



PARAMOUNT



**HMO Individual Exchange
Member Handbook and
Evidence of Coverage
Provided by: Paramount Insurance Company**

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.

Welcome!

**HMO Individual Exchange
Member Handbook and
Evidence of Coverage**

Provided by:



PARAMOUNT
Insurance Company

PARAMOUNT INSURANCE COMPANY

P. O. Box 928

Toledo, Ohio 43697-0928

419-887-2500

Member Services: 419-887-2525

EVIDENCE OF COVERAGE SPECIFICATIONS

RATE PERIOD: _____ **THRU:** _____

PREPAYMENT DUE: BY THE FIRST DAY OF EACH MONTH FOR WHICH COVERAGE IS OFFERED.



Our Mission
is to improve
your health
and well-being.

Your health. Our mission.

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I. WELCOME TO PARAMOUNT

Welcome to Paramount Insurance Company (Paramount), a health maintenance organization (HMO) licensed in Ohio. We are pleased that you have selected our Health Plan. Paramount Members are entitled to a wide range of health care services. The information contained in this Handbook will help you become familiar with the Health Plan. This will enable you to use your benefits most effectively.

The Primary Care Provider you selected when you joined Paramount will assist you as you seek medical care. **EXCEPT FOR EMERGENCY MEDICAL CONDITIONS and OB/GYN CARE, ALWAYS REMEMBER TO CONTACT YOUR PRIMARY CARE PROVIDER FIRST IF YOU NEED MEDICAL CARE.**

This Member Handbook and Evidence of Coverage contains detailed information regarding eligibility, procedures and benefits. Please take a few minutes to read it.

Paramount offers the following exchange options in the individual market:

- Bronze
- Silver
- Gold
- Catastrophic

If you have any questions, or if you require assistance, please feel free to call:

**Member Service Department
(419) 887-2525
Toll-Free 1-800-462-3589
TTY (419) 887-2526
TTY Toll-Free 1-888-740-5670
Monday through Friday
8:00 A.M. to 5:00 P.M.**

II. YOUR MEMBERSHIP CARD

Every Paramount Member receives a Paramount identification card with his or her name. The name of that person's Primary Care Provider (PCP) is on the card.

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

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

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

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

III. YOUR PRIMARY CARE PROVIDER (PCP)

When you enrolled in Paramount, you selected a Primary Care Provider (PCP) for yourself, and for each Member of your family. Your PCP will coordinate your medical care with other Participating Providers in the Paramount network. Female Members may receive OB/GYN care from a participating obstetrics/gynecology specialist without Prior Authorization from the Primary Care Provider. Prior Authorization is required for certain procedures or services. It is the responsibility of the Participating Provider to obtain Prior Authorization from Paramount in advance of these procedures or services.

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

A directory of Participating Providers is also available at: www.paramountinsurancecompany.com.

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

For doctor appointments, call your PCP's office.

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

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

ACCESS STANDARDS for MEDICAL HEALTH CARE SERVICES	
Type of Care Required	Recommended Lead Time
Routine assessments, physicals or new visits	30 days
Routine follow-up visits (for recurring problems related to chronic ailments like high blood pressure, asthma, diabetes, etc.)	14 days
Symptomatic, non urgent (cold, sore throat, rash, muscle pain, headache)	2 - 4 days
Urgent medical problems (unexpected illnesses or injuries requiring medical attention soon after they appear; urgent care problems are not permanently disabling or life-threatening; an example would be a persistent high fever)	1 - 2 days
Emergency Medical Conditions (such as heart attack, stroke, poisoning, loss of consciousness, inability to breathe, uncontrolled bleeding and convulsions)	Immediately call 911 or seek medical treatment. Call your physician and/or Paramount within 24 hours, or as soon as possible.

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

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

After Hours Care

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

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

When your doctor recommends a treatment or test, in most cases it will be covered. However, some treatments may not be covered or are covered only when authorized in advance by Paramount. Your doctor may be working with several Paramount plans, the service your doctor recommends for you may be covered under some similar plans, but not under your particular plan.

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

IF YOU HAVE A QUESTION about whether a service is covered, you can find out by calling Member Services. If you do not have Prior Authorization before you get the services, you may be held responsible for total payment.

If another doctor is covering for your Primary Care Provider during off-hours or vacation, you do not need Paramount Prior Authorization before you see that doctor. But be sure to tell the doctor you are a Member of Paramount.

You may change your Primary Care Provider. You must notify Paramount first, before you see any new Primary Care Provider. Call the Member Services Department or email through the Paramount web site at: www.paramountinsurancecompany.com. The change can be made effective the day you call. You will receive a new identification card with your new physician's name. If you need to see the doctor before your card arrives, your doctor can call Member Services to check your membership.

What to Consider When Selecting a Physician or Hospital

If you need specific information about the qualifications of any participating physicians, you may call the Academy of Medicine, the Member Services Department or you may use the on-line Provider Directory available through our web site at www.paramountinsurancecompany.com with links to the Ohio State Medical Association.

The following qualifications are important to consider in selecting a Primary Care Provider or specialist:

- Professional education – medical school/residency training,
- Current Board Certification status,
- Number of years in practice and
- Languages spoken

The following qualifications are important when selecting a hospital:

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

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

Obstetrical/Gynecological Care

You do not need Prior Authorization from Paramount or from any other person (including your PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in the Paramount network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining Prior Authorization for certain services or following a pre-approved treatment plan. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Paramount Member Services at (419) 887-2525 or toll-free 1-800-462-3589. A directory of Participating Providers is also available at: www.paramountinsurancecompany.com.

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

IV. SPECIALIST CARE

Most of your health care needs can and should be handled by your Primary Care Provider. If your Primary Care Provider believes you need to see a specialist - a cardiologist, orthopedist or others - your Primary Care Provider will recommend a Participating Specialist. Or you may choose the Participating Specialist you wish to see from those listed in the Participating Physicians and Facilities directory (also available on the website) and make an appointment.

Newly enrolled Members of Paramount who are already seeing a specialist should verify that the specialist is participating with Paramount.

Prior Authorizations

If a medically necessary covered service or procedure is not available from any Participating Providers, Paramount will make arrangements for an “out-of-plan Prior Authorization”. Your Primary Care Provider must request an “out of plan Prior Authorization” in advance. Consultations with Participating Specialists will be required before an “out-of-plan Prior Authorization” can be considered. If Paramount approves the “out-of-plan Prior Authorization”, written

confirmation will be sent to you, your PCP and the non-participating provider. All eligible authorized services will be covered subject to appropriate Deductible and Copayments/Coinsurance.

If you have a life-threatening, degenerative or disabling condition that requires the services of a Participating Specialist over a long period of time, you should discuss this with your Primary Care Provider. If your Primary Care Provider and the Specialist agree that your condition requires the coordination of a Specialist, your PCP will contact Paramount. Together, you, your PCP, your Specialist and Paramount will agree on a treatment plan. Once this is approved, the specialist will be authorized to act as your Primary Care Provider in coordinating your medical care.

Utilization Management

Participating physicians and providers have direct access to Paramount's Utilization Management Department to authorize specific procedures and certain other services based on Medical Necessity. It is the responsibility of the Participating Provider to obtain Prior Authorization when required. If you experience an Emergency Medical Condition after normal office hours, you should call 911, an ambulance or rescue squad or go to the nearest medical facility. You may also call the Member Services number on the back of your I.D. Card at (419) 887-2525 or Toll-Free 1-800-462-3589 24 hours/7 days per week for information as to where and how health care services may be obtained. You do not need to obtain prior approval from your PCP or Paramount. Afterward, you should notify your Primary Care Provider that you were treated.

Utilization management decisions are not subject to incentives to restrict or deny care and services. In fact, Paramount monitors under-utilization of important preventive services, health screening services (immunizations, pap tests, etc.), medications and other services to care for chronic conditions, such as asthma and diabetes. Paramount will send reminder cards to the Member and physician if a claims review suggests that important services were missed.

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

Initial Determinations

When Prior Authorization is required, Paramount will make a decision within two (2) working days from obtaining all the necessary information about the admission, or procedure that requires Prior Authorization. Paramount will advise the provider of the decision within three (3) working days after making the decision.

If Paramount makes an adverse determination (i.e., denies approval or coverage), Paramount will notify the requesting provider in writing or electronically within three (3) working days after making the decision.

Concurrent Reviews

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

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

Retrospective Reviews

Paramount will make a decision within twenty-five (25) calendar days after receiving all necessary information on retrospective reviews. Paramount will notify the provider and the Member in writing.

If Paramount makes an adverse determination, Paramount will notify the provider and the Member in writing within five (5) calendar days from making the decision.

Expedited Appeals

If the seriousness of the Member's medical condition requires an expedited appeal, Paramount will make the decision as expeditiously as the medical condition requires but no later than twenty-four (24) hours after the request has been made. Paramount will provide written confirmation of the decision within twenty-four (24) hours of receipt of the request, if the initial decision was not in writing.

Adverse Determinations

Paramount's written notification will include the principal reasons for the decision and instructions for requesting a written statement of the clinical rationale used to make the decision. Paramount will provide a written statement of the clinical rationale to any person making the request and following the instructions.

Obtaining Necessary Information

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

V. CHANGE IN PROVIDER STATUS

If your Primary Care Provider or any Participating Hospital can no longer provide medical services because their Paramount agreement ends, we will notify you in writing within thirty (30) days. We will cover all eligible services they provide between the date of termination and five (5) business days from the date on the postmark.

If you are being seen regularly by a Participating Specialist or a specialty group whose agreement with Paramount ends, you and your PCP will be notified. You may contact a new Participating Specialist for an appointment.

VI. URGENT CARE AND EMERGENCY SERVICES

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

- Colds and cough, sore throat, flu
- Earache
- Persistent high fever
- Minor cuts where bleeding is controlled

- Sprains
- Sunburn or minor burn
- Skin rash

Urgent Medical Conditions should be treated by your Primary Care Provider (PCP) or, in the event your PCP is not available, in a participating urgent care facility. You should not go to a hospital emergency room for Urgent Medical Conditions. Services received in a hospital emergency room for an Urgent Medical Condition without prior direction from your PCP, a participating Paramount physician or Paramount are not covered

What to do:

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

Participating providers are listed in your Directory of Participating Physicians and Facilities or the Paramount web site at www.paramountinsurancecompany.com.

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

Outside the Service Area: **Call your Primary Care Provider** first and explain your condition. If you cannot call your PCP, go to the nearest urgent care or walk-in clinic. The service will be subject to a Coinsurance. Your Coinsurance may be found in your Summary of Benefits.

Follow-up care within the Service Area: Your Primary Care Provider will coordinate what care you need after your Urgent Care Services.

Follow-up care outside the Service Area: Follow-up services outside the Paramount Service Area will not be covered unless authorized by your Primary Care Provider and Paramount in advance.

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

Emergency Services

Emergency Services that are required as the result of an Emergency Medical Condition are covered at any medical facility, anytime, anywhere **without Prior Authorization**. There will be Coinsurance, which would be shown in your Summary of Benefits.

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

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

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

Emergency Services means the following:

1. 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;
2. Such further medical examination and treatment that are required by federal law to *stabilize* an Emergency Medical Condition and are within the capabilities of the staff and facilities available at the hospital, including any trauma and the burn center of the hospital.

