



**Human Resources – Benefits  
2801 W. Bancroft Street – Mail Stop 405  
Toledo, Ohio 43606-3390  
(419) 530-4747**

## **Blue Plan HSA**

# **Medical Plan Benefit Description**

**Effective: January 1, 2021**

**NOTICE CONCERNING COORDINATION OF BENEFITS (COB)**

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



## **Notice of Nondiscrimination and Accessibility: Discrimination is Against the Law**

Paramount complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Paramount does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Paramount provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Member Services at 1-800-462-3589.

If you believe that Paramount has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance. You can file a grievance in person or by mail, fax, or email.

Member Services  
1901 Indian Wood Circle, Maumee OH 43537  
Phone: 419-887-2525  
Toll Free: 1-800-462-3589  
TTY: 1-888-740-5670  
Fax: 419-887-2047  
Email: [Paramount.MemberServices@ProMedica.org](mailto:Paramount.MemberServices@ProMedica.org).

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

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

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

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

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## SUMMARY OF PLAN INFORMATION

This is a self-insured comprehensive program of health care benefits (“Plan”). The Plan is administered through the Human Resources office of the Plan Sponsor. The Plan Sponsor has retained the services of an independent Plan Administrator experienced in processing claims.

### **Plan Administrator:**

Paramount Care, Inc.

Claims Address: P.O. Box 691  
Toledo, Ohio 43697-0691

### **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.

### **Grandfathered Health Plan Disclosure:**

This group health plan or health insurance issuer believes this plan or coverage is a “non- grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act) as of January 1, 2013. As required Affordable Care Act, this plan is intended to comply with the law’s non-grandfathered provisions.

## INTRODUCTION

This booklet, referred to as a Benefit Description, including the accompanying Schedule of Benefits is provided to describe the Plan. To determine your benefits for a specific service, you should refer to both this Benefit Description and the Schedule of Benefits. **You should check both sources for information about the Plan because this booklet presents information about the basic Plan, while the Schedule of Benefits explains the specific benefits and associated limitations as well as Deductible and Coinsurance requirements.** Questions regarding the Plan can also be directed to the Paramount Member Services Department at (419) 887-2531; toll free 1-866-452-6128.

The Definition Section of this booklet lists the definitions of key terms used in this Benefit Description and the Schedule of Benefits. Capitalized terms (Glossary) are defined at the end of the Benefit Description.

## SECTION ONE: HOW THE PLAN WORKS

### 1. Health Care Reimbursement Choices

The Plan provides you with three (3) flexible choices for reimbursement any time Covered Services are required. The amount paid for the care received depends upon whether care is received from a UT Network, Paramount/First Health Network or Non-Network Provider.

**UT Network Option** – You may seek care from any Provider that is part of the UT Network. Under this option your share of the cost for services will be lower compared to obtaining service from Paramount/First Health Network or Non-Network Providers.

**Paramount/First Health Network Option** – You may seek care from any Paramount Network Provider. In addition, You may seek care from First Health Network Providers who are **located outside of the Paramount Service Area**. Visit the Paramount website for a list of Paramount/First Health Network Providers (see definition) at [www.paramounthealthcare.com](http://www.paramounthealthcare.com). You must satisfy the Deductible under the Paramount/First Health Network option before any benefits will be paid and your share of the cost for services will be higher compared to obtaining service from UT Network Providers, but lower compared to obtaining services from Non-Network Providers. **In-Network Hospitals, Physicians, and Providers have agreed to limit their charges through their contracts with the Networks and will not balance bill you for charges above the allowed amount.** See Your Schedule of Benefits for details.

**Non-Network Option** – You may seek care from Providers outside the UT Network and Paramount/First Health Network options. You must satisfy the Deductible under the Non-Network option before any benefits will be paid and your share of the cost for services will be higher. **Please note, Covered Services provided by First Health Providers located within the Paramount Service Area will be paid at the Non-Network level of benefits.**

To receive benefits under the UT Network Option or Paramount/First Health Network Option, You must use UT Network or Paramount/First Health Network Providers (for Providers located outside of the Paramount Service Area only) to obtain Covered Services. **It is Your responsibility to ensure that Covered Services are obtained from UT Network and Paramount/First Health Network Providers to be eligible for coverage under the UT Network Option or the Paramount/First Health Network Option.**

You are required to pay Copayments and/or Coinsurance for Covered Services as noted in the Schedule of Benefits. Copayments and/or Coinsurance amounts are higher for Paramount/First Health Network and Non-Network care than for care received from UT Providers.

