Self Insured
HMO PLAN(S)
1/1/2016

ProMedica

Summary Plan Description

ASO HMO Member Handbook

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

SUMMARY OF PLAN INFORMATION

TYPE OF PLAN:

This is a self-insured managed care plan providing medical benefits. “The Benefit Plan” is administered through the Human Resources office of the Plan Sponsor, ProMedica Health System. The Plan Sponsor has retained the services of an independent Plan Administrator experienced in processing claims.

PLAN ADMINISTRATOR:

Paramount Insurance Company
P.O. Box 928
Toledo, OH 43697-0928
(419) 887-2525
1-800-462-3589

TYPE OF ADMINISTRATION:

Administrative services only. The Plan Administrator provides administrative services only and does not insure that any Benefit Plan expenses will be paid. Complete and proper claims will be processed promptly but in the event that there are delays in processing, the participants will have no greater rights to interest or other remedies than otherwise afforded by law.

THE BASICS

How Paramount Medical Home Works

If you enrolled in Paramount Medical Home refer to attached addendum “Program Guidelines for ProMedica, Inc.”.

How the Paramount HMO Benefit Plan Works

Your Primary Care Provider is your first contact when you need medical care. 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 (PCP). 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 Identification Card

Every Benefit Plan 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. Each Member's identification number is a unique number assigned to the Subscriber followed by two digits.

If your card is lost or stolen or any information is incorrect, call Paramount Member Services.

What Are Deductibles?

A Deductible is the amount you must pay for Covered Services within each Contract Year before benefits will be paid by Paramount. If your plan has a Deductible, it will be stated in your Summary of Benefits. The single Deductible is the amount each Member must pay, and the family Deductible is the total amount any two or more covered family members must pay**.** Preventive Health Services/Benefits and Covered Services requiring a Copayment are not subject to the Deductible. See “Preventive Health Services/Benefits” for a list of Preventive Health Services.

What Are Copayments and Coinsurance?

Benefit Plan members pay Copayments (copays) or Coinsurance for Essential Health Benefits 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 and preventive health services. See your Summary of Benefits for Copayments/Coinsurance on specific services. Copayments are payable at the time you receive services.

The Out-of-Pocket Copayment Limit is the maximum amount of Copayments and Coinsurance including the medical and prescription drug Deductible you pay every calendar year. Once the Out-of-Pocket Copayment Limit is met, there will be no additional Cost Sharing during the remainder of the calendar year**.** The Out-of-Pocket Copayment Limit is stated in your Summary of Benefits. **Please note that there are different Out-of-Pocket Copayment Limits for PHS-Aligned Providers and Paramount HMO Network Providers.** The Copayment/Coinsurance on Covered Services received from ProMedica-aligned Providers applies toward satisfying both the ProMedica-aligned and Paramount HMO Network Coinsurance Limits. Similarly, the Copayments/Coinsurance on Covered Services received from Paramount HMO Network Providers applies toward satisfying

both the Paramount HMO Network and ProMedica-aligned Coinsurance Limits. The single Out-of-Pocket Copayment Limit is the amount each Member must pay, and the family Out-of-Pocket Copayment Limit is the total amount any two or more covered family members must pay. ***Any Copayments and Coinsurance for infertility services, morbid obesity surgery, any penalties do not count toward the Out-of-Pocket Copayment Limit.***

Who to Call for Information

The Paramount Member Services Department will help you.

Call, if you:

- Have any questions about your coverage
- Have questions about the providers who participate with Paramount
- Have questions about how to obtain health care services
- Need help understanding how to use your benefits
- Need to change your Primary Care Provider
- Are changing addresses, or need to add a new family member to your plan
- Lose your Paramount identification card
- Or have any other health care coverage concerns

GETTING A DOCTOR'S CARE

Start with Your Primary Care Provider (PCP)

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. For children, you may designate a pediatrician as the 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.paramounthealthcare.com.

Your PCP is the doctor you chose to handle your medical care through your HMO Benefit Plan. PCPs are family practitioners, internists and pediatricians participating in the Paramount network. Each family member can have a different PCP.

If you have chosen an available doctor whom 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.

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.

Type of Care Required	Recommended Lead Time
Routine assessments, physicals or new visits	Call 30 days in advance
Routine follow-up visits (for recurring problems related to chronic ailments like high blood pressure, asthma, diabetes, etc.)	Call 10 days in advance
Symptomatic, non urgent (cold, sore throat, rash,	Call 2-4 days in advance

muscle pain, headache)	
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)	Call for same-day or next-day appointment
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	Call 14 days in advance
Routine Care/ Office Follow-Up Visits	Call 30 days in advance
Urgent Care, may not be life-threatening, but requires immediate attention (complex or dual problems)	Call for same-day or next-day appointment
Emergency Care, immediate threat to self or others (acutely suicidal or homicidal)	Immediately call 911 or seek medical treatment. Call your physician and/or Paramount within 24 hours, or as soon as possible.

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. The Benefit Plan will not cover claims associated with missed appointments.

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; plans are often different from one company to the next. 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 another doctor is covering for your Primary Care Provider during off-hours or vacation, you do not need Plan 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 the Benefit Plan first, before you see any new Primary Care Provider. Call the Paramount Member Services Department. The change can be made effective the day you call. You will receive a new identification card with your new physician's name and number. If you need to see the doctor before your card arrives, your doctor can call Paramount Member Services to check your membership.

If you need specific information about the qualifications of any participating physicians or specialists, 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.paramounthealthcare.com with links to the Ohio State medical Association. If you need a current directory, you may request one free of charge by calling the Paramount Member Services Department.

IF YOU HAVE A QUESTION about whether a service is covered, you can find out by calling Paramount Member Services.

ProMedica OB/GYN Specialists and Facilities

The services of ProMedica-aligned OB/GYN Specialists and certain ***elective*** services performed at ProMedica owned facilities are subject to a lower Member Copayment or Coinsurance than other Paramount HMO-contracted OB/GYN and Network facilities. See your Summary of Benefits for details. It is ***your*** responsibility to assure that ProMedica OB/GYNs and ProMedica owned facilities are being utilized where applicable to maximize your level of benefits. A list of ProMedica-aligned OB/GYNs and ProMedica owned facilities is available from the Paramount Member Services Department and on the Aliquant web site.

When You Need OB/GYN 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.paramounthealthcare.com.

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

When You Are Referred to a Specialist

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 Benefit Plan who are already seeing a specialist should verify that the specialist is participating with Paramount

Prior Authorizations

If a Medically Necessary covered service is not available from any Participating Providers, Paramount will make arrangements for an "out of plan Prior Authorization". Your Primary Care Physician 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 Participating Specialist agree that your condition requires the coordination of a Participating Specialist, your PCP will contact Paramount. Together, you, your Primary Care Provider, your Participating Specialist and Paramount will agree on a treatment plan. Once this is approved, the Participating 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 physician or 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 do not need to obtain prior approval from your PCP or Paramount. You should notify your Primary Care Provider as soon as reasonably possible that you were treated.

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

Pre-Service, Post-Service and Urgent Care Claims

Paramount will follow the guidelines below for processing initial requests for pre-service, post-service and urgent care claims in accordance with the Department of Labor (ERISA) requirements:

Type of Initial Request	Paramount Notification/Decision
If request for pre-service approval is incomplete	15 days from receipt of request (24 hours for urgent care claims)
Request for pre-service approval	15 days from receipt of request
Request for urgent care pre-service approval	72 hours for urgent care claims
Request for post-service reimbursement (claim)	30 days from receipt of claim
Additional information is needed for determination of post-service claim	15 day extension – Additional information may be provided at a minimum within 45 days from receipt that additional information is needed

Initial Determinations

When Prior Authorization is required, Paramount will make a decision within the above time periods for admissions to hospitals, out-of-plan Prior Authorization or other procedures that require Prior Authorization. Paramount will advise the provider of the decision by and will send written confirmation of the decision to the provider and the Member.

If Paramount makes an adverse determination (i.e., denies approval or coverage), Paramount will notify the requesting provider by telephone and will send written confirmation of the decision to the provider and the Member.

Adverse Determinations

If your claim is denied, Paramount will provide you with written or electronic notification of the determination. The notification will tell you the specific reason(s) for the adverse determination, the specific plan provisions on which the benefit determination is based, that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits, a statement describing any additional appeal procedures offered by the plan and your right to obtain the information about those procedures, and a statement of your right to bring an action under section 502(a) of ERISA.

If your claim involves urgent care, the notice may be provided orally to you within the time frames for urgent care claims described above. A written or electronic notice will be furnished to you within 24 hours after the oral notice.

(For additional appeal information see What to Do When You Have Questions, Complaints or Appeals)

Entering the Hospital

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*. Show your Paramount Identification card when you are admitted.

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

An emergency admission to a nonparticipating 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.

Leaving the Hospital "Against Medical Advice"

If you discharge yourself from any hospital or facility *"against medical advice"* (AMA), there will be a penalty on all charges related to that admission. Also, if a hospital or facility requires your discharge (a "*disciplinary discharge"*) for any reason, you will be responsible for a penalty on all charges related to that admission.

Change in Benefits

The Plan Administrator will notify you in writing thirty (30) days in advance if any benefits described in this document change.

If a Provider Leaves the Benefit Plan

If your Primary Care Provider or any Participating Hospital can no longer provide medical services because its Paramount agreement has terminated, the Plan Administrator will notify you in writing within thirty (30) calendar days of the contract termination date. The Benefit Plan will cover all eligible services provided between the date of termination and five (5) working days from the postmark date on the notification letter.

If a Specialist Leaves the Benefit Plan

If you are regularly visiting a Participating Specialist or a specialty group whose agreement with Paramount has terminated, you and your PCP will be notified. You may then contact a Participating Specialist for an appointment.

Provider Reimbursement

You should always show your Paramount ID card to all providers. You are responsible for paying any office visit Copayments at the time you receive services. Participating Providers will notify the Benefit Plan of the services rendered. The Plan 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. The Plan Administrator will send you a notice if any service is not covered. If you receive a denial notice and need further explanation or wish to appeal, you may call the Paramount Member Services Department for assistance.

Paramount contracts with providers for health care services on an economically competitive basis, while taking steps to ensure that all members receive appropriate and timely access to qualified providers. Through contracts with participating providers, Paramount obtains discounts and rebates. When copayments are charged as a percentage of eligible expenses, the amount you pay is determined as a percentage of the allowed amount between Paramount and the participating provider, rather than a percentage of the provider's billed charge. Paramount's allowed amount is ordinarily lower than the participating provider's billed charge.