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

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

Paramount will cover Emergency Services provided at participating facilities. Your Plan covers Emergency Services for an Emergency Medical Condition treated in any hospital emergency department. Paramount will cover Emergency Services at nonparticipating facilities when one of the following situations occurs:

1. Due to circumstances beyond the Member's control, the Member was unable to utilize a participating facility without serious threat to life or health.
2. A prudent layperson with an average knowledge of health and medicine would reasonably believe that the time required to travel to a participating facility could result in one or more adverse health consequences described under Emergency Medical Condition above.
3. A Paramount representative refers the Member to an emergency room and does not specify a participating emergency room.
4. An ambulance takes the Member to a non-participating facility other than at the direction of the Member.
5. The Member is unconscious.
6. A natural disaster prevented the use of a participating facility.
7. The status of a participating emergency facility changed to a non-participating emergency facility and Paramount did not inform the Member of the change.

The determination as to whether or not an **Emergency Medical Condition** exists in accordance with the definition stated in this section rests with Paramount. Examples of **Emergency Medical Conditions** include: heart attack, stroke, poisoning, loss of consciousness, inability to breathe, uncontrolled bleeding and convulsions. Paramount may determine that other similarly acute conditions are also **Emergency Medical Conditions**.

What to do:

Inside the Service Area: In the event of an **Emergency Medical Condition**, call 911, an ambulance or rescue squad or go directly to the nearest medical facility. In the event you are unsure about whether a condition is an **Emergency Medical Condition**, you may contact your Primary Care Provider for instructions. Medical care is available through Paramount Physicians seven (7) days a week, 24 hours a day. Paramount will cover Emergency Services from non-Participating Providers inside the Service Area related to Emergency Services. Coinsurance will be applicable.

Afterward, you should contact your Primary Care Provider for advice on follow-up care.

Outside the Service Area: Call 911, an ambulance or rescue squad or go to the nearest emergency facility for treatment. Show your Paramount card. In some cases, you may be required to make payment and seek reimbursement from Paramount. Paramount will cover Emergency Services from non-Participating Providers outside the Service Area related to Emergency Services. Coinsurance will be applicable.

Follow-up care within the Service Area: your Primary Care Provider must arrange follow-up medical care with Participating Providers.

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

If you are admitted to a hospital outside the Paramount Service Area, you or your authorized representative must call Paramount within 24 hours or as soon as reasonably possible, or the services may not be covered. Follow-up care must be coordinated through your Primary Care Provider.

The Paramount Service Area

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

VII. HOSPITAL ADMISSIONS

Your Primary Care Provider or Participating Specialist will make the arrangements when you need hospital care. Paramount Participating Hospitals are listed in your *Participating Physicians and Facilities* directory or the Paramount web site at www.paramountinsurancecompany.com. Present your I.D. card when you are admitted.

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

An emergency admission to a Non-Participating Hospital must be called in to Paramount within 24 hours (or as soon as reasonably possible) or your hospital care may not be covered. If and when your medical condition allows, your Primary Care Provider and Paramount may arrange for you to be transferred to a Participating Hospital.

VIII. DEDUCTIBLE, COPAYMENTS (COPAYS)/COINSURANCE AND OUT-OF-POCKET MAXIMUM

Your share in the cost of Covered Services may include a Deductible, Copayment, and Coinsurance as shown in the Summary of Benefits.

Aggregate Deductible. The amount You and Your Dependents must pay for Covered Services including Prescription Drugs within a calendar year, before any benefits will be paid by the Plan. If You have single coverage (self only), the single Deductible is the amount You must pay. If You have family coverage (two or more covered family members), the family Deductible is the total amount any one or more covered family members must pay. Preventive Health Services are not subject to the Deductible on all four (4) plan options Catastrophic, Bronze, Silver and Gold.

Embedded Deductible. The amount You and Your Dependents must pay for Covered Services within a calendar year, before any benefits will be paid by the Plan. The single Deductible is the amount each Covered Person must pay. The family Deductible is the total amount any **two** or more covered family members must pay. Preventive Health Services are not subject to the Deductible on all four (4) plan options Catastrophic, Bronze, Silver and Gold.

See your Summary of Benefits for the type of Deductible and Deductible amount under your Plan.

Catastrophic Plan Option: The first three (3) Primary Care Provider office visits for a Member covered by the Paramount Catastrophic Health Plan are not subject to the Deductible. Expenses incurred for Covered Services including prescription drugs apply to a combined medical and prescription drug Deductible.

Bronze Plan Option: Expenses incurred for Covered Services including prescription drugs apply to a combined medical and prescription drug Deductible.

Silver Plan Option: Primary Care Provider office visits, pre/postnatal visits and Urgent Care Services provided for Members covered by the Silver Health Plans are not subject to the Deductible. Prescription Drug expenses may be subject to a separate prescription drug deductible.

Gold Plan Option: Primary Care Provider office visits, pre/postnatal visits and Urgent Care Services provided for Members covered by the Gold Health Plans are not subject to the Deductible. Prescription Drug expenses are subject to a separate prescription drug deductible.

Paramount members pay Copayments (copays) or Coinsurance for certain Covered Services such as: office visits and services, inpatient services (services you receive while a patient in a hospital or other medical facility), outpatient medical services, Emergency Services, laboratory and radiology services. See your Summary of Benefits for Copayments/Coinsurance due for specific Covered Services. Copayments are payable at the time you receive services and do not apply toward your Deductible.

The **Out-of-Pocket Maximum** is the maximum amount of Copayments and Coinsurance including the Medical and Prescription Deductible(s) you pay every Calendar Year. Once the Out-of-Pocket Maximum is met, there will be no additional Copayments and Coinsurance. The Out-of-Pocket Maximum is stated in your Summary of Benefits. The single Out-of-Pocket Maximum is the amount each Member must pay, and the family Out-of-Pocket Maximum is the total amount any two or more covered family members must pay.

IX. PROVIDER REIMBURSEMENT

You should always show your Paramount I.D. card to all providers. You are responsible for paying any office visit Copayments at the time you receive services. Participating Providers must notify Paramount of the services rendered.

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

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

Paramount will send reimbursement directly to Participating Providers for Covered Services. In most cases, reimbursement for Covered Services will be sent directly to a non-Participating Provider, but instead may be paid directly to you. Claims are processed within 30 days from receipt of a fully completed claim. If any claim is denied,

Paramount will send you an “Explanation of Benefits” with the reason for the denial. If you receive a denial on a claim and need further explanation or wish to appeal the denial, you may call the Member Services Department for assistance. The appeal process is also described in Section XVII of this Handbook.

Non-Covered Services If you receive services that are not covered under your benefit plan, you are responsible for full payment to the provider of those services.

X. MEMBERS' RIGHTS AND RESPONSIBILITIES

Members' Rights

As a Member of Paramount, you have certain rights you can expect from Paramount and Paramount providers. You have the right to:

1. Receive information about Paramount, its services, providers and your rights and responsibilities.
2. Participate with your physicians in decision-making regarding your health care.
3. A candid discussion of appropriate or Medically Necessary treatment options for the conditions regardless of cost or benefit coverage.
4. Voice complaints or appeals about the Health Plan or care provided.
5. Be treated with respect, recognition of your dignity and the need for privacy.
6. Make recommendations regarding Paramount’s Member rights and responsibilities policies.

Members' Responsibilities

As a Member of Paramount, you have certain responsibilities that Paramount and Paramount providers can expect from you. You have the responsibility to:

1. Provide to the extent possible information that Paramount and the Participating Providers need to care for you. Help your PCP fill out current medical records by providing current prescriptions and your previous medical records.
2. Engage in a healthy lifestyle, become involved in your health care and follow the plans and instructions for the care that you have agreed on with your PCP or specialists.
3. Understand your health problems and participate in developing mutually agreed-upon treatment and goals to the degree possible.

XI. COVERED SERVICES

This section describes the Covered Services available under your Health Plan benefits when provided and billed by Participating Providers. To receive maximum benefits for Covered Services, care must be received from a Primary Care Provider (PCP), Participating Specialist or another Participating Provider, except for Emergency Services. Services which are not received from a Participating Provider or approved with a Prior Authorization will be considered a

non-covered service, except as specified above. The amount payable for Covered Services varies depending on the type of Participating Provider providing care.

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

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

Ambulance Services

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

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

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

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

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

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

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

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

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

Behavioral Health Services

Services for a Biologically and/or Non-Biologically based mental illness are covered for inpatient and outpatient care subject to the same Deductible, Copayments and/or Coinsurance as any other physical disease or condition.

Covered Services include but are not limited to:

- **Inpatient services** – individual or group psychotherapy, psychological testing, family counseling with family members to assist in your diagnosis and treatment, convulsive therapy including electroshock treatment or convulsive drug therapy.
- **Partial hospitalization** - an intensive structured setting providing 3 or more hours of treatment or programming per day or evening, in a program that is available 5 days a week. The intensity of services is similar to Inpatient settings. Skilled nursing care and daily psychiatric care (and Substance Abuse care if the patient is being treated in a partial hospital Substance Abuse program) are available, and treatment is provided by a multidisciplinary team of Behavioral Health professionals.
- **Intensive Outpatient treatment or day treatment** - a structured array of treatment services, offered by practice groups or facilities to treat Behavioral Health Conditions. Intensive Outpatient Programs provide 3 hours of treatment per day, and the program is available at least 2-3 days per week. Intensive Outpatient Programs may offer group, DBT, individual, and family services.
- **Outpatient treatment**, or individual or group treatment - office-based services, for example Diagnostic evaluation, counseling, psychotherapy, family therapy, and medication evaluation. The service may be provided by a licensed mental health professional and is coordinated with the psychiatrist.

Two (2) days of partial hospitalization treatment or intensive Outpatient treatment are the equivalent of one (1) day as an Inpatient.

Non-Covered Behavioral Health Services (please also see Section XII Non Covered Services/Exclusions of this Handbook)

- **Residential Treatment services.** Residential treatment means individualized and intensive treatment in a residential setting, including observation and assessment by a psychiatrist weekly or more frequently, an individualized program of rehabilitation, therapy, education, and recreational or social activities.
- **Custodial or Domiciliary Care.**
 - Supervised living or halfway houses.
 - Room and board charges unless the treatment provided meets our Medical Necessity criteria for Inpatient admission for your condition.
 - Services or care provided or billed by a residential treatment center, school, halfway house, custodial care center for the developmentally disabled, residential programs for drug and alcohol, or outward bound programs, even if psychotherapy is included.
 - Services related to non-compliance of care if the Member ends treatment for substance abuse against the medical advice of the Provider.

Clinical Trials

Benefits are available for services for routine patient care rendered as part of a clinical trial if the services are otherwise Covered Services under this Handbook and the clinical trial meets all of the following criteria:

- The purpose of the trial is to test whether the intervention potentially improves the trial participant's health

or the treatment is given with the intention of improving the trial participants health, and is not designed simply to test toxicity or disease pathophysiology;

- **The trial does one of the following:**
 1. Tests how to administer a health care service, item, or drug for treatment;
 2. Tests responses to a health care service, item, or drug for treatment;
 3. Compares the effectiveness of health care services, items, or drugs for treatment; or
 4. Studies new uses of health care services, items, or drugs for treatment;
- **The trial is approved by one of the following:**
 1. The National Institute of Health, or one of its cooperative groups or centers under the United States Department of Health and Human Services;
 2. The United States Food and Drug Administration;
 3. The United States Department of Defense; or
 4. The United States Department of Veteran's Affairs.