**Benefit Limits** - Some benefits described in this Medical Plan Benefit Description are limited, may vary, or require payment of additional amounts. Please refer to the Schedule of Benefits and to the specific conditions, limitations, exclusions, and/or payment levels that are set forth in the section which describes that benefit in detail and in Section Eight, Exclusions, for a description of services and supplies that are not covered under this Plan. Always call Paramount at 419-887-2531 or toll-free 1-866-452-6128 if You have any questions about specific conditions, limitations, exclusions, or payment levels.

### 2. Prior-Authorization

Prior-Authorization is required by You or Your Provider for, **but not limited to**, the following list of services, procedures and equipment. **A more comprehensive list can be found at [www.paramounthealthcare.com/priorauth](http://www.paramounthealthcare.com/priorauth).**

- A. Services requiring Prior-Authorization (not an all-inclusive listing, refer to [www.paramounthealthcare.com/priorauth](http://www.paramounthealthcare.com/priorauth)):
  - i. Inpatient admission to a Hospital, Intensive Outpatient Programs (IOP), partial hospitalizations (PHP), and Inpatient admissions at rehabilitation/residential facilities; or
  - ii. Inpatient admission to a Skilled Nursing Facility; or

- iii. Home Health services; or
- iv. Organ/Bone Marrow Transplant services. Please refer to Section Six Transplant Benefits in this Summary Plan Description for more information regarding pre-authorization requirements.

B. Procedures requiring Prior-Authorization (not an all-inclusive listing, refer to [www.paramounthealthcare.com/priorauth](http://www.paramounthealthcare.com/priorauth)):

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

C. Equipment requiring Prior-Authorization (not an all-inclusive listing, refer to [www.paramounthealthcare.com/priorauth](http://www.paramounthealthcare.com/priorauth)):

- i. Air fluidized beds;
- ii. Bone stimulators and supplies;
- iii. Power operated vehicles, power wheelchairs and power wheelchair accessories;
- iv. Chest wall oscillation vest (ThAIRapy Vest System);
- v. Enteral nutrition;
- vi. Speech generating devices
- vii. Continuous Blood Glucose Monitoring services – Long Term.
- viii. Cranial orthotic remolding device
- ix. Orthotics/prosthetics and DME beyond benefit limits
- x. Hearing aids/Bone-Anchored Hearing Aids (BAHA)

For Emergency admissions to a Hospital or Skilled Nursing Facility, You do not have to provide pre-notification in advance. However, You, a family member, or Your Physician must notify Paramount within 48 hours of an Emergency admission, or as soon as possible. If You have any questions, or to provide notice, call 419-887-2549 or toll-free 1-800-891-2549.

**Remember that You or Your Provider must provide Prior-Authorization to Paramount before You obtain the services, procedures and equipment listed above.**

### 3. Filing Claims

For all Covered Services, a claim form or written proof of loss must be submitted to Paramount. UT Network and Paramount/First Health Network Providers will submit the required claim forms to Paramount for you. You must show your Paramount identification card to the Provider.

Non-Network Providers may decline to submit claims to Paramount for you. In that case, it is your responsibility to file appropriate claims in order to receive reimbursement from Paramount. You must show your Paramount identification card to the Non-Network Provider.

In order for payments to be made under this Plan, Paramount must receive claims for benefits within 90 calendar days after a service is received. Failure to submit a completed claim within that time will neither invalidate nor reduce any claim if it is shown that: 1) it was not reasonably possible to furnish a claim



within that time; and 2) such claim was furnished as soon as reasonably possible. In no event, in the absence of legal capacity, may a claim be furnished later than **1 year** from the time the claim is otherwise required. After an initial claim is submitted to Paramount, Paramount may request additional medical or other information necessary to process the claim. The claimant must respond to a written request from Paramount for additional information within 6 months of the receipt of the request for additional information. Failure to respond within this timeframe may invalidate the claim.

Payment for Covered Services will be made directly to the Providers, unless you pay for the Covered Services and request reimbursement from Paramount. Claim forms are available by calling the Paramount Member Services Department at (419) 887-2531; toll free 1-866-452-6128.

**Special Note: Non-Network Providers.** For Non-Network Hospitals, Physicians and Providers, Paramount pays for benefits based on the lesser of the Usual, Customary and Reasonable (UCR) Charge or the actual charge for the service.