Non-Covered Services

If you receive care for services that are not covered by this Benefit Plan, you are responsible for full payment to the provider of those services.

If You Receive a Bill

With the exception of Deductible, Copayments 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 Paramount Member Services.

Explanation of Benefits (EOB)

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

Paramount to help You understand the coverage You are receiving. The EOB shows:

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

New Technology Assessment

Paramount investigates all requests for coverage of new technology using the most current 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. This information is evaluated by Paramount's Medical Director and other physician advisors.

Privacy and Confidentiality

Paramount will keep all documented Member medical and personal information, whether obtained in writing or verbally, in the strictest confidence in accordance with HIPAA Privacy Standards. Paramount will provide Members with the opportunity to approve or deny the release of identifiable personal information, except when such release is required by law.

Insurance Fraud

Insurance fraud significantly increases the cost of health care. Paramount encourages you to let us know if you have any questions or concerns about Paramount providers and/or the services you receive. Please contact the Paramount Member Service Department for confidential handling at (419) 887-2525, or toll-free at 1-800-462-3589. TTY services for the hearing impaired are available at (419) 887-2526 or toll-free 1-800-740-5670. You may also contact the ProMedica Health System Compliance Hotline for confidential investigation. That hotline number is (419) 824-1815 or toll-free 1-800-807-2693.

WHAT TO DO FOR URGENT CARE OR EMERGENCY MEDICAL CONDITIONS

Urgent Care Services

URGENT CARE SERVICES means covered services provided for an Urgent Medical Condition. An Urgent Medical Condition is an unexpected illness or injury requiring medical attention ***soon*** after it appears. It is not permanently disabling or life-threatening. 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 copay or coinsurance, depending on where you receive treatment. Your Copay/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.paramounthealthcare.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 facility or walk-in clinic. The service will be subject to a Copay/Coinsurance, depending on where you receive treatment. Your Copay/Coinsurance may be found in your Summary of Benefits.

Follow-up care within the Service Area: Your Primary Care Provider will decide 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 Paramount Member Services BEFORE you get the services. Paramount 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" which are required as the result of an "Emergency Medical Condition" are covered at any medical facility, anytime, anywhere world-wide ***without Prior Authorization***. The service will be subject to an emergency room, urgent care facility or office visit copay, depending on where you receive treatment and the plan option you selected. Your Copay/Coinsurance may be found 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, which 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:

a) 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;
b) Serious impairment to bodily functions; or
c) Serious dysfunction of any bodily organ or part.

"Emergency Services" mean the following:

a) A medical screening examination, as required by federal law, which is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department, to evaluate an Emergency Medical Condition;

b) Such further medical examination and treatment that are required by federal law to stabilize an Emergency Medical Condition and are within the capabilities of the staff and facilities available at the hospital, including any trauma and 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 physical location transfer, if the medical condition could result in any of the following:

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

The Benefit Plan will cover Emergency Services provided at participating facilities. The Benefit Plan will cover Emergency Services at nonparticipating facilities when one of the following situations occurs:

a) Due to circumstances beyond the Member's control, the Member was unable to utilize a participating facility without serious threat to life or health.
b) 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.
c) A Paramount representative refers the Member to an emergency room and does not specify a participating emergency room.
d) An ambulance takes the Member to a non-participating facility other than at the direction of the Member.
e) The Member is unconscious.
f) A natural disaster prevented the use of a participating facility.
g) 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 or its Designated Representative. 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 that 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. The Plan will cover "Emergency Services" from non-participating providers inside the Service Area related to "Emergency Services". Appropriate copays will be applicable.

You must contact your Primary Care Provider or Paramount within 24 hours after the emergency has occurred (or as soon after as possible).

Outside the Service Area: Call 911, an ambulance or rescue squad or go to the nearest emergency facility for treatment. Show your Paramount Identification card. In some cases, you may be required to make payment and seek reimbursement from the Benefit Plan. The Benefit Plan will cover "Emergency Services" from non-participating providers outside the Paramount Service Area related to emergency services. Appropriate copays will be applicable.

Follow-up care within the Service Area: Follow-up medical care must be arranged by your Primary Care Provider 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 Paramount Service Area is not covered unless authorized by your Primary Care Provider and Paramount BEFORE the follow-up care begins.

Out-of-Area Student Coverage

Your ProMedica Benefit Plan includes coverage for emergency, urgent, and follow-up care as well as care provided by college or university student health centers while your full-time student Dependent is away at school outside the Paramount HMO Service Area through Paramount's *Student Coverage 101 Program*. If your Dependent student needs medical care away from home that is not available from the student health center and it is not an emergency or urgent condition, before seeking services You or Your Dependent student should contact our Utilization Management department to obtain prior authorization. In the event of an Emergency Medical Condition, call 911, an ambulance or rescue squad or go directly to the nearest medical facility.

Paramount's Utilization Management department is also available to assist You and/or Your Dependent student in locating providers outside of the Paramount HMO Service Area; contact Utilization Management at (419) 887-2520 or 1-800-891-2520.

If you are admitted to a hospital outside the Paramount Service Area, you 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 HMO Service Area

The Paramount HMO 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 and Monroe and Lenawee counties in Michigan. Paramount may periodically add or remove certain counties from their service area. Benefit Plan Participants should contact Paramount Member Services for an updated listing of the Paramount HMO Service Area.

YOUR BENEFIT PLAN

What Is Covered - In General

The basic steps you must take to get a doctor's care under this Benefit Plan, and situations in which the Benefit Plan will not pay for care, are explained beginning with Getting a Doctor's Care.

To be covered by the Benefit Plan, the health services you receive must meet Medical Necessity criteria and be from Paramount Participating Providers, except in emergencies or with written Prior Authorization from Paramount.

What Is Not Covered - In General

These services and supplies are not covered:

1. Services by providers chosen only for convenience (for example, if you use a nonparticipating X-ray or lab provider because their offices are nearby).

2. Any service received from any other nonparticipating physician, hospital, person, institution or organization unless:

a. Prior special arrangements are made by Paramount or

b. Such services are for Emergency Medical Conditions as described in What to Do for Urgent Care or Emergency Medical Conditions.

3. Services received before coverage began or after coverage ended. However, if coverage ends while the Member is a patient in a hospital for a service covered by the Benefit Plan, charges related to that hospital stay will be covered according to the Benefit Plan until the Member is discharged if the Member has no other coverage. If the Member has new coverage, this Benefit Plan will provide coverage up to the effective date of the new plan.

4. Non-emergency services from non-participating providers without Prior Authorization from Paramount.

5. Any court-ordered testing, treatment or hospitalization, unless determined to be Medically Necessary by Paramount and rendered by a Participating Provider.

6. Care for conditions which state or local laws require to be treated in a public facility or for which a Member is not legally required to pay.

7. Care for disabilities related to military service to which the Member is legally entitled.

8. Care provided to Members by relatives.

9. All charges incurred as a result of a non-covered procedure. (Medically necessary services due to complications of a non-covered procedure are covered.)

10. All charges for completion of reports, transfer of medical records, or missed appointments. Self-help audio cassettes, videos and books.

11. Assisted reproductive technology such as, artificial insemination, in vitro fertilization, embryo transplant services, GIFT, ZIFT infertility drugs and related services and any other assisted reproductive technology. May vary by Business Unit; see your Summary of Benefits

12. Surrogate parenting/pregnancy and related services.

13. Non-Emergency Services from hospital emergency facilities and providers unless prior direction is received from the Primary Care Provider or Paramount.

14. Examinations and/or immunizations specifically for the purpose of obtaining or maintaining employment, obtaining insurance and/or professional or other licenses; examinations prior to engaging in athletic or recreational activities or attending camp, school or other program and services for other than therapeutic purposes such as custody evaluations, adoption, research and judicial proceedings.

15. All claims for benefits submitted by or on behalf of the Member after one (1) year from the date of service.

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

What Is Covered/What Is Not Covered - Specific Services

The notation (C/L) means that a Copayment or Coinsurance may be required for Covered Services or that there may be additional limitations to these services according to the Benefit Plan's benefits. Benefit limits for certain services may be day or visit limits or a maximum benefit limit each calendar year. At the start of a new calendar year, benefits with limitations will renew. **See your Summary of Benefits for your copay requirements and specific limitations on services.**

A list of services follows, in alphabetical order:

Abortion Not covered, unless medically necessary (i.e., to save the life or protect the health of the mother).

Acupuncture Not covered.

Alcoholism and drug addiction treatment (See Substance Abuse services)

Allergy testing and therapy (injections) (C/L) Covered.

Alternative Medicine/Therapy Not covered. Including but not limited to: non-prescription drugs or medicines, vitamins, nutrients, food supplements, biofeedback training, neurofeedback training, hypnosis, acupuncture, acupressure, massage therapy, aromatherapy, Chelation therapy, rolfing and related diagnostic tests.

Ambulance (C/L) Covered for Emergency Medical Conditions when medically necessary and to the nearest medically appropriate facility.

Not covered: Transportation services in non-emergency situations and to hospitals beyond the nearest medically appropriate facility.

Asthma Supplies (C/L) the asthma supplies below are covered subject to the Durable Medical Equipment Coinsurance and limits.

- Peak expiratory flow rate meter (hand-held), and
- Spacers for metered dose inhalers.

Biofeedback Not covered.

Blood Covered for the cost of administration and storage of blood and blood products, when a volunteer replacement program is not available.

Breast Augmentation or Reduction Not covered.

Chiropractic services Not covered.

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 participant's 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 or funded by one or more of the following**:
  1. The National Institute of Health
  2. The Centers for Disease Control and Prevention.
  3. The Agency for Health Care Research and Quality.
  4. The Centers for Medicare & Medicaid Services.
  5. Cooperative group or center of any of the entities described in clauses 1-4 or the Department of Defense or the Department of Veterans Affairs.
  6. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.

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

Contraceptive services (C/L) Sterilization for men (Vasectomies). FDA Contraceptive Services for women are covered under Preventive Health Services.

Cosmetic surgery Not covered. Cosmetic therapy or surgery is a procedure primarily for the purpose of altering or improving appearance.

Including but not limited to:

- Skin tags
- Sclerotherapy for spider angiomas (veins)
- Breast reduction/augmentation
- Face lifts, tummy tucks, panniculectomy and liposuction. Blepharoplasty (eyelid lift) unless Medically Necessary.
- Scar revision and correction.
- Torn pierced ear lobes.
- Chemical face peels and dermabrasion

Custodial Care Not covered.