Benefits do not, however, include the following:

- A health care service, item, or drug that is the subject of the clinical trial or is provided solely to satisfy data collection and analysis needs for the clinical trial that is not used in the direct clinical management of the patient;
- An investigational or experimental drug or device that has not been approved for market by the United States Food and Drug Administration;
- 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 clinical trial;
- An item or drug provided by the clinical trial sponsors free of charge for any patient;
- A service, item, or drug that is eligible for reimbursement by a person other than the insurer, including the sponsor of the clinical trial.

Dental Services

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

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

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

Other Dental Services

Dental x rays, supplies & appliances and all associated expenses, including hospitalization and anesthesia **as required by law**, and;

- transplant preparation
- initiation of immunosuppressives
- direct treatment of cancer or cleft palate.

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

Diabetic Equipment, Education and Supplies

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

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

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

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

Diagnostic Services

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

- X-ray and other radiology services, including mammograms for any person diagnosed with breast disease
- Magnetic Resonance Angiography (MRA)
- Magnetic Resonance Imaging (MRI)
- CAT scans
- Laboratory and pathology services
- Cardiographic, encephalographic, and radioisotope tests
- Nuclear cardiology imaging studies
- Ultrasound services
- Allergy tests
- Electrocardiograms (EKG)
- Electromyograms (EMG) except that surface EMG's are not Covered Services
- Echocardiograms
- Bone density studies
- Positron emission tomography (PET scanning)
- Diagnostic Tests as an evaluation to determine the need for a Covered Transplant Procedure

- Echographies
- Doppler studies
- Brainstem evoked potentials (BAER)
- Somatosensory evoked potentials (SSEP)
- Visual evoked potentials (VEP)
- Nerve conduction studies
- Muscle testing
- Electrocorticograms

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

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

Emergency Services

Covered for facility and physician services for Emergency Medical Conditions meeting the definition in Section XXII of this Handbook. The facility (hospital) charge will be subject to the appropriate Copayment/Coinsurance. If there is a Copayment it will be waived if the Member is admitted as a hospital inpatient.

Care and treatment provided once you are stabilized is no longer considered Emergency Care. Continuation of care from a Non-Participating Provider beyond that needed to evaluate or stabilize your condition in an Emergency will be covered if we authorize the continuation of care and it is Medically Necessary.

Urgent Care Center Services

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

Not covered:

Services received in a hospital emergency room for an Urgent Medical Condition without prior direction from your PCP, a participating Paramount physician or Paramount.

Home Care Services

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

Covered Services include but are not limited to:

- Intermittent Skilled Nursing Services (by an R.N. or L.P.N.)
- Medical/Social Services
- Diagnostic Services
- Nutritional Guidance
- Home Health Aide Services. The Member must be receiving skilled nursing or therapy. Services must be furnished by appropriately trained personnel employed by the Home Health Care Provider.

Other organizations may provide services only when approved by Paramount, and their duties must be assigned and supervised by a professional nurse on the staff of the Home Health Care Provider.

- Therapy Services (except for Manipulation Therapy which will not be covered when rendered in the home). Home Care Visit limits specified in the Summary of Benefits for Home Care Services apply when Therapy Services are rendered in the home.
- Medical/Surgical Supplies
- Durable Medical Equipment
- Prescription Drugs (only if provided and billed by a Home Health Care Agency)
- Private Duty Nursing

Non Covered Services include but are not limited to:

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

Home infusion therapy

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

Hospice Services

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

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

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

Non Covered Services include but are not limited to:

- Services provided by volunteers.
- Housekeeping services.

Infertility Services

Covered for the medically necessary diagnosis and treatment of infertility conditions.

Inpatient Services

Inpatient Services include:

- Charges from a Hospital, Skilled Nursing Facility (SNF) or other Provider for room, board and general nursing services.
- Ancillary (related) services.
- Professional services from a Physician while an Inpatient.
- **Room, Board, and General Nursing Services**
 - A room with two or more beds.
 - A private room. The private room allowance is the Hospital's average semi-private room rate unless it is Medically Necessary that you use a private room for isolation and no isolation facilities are available.
 - A room in a special care unit approved by Paramount. The unit must have facilities, equipment and supportive services for intensive care of critically ill patients.
- **Ancillary (Related) Services**
 - Operating, delivery and treatment rooms and equipment.
 - Prescribed Drugs.
 - Anesthesia, anesthesia supplies and services given by an employee of the Hospital or other Provider.
 - Medical and surgical dressings, supplies, casts and splints.
 - Diagnostic Services.
 - Therapy Services.
- **Professional Services**
 - **Medical care** visits limited to one visit per day by any one Physician.
 - **Intensive medical care** for constant attendance and treatment when your condition requires it for a prolonged time.
 - **Concurrent care** for a medical condition by a Physician who is not your surgeon while you are in the Hospital for Surgery. Care by two or more Physicians during one Hospital stay when the nature or severity of your condition requires the skills of separate Physicians.
 - **Consultation** which is a personal bedside examination by another Physician when requested by your Physician. Staff consultations required by Hospital rules; consultations requested by the patient; routine radiological or cardiographic consultations; telephone consultations; EKG transmittal via phone are excluded.
 - **Surgery and the administration of general anesthesia.**
 - **Newborn exam.** A Physician other than the Physician who performed the obstetrical delivery must do the examination.

Maternity Services

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

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

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

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

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

- In the opinion of your attending Physician, the newborn Child meets the criteria for medical stability in the Guidelines for Perinatal Care prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists that determine the appropriate length of stay based upon evaluation of:
 1. the antepartum, intrapartum, and postpartum course of the mother and infant;
 2. the gestational stage, birth weight, and clinical condition of the infant;
 3. the demonstrated ability of the mother to care for the infant after discharge; and
 4. the availability of postdischarge follow-up to verify the condition of the infant after discharge.
- **Covered Services include at-home post delivery care visits** at your residence by a Physician or Nurse performed no later than 72 hours following you and your newborn Child's discharge from the Hospital. Coverage for this visit includes, but is not limited to:
 1. parent education;
 2. assistance and training in breast or bottle feeding; and
 3. performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care for you or your newborn Child, including the collection of an adequate sample for the hereditary and metabolic newborn screening.

Medical Supplies, Durable Medical Equipment, and Appliances

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

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

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

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

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

Benefits for repairs and replacement do not include the following:

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

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

Covered Services may include, but are not limited to:

- **Medical and surgical supplies** - Certain supplies and equipment for the management of disease that we approve are covered under the Prescription Drug benefit. Covered Services do not include items usually stocked in the home for general use like Band-Aids, thermometers, and petroleum jelly.

Covered Services may include, but are not limited to:

1. Allergy serum extracts
2. Chem strips, Glucometer, Lancets
3. Clinitest
4. Needles/syringes
5. Ostomy bags and supplies except charges such as those made by a Pharmacy for purposes of a fitting are not Covered Services.
6. Contraceptive devices including diaphragms, intra uterine devices (IUDs), and implants.

Non Covered Services include but are not limited to:

1. Adhesive tape, band aids, cotton tipped applicators
2. Arch supports
3. Doughnut cushions

4. Hot packs, ice bags
5. Vitamins
6. Medijectors

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

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

Covered Services may include, but are not limited to:

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

Non-covered items may include but are not limited to:

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

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

- **Prosthetics** – Artificial substitutes for body parts and tissues and materials inserted into tissue for functional or therapeutic purposes. Covered Services include purchase, fitting, needed adjustment, repairs, and replacements of prosthetic devices and supplies that:
 1. Replace all or part of a missing body part and its adjoining tissues; or
 2. Replace all or part of the function of a permanently useless or malfunctioning body part.

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

Covered Services may include, but are not limited to:

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

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

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

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

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

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

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

8. Built-up shoe.
9. Custom made shoe inserts.

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

Non-Covered Services include but are not limited to:

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

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

Outpatient Services

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

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

For Emergency Accident or Medical Care refer to the Urgent Care and Emergency Services Section VI of this Handbook.

Physician Home Visits and Office Services

Covered Services include care provided by a Physician in their office or your home. Refer to the sections titled "Preventive Care", "Maternity Care", "Home Care Services" and "Behavioral Health Services for services covered by the Health Plan. For Emergency Care refer to the Urgent Care and Emergency Services Section VI of this Handbook.

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

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

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

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

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

Online clinic visits. When available in your area, your coverage will include online clinic visit services. Covered Services include a medical consultation using the internet via a webcam, chat or voice. Non Covered Services include, but are not limited to communications used for:

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

Preventive Care Services

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

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

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

1. Services with an “A” or “B” rating from the United States Preventive Services Task Force. Examples of these services are screenings for:
 - a. Breast cancer;
 - b. Cervical cancer;
 - c. Colorectal cancer;
 - d. High Blood Pressure;
 - e. Type 2 Diabetes Mellitus;
 - f. Cholesterol;
 - g. Child and Adult Obesity.
2. Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
3. Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
4. Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration. You may call Member Services using the number on your ID card for additional information about these services. (or view the federal government’s web sites, <http://www.healthcare.gov/center/regulations/prevention.html>; or <http://www.ahrq.gov/clinic/uspstfix.htm>; [http://www.cdc.gov/vaccines/recs/acip/.](http://www.cdc.gov/vaccines/recs/acip/))

Covered Services also include the following services required by state and federal law:

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

Other Covered Services are:

- Routine hearing screenings
- Routine children's vision screenings

Surgical Services

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

- Performance of accepted operative and other invasive procedures;
- The correction of fractures and dislocations;
- Anesthesia and surgical assistance when Medically Necessary;
- Usual and related pre-operative and post-operative care;
- Other procedures as approved by Paramount.

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

Covered Surgical Services include, but are not limited to:

- Operative and cutting procedures;
- Endoscopic examinations, such as arthroscopy, bronchoscopy, colonoscopy, laparoscopy;
- Other invasive procedures such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine.

Reconstructive Services

Certain reconstructive services required to correct a deformity caused by disease, trauma, congenital anomalies, or previous therapeutic process are covered. Reconstructive services required due to prior therapeutic process are payable only if the original procedure would have been a Covered Service under this Plan. Covered Services are limited to the following:

- Necessary care and treatment of medically diagnosed congenital defects and birth abnormalities of a newborn Child. Breast reconstruction resulting from a mastectomy. See "Mastectomy Notice" below for further coverage details.
- Hemangiomas, and port wine stains of the head and neck areas for children ages 18 years of age or younger;
- Limb deformities such as club hand, club foot, syndactyly (webbed digits), polydactyly (supernumerary digits), macrodactyly;
- Otoplasty when performed to improve hearing by directing sound in the ear canal, when ear or ears are absent or deformed from trauma, surgery, disease, or congenital defect;
- Tongue release for diagnosis of tongue-tied;

- Congenital disorders that cause skull deformity such as Crouzon's disease;
- Cleft lip;
- Cleft palate.

Mastectomy Notice

A Member who is receiving benefits for a covered mastectomy or for follow-up care in connection with a covered mastectomy, on or after the date the Women's Health & Cancer Rights Act became effective for this Plan, and who elects breast reconstruction, will also receive coverage for:

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

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

Sterilization

Sterilization is a Covered Service.