For Covered Services received from Non-Network Providers, reimbursement is based on the lesser of the UCR Charge or the actual charge for the service. If the charge billed is greater than the UCR Charge, You will be Balanced Billed and *You must pay the excess portion*. For Covered Services rendered by Non-Network Providers, Deductibles, Coinsurance and benefit maximums are based on the lesser of the UCR Charge or the actual charge for the service.

#### 4. **Payments under This Plan**

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

- A. **Deductible.** The amount You and Your Dependents must pay for Covered Services within a calendar year, before benefits will be paid by the Plan. See Your Schedule of Benefits for the Deductible amount that applies to You and Your Dependents. The single Deductible is the amount each Covered Person must pay, but the single +1 and/or the family Deductible is the total amount any two or more Covered Persons must pay. Covered Services requiring a Copayment are not subject to the Deductible.

Any amounts applied to your Tier 1 Deductible or Coinsurance Limit will also be applied to your Tier 2 Deductible or Coinsurance Limit. Any amounts applied to your Tier 2 Deductible or Coinsurance Limit will also be applied to your Tier 1 Deductible or Coinsurance Limit. Any amounts applied to your Tier 3 Deductible or Coinsurance Limit will only be applied to your Tier 3 Deductible or Coinsurance Limits.

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

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

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

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

- Infertility Services; and
- Non-Network charges in excess of UCR.

The single Out-of-Pocket Maximum is the amount each Covered Person must pay, but the single +1 and/or family Out-of-Pocket Maximum is the total amount any two or more Covered Persons must pay.

Any amounts applied to your Tier 1 Deductible or Coinsurance Limit will also be applied to your Tier 2 Deductible or Coinsurance Limit. Any amounts applied to your Tier 2 Deductible or Coinsurance Limit will also be applied to your Tier 1 Deductible or Coinsurance Limit. Any amounts applied to your Tier 3 Deductible or Coinsurance Limit will only be applied to your Tier 3 Deductible or Coinsurance Limits.

#### 5. **Medically Necessary**

Covered Services must be Medically Necessary (see the Definition Section). Paramount will determine what is Medically Necessary after considering the advice of trained medical professionals. The fact that Your Provider prescribed the care or service does not automatically mean that the care is Medically Necessary or that it qualifies for coverage.

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

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

#### 6. **Coverage for Emergency Services**

If You have an accident, unforeseen illness, or injury that requires immediate care, You may seek Emergency Services 24 hours a day and 7 days a week at the nearest health care facility.

### **SECTION TWO: MEDICAL SERVICES**

**Covered Medical Services.** Paramount will provide benefits for the Medically Necessary services described in this section when they are performed or ordered by a licensed Provider. The level of benefits for these services will depend on whether these services are obtained through UT Network, Paramount/ First Health Network or Non-Network Providers.

1. **Physician Office Visit Fees.** A Copayment and/or Coinsurance must be paid for each office or home visit with an UT Network, Paramount/ First Health Network or Non-Network Physician. Please refer to the Schedule of Benefits for details.
2. **Physician Office Visit Coverage.** You are entitled to benefits for the following services at a Physician's office:
  - A. **Diagnosis and Treatment:** Services of Physicians and other medical personnel for diagnosis and treatment of disease, injury, or other conditions; and Urgent Care Services and Emergency Services provided 24 hours a day and 7 days a week. This includes surgical procedures performed in a Physician's office and consultations with specialists.
  - B. **Allergy Tests and Treatment:** Allergy tests and treatments (serums/injections) which are performed and related to a specific diagnosis.
  - C. **X-Ray and Laboratory Services:** X-ray and laboratory tests and services when ordered by a Physician. This includes prescribed diagnostic X-rays, electrocardiograms, laboratory tests and diagnostic clinical isotope services.
  - D. **Physical and Occupational Therapy:** Physical and occupational therapy services, up to the maximum indicated in Your Schedule of Benefits.