Dental emergency treatment and oral surgery (C/L) A dental plan will be primary when available. The following services are covered ONLY for the following limited oral surgical procedures when you have Prior Authorization:

- First aid received within forty-eight (48) hours of an accidental injury to sound natural teeth, the jaw bones or surrounding tissues. This includes only extraction of teeth, emergency treatment of teeth and repair of soft tissue. Not covered: Replacement or restoration of teeth.
- Medically necessary orthognathic (jaw) surgery, as determined by Paramount
- Treatment for tumors and cysts (including pathological examination) of the jaws, cheeks, lips, tongue, roof and floor of the mouth
- Medically necessary oral surgery to repair fractures and dislocations of the upper and/or lower jawbone only
- Medical treatment for temporomandibular joint syndrome or dysfunction (TMJ)

Not covered: General dental care services, including but not limited to:

- Treatment on or to the teeth, bridges or crowns
- Extraction of teeth, including impacted wisdom teeth
- Treatment of granuloma
- Dental treatment including splints and oral appliances for temporomandibular joint syndrome or dysfunction (TMJ)
- Placement, removal or replacement or implants of the teeth and alveolar ridge including preparatory oral and maxillofacial surgery (bone grafts)
- Treatment of periodontal (gum) disease and abscesses
- Root canals
- Bite plates, retainers, snore guards, splints or any appliance or device that is fitted to the mouth.
- Any other dental products or services
- Treatment required for an injury as a result of chewing or biting
- Upper and lower jawbone surgery except as required for direct treatment of acute traumatic injury or cancer, or as necessary to safeguard a Member's health due to a non-dental physiological impairment.

Diabetic Supplies (C/L) The diabetic supplies below are covered if the Group has purchased the optional Durable Medical Equipment Rider subject to the Coinsurance and limits of the Durable Medical Equipment Rider.

- Needles with syringes (1 cc or less),
- Tubing for infusion pump,
- Blood glucose monitor, test strips and control solutions, and
- Lancing devices, lancets.

Diagnostic services (C/L) Covered for medically necessary outpatient diagnostic testing by a Participating Provider. Covered Services include:

- X-rays
- Laboratory tests
- EKGs, EEGs
- Hearing tests
- Pre-admissions tests
- Mammograms and pap smears. Screening mammograms and pap smears are covered when ordered by the PCP or Participating Specialist.
- Imaging/Nuclear cardiology studies when preauthorized by PCP or Participating Specialist.

Not covered: Court-ordered testing unless determined to be Medically Necessary by Paramount and rendered by a Participating Provider.

Drugs and other medicines (C/L) Covered when given during a hospital stay or as an outpatient

Not covered:

- Growth hormones or steroids used for growth and development.

Drug addiction treatment (See Substance abuse services)

Durable Medical equipment (C/L) Covered from Participating Providers if the item serves a medical purpose only and can withstand repeated use. The Benefit Plan covers medical equipment and supplies that are covered by Medicare Part B and meet Medicare Part B criteria. This includes but is not limited to: oxygen, crutches, wheelchairs, hospital beds, ostomy supplies, etc.

Not covered:

- Medical equipment and supplies not covered by Medicare Part B
- Disposable supplies (except for ostomy supplies), test kits etc.
- Exercise equipment, air conditioners
- Hearing aids
- Penile implants, erectile devices
- Wigs
- Bite plates, retainers, snore guards, splints or any appliance or device which is fitted to the mouth

Emergency services (C/L) Covered for facility and physician services for Emergency Medical Conditions meeting the definition in this document. The facility (hospital) charge will be subject to the emergency room Copayment noted on your Paramount card. The emergency room copay will be waived if the Member is admitted as a hospital inpatient.

Employer requested exams and treatment Not covered, unless determined to be Medically Necessary by Paramount and rendered by a Participating Provider.

Experimental organ transplants, drugs, devices, tests, medical or surgical procedures Not covered

Foot Care (C/L) Covered when using a Participating Specialist.

Not covered:

- Trimming and/or scraping of calluses, corns and nails except for services with a diagnosis of diabetes or other conditions causing loss of sensation.
- Extra Corporeal Shock Wave Therapy (ESWT)

Growth hormones/steroids Not covered for use to promote growth and development.

Home health care (C/L) Covered when using a Participating Provider.
Services include:

- Physician services
- Intermittent skilled nursing care
- Physical, occupational and speech therapy
- Other medically necessary services

Not covered:

- Personal comfort and convenience items and services such as meals, housekeeping, bathing and grooming.
- Any services or supplies furnished by a non-eligible institution, which is any institution other than a hospital or skilled nursing facility (for example, custodial, convalescent, domiciliary and intermediate or day care)
- Care provided by family members
- Trimming of calluses, corns and nails
- Custodial or respite care

Hospice services (C/L) Covered when medically necessary for terminally ill patients and when properly referred to Participating Providers.

Hospital and other facility services

Inpatient services: (C/L) Covered for inpatient room, board and general nursing care in non-private rooms. (See Entering the Hospital)

Outpatient services: (C/L) Covered; including surgery, observation care and diagnostic testing. Outpatient emergency room care is covered under certain conditions. (See What to Do for Urgent Care or Emergency Medical Conditions)

Outpatient Surgery: (C/L) Certain benefit plans have a copay if an outpatient surgical facility or hospital surgical treatment room is used. Outpatient surgical facilities or hospital surgical treatment rooms are used for surgical procedures and other procedures including but not limited to endoscopic procedures such as colonoscopy and laparoscopy. See your Summary of Benefits.

Professional services: (C/L) The services of physicians and other professionals are covered when related to eligible inpatient and outpatient hospital services. Covered services include:

- Surgery
- Medical Care
- Newborn Care
- Obstetrical Care
- Anesthesiology
- Radiology and pathology

Except in an emergency, admissions must be to Participating Hospitals and must have prior authorization from Paramount.

Services and supplies: Covered when medically necessary if you are an Inpatient or Outpatient.

Not covered:

- Personal convenience items and services (telephone or television rental, guest meals, etc.)
- Private rooms, unless determined to be medically necessary by Paramount
- Private-duty nursing while an inpatient
- Any services or supplies furnished by a non-eligible institution, which is any institution other than a hospital or skilled nursing facility (for example, custodial, convalescent, domiciliary and intermediate or day care)

PLEASE REFER TO YOUR SUMMARY OF BENEFITS for inpatient and outpatient limitations.

Infertility Services (C/L) Covered for the medically necessary diagnosis and treatment of infertility conditions up to the Infertility Lifetime Maximum Benefit. **Copay/Coinsurance will not apply to annual Out-of-Pocket Copayment Limit.**

Not Covered

- Infertility drugs (Covered under the Prescription Drug Program)
- Any assisted reproduction technology (ART) such as:
  - Artificial insemination
  - In vitro fertilization and related services,
  - Embryo transplant services, GIFT, ZIFT, zygote transfer,
  - Reversal of voluntary sterilization,
  - Cost of donor sperm or donor egg, and
  - Services and supplies related to ART procedures.

Kidney disease treatments (C/L) Covered for:

- Hemodialysis
- Peritoneal dialysis
- Kidney transplant services
- If the patient qualifies for End-Stage Renal Disease (ESRD) benefits under Medicare, the Plan will coordinate benefits as the secondary payor. All Paramount procedures must be followed.

Laser treatment including Candela, V-beam and photodynamic therapy for rosacea, port wine stains and other skin disorders. Not Covered

Maternity care and family planning (C/L) Covered for:

- Prenatal and postnatal care (office visit copay does not apply to prenatal and postnatal visits)
- Delivery including complications of pregnancy, hospitalization and anesthesia. A minimum hospitalization of forty-eight (48) hours will be allowed for normal vaginal delivery and ninety-six (96) hours for cesarean delivery unless you and your physician determine otherwise. If you are discharged earlier, follow-up home health care by a participating provider will be covered for at least seventy-two (72) hours after discharge.
- Voluntary sterilization.

Not covered:

- Surrogate parenting/ pregnancy and related services.
- Abortions, unless medically necessary (i.e., to save the life or protect the health of the mother)
- Outpatient self-administered prescription drugs

Mental Health Services (C/L)

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

- **Services for a Biologically and/or Non-Biologically Based Mental Illness** (C/L) Covered for inpatient and outpatient care, emergency care and prescription drugs (if Group has purchased the optional Prescription Drug rider) subject to the same Deductible, Copayments and/or Coinsurance, plan standards and medical management processes as any other medical/surgical benefit within the same classification or sub

classification. This includes intermediate levels of care such as residential treatment, partial hospitalization and intensive outpatient services.

- Outpatient office visits are subject to the Primary Care Physician Copayment/Coinsurance.

Not covered:

- Court-ordered testing or treatment unless determined to be Medically Necessary by Paramount and rendered by a Participating Provider
- Testing and treatment for learning disabilities and mental retardation
- Marriage counseling and relationship counseling
- Hypnosis and biofeedback
- Social skills classes, behavioral modification and other training programs including but not limited to Applied Behavioral Analysis (ABA) programs

Morbid Obesity Surgery (C/L) Surgery for the purpose of weight reduction or control is not covered except when specifically approved in advance by Paramount as medically necessary for severely obese Members with documented high-risk co-morbidities. Prior Authorization from Paramount must be obtained before coverage will be provided for the surgery and services will be referred to Paramount authorized providers. To obtain Prior Authorization, the Member must qualify under Paramount's Morbid Obesity Surgery Policy. If approved for coverage, the Member will be responsible for coinsurance on services related to the surgery and related post-surgical services. See Summary of Benefits for specific plan details. ***Coinsurance related to the surgery and post surgical services will not apply to annual Out-of-Pocket Copayment Limit.***

Office visits (C/L) Covered for:

- Your Primary Care Provider (PCP)
- Participating OB/GYNs and other Participating Specialists
- Eligible services provided during each visit, may include:

  - Periodic physical exams
  - Well-baby/child exams
  - Gynecological exams
  - Immunizations
  - Diagnostic procedures
  - Medical/surgical procedures

Not covered:

Charges for completion of reports, transfer of records, or missed appointments.

Oral surgery (See Dental emergency treatment and Oral Surgery.)

Plastic surgery (See Reconstructive surgery)

Penile implants Not covered.

Physical exams (C/L) Covered if exams are periodic physical exams as considered medically necessary by the physician.