Temporomandibular or Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder

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

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

Therapy Services

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

Physical Medicine Therapy Services

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

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

- **Occupational therapy** for the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the person's particular occupational role. Occupational therapy does not include diversional, recreational, vocational therapies (e.g. hobbies, arts and crafts). Non Covered Services include but are not limited to: supplies (looms, ceramic tiles, leather, utensils); therapy to improve or restore functions that could be expected to improve as the patient resumes normal activities again; general exercises to promote overall fitness and flexibility; therapy to improve motivation; suction therapy for newborns (feeding machines); soft tissue mobilization (visceral manipulation or visceral soft tissue manipulation), augmented soft tissue mobilization, myofascial; adaptations to the home such as rampways, door widening, automobile adaptors, kitchen adaptation and other types of similar equipment.
- **Manipulation Therapy** includes Osteopathic/Chiropractic Manipulation Therapy used for treating problems associated with bones, joints and the back. The two therapies are similar, but chiropractic therapy focuses on the joints of the spine and the nervous system, while osteopathic therapy includes equal emphasis on the joints and surrounding muscles, tendons and ligaments. Manipulations whether performed and billed as the only procedure or manipulations performed in conjunction with an exam and billed as an office visit will be counted toward any maximum for Manipulation Therapy services as specified in the Summary of Benefits. Manipulation Therapy services rendered in the home as part of Home Care Services are not covered.

Other Therapy Services

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

Physical Medicine and Rehabilitation Services

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

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

Covered Services include habilitative services to children (ages 0 - 21) with a medical diagnosis of autism spectrum disorder, which at a minimum includes:

1. Out-Patient Physical Rehabilitation services including:
 - a. Speech and Language therapy and/or Occupational therapy, performed by a licensed therapist; and
 - b. Clinical Therapeutic intervention defined as therapies supported by empirical evidence, which include but are not limited to Applied Behavioral Analysis, provided by or under the supervision of a professional who is licensed, certified, or registered by an appropriate agency of this state to perform the services in accordance with a treatment plan, 20 hours per week;
2. Mental/Behavioral Health Outpatient Services performed by a licensed Psychologist, Psychiatrist, or Physician to provide consultation, assessment, development and oversight of treatment plans, 30 visits per year total.

Non-Covered Services for physical medicine and rehabilitation

Include, but are not limited to:

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

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

Vision Services

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

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

Additional Covered Services for all Members include:

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

These additional services are not part of the “Preventive Care” benefit and will be based on the setting which services are received.

Additional Covered Services discussed below are only available for Members under age 19:

- Standard Eyeglass Lenses: Contact lenses may be obtained in lieu of glasses.
- Frames

Transplants

Covered for certain clinical indications with written Prior Authorization at a Paramount approved Center of Excellence for heart, lung, liver, pancreas, heart-lung, kidney-pancreas, bowel and bone marrow transplants. (Kidney and cornea transplants are covered as any other illness.) Please notify Member Services as soon as possible after you are recommended for a transplant. This will enable a Paramount Nurse Case Manager to work with you, your PCP and Specialist to coordinate your care.

When Paramount selects a Center of Excellence for transplant services outside the Service Area, Paramount will reimburse IRS allowance on mileage for car travel or coach commercial air travel. Reasonable costs for lodging and meals (excluding alcohol) for the transplant candidate only during medically necessary, approved visits to the institution will be reimbursed. Any eligible reimbursement will be made following receipt of itemized statements. Paramount does not cover travel, lodging or meal expenses for donors or family Members.

Prescription Drug Benefits

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

Pharmacy Benefits Manager

The pharmacy benefits available to you under this Handbook are administered by Our Pharmacy Benefits Manager (PBM). The PBM is a pharmacy benefits management company with which we contract to manage your pharmacy benefits. The PBM has a nationwide network of retail pharmacies, a Mail Service pharmacy.

The services the PBM provides include, among others, managing a network of retail pharmacies and operating a Mail Service pharmacy. The PBM, in consultation with Paramount, also provides services to promote and enforce the appropriate use of pharmacy benefits, such as review for possible excessive use; recognized and recommended dosage regimens; Drug interactions or Drug/pregnancy concerns.

You may request a copy of Paramount's Preferred Drug list by calling the Member Services telephone number on the back of your Identification Card. The Preferred Drug list is subject to periodic review and amendment. Inclusion of a Drug or related item on the covered Prescription Drug list is not a guarantee of coverage.

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

Prior Authorization may be required for certain Prescription Drugs (or the prescribed quantity of a particular Drug). Prior Authorization helps promote appropriate utilization and enforcement of guidelines for Prescription Drug benefit coverage. At the time you fill a prescription, the Network pharmacist is informed of the Prior Authorization requirement through the pharmacy's computer system. The PBM uses pre-approved criteria, developed by our Pharmacy and Therapeutics Committee which is reviewed and adopted by Paramount. Paramount or the PBM may contact your Provider if additional information is required to determine whether Prior Authorization should be granted. We communicate the results of the decision to your Provider.

If Prior Authorization is denied, you have the right to appeal through the appeals process outlined in Section XVII of this Handbook.

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

Step Therapy

Step therapy protocol means that a Member may need to use one medication before another. Paramount monitors some Prescription Drugs to control utilization, to ensure that appropriate prescribing guidelines are followed, and to help Members access high quality yet cost effective Prescription Drugs. If a Physician decides that the monitored medication is needed the Prior Authorization process is applied.

Specialty Pharmacy Network

Paramount's Specialty Pharmacy Network is available to Members who use Specialty Drugs.

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

You may obtain a list of the Network Specialty Pharmacies, and covered Specialty Drugs, by calling the Member Services telephone number on the back of your ID card, or review the lists on Our website at www.paramountinsurancecompany.com.

Covered Prescription Drug Benefits (a valid prescription is required)

- Prescription Legend Drugs.
- Specialty Drugs.
- Injectable insulin and syringes used for administration of insulin.
- Contraceptive Drugs.
- Certain supplies and equipment obtained by Mail Service or from a Network Pharmacy (such as those for diabetes and asthma) are covered. Contact Paramount to determine approved covered supplies. If certain supplies, equipment or appliances are not obtained by Mail Service or from a Network Pharmacy then they are covered as Medical Supplies, Equipment and Appliances instead of under Prescription Drug benefits.
- Off label use of FDA approved drugs as defined in ORC 1751.66. Paramount shall not limit or exclude coverage for any drug approved by the United States food and drug administration on the basis that the drug has not been approved by the United States food and drug administration for the treatment of the particular indication for which the drug has been prescribed, provided the drug has been recognized as safe and effective for treatment of that indication in one or more of the standard medical reference compendia adopted by the United States department of health and human services.

Non Covered Prescription Drug Benefits (please also see Section XII Non Covered Services/ exclusions of this Handbook):

- Prescription Drugs dispensed by any Mail Service program other than the PBM's Mail Service, unless prohibited by law.
- Drugs, devices and products, or Prescription Legend Drugs with over the counter equivalents and any

Drugs, devices or products that are therapeutically comparable to an over the counter Drug, device, or product.

- Off label use, except as otherwise prohibited by law or as approved by Paramount or the PBM.
- Drugs in quantities exceeding the quantity prescribed, or for any refill dispensed later than one year after the date of the original Prescription Order.
- Drugs not approved by the FDA.
- Charges for the administration of any Drug.
- Drugs consumed at the time and place where dispensed or where the Prescription Order is issued, including but not limited to samples provided by a Physician. This does not apply to Drugs used in conjunction with a Diagnostic Service, with Chemotherapy performed in the office or Drugs eligible for coverage under the Medical Supplies benefit; they are Covered Services.
- Any Drug which is primarily for weight loss.
- Drugs not requiring a prescription by federal law (including Drugs requiring a prescription by state law, but not by federal law), except for injectable insulin.
- Drugs in quantities which exceed the limits established by the Health Plan, or which exceed any age limit established by Paramount.
- Drugs for treatment of sexual or erectile dysfunctions or inadequacies, regardless of origin or cause.
- Fertility Drugs.
- Contraceptive devices, oral immunizations, and biologicals, although they are federal legend Drugs, are payable as medical supplies based on where the service is performed or the item is obtained. If such items are over the counter Drugs, devices or products, they are not Covered Services.
- Drugs in quantities which exceed the limits established by the Health Plan.
- Human Growth Hormone
- Compound Drugs without at least one ingredient that requires a prescription.
- Compound Drugs with an equivalent commercially available product.
- Certain Prescription Legend Drugs are not Covered Services when any version or strength becomes available over the counter. **Please contact Paramount for additional information on these Drugs.**
- Refills of lost or stolen medications.
- Certain Prescription Drugs may not be covered when clinically equivalent alternatives are available, unless otherwise required by law. “Clinically equivalent” means Drugs that, for the majority of Members, can be expected to produce similar therapeutic outcomes for a disease or condition. If you have questions regarding whether a particular drug is covered and which drugs fall into this category, please call the member services number on the back of your Identification Card, or visit Our website at www.paramountinsurancecompany.com. If you or your Physician believe you require continued coverage for a certain Prescription Drug, please have your Physician or Pharmacist contact Paramount. We will cover your current Prescription Drug only if we agree that it is Medically Necessary and appropriate over its clinically equivalent alternative. Continued coverage of the Prescription Drug will be subject to periodic review by Paramount.

Deductible/Coinsurance/Copayment

Each Prescription Order may be subject to a Deductible and Coinsurance/Copayment. If the Prescription Order includes more than one covered Drug, a separate Coinsurance/Copayment will apply to each covered Drug. Your Prescription Drug Coinsurance/Copayment will be the lesser of your scheduled Copayment/Coinsurance amount or the Maximum Allowable Amount. Please see the Summary of Benefits for any applicable Deductible and Coinsurance/Copayment.

Days Supply

The number of days supply of a Drug which you may receive is limited. The days supply limit applicable to Prescription Drug coverage is shown in the Summary of Benefits.

Tiers

Your Copayment/Coinsurance amount may vary based on whether the Prescription Drug, including covered Specialty Drugs, has been classified by Paramount as a first, second, third, fourth, or fifth “tier” Drug. The determination of tiers is made by Paramount based upon clinical information, and where appropriate the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition; the availability of over-the-counter alternatives; and where appropriate certain clinical economic factors.

- Tier 1 Prescription Drugs have the lowest Coinsurance or Copayment. This tier will contain low cost preferred generic medications.
- Tier 2 Prescription Drugs will have a higher Coinsurance or Copayment than those in Tier 1. This tier will contain generic drugs.
- Tier 3 Prescription Drugs will have a higher Coinsurance or Copayment than those in Tier 2. This tier will contain preferred brand medications.
- Tier 4 Prescription Drugs will have a higher Coinsurance or Copayment than those in Tier 3 and will contain non-preferred brand drugs.
- Tier 5 Prescription Drugs will have the highest Coinsurance or Copayment and will contain Specialty and Injectable medications.

Tier and Formulary Assignment Process

We have a Pharmacy and Therapeutics (P&T) Committee, consisting of health care professionals, including local pharmacists, and physicians. The purpose of this committee is to assist in determining clinical appropriateness of drugs; determining the tier assignments of drugs; and advising on programs to help improve care. Such programs may include, but are not limited to, drug utilization programs, Prior Authorization criteria, therapeutic conversion programs, cross-branded initiatives, drug profiling initiatives and the like.