- E. **Speech Therapy:** Speech and speech therapy services for medical conditions up to the maximum indicated in Your Schedule of Benefits. This does not include non-medical conditions such as stuttering, lisping, articulation disorders, tongue thrust and delayed onset of speech.
  - F. **Radiation Therapy and Chemotherapy.**
  - G. **Medications Used in The Physician's Office:** Medications, injectables, radioactive materials, dressings and casts, administered or applied by a Physician or other Provider in the Physician's office for preventive or therapeutic purposes.
  - H. **Second Surgical Opinion.**
  - I. **Neuro/Muscular Manipulation or Adjustments Including Chiropractic Services:**  
Neuro/Muscular manipulation or adjustments including chiropractic services.
  - J. **Preventive Health Services:** Please refer to Your Schedule of Benefits for coverage levels.
    - 1. Well-baby and well-child care;
    - 2. Childhood and adult immunizations according to CDC recommended guidelines;
    - 3. Physical examinations;
    - 4. Cytologic screenings (Pap smears) for cervical cancer;
    - 5. Colorectal screening;
    - 6. Pre- and post-natal standard care;
    - 7. Allergy desensitization treatment;
    - 8. Mammography screening.
  - K. **Routine Vision Exam:** An annual routine vision exam for refractory disorders of the eye.
  - L. **Immunizations for Travel:** Immunizations for the purpose of fulfilling requirements for international travel are covered when provided by UT Network and/or Paramount/ First Health Network Providers.
  - M. **Contraceptive/Birth Control:** contraceptive injections, devices, implants and IUD removal.
3. **Visits to an Urgent Care Center.** If Your Physician is not available, diagnosis and treatment may be obtained from an urgent care center for the sudden occurrence of a condition that requires medical attention without delay, but that does not pose a threat to Your life, limb or permanent health.
4. **Medical Services While Hospitalized.** During any period of covered hospitalization the following are covered:
- A. Surgery includes:
    - 1. The performance of generally accepted operative and other invasive procedures;
    - 2. The correction of fractures and dislocations;
    - 3. Usual and related preoperative and post-operative care; and
    - 4. Other procedures as reasonably approved by Paramount.

The Plan will also cover medical and surgical procedures for:

- 1. Correction of functional defect or functional impairment which results from an acquired and/or congenital disease or injury; and
- 2. Reconstructive surgery to correct congenital malformations or anomalies resulting in a functional defect or functional impairment of a covered child 19 or Younger; and
- 3. Breast reconstruction following a covered mastectomy including:
  - a. Reconstruction of the breast on which the mastectomy was performed;
  - b. Surgery and construction of the other breast to produce a symmetrical appearance; and
  - c. Prostheses and physical complication during all stages of the mastectomy, including lymphedemas.

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

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

Payment for surgery is also subject to the following limitation: When multiple surgical procedures are performed at the same operative session, the Plan will cover the major or first procedure at the level of reimbursement in the Schedule of Benefits, depending on whether these services are performed by UT

Network, Paramount/ First Health Network or Non-Network Providers. The Plan will cover the lesser or subsequent surgical procedures at one-half of the payment otherwise payable.

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

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

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

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

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

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

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

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

5. **Services at Home. These services include:**

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

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

Home health care includes any of the following:

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

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

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

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

Medical supplies are small and often disposable items that are part of medical treatment for an illness or injury. The supply must be compatible with the diagnosis and generally must not be useful in the absence

of illness or injury for which it is used.

7. **Durable Medical Equipment (DME).** These items are covered when ordered by a Physician, supplied by a Physician, supplier or pharmacy and eligible under Medicare Part B guidelines.

**Benefits will be subject to the Coinsurance amount and/or Benefit Limit indicated in the Schedule of Benefits.**

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

8. **Prosthetic Devices.** These items are covered when ordered by a Physician, supplied by a Physician, supplier or pharmacy and eligible under Medicare Part B guidelines. **Benefits will be subject to the Coinsurance amount and/or Benefit Limit indicated in the Schedule of Benefits.**

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

9. **Infertility Services.** Diagnosis and treatment of the underlying cause of infertility by UT Network and Paramount/ First Health Network Providers. See Schedule of Benefits for limits. Coinsurance for Infertility Services is not counted toward the Coinsurance Out-of-Pocket Maximum.

10. **Surgical Sterilization.** Voluntary sterilization (including tubal ligations and vasectomies).

11. **Temporomandibular Joint Syndrome or Dysfunction (TMJ).** Medical treatment only.

12. **Foot Orthotic Devices.** These items are covered when ordered by a Physician and are eligible under Medicare Part B guidelines.

13. **Specialty Drugs.** Specialty Drugs are covered, subject to preauthorization. Specialty Drugs are complex Prescription Drugs, as determined by Paramount, used to treat chronic conditions. These drugs are self-administered as injectable/infused or oral drugs and often require special handling and monitoring. Refer to the Specialty Drug List posted on the UT HR website.