Not covered when requested for:

- Obtaining or maintaining employment or governmental licensure

- Employer-requested physical exams
- Court-ordered or forensic evaluations unless determined to be Medically Necessary by Paramount and rendered by a Participating Provider
- Physicals and immunizations required for travel

Preventive Health Services (C/L) Covered Preventive Health Services include the following:

- Well-baby and well-child care including hearing screenings,
- Childhood immunizations,
- Periodic health evaluations, health screenings (obesity, type 2 diabetes, osteoporosis, gestational diabetes and HPV) and physical examinations for children and adults, including well women visits
- Cytologic screenings (Pap smears),
- Mammography screenings,
- Immunizations for influenza, tetanus and pneumonia,
- Colorectal screening (includes screening hemoccult, sigmoidoscopy and colonoscopy), and
- Prostate screening (PSA),
- Tobacco cessation classes.
- Contraceptive methods and counseling-injections, tablets under the skin, IUD
- Sterilization-tubal (preventive diagnosis)

Not covered:

- Immunizations for travel

NOTE: Additional preventive services, as determined by recommendations and comprehensive guidelines of governmental scientific committees and organizations are covered in full. For a comprehensive list of recommended preventive services please visit www.healthcare.gov/center/regulations/prevention.html.

Private Duty Nursing Not Covered.

Prosthetic devices (C/L) Covered from a Participating Provider subject to coverage by Medicare Part B. Refer to your Summary of Benefits for further Copayment or Coinsurance. Repair and replacement of a prosthetic device is covered subject to meeting Medicare Part B criteria. A Prosthetic Device is an artificial substitute that replaces all or part of a missing body part and its adjoining tissues.

Not covered:

Prosthetic devices not covered by or eligible under Medicare Part B.

Radial keratotomy or refractive surgery (Lasik) (surgery on the eyes to correct near-sightedness or far-sightedness) Not covered

Reconstructive surgery Covered when required for:

- Repair of anatomical impairment to improve or correct functional disability within 2 years of accident or injury.
- Breast reconstruction following a mastectomy; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas in accordance with the Women's Health and Cancer Rights Act of 1998.
- Plastic surgery following an accidental injury that results in a significant defect or deformity within 2 years of the accident.

- A malignant or non-malignant neoplasm within 2 years following initial surgery for neoplasm.

The above services are covered when required for the repair of a significant defect or deformity, as determined by Paramount.

Not covered:

- Cosmetic surgery
- Breast reduction/augmentation

Sclerotherapy for spider angiomas (veins) Not covered

Skilled nursing facility/Inpatient rehabilitation facilities (C/L) Covered when medically necessary with prior authorization from Paramount. Services must be at a participating facility approved by Paramount.

Not covered: Custodial care

Skin Tag Removal Not covered.

Sleep Studies (C/L) Coverage is available in participating facilities for certain clinical indications of obstructive sleep apnea, narcolepsy and seizure disorder when approved in advance by Paramount.

Not covered: Sleep studies for sexual dysfunction

Smoking cessation classes Covered at Participating Hospitals.

Specialty Drugs Specialty Drugs are not covered under the medical benefit plan. Specialty Drugs are covered under a Specialty Drug Rider administered by Paramount's pharmacy benefits manager through Specialty Pharmacies.

Substance Abuse Services (alcohol and drug abuse/addiction) (C/L) Covered for inpatient and outpatient care, emergency care and prescription drugs (if Group has purchased the optional Prescription Drug rider) for the diagnosis, crisis intervention and short-term treatment of substance abuse services. Covered services are subject to the same Deductible, Copayments and/or Coinsurance, plan standards and medical management processes as any other medical/surgical benefit within the same classification or sub classification**.** Outpatient office visits subject to Primary Care Physician Copayment/Coinsurance. This includes intermediate levels of care such as residential treatment, partial hospitalization and intensive outpatient services.

Not covered:

- Court-ordered testing or treatment unless determined to be Medically Necessary by Paramount and rendered by a Participating Provider

Surrogate Parenting and Pregnancy and related services Not covered.

Therapy services (C/L) Covered for:

- Chemotherapy, radiotherapy and radiation therapy
- Outpatient physical/occupational therapy. See Summary of Benefits for limitations.
- Speech therapy. See Summary of Benefits for limitations.

Not covered:

- Non-medical services such as vocational rehabilitation and employment counseling
- Testing, training and educational therapy for learning disabilities including developmental

delays in children
- Physical/occupational therapy beyond benefit limits
- Speech therapy beyond benefit limits
- Speech therapy for development or language disorders in children (aphasia, stuttering, hyperkinesia and extreme mental retardation). Equestrian therapy.
- Extra Corporeal Shock Wave Therapy (ESWT) for conditions of the feet, elbows and shoulders

Transplants (C/L) 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. 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 lodging and meals (not to exceed $30.00 per day 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.

Not covered:

- Services related to a Paramount organ/bone marrow donor for a non-Paramount recipient.
- Any transplant not approved by the Ohio Solid Organ Transplant Consortium or the Ohio Bone Marrow Transplant Consortium
- Coverage of non-Paramount donor unless no other coverage exists.
- Any services rendered at a non-Paramount Center of Excellence transplant site.

Transsexual surgery and related services Not covered.

Trimming of nails, calluses and corns Not covered except for services with a diagnosis of diabetes or other conditions causing loss of sensation.

Urgent care services (C/L) 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.

Vision care (C/L) Covered as needed for treatment related to a medical condition or disease of the eyes. One routine vision exam every twelve (12) months to monitor refractory disorders of the eyes will be covered. Service must be rendered by a Participating Specialist.

Not covered:

- Routine vision exams more often than every twelve (12) months
- Orthoptic/vision training
- Contact lenses, eyeglasses and other corrective lenses except following cataract surgery and as specified in the Summary of Benefits

Weight-loss/maintenance programs and treatments Not covered. This includes but is not limited to weight-loss programs and prescription drugs for weight loss.

Dietary or nutritional supplements for gaining or maintaining weight are not covered, except for charges for non-milk or non-soy formula required to treat diagnosed diseases and disorders of amino acid or organic acid metabolism, protein sensitivity resulting severe chronic diarrhea, and severe malabsorption syndrome resulting in malnutrition, provided the formula is prescribed by a Participating Physician, and the Physician furnishes supporting documentation to Paramount. The benefits will be limited to those conditions where the formula is the primary source of nutrition as certified by the treating physician by diagnosis."

WHO IS ELIGIBLE

The following persons are eligible for coverage. They must reside in the Paramount Service Area (see Option to Waive Out-of-Area Plan Coverage) and the Subscriber (ProMedica Health System employee) must list them on the enrollment application.

Subscriber If you are an active, full-time or part-time ProMedica Health System employee (based on the hours listed below), you are eligible to enroll as a Subscriber in one of the medical plans on the first of the month after your date of hire with ProMedica.

Employment status:		**Budgeted hours for medical eligibility**
Full-time		Works more than 70 hours per pay
Part-time		Works more than 32 hours per pay but less than 70 hours per pay

If you enroll, you can cover eligible dependents including:

- **Spouse** The legal spouse of the Subscriber.

  New Marriage - When a completed enrollment application is received by the Plan Sponsor within thirty (30) days from the date of marriage, coverage of new spouses becomes effective on the date of marriage.

  Divorce - You must notify the Plan Sponsor 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 on the date of divorce.

  Covering your working spouse – (Only applies to Full-Time and Non-Physician Employees). *Your spouse may not enroll as a Dependent under a ProMedica medical plan if he or she has access to single coverage from their employer for $225 per month or less, their employer provides an annual dollar amount to purchase coverage, their employer offers an incentive to decline coverage. If **one** of the situations below applies to your spouse, they will be eligible for medical coverage as your Dependent:*
  - Your spouse is not actively employed or is eligible for Medicare.
  - Your spouse is actively employed by ProMedica Health System.
  - Your spouse is actively employed but their employer does not offer medical coverage to employees in his/her status.
  - Your spouse is actively employed and their employer offers medical coverage to employees in his/her status, but the cost from his/her paycheck exceeds $225 per month ($103.84 per pay period for 26 bi-weekly pays or $112.50 per pay period for 24 semi-monthly pays per year) for the lowest level of single coverage.
  - Your spouse is actively employed outside the home and the employer offers medical coverage to employees in his/her status, but the only coverage available is through a plan network that does not include ProMedica Health System facilities.

Contact Human Resources for further questions or assistance.

- **Dependent children** Your child (ren) (including stepchildren or legally adopted children) until the end of the month in which he or she turns age 26. Disabled dependent children may continue to be eligible beyond age 26 under certain circumstances.)

- **Newborn children** A newborn child of a Subscriber (or the Subscriber's spouse). A completed enrollment application must be received within the first thirty (30) days following the birth. If the application is not received, the newborn child will not be eligible for coverage.

- **Adopted children** Natural and legally adopted children, children placed with you for adoption, or any other children for whom you or your spouse are named as legal guardian, according to a letter of guardianship. The adopted child must be enrolled within thirty (30) days from the event.

- **Court-ordered dependent Biological** or legally adopted children for whom you (or your spouse, if covered) are obligated through a court order to provide medical coverage.

- **Qualified Medical Child Support Order (QMCSO)** Biological or legally adopted children for whom the plan is obligated under a Qualified Medical Child Support Order (QMCSO) to provide medical coverage.

All dependents must be qualified in order to enroll in the ProMedica medical plan as either primary or secondary coverage.

Option to Waive Out-of-Area Medical Plan Coverage ProMedica-aligned and Paramount HMO Network Providers are located in the Paramount HMO Service Area. In order to conveniently access these providers, Subscribers should reside in the Paramount HMO Service Area. However, enrollment in one of the HMO options is permitted if the Subscriber waives the Out-of-Area Plan, agrees to abide by all the rules of the HMO option chosen and signs and submits a Waiver Form. See your Human Resources Department for details. Abiding by rules of the HMO includes selecting a Primary Care Provider (PCP) and utilizing ProMedica-aligned and Paramount HMO Network facilities and providers.

Changing Your Benefits The benefits you elect during the enrollment period will remain in effect through December 31. During the year, you can make changes only if you have a qualified change in status, which includes the following:

- Newly hired employee
- Changes in employee work schedule
- Rehired employee
- Marital status
- Birth of newborn
- Adoption/guardianship of child
- Disability of dependent child
- Loss of other coverage
- Court-ordered coverage for dependent child
- Medical Child Support Order
- Moving into service area
- Change in number of dependents

If you have a qualified change in status, contact Human Resources for instructions on making a benefit change. Any benefit changes must be made within 30 days of the event and must be consistent with the change in status.