The determinations of tier assignments and formulary inclusion are made by Paramount based upon clinical decisions provided by the P&T Committee, and where appropriate, the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition; the availability of over-the-counter alternatives; generic availability, the degree of utilization of one Drug over another in our patient population, and where appropriate, certain clinical economic factors.

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

Special Programs

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

Payment of Benefits

The amount of benefits paid is based upon whether you receive the Covered Services from a Network Pharmacy, including a Network Specialty Pharmacy, a Non-Network Pharmacy, or the PBM’s Mail Service Program. It is also based upon which Tier we have classified the Prescription Drug or Specialty Drug. Please see the Summary of Benefits for the applicable amounts, and for applicable limitations on number of days supply.

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

Your Copayment(s), Coinsurance and/or Deductible amounts will not be reduced by any discounts, rebates or other funds received by the PBM and/or the Health Plan from Drug manufacturers or similar vendors. For Covered Services provided by a Network or Specialty Drug Network Pharmacy or through the PBM's Mail Service, you are responsible for all Deductibles and/or Copayment/Coinsurance amounts.

How to Obtain Prescription Drug Benefits

How you obtain your benefits depends upon whether you go to a Network or a Non-Network Pharmacy.

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

The Mail Service Program – Complete the Order and Patient Profile Form. You will need to complete the patient profile information only once. You may mail written prescriptions from your Physician, or have your Physician fax the prescription to the Mail Service. You will need to submit the applicable Deductible, Coinsurance and/or Copayment amounts to the Mail Service when you request a prescription or refill.

XII. NON COVERED SERVICES/EXCLUSIONS

The following section indicates items which are excluded from benefit consideration, and are not considered Covered Services. Excluded items will not be covered even if the service, supply, or equipment would otherwise be considered Medically Necessary. This information is provided as an aid to identify certain common items which may be misconstrued as Covered Services, but is in no way a limitation upon, or a complete listing of, such items considered not to be Covered Services. We are the final authority for determining if services or supplies are Medically Necessary.

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

1. Which we determine are not Medically Necessary or do not meet our medical policy, clinical coverage guidelines, or benefit policy guidelines.
2. Received from an individual or entity that is not a Provider, as defined in this Handbook, or recognized by Paramount.
3. Which are Experimental/Investigative or related to such, whether incurred prior to, in connection with, or subsequent to the Experimental/Investigative service or supply, as determined by Paramount. The fact that a service is the only available treatment for a condition will not make it eligible for coverage if we deem it to be Experimental/Investigative.
4. For any condition, disease, defect, ailment, or injury arising out of and in the course of employment if benefits are available under any Workers' Compensation Act or other similar law. If Workers' Compensation Act benefits are not available to you, then this Exclusion does not apply. This exclusion applies if you receive the benefits in whole or in part. This exclusion also applies whether or not you claim the benefits or compensation. It also applies whether or not you recover from any third party.
5. To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.

6. For any illness or injury that occurs while serving in the armed forces, including as a result of any act of war, declared or undeclared.
7. For a condition resulting from direct participation in a riot, civil disobedience, nuclear explosion, or nuclear accident.
8. For court ordered testing or care unless Medically Necessary.
9. For which you have no legal obligation to pay in the absence of this or like coverage.
10. For the following:
 - Physician or Other Practitioners' charges for consulting with Members by telephone, facsimile machine, electronic mail systems or other consultation or medical management service not involving direct (face-to-face) care with the Member except as otherwise described in this Handbook.
 - Surcharges for furnishing and/or receiving medical records and reports.
 - Charges for doing research with Providers not directly responsible for your care.
 - Charges that are not documented in Provider records.
 - Charges from an outside laboratory or shop for services in connection with an order involving devices (e.g., prosthetics, orthotics) which are manufactured by that laboratory or shop, but which are designed to be fitted and adjusted by the attending Physician.
 - For membership, administrative, or access fees charged by Physicians or other Providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results.
11. Received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group.
12. Prescribed, ordered or referred by or received from a member of your immediate family, including your spouse, Child, brother, sister, parent, in-law, or self.
13. For completion of claim forms or charges for medical records or reports unless otherwise required by law.
14. For missed or canceled appointments.
15. For mileage, lodging and meals costs, and other Member travel related expenses, except as authorized by Paramount or specifically stated as a Covered Service.
16. For which benefits are payable under Medicare Parts A, B, and/or D or would have been payable if a Member had applied for Parts A, B and/or D, except, as specified elsewhere in this Handbook or as otherwise prohibited by federal law,. For the purposes of the calculation of benefits, if the Member has not enrolled in Medicare Part B, we will calculate benefits as if they had enrolled.
17. Charges in excess of Our Maximum Allowable Amounts.
18. Incurred prior to your Effective Date.
19. Incurred after the termination date of this coverage except as specified elsewhere in this Handbook.
20. For any procedures, services, equipment or supplies provided in connection with cosmetic services. Cosmetic services are primarily intended to preserve, change or improve your appearance or are furnished for psychiatric or psychological reasons. No benefits are available for surgery or treatments to change the texture or appearance of your skin or to change the size, shape or appearance of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts). Complications directly related to cosmetic services treatment or surgery, as determined by Paramount, are not covered. This exclusion applies even if the original cosmetic services treatment or surgery was performed while the Member was covered by another carrier/self funded plan prior to coverage under this Handbook. Directly related means that the treatment or surgery occurred as a direct result of the cosmetic services treatment or surgery and would not have taken place in the absence of the cosmetic services treatment or surgery. This exclusion does not apply to conditions including but not limited to: myocardial infarction; pulmonary embolism; thrombophlebitis; and exacerbation of co-morbid conditions.
21. For maintenance therapy, which is treatment given when no additional progress is apparent or expected to occur. Maintenance therapy includes treatment that preserves your present level of functioning and prevents loss of that functioning, but which does not result in any additional improvement.
22. For the following:
 - Custodial Care, convalescent care or rest cures.
 - Domiciliary care provided in a residential institution, treatment center, halfway house, or school

- because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
- Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
 - Care provided or billed by residential treatment centers or facilities, unless those centers or facilities are required to be covered under state law. This includes but is not limited to individualized and intensive treatment in a residential facility, including observation and assessment by a Provider weekly or more frequently, an individualized program of rehabilitation, therapy, education, and recreational or social activities.
 - Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, residential programs for drug and alcohol, or outward bound programs, even if psychotherapy is included.
 - Wilderness camps.
23. For routine foot care (including the cutting or removal of corns and calluses); Nail trimming, cutting or debriding; Hygienic and preventive maintenance foot care, including but not limited to:
- cleaning and soaking the feet.
 - applying skin creams in order to maintain skin tone.
 - other services that are performed when there is not a localized illness, injury or symptom involving the foot.
24. For surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.
25. For dental treatment, regardless of origin or cause, except as specified elsewhere in this Handbook. "Dental treatment" includes but is not limited to: Preventive care, diagnosis, treatment of or related to the teeth, jawbones (except that TMJ is a Covered Service) or gums, including but not limited to:
- extraction, restoration and replacement of teeth.
 - medical or surgical treatments of dental conditions.
 - services to improve dental clinical outcomes.
26. For treatment of the teeth, jawbone or gums that is required as a result of a medical condition except as expressly required by law or specifically stated as a Covered Service.
27. For Dental implants.
28. For Dental braces.
29. For Dental x rays, supplies & appliances and all associated expenses, including hospitalization and anesthesia, except as required by law. The only exceptions to this are for any of the following:
- transplant preparation.
 - initiation of immunosuppressives.
 - direct treatment of acute traumatic injury, cancer or cleft palate.
30. Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly.
31. Weight loss programs, whether or not they are pursued under medical or Physician supervision, unless specifically listed as covered in this Handbook. This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.
32. For bariatric surgery, regardless of the purpose it is proposed or performed. This includes but is not limited to Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgical procedures that reduce stomach capacity and divert partially digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastroplasty, (surgical procedures that decrease the size of the stomach), or gastric banding procedures. Complications directly related to bariatric surgery that result in an Inpatient stay or an extended Inpatient stay for the bariatric surgery, as determined by Paramount, are not covered. This exclusion applies when the bariatric surgery

- was not a Covered Service under this Plan or any previous Paramount plan, and it applies if the surgery was performed while the Member was covered by a previous carrier/self funded plan prior to coverage under this Handbook. Directly related means that the Inpatient stay or extended Inpatient stay occurred as a direct result of the bariatric procedure and would not have taken place in the absence of the bariatric procedure. This exclusion does not apply to conditions including but not limited to: myocardial infarction; excessive nausea/vomiting; pneumonia; and exacerbation of co-morbid medical conditions during the procedure or in the immediate post operative time frame.
33. For marital counseling.
 34. For prescription, fitting, or purchase of eyeglasses or contact lenses except as otherwise specifically stated as a Covered Service. This Exclusion does not apply for initial prosthetic lenses or sclera shells following intraocular surgery, or for soft contact lenses due to a medical condition.
 35. For vision orthoptic training.
 36. For hearing aids or examinations to prescribe/fit them, unless otherwise specified within this Handbook.
 37. For services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein.
 38. For services to reverse voluntarily induced sterility.
 39. Assisted reproductive technology (ART) such as artificial insemination, in vitro fertilization, embryo transplant services, GIFT, ZIFT, zygote transfer, reversal of voluntary sterilization, ovarian tissue transplant and related services, cost of donor sperm or donor egg, and services and supplies related to ART procedures.
 40. For personal hygiene, environmental control, or convenience items including but not limited to:
 - Air conditioners, humidifiers, air purifiers;
 - Personal comfort and convenience items during an Inpatient stay, including but not limited to
 - daily television rental, telephone services, cots or visitor's meals;
 - Charges for non-medical self-care except as otherwise stated;
 - Purchase or rental of supplies for common household use, such as water purifiers;
 - Allergenic pillows, cervical neck pillows, special mattresses, or waterbeds;
 - Infant helmets to treat positional plagiocephaly;
 - Safety helmets for Members with neuromuscular diseases; or
 - Sports helmets.
 41. Health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. This exclusion also applies to health spas.
 42. For telephone consultations or consultations via electronic mail or internet/web site, except as required by law, authorized by Paramount, or as otherwise described in this Handbook.
 43. For care received in an emergency room which is not Emergency Care, except as specified in this Handbook. This includes, but is not limited to suture removal in an emergency room.
 44. For eye surgery to correct errors of refraction, such as near-sightedness, including without limitation LASIK, radial keratotomy or keratomileusis or excimer laser refractive keratectomy.
 45. For self-help training and other forms of non-medical self care, except as otherwise provided in this Handbook.
 46. For examinations relating to research screenings.
 47. For stand-by charges of a Physician.
 48. Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes.
 49. For Private Duty Nursing Services rendered in a Hospital or Skilled Nursing Facility; Private Duty Nursing Services are Covered Services only when provided through the Home Care Services benefit as specifically stated in the "Covered Services" section.
 50. For Manipulation Therapy services rendered in the home as part of Home Care Services.
 51. Services and supplies related to sex transformation and/or the reversal thereof, or male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This Exclusion includes sexual therapy and counseling. This exclusion also includes penile prostheses or implants and vascular or

- artificial reconstruction, Prescription Drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related Diagnostic Testing.
52. For (services or supplies related to) alternative or complementary medicine. Services in this category include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage and massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergetic synchronization technique (BEST), iridology-study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy, electromagnetic therapy, and neurofeedback.
 53. For any services or supplies provided to a person not covered under the Handbook in connection with a surrogate pregnancy (including, but not limited to, the bearing of a Child by another woman for an infertile couple).
 54. For surgical treatment of gynecomastia.
 55. For treatment of hyperhidrosis (excessive sweating).
 56. For any service for which you are responsible under the terms of this Handbook to pay a Copayment, Coinsurance or Deductible, and the Copayment, Coinsurance or Deductible is waived by a Non-Participating Provider.
 57. Human Growth Hormone for children born small for gestational age. It is only a Covered Service in other situations when allowed by Paramount through Prior Authorization.
 58. Complications directly related to a service or treatment that is a non Covered Service under this Handbook because it was determined by Paramount to be Experimental/Investigational or non Medically Necessary. Directly related means that the service or treatment occurred as a direct result of the Experimental/Investigational or non Medically Necessary service and would not have taken place in the absence of the Experimental/Investigational or non Medically Necessary service.
 59. For Drugs, devices, products, or supplies with over the counter equivalents and any Drugs, devices, products, or supplies that are therapeutically comparable to an over the counter Drug, device, product, or supply.
 60. Sclerotherapy for the treatment of varicose veins of the lower extremities including ultrasonic guidance for needle and/or catheter placement and subsequent sequential ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy.
 61. Treatment of telangiectatic dermal veins (spider veins) by any method.
 62. Reconstructive services except as specifically stated in the **Covered Services** section of this Handbook, or as required by law.
 63. Nutritional and/or dietary supplements, except as provided in this Handbook or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written Prescription or dispensing by a licensed Pharmacist.
 64. Abortion is not covered, unless medically necessary (i.e., to save the life or protect the health of the mother).

