risk pool, the Federal Employees Health Benefits Program, a public health plan, State Children's Health Insurance Programs, coverage provided by a foreign country or a health plan through the Peace Corps.

Creditable Coverage does not include coverage for accidents only, disability income, liability or supplemental liability insurance, workers' compensation insurance, automobile medical payment insurance, credit-only insurance, on-site medical clinics, limited scope dental insurance, limited scope vision insurance, limited scope long term care insurance, benefits that do not coordinate, Medicare supplemental insurance, CHAMPUS supplemental programs, and other supplemental coverage.

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

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.

Eligible Cancer Clinical Trial means a cancer clinical trial that meets all of the following criteria:

(a) A purpose of the trial is to test whether the intervention potentially improves the trial participant's health outcomes.

(b) The treatment provided as part of the trial is given with the intention of improving the trial participant's health outcomes.

(c) The trial has a therapeutic intent and is not designed exclusively to test toxicity or disease pathophysiology.

(d) The trial does one of the following:
  (i) Tests how to administer a health care service, item, or drug for the treatment of cancer;
  (ii) Tests responses to a health care service, item, or drug for the treatment of cancer;
  (iii) Compares the effectiveness of a health care service, item, or drug for the treatment of cancer with that of other health care services, items, or drugs for the treatment of cancer;
  (iv) Studies new uses of a health care service, item, or drug for the treatment of cancer.

(e) The trial is approved by one of the following entities:
  (i) The national institutes of health or one of its cooperative groups or centers under the United States department of health and human services;
  (ii) The United States food and drug administration;
  (iii) The United States department of defense;
  (iv) The United States department of veterans' affairs.

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.

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. 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.

Experimental, Investigational or Unproven Medications or Therapies - Experimental, investigational or unproven medications or therapies are medications or therapies that are 1) not yet approved by the FDA to be lawfully marketed for the proposed use and not demonstrated through prevailing peer-reviewed medical literature to be safe and effective for treating and diagnosing the condition, illness or diagnoses for which its use is proposed; and 2) subject to review and approval by an institutional review board for the proposed use; and 3) the subject of an ongoing clinical trial that meets the definition of Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight; and/or 4) at the exclusive discretion of Paramount.

Federally Eligible Individual - Any individual:

(1) Who has at least 18 months of Creditable Coverage; however, if Your coverage otherwise eligible to be counted as Creditable Coverage was followed by a Significant Break in Coverage, such coverage will not be counted in determining Creditable Coverage. For the purposes of this definition only, a "Significant Break in Coverage" means a continuous period of 63 calendar days or more without Creditable Coverage;

(2) Whose most recent prior Creditable Coverage was under or in connection with a group health plan, governmental plan, or church plan;

(3) Who is not eligible for coverage under any other group health benefit plan, Medicare, or Medicaid;

(4) Who does not have any other health insurance coverage;

(5) Whose most recent coverage was not terminated for nonpayment of premiums or fraud; and

(6) Who has elected and exhausted any applicable COBRA continuation coverage or continuation coverage under any similar state program.

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

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

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

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

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

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

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

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

Maximum Lifetime Benefit - The maximum dollar amount Paramount will pay for Covered Services during Your lifetime. The benefits paid for Covered Services received from In-Network or Out-of-Network Providers will be counted toward Your Maximum Lifetime Benefit. No additional Covered Services will be provided to You after You have received Your Maximum Lifetime Benefit. See Your Schedule of Benefits for the Maximum Lifetime Benefit amount that applies to You and Your dependents.

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

Medically Necessary - Any service or supply that meets all of the following criteria;

(1) It is provided by a Physician, Hospital, or other Provider under the Plan and is consistent with the diagnosis or treatment of the patient's sickness or injury. Certain routine and preventive health care services and supplies will be considered needed and appropriately provided for medical care only if they are included in the list of Covered Services and supplies;

(2) The prevailing opinion within the appropriate specialty of the United States medical profession is that it is safe and effective for its intended use, and that its omission would adversely affect the patient's medical condition;

(3) It is furnished by a Provider with appropriate training, experience, staff and facilities for the administering of the particular service or supply;

(4) It must be the appropriate supply or level of service which can be safely provided to the patient; and with regard to a person who is an Inpatient, it must mean the patient's illness or injury requires that the service or supply cannot be safely provided to that person on an Outpatient basis;

(5) It must not be primarily for the convenience of the patient or Provider;

(6) It must not be scholastic, vocational training, educational or developmental in nature, or experimental or investigational; and

(7) It must not be provided primarily for the purpose of medical or other research.

In the case of a Mental Disorder or Illness, Medically Necessary additionally means that a service or supply:

(1) meets national standards of mental health professional practice (psychiatry, clinical psychology, clinical social work): and
(2) reasonably can be expected to improve or prevent further deterioration of the patient's condition or level of functioning.

The fact that a patient's Physician has ordered a particular treatment or supply does not make it Medically Necessary under terms of the Plan.

Among the factors used in determining medical necessity are: (1) published reports in authoritative medical literature; (2) regulations, reports, publications or evaluations issued by government agencies such as the Agency for Health Care Policy and Research, the National Institutes of Health and the Food and Drug Administration (FDA); (3) listings in drug compendia such as *The American Medical Association Drug Dispensing Information;* and (4) other authoritative medical sources to the extent the Claims Administrator determines it necessary. The presence of 1 through 3 will not automatically result in a determination of medical necessity if Paramount determines one or more of the seven requirements listed above has not been met.

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

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

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

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

Non-Biologically Based Mental Illness - Non-biologically Based Mental Illness means mental illnesses that are defined in the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* and are not Biologically Based Mental Illnesses.

Non-Contracting Amount (NCA) – The maximum amount determined as payable and allowed by Paramount for a Covered Service provided by an Out-of-Network Hospital Provider in Lucas County.

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 - After that amount has been paid, there will be no additional payments required for Coinsurance during the remainder of that 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 - A legally qualified person acting within the scope of his or her license and holding the degree of Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.).

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

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

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

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

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 in this Certificate for details.

Provider - A person or organization responsible for furnishing health care services, including a: Hospital, Skilled Nursing Facility, Physician, Doctor of Podiatry (D.P.M.), Licensed Psychologist, Certified Nurse Midwife acting within the scope of her or her license, under the direction and supervision of a licensed Physician; Licensed Physician Therapist (L.P.T.); Licensed Occupational Therapist (L.O.T.); Licensed Speech Therapist (L.S.T.); Licensed Optometrist; Certified Mechanotherapist acting within the scope of his or her license, and performing services ordered by a Physician; Professional Clinical Counselor; Professional Counselor; or Independent Social Worker.

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.

Usual, Customary and Reasonable (UCR) Charges – Charges for hospitals, except for those located in Lucas County, 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.

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.

You, Your, Yourself - Refers to a Covered Person.

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Affiliate of ProMedica

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