Adding and Removing Members When you need to change the number of Members covered under your plan, it is your responsibility to notify the Plan Sponsor promptly**. YOU MAY BE REQUIRED TO ENROLL ON-LINE VIA THE PHS BENEFITS WEB SITE WHEN YOU NEED TO ADD A MEMBER TO OR REMOVE A MEMBER FROM YOUR PLAN. Contact Human Resources.**

Annual Open Enrollment Period If you have a new Dependent due to marriage, adoption (including placement) or birth of a baby, they may be added to this plan if the Subscriber completes enrollment with the Plan Sponsor within thirty (30) days from the event. If you do not enroll eligible Dependents for coverage during the first enrollment period or within thirty (30) days of eligibility, you must wait until the Plan Sponsor's next annual open enrollment period to add them. See Human Resources for details

Special Enrollment Period If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or 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, and meeting or exceeding lifetime limit on all benefits. 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 employee or dependent becomes eligible for premium assistance under Medicaid or CHIP or the date you or 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 yourself and 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. See your benefits office for details.

Termination of Member Coverage

A Member's coverage under the Benefit Plan may end for any of the following reasons:

- You fail to pay, or have paid for you, the required prepayments.
- You no longer meet the eligibility requirements.
- You no longer reside in the Paramount Service Area (except for court-ordered dependents).
- You have performed an act or practice that constitutes fraud or material misrepresentation of material fact under the terms of the coverage.

The termination may not be based, either directly or indirectly, on any health status-related factor concerning the Member. Do not use your ID card after your coverage ends.

Rescission of Coverage

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

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

Benefits After Cancellation of Coverage

If a Member is an Inpatient on the date coverage ends, the benefits of this coverage for hospital and professional services will continue for only that Member until the ***earliest*** of:

- The effective date of any new coverage.
- The date of discharge,
- The attending physician certifies that inpatient care is no longer medically indicated,
- The maximum in benefits have been reached.

WHAT HAPPENS WITH YOUR PLAN

When You Have Other Coverage

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 do 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 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 the you believe that Paramount has not paid a claim properly, you should first attempt to resolve the problem by contacting Paramount at (419) 887-2525 or refer to Section 6, 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

When You Qualify for Workers’ Compensation

If you or your Dependents receive health care services due to an injury which may be covered by Workers' Compensation, you must notify Paramount Member Services as soon as possible.

If you filed a claim for Workers' Compensation, the Benefit Plan will withhold payment to your providers until the case is settled. If the Benefit Plan has made any payment to your provider and services are covered by Workers' Compensation, you are expected to reimburse the Benefit Plan for the amounts paid.

When Someone Else Is Liable (Subrogation and Reimbursement)

Where a Member has benefits paid by the Benefit Plan for the treatment of sickness or injury caused by a third party or the Member, 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, medical payments coverage, excess umbrella, and any uninsured and/or underinsured motorist insurance, or any other source (including the party causing sickness or injury). As an alternative to reimbursement by the Member, the Benefit Plan may subrogate to the Member's rights of recovery and remedies by joining in the Member's lawsuit, assigning its rights to Member to pursue on the Benefit Plan's behalf, or bringing suit in the Member's name as subrogee.

The Benefit Plan's reimbursement and subrogation rights are equal to the value of medical benefits paid for Covered Services provided to the Member. The Benefit Plan's subrogation rights are a first priority claim against any recovery and must be paid before any other claims, including claims by the Member for damages. This means the Member must reimburse the Benefit Plan in full, 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 for attorney's fees, costs or other expenses incurred by the Member. The Benefit Plan is always a secondary payor when there are no fault and/or personal injury protection benefits available to the Member.

WHEN YOU LEAVE YOUR JOB

How You May Continue Group Coverage

Members who no longer meet eligibility requirements may be eligible for continuation coverage under the Plan Sponsor's Benefits Plan.

To get continuation coverage when you are no longer eligible for the Plan Sponsor's Benefits Plan, you must pay the required monthly prepayment to the Benefit Plan. How long you are allowed to continue coverage depends on the circumstances and the conditions provided in the Plan Sponsor's Benefits Plan. See Human Resources for details.

The following are conditions under which you may continue coverage under the current benefits plan. See Human Resources for further information.

If any of the following events occur, you or your dependents may be able to continue your coverage under the federal Consolidated Omnibus Budget Reconciliation Act (COBRA):

- Termination of your employment (for reasons other than gross misconduct) or reduction of your hours of employment.
- Termination of your employment due to Chapter 11 Reorganization by the Plan Sponsor.
- Your death.
- Your divorce or legal separation.
- The end of a child's status as a dependent under the Benefits Plan.
- Your eligibility for Medicare benefits

Group coverage may be continued, if a covered subscriber (employee) is called to active duty in the Armed Forces of the United States including the Ohio National Guard and the Ohio Air National Guard.

1) The covered Subscriber and Dependents may continue coverage for up to twenty-four (24) months.

2) Covered Dependents may continue coverage for up to thirty-six (36) months if any of the following events occur during the eighteen-month period:

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

3) The continuation period begins on the date coverage would have terminated because the reservist was called to active duty.

4) The Subscriber and/or Dependent must complete and return to the Plan Sponsor an election form within thirty-one (31) days of the date coverage would terminate.

5) The Subscriber and/or Dependent must pay any required contribution to the Plan Sponsor, not to exceed 102% of the group rate.

6) Continuation Coverage will end on the date any of the following occurs:

    a. The period of eighteen (18) months or thirty-six (36) months expires.
    b. The Subscriber or Dependent does not make the required payment.
    c. The group contract with the Plan Sponsor is terminated.

WHAT TO DO WHEN YOU HAVE QUESTIONS, COMPLAINTS OR APPEALS

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

If you call the Paramount Member Services Department after hours, you may leave a message and they will call you back on the next working day.

The Paramount Member Services Department's goal is to help you with any questions about procedures, benefits, participating providers, payment for services, etc. You are encouraged to call with any questions. You are also encouraged to develop a good relationship with your physician so that you fully understand the diagnosis and treatment prescribed.

Appeals for Claim/Service Denials

If all or part of a claim has been denied, reduced or terminated, you have the right to appeal the adverse benefit determination by contacting your health plan's Plan Administrator.

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

- A determination of an individual's eligibility for coverage;
- A determination that a benefit is not a covered benefit;
- The imposition of a, source-of-injury exclusion, network exclusion, or other limitation on otherwise covered benefits;
- A determination that a benefit is experimental, investigational, or not medically necessary or

appropriate; or

- Any rescission of coverage, whether or not there is an adverse effect on any particular benefit at that time.

You must appeal in writing, unless your claim involves urgent care, in which case the appeal may be requested orally. You may appeal the adverse determination ***within 180 days*** of receiving the notification. A review will be conducted by an appeal representative of the Plan Administrator who will issue a written decision within:

Post Service Claims:	60 calendar days from receipt of the appeal
Pre-Service Claims:	30 calendar days from receipt of the appeal
Urgent Care Claims:	72 hours from receipt of the appeal

The Plan Administrator will notify you of a benefit determination, whether adverse or not, with respect to an urgent care claim as soon as possible, but not later than 72 hours from receipt of the appeal, unless you fail to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under your benefit plan. In addition, concurrent internal and external review is allowed for claims involving urgent care or an ongoing course of treatment.

Rights on Appeal

In connection with your right to appeal an adverse determination regarding your claim, 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 your claim for benefits;

3. will receive a review of the determination that takes into account all comments, documents, records, and other information that you submit relating to the claim, without regard to whether this information was submitted or considered in the initial benefit determination;

4. will receive a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appeal representative of the Plan Administrator 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;

5. will receive a review from the appeal representative of the Plan Administrator 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.

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

7. will receive, free of charge, any new or additional evidence or rationale considered, relied upon, or generated by the Plan Administrator 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;

8. will receive no reduction or termination of an ongoing course of treatment without advance notice from the Plan Administrator or an opportunity for advance review;

9. will be provided, upon request, with the identification of the health care professional whose advice was obtained on behalf of the plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination;

10. will be deemed to have exhausted the internal appeals process and may initiate an external review if the Plan Administrator has failed to adhere to all the requirements of the internal appeals process; provided, however, that the internal appeals will not be deemed exhausted based on *de minimis* violations that do not cause, and are not likely to cause, prejudice or harm to the covered person so long as the Plan Administrator demonstrates that the violation was for good cause or due to matters beyond the control of the Plan Administrator and that the violation occurred in the context of an ongoing, good faith exchange of information between the Plan Administrator and the covered person, and is not reflective of a pattern or practice of noncompliance except that:

    a. If the Plan Administrator denies a request for external review under this section, the Member may request written explanation from Plan Administrator, and Plan Administrator shall provide explanation within ten days, including a specific description of its bases, if any, for asserting that the delay should not cause the internal appeals process to be considered exhausted

    b. If an external reviewer or court rejects the Member's request for immediate review on the basis that the Plan Administrator met the requirements for the exception, the Plan Administrator shall then, within ten days, provide the Member with notice of the opportunity to resubmit and pursue the internal appeal of the claim. Time periods for re-filing the internal appeal shall begin to run upon receipt of such notice by the Member.

11. Appeals to the Plan Administrator should be sent to the following address:

Paramount Insurance Company
Member Service Dept - Appeals
P.O. Box 928
Toledo, Ohio 43697-0928
(419) 887-2525
1-800-462-3589

You have the right to request an external review for an adverse benefit determination (including final internal adverse benefit determinations) that is based on medical judgment (excluding those that involve only contractual or legal interpretation without any use of medical judgment), as determined by the external reviewer; or a rescission of coverage. Your rights are explained below.

STANDARD EXTERNAL REVIEW

You must request an external review in writing ***within four (4) months*** after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determinations. You (the member), your Legal Representative, an Authorized Person, the provider, or the health care facility may request the review. The provider and health care facility must have the member's authorization to request a review. You do not need the authorization of the provider. You cannot be required to pay for the review. The review is paid for by Group.

Preliminary Review:

Paramount will conduct a preliminary review within five (5) business days following the date of receipt of your request to determine whether:

1. you were covered under the Group Health Plan at the time the health care item or service was requested or, in the case of a retrospective review, were covered under the Group Health Plan at the time the health care item or service was provided;

2. the adverse benefit determination or the final internal adverse benefit determination does not relate to your failure to meet eligibility requirements under the terms of the Group Health Plan;

3. you have exhausted the internal appeal process, when required to do so; and

4. you have provided all the information and forms required to process an external review.

Within one (1) business day after completion of the preliminary review, Paramount will issue a notification in writing to you as follows:

1. If your request is complete but not eligible for external review, the notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration.

2. If the request is not complete, the notification will describe the information or materials needed to make the request complete. You may perfect the request for external review within the four (4) month filing period or within the 48 hour period following your receipt of the notification, whichever is later.