EXPERIMENTAL/INVESTIGATIVE SERVICES EXCLUSION

Any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which we determine in Our sole discretion to be Experimental/Investigative is not covered under the Health Plan.

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

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

- is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function; or
- is provided pursuant to informed consent documents that describe the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental/Investigative, or otherwise indicate that the safety, toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.

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

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

The information considered or evaluated by Paramount to determine whether a Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative under the above criteria may include one or more items from the following list which is not all inclusive:

- published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or
- evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
- documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- documents of an IRB or other similar body performing substantially the same function; or
- consent document(s) and/or the written protocol(s) used by the treating Physicians, other medical professionals, or facilities or by other treating Physicians, other medical professionals or facilities studying substantially the same Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- medical records; or
- the opinions of consulting Providers and other experts in the field.

We have the sole authority and discretion to identify and weigh all information and determine all questions pertaining to whether a Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative.

XIII. ELIGIBILITY GUIDELINES

To be eligible to enroll in this plan Subscriber and Dependents:

1. Must be a United State citizen or national or must be lawfully present in the United States;

2. Cannot be incarcerated (in prison; does not apply if you are awaiting disposition of charges); and
3. Must reside in the Paramount Service Area. Persons residing outside the service area for more than ninety (90) consecutive days within a twelve (12) month period are ineligible. (See “Dependents” for exception.)

For a description of special circumstances pertaining to these requirements, see 45 CFR § 155.305(a). The Plan can be written as a Child-Only Plan for individuals who are less than 21 years of age.

During enrollment, if an individual asks for financial assistance in obtaining health care coverage, the Exchange is responsible for determining or assessing:

- Medicaid eligibility
- Children’s Health Insurance Program (CHIP) eligibility
- Primary tax payers’ eligibility for an advance payment of premium tax credits.
- Eligibility for cost-share subsidy

Individuals eligible to enroll in the Catastrophic Plan must meet the following criteria:

1. Has not attained the age of 30 before the beginning of the plan year, or
2. Does not have access to affordable coverage as defined under section 5000A (e) of the Internal Revenue Code of 1986, or
3. Has experienced a hardship

Subscriber The Subscriber is the person who makes application for Individual coverage and meets eligibility requirements.

Spouse The Subscriber’s legal spouse.

Dependent Children: The married or unmarried Dependent children, stepchildren or legally adopted children of the Subscriber or the Subscriber's spouse under the age of twenty-six (26) and meeting the eligibility requirements.

Eligible Dependent children are covered through the last day of the month in which they turn age twenty-six (26).

If a Subscriber or Subscriber's spouse has been court-ordered to maintain health care coverage on their Dependent Child who resides outside the Paramount Service Area, that Child shall be eligible to enroll in this plan. Coverage for service rendered outside the Service Area by non-participating providers will be limited to Emergency Medical Conditions.

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

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

In accordance with ORC 1751.14, and upon the written request of the Subscriber, Paramount will cover an unmarried Child under the Health Plan until the Child reaches age 28, if all of the following is true;

- The Child is the natural Child, step-Child or adopted Child of the Subscriber;

- The Child is a resident of Ohio, within the Paramount Service Area or a full-time student at an accredited public or private institution of higher learning;
- The Child is not employed by an employer that offers any health benefit plan under which the Child is eligible for coverage; and
- The Child is not eligible for coverage under Medicaid or Medicare.

A Child may be enrolled:

1. When the Child reaches the Dependent limiting age.
2. When the Child experiences a change in circumstances. Change in circumstance includes moving back to the Paramount Service Area or the Child losing employer-sponsored coverage.
3. During the Annual Open Enrollment Period.

Within 30 days of one of the above events, the Subscriber must certify in writing that the Child is eligible under the above conditions. To obtain the form required to apply for extension of Child coverage to age 28, the Subscriber should contact Paramount Member Services at (419) 887-2531 or toll-free at 1-866-452-6128. Paramount will require certification of eligibility and proof of residency or full-time student status if living out of state and continued eligibility certification annually until the Child reaches age 28.

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

Adopted children Coverage for newly adopted children will be effective from the date of adoptive placement. Adoptive placement means the assumption and retention by a person of a legal obligation for total or partial support of a Child in anticipation of the adoption of the Child. The Child's placement with a person terminates upon termination of the legal obligation. The adopted Child must be enrolled within thirty-one (31) days from the event.

The only other time you may enroll adopted children or stepchildren is during open enrollment period, or a special enrollment period.

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

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

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

Death of a subscriber Dependents of a deceased Subscriber may be eligible for continuation coverage.

ELIGIBILITY FOR COST SHARING REDUCTIONS (CSR) 45 CFR § 155.305(G)

Cost-sharing reductions decrease the overall out of pocket cost (deductibles, copayments, coinsurance and out of pocket maximum) for eligible individuals. You may be eligible for cost sharing reductions if (see the next section for special cost sharing rules for American Indians and Alaskan Natives):

- You are eligible for Advance Payments of the Premium Tax Credit (APTC);
- Your household income is no more than 250 percent of the Federal Poverty Level (FPL); and

- You are enrolled in any silver plan in the individual market through Paramount.

To understand how cost sharing reductions work, we must first understand actuarial value (AV). AV is a measure of the richness or generosity of the cost sharing of a health plan. A plan with a higher AV is a richer plan- which means the insurance carrier pays more and you pay less. For example, a plan with a 100% AV pays 100% of all claims while you pay nothing (after premium). If you were to purchase a plan with an 80% AV the plan would generally pay, on average, 80% of a standard population's expected medical expenses while you would pay the remaining 20%. The downside of purchasing a plan with a higher AV is that the monthly premiums are usually higher.

To help you make an apple to apple comparison of plans, each carrier is required to input the cost sharing combination into an AV calculator with a national data set provided by the Centers for Medicare and Medicaid Services. Each plan must be certified and fall within one of the following standard metal tiers (+/-2%)

- Platinum: 90% AV
- Gold: 80% AV
- Silver: 70% AV
- Bronze: 60% AV

Individuals enrolled in silver plans, assuming everything else is equal, would expect to pay higher premiums than those enrolled in a bronze plan and smaller premiums than those enrolled in a gold or platinum plan. However, cost sharing reductions allow an individual to pay the same silver premium and receive the benefits of a higher AV (richer plan).

SPECIAL ELIGIBILITY STANDARDS AND PROCESS FOR INDIANS 45 CFR § 155.350

If you are a verified American Indian or Alaskan Native, you are permitted to change your Qualified Health Plan (QHP) selection a maximum of once every 30 days. Paramount will check your tribal status against available federal data sources or a roster of tribe members from an authorized representative of your federally recognized tribe, if provided. If Paramount cannot verify your status as a tribe member, you may be required to provide other proof of tribal status. Please note that if you change your plan selection, all of your plan accumulators such as Deductibles and out of pocket maximums will be reset under the new plan.

Additionally, if you are an American Indian or Alaskan Native, you may be eligible for no cost sharing (100% AV) plan; you will not pay Deductibles, Coinsurance, Copayments or out of pocket maximums. To qualify for these special cost sharing reductions:

- You must be eligible for Advance Payments of the Premium Tax Credit (APTC);
- Your household income must be no more than 300 percent of the Federal Poverty Level (FPL); and
- You must be enrolled in a plan in the individual market through Paramount.

Further, the Affordable Care Act directs a QHP issuer to eliminate cost sharing for an Indian, regardless of household income, for items or services furnished directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services, and prohibits the QHP issuer from reducing payments to any such entity for such items or services.

For more information regarding AV and cost sharing reductions, please see the Eligibility for Cost Sharing Reductions section above.

EFFECTIVE DATES FOR ELIGIBILITY DETERMINATIONS 45 CFR § 155.310(F)

Paramount will use the following guidelines to establish your Effective Dates of coverage:

- The initial open enrollment period begins October 1, 2013 and extends through March 31, 2014.
- The annual open enrollment period for plan years beginning on or after January 1, 2015 begins October 15 and extends through December 7 of the preceding Calendar Year. During that period, generally, if you select a plan and remit payment to Paramount on or before December 7 your coverage Effective Date will be the following January 1.
- Certain special enrollment situations may result in a mid-plan-year eligibility redetermination that varies from the above open enrollment periods. See the Special Enrollments Period section for more details.

SPECIAL ENROLLMENT PERIODS 45 CFR § 155.420

Outside of the initial open enrollment period and the annual open enrollment periods, you may encounter a life event that makes you newly eligible for another plan, ineligible for your current plan, or entitles you to add or delete from coverage a Member of your household. These life events trigger a special enrollment period, in which you are permitted to change your plan selection.

If you are declining enrollment for your Dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll your Dependents in this plan, provided that you request enrollment within 30 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. Loss of eligibility for coverage does not include loss due to the individual’s failure to pay premiums or termination of coverage for cause, such as fraud.

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

In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll your Dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Coverage under the special enrollment period will be effective on the day following the date other coverage ends or the date of the event.

Nondiscrimination No one who is eligible to enroll or renew as a Subscriber, Dependent or Dependent with disabilities will be refused by Paramount based on subsidy eligibility, student status, health-status related factor, pre-existing condition, genetic testing or the results of such testing, health care needs or the exercise of rights under Paramount’s internal review procedures.