Referral to Independent Review Organization:

Paramount will assign eligible external review requests to an independent review organization (IRO). To ensure impartiality, Paramount contracts with at least three (3) separate IROs and assigns the reviews in an unbiased manner. The IROs do not receive any financial incentives based on the likelihood that the IRO will support the denial of benefits.

The assigned IRO will:

1. utilize legal experts where appropriate to make coverage determinations under the Group Health Plan;

2. timely notify you in writing of the request's eligibility and acceptance for external review and that you may submit in writing to the assigned IRO within ten (10) business days following the date of receipt of the notice additional information that the IRO must consider when conducting the external review;

3. upon receipt of any information submitted by you will forward the information to Paramount within one (1) business day. Paramount may reconsider its adverse benefit determination or final internal adverse benefit determination based on the information but must not delay the external review; however, it may terminate the external review if it decides to reverse its adverse benefit determination or final internal adverse benefit determination and provide coverage or payment in which case Paramount will notify both you and the IRO within one (1) business day after making such a decision;

4. receive from Paramount, within five (5) business days after the date of assignment to the IRO, the documents and any information Paramount considered in making the adverse benefit determination or final internal adverse benefit determination;

5. notify you and Paramount within one (1) business day after terminating an external review and making a decision due to Paramount's failure to promptly provide the documents and any information Paramount considered in making the adverse benefit determination or final internal adverse benefit determination;

6. review all of the information and documents timely received and will review the request (claim) de novo and not be bound by any decisions or conclusions reached during Paramount's internal claims and appeals process;

7. consider, to the extent the information or documents are available and considers them appropriate the following in reaching a decision:

    a. Your medical records;
    b. The attending health care professional's recommendation;
    c. Reports from appropriate health care professionals and other documents submitted by Paramount, you, or your treating provider;
    d. The terms of Group Health Plan to ensure that the IROs decision is not contrary to the terms of the plan, unless the terms are inconsistent with applicable law;
    e. Appropriate practice guidelines, which must include applicable evidence based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;
    f. Any applicable clinical review criteria developed and used by Group Health Plan, unless the criteria are inconsistent with the terms of the plan or with applicable law; and
    g. The opinion of the IRO's clinical reviewer(s) after considering the information described here to the extent the information or documents are available and the clinical reviewer(s) consider appropriate.

The assigned **IRO must provide written notice of the final external review decision within forty-five (45) days after it receives the request for the external review**. The IRO must deliver the notice of final external review decision to you and to Paramount, which is to contain:

1. A general description of the reason for the request for external review, including information sufficient to identify the claim;

2. The date the IRO received the assignment to conduct the external review and the date of the IRO decision;

3. References to the evidence or documentation, including specific coverage provisions and evidence-based standards, considered in reaching its decision;

4. A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

5. A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Group Health Plan or to you;

6. A statement that judicial review may be available to you; and

7. Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS ACT 2793.

Reversal of Paramount's Decision:

Upon receipt of a final external review decision reversing the adverse benefit determination or final internal adverse benefit determination, Benefit Plan immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim regardless of whether the Benefit Plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

The IRO will maintain records of all claims and notices associated with the external review process for six (6) years and make such records available for examination by you, Group Health Plan, or State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws.

EXPEDITED EXTERNAL REVIEW

You may make a request for an expedited external review at the time you receive:

1. An adverse benefit determination if it involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health or your ability to regain maximum function and you have filed a request for an expedited internal appeal; or

2. A final internal adverse benefit determination, if you have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or your ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but has not been discharged from a facility.

Preliminary Review:

Paramount will conduct a preliminary review immediately upon receipt of your request for an expedited external review to determine whether the request meets the reviewability requirements set forth above for standard external review.

Paramount will immediately send a notice to you, as described above for standard external review, advising you of its eligibility determination.

Referral to Independent Review Organization:

Upon a determination that a request is eligible for an expedited external review, Paramount will assign an IRO as described above for standard external review.

Paramount will provide or transmit all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefit determination to the assigned IRO electronically or by telephone or fax or any other available expeditious method.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents described above for standard external review. In reaching a decision, the assigned IRO must review the claim de novo and is not bound by any decisions or conclusions reached during Paramount's internal claims and appeals process.

The assigned **IRO must provide notice of the final external review decision, as described above for standard external review, as expeditiously as your medical condition or circumstances require, but in no event more than seventy-two (72) hours after the IRO receives the request for an expedited external review**. If the notice is not in writing, within forty-eight (48) hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to you and to Paramount.

TERMS AND DEFINITIONS

Affiliation, Probationary or Waiting Period is the period between the date on which the individual files a substantially complete application for coverage and the first day of coverage.

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

Coinsurance is your share of the cost of some covered services (a percentage of the allowed provider charges). For example, you may be responsible for 20% of billed charges for authorized Covered Services.

Copayment is your share of the cost of some Covered Services. This may be a specific dollar amount, such as $10.00 or $20.00 or a percentage of the allowed provider charges. Copayments that are for specific dollar amounts are due and payable at the time services are provided.

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

Covered Person means an individual (EMPLOYEE, SPOUSE OR CHILD) covered by this Plan.

Covered Services are authorized services shown in our list of services covered and rendered by a provider for which the Benefit Plan will provide payment. A Covered Service may be subject to a Copayment or other limitations.

Deductible is the amount you must pay for Covered Services within each Contract 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 covered family members must pay.

Eligible Dependent means any member of a Subscriber's family who meets all the applicable eligibility requirements, has been enrolled in the Benefit Plan and for whom the payment required by the Benefit Plan has been received by the Benefit Plan.

Eligible Employee means any Employee meeting the eligibility requirements of the Benefit Plan.

Employee means anyone who is employed by the Plan Sponsor.

Effective Date is the date on which your coverage begins**.**

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:

a) 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;
b) Serious impairment to bodily functions; or
c) 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:

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

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

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

Enrollment Application/Form can be an electronic form, paper form or Interactive Voice Response (IVR) as determined by Plan Sponsor.

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

Experimental is any treatment, procedure, facility, equipment, drug, device or supply which Paramount 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:

- Are still in the investigative or research state;
- Have not been adopted for general clinical use;
- Have not been approved or accepted by the appropriate review body; or
- Are not generally accepted by the local medical community as safe, appropriate and effective treatment.

Inpatient is a patient who stays overnight in a hospital or other medical facility.

Maximum Lifetime Benefit is the maximum dollar amount the Benefit Plan will pay for Covered Services for certain conditions during Your lifetime. The benefits paid for Covered Services received from ProMedica-aligned and Paramount Providers will be counted toward Your Maximum Lifetime Benefit for certain conditions. No additional Covered Services will be provided to You after You have received Your Maximum Lifetime Benefit for certain conditions. The Essential Health Benefits provided by the Benefit Plan are not subject to a Maximum Lifetime Benefit.

Medical Necessity 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.

Out-of-Pocket Copayment Limit is the maximum amount of Copayments and Coinsurance you pay every calendar year on basic health services. Once the Out-of-Pocket Copayment Limit is met, there will be no additional Copayments and Coinsurance on basic health services during the remainder of the calendar year**. Please note that there are different Out-of-Pocket Copayment Limits for ProMedica-Aligned Providers and non-ProMedica-Aligned Providers.** The single Out-of-Pocket Copayment Limit is the amount each Member must pay, the family Out-of-Pocket Copayment Limit is the total amount any two or more covered family members must pay.

Outpatient refers to services or supplies provided to someone who has not been admitted as an inpatient to a hospital.

Paramount Service Area means 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 and Monroe and Lenawee counties in Michigan. Paramount may periodically add or remove certain counties from their service area. Benefit Plan Participants should contact Paramount Member Services for an updated listing of the Paramount Service Area.

Participating Hospital means any hospital with which Paramount has contracted or established arrangements for inpatient/outpatient hospital services and/or emergency services.

Participating Provider means a physician, hospital or other health professional or facility that has a contract with Paramount to provide 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.

Plan Sponsor means the ProMedica Health System.

Plan Administrator means Paramount Insurance Company.

Post-Service Claim means any claim for a benefit under the Benefit Plan that is not a Pre-Service Claim.

Pre-Service Claim means any claim for a benefit under the Benefit Plan where the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

Preventive Health Services 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 physician or provider who specializes in family general practice, internal medicine or pediatrics and is designated by Paramount as a Primary Care Provider. The Primary Care Provider is responsible for managing and coordinating the full scope of a Member's medical care, including, but not limited to, performing routine evaluations and treatment, ordering laboratory tests and x-ray examinations, prescribing required medications, and arranging for a Member's hospitalizations or other services when appropriate, and who meets all other requirements as adopted by Paramount from time to time.

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

Specialist Physician means a physician who provides Covered Services to Members within the range of his or her medical specialty, who is designated by Paramount as a Specialist Physician, and who meets all other requirements as adopted by Paramount from time to time.

Specialty Drugs are complex Prescription Drugs as determined by Paramount's Pharmacy & Therapeutics Working Group (P & T) used to treat chronic conditions such as multiple sclerosis, cancer, hepatitis and rheumatoid arthritis, These drugs are self-administered as injectable or oral drugs and often require special handling and monitoring.

Subscriber means a person who meets all applicable eligibility requirements, is employed by the Plan Sponsor and enrolls with the Benefit Plan as the subscriber.

Urgent Medical Condition is an unexpected illness or injury requiring medical attention soon after it appears (a persistent high fever, colds, sprains, etc.). It 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.

MISCELLANEOUS PROVISIONS

Right to Receive and Release Necessary Information

For the purposes of determining the applicability of and implementing the terms of this provision of this Benefit Plan or other Benefit Plan, the Benefit Plan may, without the consent of or notice to any person, release to, or obtain from, any insurance company or other organization or any person any information, with respect to any person, which it deems to be necessary for such purposes, as permitted by law. Any person claiming benefits under this Benefit Plan shall furnish to the Benefit Plan such information as may be necessary to implement this provision – subject to the Confidentiality provisions.

Facility of Payment

Whenever payments which should have been made under the Benefit Plan in accordance with this provision have been made under any other Benefit Plan, the Benefit Plan shall have the right, exercisable alone and at its sole discretion, to pay over to any organization making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this Benefit Plan and to the extent as such payments for Covered Services, the Benefit Plan shall be fully discharged from liability.

Rights of Recovery

Whenever payments have been made by the Benefit Plan with respect to Covered Services in a total amount in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, irrespective of to whom paid, the Benefit Plan shall have the right to recover such payments to the extent of such excess from among one or more of the following, as the Benefit Plan shall determine: any persons to or for with respect to whom such payments were made; any insurance companies; or any other organizations or persons.