XIV. TERMINATION OF COVERAGE

TERMINATION OF COVERAGE 45 CFR § 155.430

During the course of the benefit plan year, either the enrollee or Paramount may need to terminate an enrollee’s coverage in a plan. The following events may trigger a termination:

- Voluntary Termination – An enrollee provides notice to Paramount that the enrollee would like to terminate coverage;

- Loss of Eligibility – The enrollee is no longer eligible for coverage in a QHP through Paramount;
- Non-payment – An individual fails to pay premiums by the appropriate deadlines and the following grace periods have been exhausted:
 - For an individual eligible to receive APTC, the 3-month grace period provided by Paramount has been exhausted; and
 - For individuals not eligible to receive APTC, the 30 day grace period has been exhausted;
- Rescission – The enrollee’s coverage is rescinded by Paramount;
- Withdrawal of Product or Decertification – The plan is withdrawn by the carrier and terminates or is decertified; or
- The enrollee changes from one QHP to another during an annual open enrollment period or special enrollment period.

For the purposes of this section, reasonable or appropriate notice is defined as fourteen days from the requested Effective Date of termination.

In the case of voluntary termination by the enrollee, the last day of coverage is –

- The termination date specified by the enrollee, if the enrollee provides reasonable notice.
- Fourteen days after the termination is requested by the enrollee, if the enrollee does not provide reasonable notice.
- On a date determined by the enrollee’s QHP issuer, if the enrollee’s QHP issuer is able to complete the termination in fewer than fourteen days and the enrollee requests an earlier termination Effective Date.
- If the enrollee is newly eligible for Medicaid, Medicare, or CHIP, the last day of coverage is the day before such coverage begins.

In the case of termination for non-payment coverage ends:

- For individuals who are eligible for the Advance Premium Tax Credit (APTC), on the last day of the month for which premium payment was received in full during the non-payment grace period, but no earlier than the last day of the first month of that grace period.
- For individuals who are not eligible for the Advance Premium Tax Credit, on the last day of the month for which premium payment was received in full.

In the case of termination due to the enrollee changing from one QHP to another during an annual open enrollment period or special enrollment period, the last day of coverage in an enrollee’s prior QHP is the day before the Effective Date of coverage in his or her new QHP.

Regardless of the date of termination, premium payments are never prorated. If coverage is in effect on the first of a month, full premium payment will be billed and is due for that month.

REFUNDS

Paramount will only process refunds for clerical or billing errors that are caused by Paramount. There are no pro-rated refunds given for terminating coverage in the middle of the month, and all coverage begins at the beginning of the month according to the policies and guidelines outlined in this document. All premiums are paid before the month of coverage, and once paid, are non-refundable. The only exception to this rule is if the enrollee has elected to pay several months ahead in their premium payments. Any credit that is on an account after Paramount settles the account for the determined Effective Date of termination will be refunded to the subscriber by check.

XV. PAYMENT FOR COVERAGE

The prepayment rate is based on the age and gender of the contract holder and the number of covered Dependents.

Paramount requires full payment by the first of each month. Invoices will be sent to the current address on file approximately ten (10) days in advance of the due date. We will not accept partial payments. A partial payment will be returned to you.

XVI. MEMBER SERVICES

Paramount values your comments and suggestions to improve our services. It is our goal to resolve any concerns as quickly and satisfactorily as possible.

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

If You Receive a Bill

With the exception of copays and non-Covered services, participating providers may not bill you for Covered Services. If you receive a bill or statement, it is usually just a summary of the activity on your account. If you have any questions about any amount(s) shown on the bill or statement, please contact Member Services.

XVII. WHAT TO DO WHEN YOU HAVE QUESTIONS, SUGGESTIONS, COMPLAINTS OR APPEALS

Paramount's Member Services Department is available to assist you with any questions from 8:00 A.M. to 5:00 P.M., Monday through Friday. If you call the Member Services Department after hours, you may leave a message and we will call you back on the next working day. You may also Email at: PHCMbrSvcAppeals@ProMedica.org.

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

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

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

How to Handle a Complaint

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

Appeal to Paramount

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

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

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

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

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

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

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

Instructions for Requesting an Internal Appeal

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

You must request an internal appeal in writing, unless the claim involves urgent care, in which case the appeal may also be requested orally. A claim involving "urgent care" is any claim for medical care or treatment with respect to which

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

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

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

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

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

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

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

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

Full and Fair Review

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

- (1) The review will take into account all comments, documents, records, and other information that you submit relating to the claim, without regard to whether this information was submitted or considered in the initial benefit determination;
- (2) The review will not afford deference to the initial adverse benefit determination and will be conducted by an appeal representative of Paramount and/or reviewed by a health care professional who is neither the individual who made or was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal, nor his or her subordinate;

- (3) The review will be conducted by an appeal representative of Paramount in consultation with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate;
- (4) The review will be conducted in a manner designed to avoid conflicts of interest by ensuring the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual will not be made based upon the likelihood that the individual will support the denial of benefits; and
- (5) There will be no reduction or termination of an ongoing course of treatment without advance notice from Paramount or an opportunity for advance review.

Concurrent Internal Appeal and External Review

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

- (1) Your treating physician certifies in writing that you have a medical condition where the time frame for completion of an expedited review of an internal appeal involving the Adverse Benefit Determination would seriously jeopardize your life or health or your ability to regain maximum function; or
- (2) In the case of experimental or investigational treatment that otherwise meets the criteria for an external review, you may request an expedited review orally or by electronic means, if your treating physician also certifies in writing that the requested health care service would be significantly less effective if not promptly initiated.

If Your Appeal is Denied

If your appeal is denied, the appeal representative of Paramount will provide you with a written or electronic notification of the determination. The notification will be called a Final Adverse Benefit Determination. The Final Adverse Benefit Determination will tell you the specific reason(s) for the denial, the specific plan provisions on which the determination is based, that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits and a statement of the right to bring an action under section 502(a) of ERISA. The Final Adverse Benefit Determination will also inform you of the right to pursue an external review, and explain the procedures for initiating the review including the time frames within which you must request external review. If the claim involves urgent care, the notice may be provided to you orally within the time frames for urgent care claims described above. A written or electronic notice will be furnished to you within three days after the oral notice.

Your Right to an Additional Appeal

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

- (1) You are entitled to an external review by an Independent Review Organization (IRO) if:
 - a. the Adverse Benefit Determination involves a medical judgment or is based on any medical information (this includes a decision that a covered person sought services at an emergency room for a condition that did not meet the prudent layperson definition of an emergency); or
 - b. the Adverse Benefit Determination indicates the requested service is experimental or investigational, is not specifically listed as an excluded benefit, and the treating physician certifies one of the following:

- i. Standard health care services have not been effective in improving your condition;
 - ii. Standard health care services are not medically appropriate for you;
 - iii. No available standard health care service covered by Paramount is more beneficial than the requested health care service.
- (2) You are entitled to an external review by the Department of Insurance if:
- a. the Adverse Benefit Determination is based on a contractual issue that does not involve medical judgment or any medical information; or
 - b. the Adverse Benefit Determination indicates that emergency medical services did not meet the prudent layperson definition of emergency and Paramount's decision has already been upheld through an external review by an IRO.

Exhaustion Requirements

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

- (1) Paramount agrees to waive the exhaustion requirement;
- (2) You did not receive a written decision on your internal appeal within the required time frame;
- (3) Paramount fails to meet all of the requirements of the internal appeal process unless the failure:
 - a. was de minimis;
 - b. does not cause or is not likely to cause you prejudice or harm;
 - c. was for good cause and beyond Paramount's control; and
 - d. is not reflective of a pattern or practice of non-compliance.

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

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

Instructions for Requesting External Review

You may at no cost to you, request an external review at any time *within 180 days* of the date of the Final Adverse Benefit Determination. When filing a request for external review, you will be required to authorize the release of your medical records as necessary to conduct the review. An authorization for the release of your medical records will be provided to you with the Final Adverse Benefit Determination. The completed authorization form must be returned with your request for external review or confirmation of your request for an expedited external review.

All requests for external review shall be made in writing, except when making a request for an expedited review. Requests for an expedited external review may be requested orally or by electronic means. When an oral or electronic request for review is made, written confirmation of the request must be submitted to Paramount no later than five days after the initial request was made. In connection with your written request for external review, you should submit comments, documents, records, and other information you believe is important to the claim for benefits that is the subject your request for external review.

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

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

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

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

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

Expedited External Review

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

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

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

External Review of Experimental or Investigational Health Care Services

You may request an external review of a Final Adverse Benefit Determination based on the conclusion that a requested health care service is experimental or investigational, except when the requested health care service is explicitly listed as an excluded benefit.

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

External Review Determination:

An IRO assigned to review a Final Adverse Benefit Determination will provide you written notice of its decision to either uphold or reverse the determination within 30 days of receipt of a request for standard review or a standard review involving experimental or investigational treatment, or within 72 hours of receipt of an expedited request.

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

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

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

XVIII. COORDINATION OF BENEFITS

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

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

Definitions

- A. A "Plan" is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for Members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.
- (1) Plan includes: group and nongroup insurance contracts, health insuring corporation (HIC) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.
 - (2) Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; supplemental coverage as described in Revised § sections 3923.37 and 1751.56; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

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

- B. “This plan” means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of the other plans. Any other part of the contract providing health care benefits is separate from This plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only similar benefits, and may apply another COB provision to coordinate other benefits.
- C. The order of benefit determination rules determine whether This plan is a Primary plan or Secondary plan when the person has health care coverage under more than one Plan.

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

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

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

- (1) The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable Expense, unless one of the plans provides coverage for private hospital room expenses.
 - (2) If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.
 - (3) If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.
 - (4) If a person is covered by one Plan that calculates its benefits or services on the basis of usual or customary fees or relative value schedule reimbursement methodology or similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fee or payment amount is different than the Primary Plan’s payment arrangement and if the provider’s contract permits, the negotiated fee or payment shall be the Allowable expense used by the Secondary plan to determine its benefits.
 - (5) The amount of any benefit reduction by the Primary plan because a covered person has failed to comply with the plan provisions is not an Allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.
- E. Closed panel plan is a Plan that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel Member.
 - F. Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the Child resides more than one half of the Calendar Year excluding temporary visitation.

Order of Benefit Determination Rules

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

- A. The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.
- B. (1) Except as provided in Paragraph (2), a Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying plan is primary.
- (2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide out-of-network benefits.
- C. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.
- D. Each Plan determines its order of benefits using the first of the following rules that apply:
- (1) Non-Dependent or Dependent. The Plan that covers the person other than as a Dependent, for example as an employee, Member, policyholder, Subscriber or retiree is the Primary plan and Plan that covers the person as a Dependent is the Secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person other than as a Dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, Member, policyholder, Subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.
- (2) Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a Dependent Child is covered by more than one Plan the order of benefits is determined as follows:
- (a) For a Dependent Child whose parents are married or are living together, whether or not they have ever been married:
- The Plan of the parent whose birthday falls earlier in the Calendar Year is the Primary plan; or
 - If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.
 - However, if one spouse's plan has some other coordination rule (for example, a "gender rule" which says the father's plan is always primary), This plan will follow the rules of that plan.
- (b) For a Dependent Child whose parents are divorced or separated or not living together, whether or not they have ever been married:
- (i) If a court decree states that one of the parents is responsible for the Dependent Child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the decree;
- (ii) If a court decree states that both parents are responsible for the Dependent Child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;
- (iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent Child, the provisions of Subparagraph (a) above shall determine the order of benefits;
- (iv) If there is no court decree allocating the responsibility for the Dependent Child's health care expenses or health care coverage, the order of benefits for the Child are as follows:
- The Plan covering the Custodial parent;
 - The Plan covering the spouse of the Custodial parent;
 - The Plan covering the non-custodial parent; and then
 - The Plan covering the spouse of the non-custodial parent.