Change in Benefits

Any change in the amount of benefits payable under the Benefit Plan due to an increase or a decrease in the benefits will apply only to expenses incurred after the effective date of the change. The benefits in force before the effective date of the change will continue in force unless, in the case of the Employee, the Employee returns to work for one full day, or, in the case of a Dependent, the Dependent is released from the Hospital after the effective date of the change in benefits.

Assignment of Benefits

The Benefit Plan Members' benefits may not be assigned, except by consent of the Benefit Plan, to other than suppliers of medical services.

Examination

The Employer shall have the right and opportunity to have the Covered Person examined whose injury or sickness is the basis of a claim hereunder when and so often as it may reasonably require during the pendency of claim hereunder, and also the right and opportunity to have an autopsy performed in case of death where it is not forbidden by law.

Workers' Compensation not Affected

This Benefit Plan is not in lieu of, and does not affect any requirement for coverage by Workers' Compensation Insurance.

Qualified Medical Child Support Orders

Upon receipt of a Medical Child Support Order (MCSO), the Benefit Plan shall notify the Eligible Employee and each child of the Eligible Employee who is recognized under the MCSO as having a right to enrollment under the Benefit Plan with respect to such Eligible Employee, of the receipt of the MCSO and the Benefit Plan's procedures for determining whether the MCSO is a Qualified Medical Child Support Order (QMCSO). The Benefit Plan Administrator shall determine whether such MCSO is a QMCSO and notify the Eligible Employee and each child of the determination. Each child may designate in writing a representative for receipt of copies of notices that are sent to the child with respect to a MCSO. If the Benefit Plan Administrator determines that the MCSO is a QMCSO, the Benefit Plan shall provide benefits in accordance with the applicable requirements of the QMCSO.

Payments of benefits under this Benefit Plan pursuant to a MCSO (that is determined to be a QMCSO) as reimbursement for expenses paid by the child or the child's custodial parent or legal guardian shall be made to the child or the child's custodial parent or legal guardian upon the Benefit Plan's receipt of sufficient evidence of payment. With respect to an MCSO issued that is determined to be a QMCSO, payments of benefits under this Benefit Plan to an official of a state or political subdivision thereof whose name and address have been substituted for the name and address of the child in a QMCSO, shall be treated as payment of benefits to the child.

MCSO means any judgment, decree, or order (including approval of a settlement agreement) that is (a) issued by a court of competent jurisdiction, or (b) issued through an administrative process established under state law and has the force and effect of law under applicable state law, which:

1. Provides for child support with respect to a child of an Eligible Employee or provides for coverage under this Benefit Plan to such child, is made pursuant to a state domestic relations law (including community property law), and relates to benefits under this Benefit Plan, or
2. Enforces a law relating to medical child support described in Section 1908 of the Social Security Act with respect to a group health plan.

QMCSO means a MCSO that meets the following requirements:

1. Creates or recognizes the existence of the right of an Eligible Employee's child to, or assigns to the child the right to, receive benefits for which a participant or beneficiary is eligible under the Benefit Plan, and
2. Clearly specifies:
   a. The name and last known address (if any) of the Eligible Employee and the name and mailing address of the child covered by the order, except that, to the extent provided in the order, the name and mailing address of an official of a state or political subdivision thereof may be substituted for the mailing address of the child; and
   b. a reasonable description of the type of coverage to be provided by the Benefit Plan to each child, or the manner in which such type of coverage is to be determined; and
   c. the period to which such order applies.
3. Does not require a plan to provide any type or form of benefit, or any option, not otherwise provided under the Benefit Plan, except to the extent necessary to meet the requirements of a law relating to medical child support described in Section 1908 of the Social Security Act.

Plan Modification and Amendment

The Employer reserves the right, subject to Federal Law, to terminate, change or amend the Benefit Plan by a written instrument. Any amendments or modifications that affect Benefit Plan Members will be communicated with at least 30 days written notice.

Plan is not a Contract

The Benefit Plan shall not be deemed to constitute a contract between the Benefit Plan Sponsor and any Employee or Member or be a consideration for, or an inducement or condition of, the employment of an Employee or Member. Nothing in the Benefit Plan shall be deemed to give an Employee or Member the right to be retained in the service of the Benefit Plan Sponsor or to interfere with the right of the Benefit Plan Sponsor to discharge any Employee or Member at any time; provided, however, that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreements which may be made by the Benefit Plan Sponsor with the bargaining representatives of any Employee or Member.

Notice

Any notice required to be given under this Benefit Plan must be in writing and sent by certified mail, return receipt requested, to the addresses provided herein.

Proof of Claims

Written proof of claims must be furnished to the Benefit Plan by Participating Providers ***within 90 days*** after the date such claims are incurred (a claim shall be considered incurred on the date the service is rendered or the supply is received). If the Member has received Covered Services from a non-participating provider, the proof of the claim must be submitted to the Benefit Plan ***with six months*** after the date such claims are incurred. Proof of claims includes the following:

- An itemized bill for the service or supply must be furnished to the Benefit Plan. An itemized bill for all professional services must include a diagnosis (ICD 9 CM) and a CPT code (Current Procedural Terminology) for each service provided.

- If Paramount as Benefit Plan Administrator requests information from the Member, the Member must furnish such information as requested.

- If Paramount as Benefit Plan Administrator requests information from a provider and the provider does not furnish the requested information, the Member will be required to obtain the requested information and furnish it to Paramount.

All of the above requirements must be met within the required time period in order for the claim to be considered.

Paramount, on behalf of the Benefit Plan, will make decisions on initial claims no later than:

- 72 hours for urgent care pre-service – If the claim is incomplete, the provider will be notified within 24 hours of the claim's receipt, and given at least 48 hours to provide the needed material. Once that information is received, the claim generally must be decided within 48 hours.
- 15 days for pre-service claims.
- 30 days for post-service claims.
- One 15-day extension for pre- and post-service claims is provided due to circumstances beyond the Benefit Plan's control. A written or electronic notice must be provided within the initial period (for faulty claims, the notice must describe the needed information and allow at least 45 days to provide the information).

Non-Payment of Claims

In the event the Benefit Plan does not ultimately pay medical expenses which are eligible for payment under the Benefit Plan for any reason, the persons covered under the Benefit Plan may be liable for such expenses.

Actions

No action at law or in equity shall be brought to recover on the Benefit Plan prior to the expiration of 60 days after proof of loss has been filed in accordance with the requirements of the Benefit Plan, nor shall such action be brought at all unless brought within 3 years from the expiration of the time within which proof of loss is required by the Benefit Plan.

Severability

If any provision of this Benefit Plan, on its effective date or thereafter, is determined to be in conflict with Ohio law, E.R.I.S.A. or applicable rules or regulations of the Department of Labor, the provision is hereby amended to conform to the applicable rules or regulations.

Conformity of Law

If any provision of this plan is contrary to any law to which it is subject, such provision is hereby amended to conform thereto.

Governing Law

This Benefit Plan will be governed in all respects by the Employee Retirement Income Security Act.

PROMEDICA HEALTH SYSTEM

PRESCRIPTION DRUG PROGRAM

Prescription drug coverage is stated on your PHC Member ID card. Refer to your Summary of Benefits for prescription drug coverage details.

The ProMedica Employee Prescription Drug Program is provided by Paramount Health Care, the ProMedica health insurance company. Paramount provides high-quality, value-based prescription drug options and choice for its members. The ProMedica Prescription Drug Program includes:

- Retail and Mail Order Pharmacy Programs with 4-Tier Copayment Arrangements
- Specialty Drug Program subject to the Paramount Specialty Pharmacy Network
- PPACA Mandated Preventive Drugs
- Infertility Drugs

Copayments under the Prescription Drug Benefit apply toward your medical Out-of-Pocket Copayment Limit.

PRESCRIPTION DRUG PROGRAM

Paramount offers best-value options for generic and selected brand prescription drugs. Prescription Drugs are subject to an out-of-pocket copayment or coinsurance. The Retail and Mail Order Pharmacy 4-Tier copayment arrangement includes **Generic Drugs** *(Tier 1 – lowest),* **Preferred Brand Drugs** *(Tier 2),* **Non-Preferred Brand Drugs** *(Tier 3) and* **Multi-Source Brand Drugs** *(Tier 4 – highest).*

Generic Drugs provide the best value for quality health care. As such, your Prescription Drug Program includes the following Generic Substitution rule:

- "Generic Substitution means generic drugs, when available, will be dispensed in place of a brand name drug.
- If the Physician writes "Dispense as Written" ("DAW") or the Member requests a Brand Name Drug for which a Generic Drug is available, the Member will pay the Multi Source Brand Drug Copayment.

Preferred Brand Drugs are commonly prescribed brand name drugs selected by Paramount's Pharmacy and Therapeutic Working Group (P&T) based on clinical effectiveness, safety, and cost-effectiveness. These drugs are listed on Paramount's Preferred Drug List (PDL).

Non-Preferred Drugs are Prescription Drugs that are denoted as "Non-Preferred" by Paramount.

Multi Source Brand Drugs are a category of Prescription Drugs as determined by Paramount that includes:

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

Days Supply, Quantity Limits and Prior Authorization - The Prescription Drug Benefit is subject to limitations of dispensing, quantity and clinical prior authorization. The dispensing limit ("days supply") as stated in your enrollment materials is the maximum number of days a prescription drug will be dispensed for a single prescription order. Quantity limits are assigned to certain medications to prevent waste, to monitor drugs with high abuse potential and to review guidelines for safety of dose and/or treatment duration. Clinical prior authorization may be required to establish appropriate use or quantity in excess of established limits.

NETWORK PHARMACY OPTIONS

Paramount Health Care contracts with CVS Caremark to act as the pharmacy benefits manager (PBM) for its Prescription Drug Programs. The PBM provides Paramount members with both a national network of participating pharmacies and options for local, independently-owned pharmacies.

Preferred Pharmacy Changes:

- **The first fill of a medication (30-day supply) can be obtained at any retail pharmacy in the CVS Caremark Network with a preferred copay (except for a $2 difference in generic copay)**
- **Additional refills will be subject to a higher copay if filled outside of the ProMedica Preferred Pharmacies. Refer to the ProMedica Preferred Pharmacies document for a list of participating pharmacies.**
- **90-day fills** will be available through The Pharmacy Counter central fill location.
- You can expect copay savings of up to 50% on 30-day refills, and up to 67% on 90-day supply prescriptions when you use ProMedica Preferred Pharmacies. Employees also save when they set up an HSA account to use pre-tax dollars to pay for prescription drug copays.

ProMedica Preferred (30-day & 90-day) Pharmacy Program – When ProMedica employees use their Paramount identification card to fill prescriptions at any ProMedica Preferred Pharmacy, they will be responsible for the lowest copays available from any network pharmacy. These specially contracted locations offer the best value, and some offer 90-day retail and home delivery options as well.

Retail Pharmacy (30-day) Program - When you use the Retail Pharmacy Program, show your Paramount identification card to the pharmacist when purchasing prescription drugs. When you use a network pharmacy, you will be responsible for your drug copay and the pharmacist will submit your claim electronically to the PBM. Prescription Drugs dispensed by a Non-Network Pharmacy are not covered.

Voluntary Mail Order (90-day) Pharmacy Program - The Mail Order Pharmacy Program is a convenient network mail order service that is beneficial for those who take medications regularly for chronic conditions. If your physician prescribes this type of medication, you may want to use the Mail Order Pharmacy Program. Your medication will be mailed directly to your home.

Specialty Drug Program - Specialty Drugs are primarily high-cost pharmaceutical drugs used to treat complex chronic conditions such as multiple sclerosis, rheumatoid arthritis, cancer and rare diseases. Specialty Drugs must be obtained through Paramount's Specialty Pharmacy Network and are subject to coinsurance with an out-of-pocket maximum. The Specialty Pharmacy Program utilizes ProMedica Outpatient Pharmacies as well as a mail order pharmacy option to provide specialty medications to members. The ProMedica Hospital Outpatient Pharmacies also offer convenient home delivery of specialty medications. Complete information on the Specialty Drug Program and the 2016 changes to the specialty network can be found at www.paramounthealthcare.com/SpecialtyDrugProgram.

PPACA Mandated Preventive Drugs - Preventive Drugs covered in accordance with PPACA mandates. Coverage includes products from the following categories: aspirin, vitamins, smoking cessation medications, women's contraceptive medications and devices, vaccines and bowel preparations. These drugs are not subject to deductible and/or copay. This list is subject to change, and preventive coverage

is subject to certain limitations, such as age, based on guidelines recommended by the U.S. Preventive Services Task Force.

Women's Preventive Health Contraceptives – Not subject to deductible and/or copay. Includes at least one product for each of the following contraceptive methods: Barrier (diaphragm), Implanted devices (IUD), Hormonal (generic orals), and Emergency Contraception, in accordance with PPACA Women's Preventive Health Services mandate. Not all contraceptive products are covered at this level of benefit. List is subject to change.

Infertility Drugs - Prescription Drugs for the treatment of infertility are subject to the Infertility Coinsurance and the Infertility Maximum Lifetime Benefit stated in the Schedule of Benefits.

Coordination of Benefits applies to the Prescription Drug Program. Prescription drug benefits will be coordinated with any other coverage when members present both ID cards at the pharmacy.

COVERED DRUG BENEFITS

The following Prescription Drugs are covered:

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

Drug Exclusions

The following exclusions apply:

1. Durable medical equipment, therapeutic devices, support garments; and other supplies or substances which may be obtained without a prescription;
2. Prescription Drugs or Refills either in excess of the number prescribed by the physician or those dispensed more than one (1) year after the physician's order;
3. Dietary supplements and some prescription vitamins (other than prenatal vitamins or those mandated by PPACA guidelines);
4. Prescription Drugs used for cosmetic purposes such as: drugs used to decrease wrinkles, drugs to promote hair growth, drugs to control perspiration, drugs for weight loss including diet pills and appetite suppressants;
5. Prescription Drugs for the amount dispensed (either days supply or quantity) that exceeds the supply limit;
6. Drugs that do not require a prescription for dispensing known as "Over-the-Counter" drugs unless approved by the Plan;
7. Any drugs that are labeled as experimental, investigational or unproven;
8. Prescription Drugs used to enhance athletic or sexual performance;
9. Compounded medications are not covered when a similarly equivalent product is available commercially or when the active ingredients do not require a Prescription Order or Refill. The Plan will not pay any preparation fee for compounded medications;
10. Prescription Drugs requiring prior authorization that are dispensed without approval by the Plan;
11. Any Prescription Drug which is determined to have been abused or otherwise misused by a Covered Person;
12. Any claim for Prescription Drug(s) submitted to the Plan or the PBM for reimbursement **more than one (1) year** from the date the Prescription Drug was dispensed will not be eligible for

reimbursement;

13. Prescription Drugs for which the cost is recoverable under any workers' compensation or occupations disease law or any federal or state agency or any drug for which no or substantially discounted charge is made;
14. Prescription Drugs that are prescribed, dispensed or intended for use during a hospital inpatient or skilled nursing facility stay;
15. Non-Formulary Prescription Drugs;
16. Prescription Drugs obtained from Non-Network Pharmacies.
17. Growth hormones for growth and development;
18. Any drugs or devices used for treatment of male/female sexual dysfunction including but not limited to erectile dysfunction, delayed ejaculation, anorgasmia and decreased libido;

(Rev.5.2016)

ADDENDUM

Paramount Medical Home 2016
Member Guidelines
for ProMedica Enrollees

1. EMPLOYEE Participation Requirements

a) Select an approved Paramount Medical Home PCP (Primary Care Physician)
b) Online Health Risk Assessment (HRA) to be completed within 90 days before or after the plan year effective date. (Typically January 1st of every year)
c) Employee to have an initial patient visit with their PCP within 90 days of plan year effective date.
d) During the initial patient visit, the patient and physician to work together to establish a personalized action plan for next 12 months. Then complete and sign the Partnership Agreement (PA) indicating the patient's goals for the next 12 months. The physician will discuss programs and services available to help the patient meet the clinical goals they've established.
e) PA to be submitted to Paramount. Submission of PA to Paramount MUST HAPPEN 90 days before or after the plan year effective date to keep the premium contribution reduced for the Employee for each current plan year – earliest effective date of enrollment to be used, where necessary (for example: if PA completed in November of 2015, PA will be used for compliance for the remainder of 2015 as well as 2016). If the PA is completed by another PCP in the Practice, credit will be given to the Employee and the PCP selected at enrollment will receive the PCP payments
f) Participation in programs when indicated on PA is required, and must be completed**.** Paramount tracks and monitors the participation in programs and services.
    1. If a follow up visit is needed the Physician will document this on the PA as to when the next patient visit is needed (within 60, 90, 180 days) – E&M codes will be used to identify any visit to the physician.
    2. If a wellness program is needed, the Physician will indicate the need on the PA. (Employee will have remainder of the year to complete the programs)
    3. If a Disease Management (DM) program is needed, the Physician will indicate the need on the PA. (DM team will update compliance data when Employee becomes non-compliant with DM program)
g) Employee can become compliant anytime throughout the year – as soon as they complete the activities needed they'll be compliant, and Medical Home Incentives can be issued.
h) New Hires are included in the program (company transfers are NOT considered new hires all incentive information will transfer to new plan, where appropriate)
i) Employees enrolling outside of Open Enrollment are eligible for the program. However, Employees enrolling after June 30th are not required to participate in the program. The Employees will be excluded from the Compliance File sent to ProMedica unless they become fully compliant and are sent with an "A" on the remaining files sent to ProMedica. These members will be included in PCP bonus payments as they become effective, but the PCP will not be eligible for the End of Year bonus, since the Employee wasn't enrolled more than 6 months.
j) Incentive activities completed in 2016 (a current year) will count toward the current year as well as the following year. (This duplication will be applied manually by putting the activity completed in December (the HRA and/or PA) in both years manually, until this process can be automated.)

k) If there is a Break in Coverage – Employees that leave ProMedica employment while in their grace period and did not yet complete their incentives to become compliant before they left will be allowed to continue in the grace period (when they return to work) for a time period equal to that which remained before the break in coverage occurred. Keep in mind, if the Employee returns after June 30th, as a "new" Employee they will be excluded from reporting until they become compliant. Employees that leave ProMedica after their grace period, and if they return in the same year they will return with the same compliance value they had when then left. If they were compliant when they left, they will return compliant and be subject to the programs selected by their PCP. If they were non-compliant when they left, they will return non-compliant. Also, if the Employee returns after June 30th, as a "new" Employee they will be excluded from reporting until they become compliant.

l) Spouses of Employees are part of this program. However, if a Spouse is added at least one day after the Employee, they are excluded from the program and will not be sent on the compliance file unless they become compliant. Any incentives met within the month of December can be used for the following year.

2. General Compliance Information

General compliance tracking with the program will be determined by Paramount with input by the PCP. Paramount will track and store the PA, the programs on the PA as well as document non-compliance reporting by the PCP for use in weekly electronic reporting to ProMedica of compliance/non-compliance of Employees. The weekly compliance file will be sent to ProMedica every Thursday.

Employee Incentive:
When enrolled in the Medical Home plan, the employee is eligible to receive a credit to their per-pay premium deduction. In order to be eligible for the credit, the employee is required to complete the participant requirements as stated above. The credit works as follows:

- First 90 days - the member must complete several of the requirements within the first 90 days of enrollment. If those requirements are met, the member will receive the credit in the first pay following the date of completion and will continue as long as the employee remains compliant.
- If the employee becomes non-compliant at any time throughout the year, the credit will stop and will not be reinstated until the member becomes compliant.

Incentive program documents available online at *myProMedica.*

Employee will be sent notification of non-compliance within 10 business days of determining non-compliance. Employee will be sent reminders 35 days before an incentive activity is due – with the exception of the Wellness Incentive which will be sent 4 months prior to the end of the current plan year if the PCP has selected the wellness incentive for the Employee and it hasn't yet been completed. The Employee's PCP will also be provided a copy of the reminder (thru Provider Relations).

Employees, Paramount or PCP may request waiver of criteria from their respective HR department(s). It is the Sole responsibility for the group HR department to approve requested waiver(s). When waiver(s) are granted PHC will denote this in the members Macess file. Waiver may be at the incentive or at the member level. Member will be seen as compliant for the incentive or on the whole if waiver is granted. Waiver form and proper approval/authorization required.

Compliance Status at the end of the year will be carried forward into the next plan year. If a Employee is non-compliant at the end of the plan year, they will begin the next year non-compliant (no grace period), however they can become compliant by completing the new plan year's incentive requirements (the HRA and the PA). If the Employee ends the current year compliant, they will continue the next plan year compliant for the grace period of 90 days. If after the 90 days the Employee is non-compliant, the compliance status will change to non-compliant.