- (c) For a Dependent Child covered under more than one Plan of individuals who are not the parents of the Child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the Child.
- (3) Active Employee or Retired or Laid-off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering the same person as retired or laid off employee is the Secondary plan. The same would hold true if a person is a Dependent of an active employee and that same person is a Dependent of a retired or laid off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.
- (4) COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, The Plan covering the person as an employee, Member, Subscriber or retiree or covering the person as a Dependent of an employee, Member, Subscriber, or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.
- (5) Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, Member, policyholder, Subscriber or retiree longer is the Primary plan and the Plan that covered the person the shorter period of time is the Secondary plan.
- (6) If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This plan will not pay more than it would have paid had it been the Primary plan.

Effect on the Benefits of this Plan

- A. When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, The Secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary plan. The Secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim. In addition, the Secondary plan shall credit to its plan Deductible any amounts it would have credited to its Deductible in the absence of other health care coverage.
- B. If a covered person is enrolled in two or more Closed panel plans, and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed panel plan, COB shall not apply between that Plan and the other Closed panel plans.

Right to Receive and Release Needed Information

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

Facility of Payment

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

Right of Recovery

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

Coordination Disputes

If you believe that Paramount has not paid a claim properly, you should first attempt to resolve the problem by contacting Paramount at (419) 887-2525 or refer to Section XVII, What to do When You Have Questions, Suggestions, Complaints and Appeals. If you are still not satisfied, you may call the Ohio Department of Insurance for instructions on filing a consumer complaint. Call 1-800-686-1526, or visit the Department’s website at <http://insurance.ohio.gov>

XIX. WORKERS’ COMPENSATION

The benefits described in this program will not duplicate any benefit you or your covered Dependents receive under Workers’ Compensation laws or similar employer liability laws. Any reimbursement by Workers’ Compensation for services provided to a Member will be assigned to Paramount.

XX. SUBROGATION AND REIMBURSEMENT

Where a Member has benefits paid by Paramount for the treatment of sickness or injury caused by a third party, these are conditional payments that must be reimbursed by the Member if the Member receives compensation, damages or other payment as a result of the sickness or injury from any person, organization or insurer, including the Member’s own insurer and any uninsured and/or underinsured motorist insurance. Paramount may subrogate to the Member’s rights of recovery.

Paramount has reimbursement and subrogation rights equal to the value of medical benefits paid for Covered Services provided to the Member. Paramount subrogation rights are a first party claim against any recovery and must be paid before any other claims, including claims by the Member for damages (with the exception of claims by the Member pursuant to the property damage provisions of any insurance policy). This means the Member must reimburse Paramount, in an amount not to exceed the total recovery, even when the Member’s settlement or judgment is for less than the Member’s total damages and must be paid without any reductions in attorney's fees.

XXI. GENERAL PROVISIONS

A. **Governing Law**

This Evidence of Coverage is made and shall be interpreted under the laws of the State of Ohio.

B. **Assignment**

The benefits provided under this Evidence of Coverage are for the personal benefit of the Subscriber and can not be transferred or assigned. Any attempt to assign this contract will automatically terminate all rights.

C. **Entire Contract**

This Evidence of Coverage, applicable riders, and the completed application form constitute the entire contract between the parties. As of the Effective Date, all other agreements between the parties are superseded.

D. **Waiver by Agents**

No agent or other person, except an executive officer of Paramount, has authority to waive any conditions or restrictions of this document or the Summary of Benefits. No change in this document shall be valid unless evidenced by an endorsement or amendment signed by an authorized executive officer of Paramount.

E. **Amendments**

Paramount may change the benefits, rates, or other terms of this Evidence of Coverage. Paramount will give you at least thirty (30) days advance written notice of any change. We will mail the notice to the address as shown on our records.

F. **If Paramount Ends Operations/Company Insolvency**

1) Company is not a member of any guaranty fund:

In the event Paramount would end operations, Members' benefits would be covered until the expiration of this Evidence of Coverage. All prepayments must be made in accordance with the terms of the agreement. Since Paramount is not part of the guaranty fund, Members are protected only to the extent of the hold harmless provision required by 1751.13. The hold harmless provision states with the exception of a Deductible, Copayments, Coinsurance and non-covered services, Participating Providers may not bill a Member for Covered Services. If you are receiving a course of treatment when Paramount ends operations, Covered Services will continue to be provided by Participating Providers as needed to complete any medically necessary follow-up care for that course of treatment. If a Member is receiving Inpatient care at a hospital, coverage will be continued for up to thirty (30) days after the end of operations. If you need additional information, call the Member Service Department at (419) 887-2525 or 1-800-462-3589.

2) Enrollee financial obligations:

If Paramount ends operations, a Member may have to pay for health care services rendered by a non-Participating Provider whether or not Paramount authorized the service.

G. **Limitation of Actions**

No legal action may be taken against Paramount prior to exhausting all available rights of appeal under the grievance procedures or later than two (2) years after the occurrence upon which the legal action is based.

H. **Notice of Claim**

Any claim for services must be filed within 120 days of receiving the service in order to receive reimbursement. Paramount will not pay for services if notice is not given within 120 days.

I. **Relationship Between Paramount And Participating Physicians/Provider**

Physicians participating with Paramount are acting as independent agents and are not employees of the Health Plan. The final responsibility for all decisions with respect to medical care rests with the physician. Paramount is not responsible for providing medical services but rather for payment of those services. No claim may be made against Paramount for the actions of any provider.

J. New Technology Assessment

Paramount investigates all requests for coverage of new technology using the HAYES Medical Technology Directory as a guide. If further information is needed, Paramount utilizes additional sources including Medicare and Medicaid policy, Food and Drug Administration (FDA) releases and current medical literature.

K. 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.

XXII. DEFINITIONS

Basic Health Care Services as defined by Section 1751.01 of the Ohio Revised Code are: Physician's services, inpatient hospital services, outpatient medical services, emergency health services, diagnostic laboratory services and diagnostic and therapeutic radiology services, diagnostic and treatment services, other than prescription drug services, for Biologically Based Mental Illnesses; preventive health services including family planning, infertility services, periodic physical examinations and prenatal obstetrical care and well-Child care; routine patient care for patients enrolled in an Eligible Cancer Clinical trial pursuant to section 3923.80 of the Ohio Revised Code.

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

Calendar Year means January 1 through December 31.

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

Coinsurance is your share of the cost of some Covered Services (a percentage of the amount allowed). For, example, you may be responsible for 30% of the charge allowed for Covered Services.

Copayment is your share of the cost of some Covered Services. Copay is a specific dollar amount such as \$25.00. Copays are due and payable at the time services are provided.

Covered Services means an authorized service shown in this Summary of Benefits and rendered by a Provider for which Paramount will provide benefits. A Covered Service may be subject to a copay.

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

1. personal care such as help in walking, getting in and out of bed, bathing, eating, tube or gastrectomy feeding, exercising, dressing, enema and using the toilet.
2. homemaking, such as preparing meals or special diets;
3. moving the patient;
4. suctioning;
5. catheter care;
6. acting as a companion or sitter;
7. supervising medication which is usually self-administered, and
8. preparation/supervision over medical supplies and/or medical equipment not requiring constant attention of trained medical personnel.

Deductible is the amount you must pay for Covered Services within each Calendar Year before benefits will be paid by Paramount. The single Deductible is the amount each Member must pay; the family Deductible is the total amount any two or more family members must pay.

Dependent means any family member who meets all the applicable eligibility requirements, who has enrolled, and for whom the payment required by this Agreement actually has been received by Paramount.

Designated Representative means any entity appointed by Health Plan to administer managed care and/or cost containment programs for this Paramount.

Effective Date is the date your coverage begins under this Evidence of Coverage.

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

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

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

Emergency Services means the following:

1. 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;
2. Such further medical examination and treatment that are required by federal law to stabilize an Emergency Medical Condition and are within the capabilities of the staff and facilities available at the hospital, including any trauma and the burn center of the hospital.

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

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

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

Experimental/Investigative Services is any treatment, procedures, facility, equipment, drug, device or supply that the Health Plan does not recognize as accepted medical practice or which did not have required governmental approval when you received it. This includes treatments and procedures which:

1. are still in the investigative research state;
2. have not been adopted for general clinical use;
3. have not been approved or accepted by the appropriate review body; or
4. are not generally accepted by the local medical community as safe, appropriate, and effective treatment.

This determination is based on the recommendation of the Medical Advisory Committee, the most recent HAYES Medical Technology Directory® and on current evidenced-based medical/scientific publications

Health Plan means Paramount.

Health Plan Physician means any physician duly licensed to practice in the State of Ohio who is under contract with Paramount to provide Covered Services to Members. Health Plan Physicians are comprised of PCPs and Specialist Physicians.

Home Health Agency is a facility or program that is licensed, certified or otherwise authorized pursuant to the laws of the State of Ohio as a Home Health Agency. It is under contract with Paramount to provide the home health care covered by this Summary of Benefits.

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

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

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

Member means any Subscriber or Dependent as defined here.

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

Non-Biologically Based Mental Illness means mental illnesses that are not Biologically Based Mental Illnesses as defined in this Member Handbook.

Out-of-Pocket Maximum is the maximum amount of Copayments and Coinsurance including the Deductible you pay every Calendar Year. Once the Out-of-Pocket Maximum is met, there will be no additional Copayments and Coinsurance on Basic Health Services during the remainder of the Calendar Year. The Out-of-Pocket maximum is

stated in your Summary of Benefits. The single Out-of-Pocket Maximum is the amount each Member must pay, and the family Out-of-Pocket Maximum is the total amount any two or more covered family members must pay.

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

Participating Hospital means any hospital with which Paramount has a contract or established arrangements to furnish Covered Services to Members.

Participating Provider means a Health Plan physician, Participating Hospital, or other licensed health professional or licensed facility who or which, at the time care is rendered to a Member, has a contract with Paramount to furnish Covered Services to Members.

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

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

Primary Care Provider (PCP) means a Participating Provider who is designated by Health Plan as a PCP. PCPs are those specializing in family practice, internal medicine, or pediatrics.

Prior Authorization is required for certain procedures or services. It is the responsibility of the Participating Provider to obtain Prior Authorization from Paramount in advance of these procedures or services.

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

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

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

Subscriber means a person who meets all applicable eligibility requirements. This person enrolls as the contract holder in accordance with those requirements, and is responsible for payment.

Summary of Benefits is the description of covered and excluded services contained.

Supplemental Health Care Services as defined by Section 1751.01 of the Ohio Revised Code are: Services of intermediate, long-term care facilities; dental care; vision care; optometric services including lenses and frames; podiatric care; mental health services excluding diagnostic and treatment services for Biologically Based Mental Illness; short-term outpatient evaluative and crisis intervention mental health services; medical or psychological treatment and referral services for alcohol and drug abuse or addiction; home health services; prescription drugs; nursing services; services of a dietician licensed under Chapter 4759 of the Revised Code; physical therapy services; chiropractic manipulation therapy and any other category approved by the superintendent of insurance.

Urgent Medical Condition is an unexpected illness or injury requiring medical attention soon after it appears that is not permanently disabling or life-threatening.

Urgent Care Services means Covered Services provided for an Urgent Medical Condition at a participating urgent care facility or physician office.

PARAMOUNT INSURANCE COMPANY

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MEMBER SERVICES

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