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

### SECTION THREE: HOSPITAL CARE

The level of benefits for these services will depend on whether these services are obtained through UT Network, Paramount/ First Health Network or Non-Network Providers. ***Covered Services must be Medically Necessary (see the Definition Section).*** Inpatient Hospital services, procedures and equipment will be covered at the appropriate benefit level indicated in Your Schedule of Benefits.

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

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

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

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

4. **Visits to the Emergency Room:** An emergency room Copayment and Coinsurance must be paid as indicated in the Schedule of Benefits for each visit to a Hospital emergency room. If You are admitted to the Hospital from the emergency room, the emergency room Copayment will be waived. If You have an Emergency Medical Condition, dial 911 for assistance or go to the nearest hospital emergency room.

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

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

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

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

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

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

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

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

8. **Receiving Care from Hospital-Based Providers:** Hospitals employ many physicians and other providers, such as emergency room physicians, radiologists, pathologists and anesthesiologists, who only serve patients in the hospital. The Paramount/ First Health Network has contracts with a vast majority of hospital-based physicians. These contracts mean the services will be paid under In-Network benefits and protects the Covered Person from being balance billed. Protection against balance billing means the Covered Person will not receive a bill for the difference between the provider's charge and the fee that the In-

Network pays for that service. However, there are cases where the Paramount Network has been unable to secure a contract with a hospital-based physician or provider. Please note that services from Out-of-Network hospital-based providers even though rendered in an In-Network hospital will be paid under Out-of-Network benefits. Additionally, Out-of-Network providers may not accept the UCR payment as payment in full and you may be responsible for additional charges.

#### SECTION FOUR: MENTAL HEALTH / SUBSTANCE ABUSE

1. **Covered Services.** Inpatient and outpatient services for the treatment of Mental Illness and Substance Abuse are covered subject to the same terms, Deductible, Copayments and/or Coinsurance as any other physical disease or condition. The level of benefits for these services will depend on whether these services are obtained through UT Network, Paramount/First Health Network or Non-Network Providers.
2. **Levels of Treatment**
  - A. **Outpatient Services:** The Outpatient benefit for mental health and substance abuse are listed in Your Schedule of Benefits. Outpatient services include the following:
    - Diagnostic evaluation,
    - Individual psychotherapy;
    - Group psychotherapy; and
    - Convulsive therapy.
  - B. **Inpatient Services:** The Inpatient benefit for mental health and substance abuse are listed in Your Schedule of Benefits.
    1. **Hospitalization Services:** Services provided while You are confined in a Hospital on a 24 hour a day basis to treat Mental Disorders, drug abuse or alcohol abuse, including room and board, Physician services, nursing care, pharmacy services, diagnostic tests, and the following:
      - Diagnostic evaluation;
      - Individual psychotherapy;
      - Group psychotherapy; and
      - Convulsive therapy.
    - C. **Partial Hospitalization Services:** The same services covered under hospitalization services described above in this section (except room and board). However, partial hospitalization services are provided only for a duration of six to eight hours a day and do not require an overnight stay in the Hospital.
    - D. **Intensive Outpatient Program (IOP) Services:** The same services covered under hospitalization services described above in this section (except room and board, nursing and pharmacy). However, intensive Outpatient program (IOP) services are structured ambulatory behavioral health services with a duration of two to four hours per day, at least three days per week.
3. **Determination of Appropriate Levels of Treatment.** In determining the appropriate levels of treatment, Paramount considers:
  - A. The intensity and scope of care necessary to meet the standard of Medical Necessity through an appropriate treatment plan that supports problem-focused treatment; and
  - B. The least restrictive environment that will provide appropriate care for You and Your family and offers the opportunity for independent functioning.

#### SECTION FIVE: HOSPICE CARE

Coverage for the following services is available when a Covered Person is diagnosed by their Physician as being terminally ill with a prognosis of six months or less to live. Your share of the cost for hospice care will depend on whether the care is obtained from an UT Network, Paramount/ First Health Network or Non-Network Provider.

1. **Hospices.** In order to receive coverage, You must obtain care from a Medicare certified hospice with all licenses, certifications, permits, and approvals required by applicable state and local law.
2. **Hospice Care Covered.** Covered Services include hospice care authorized by Your Physician during the period when hospice has admitted You to its program. Covered Services include the following services provided by the hospice:
  - A. Inpatient palliative care, excluding room and board, in a free standing hospice, hospice unit within a Hospital or Skilled Nursing Facility, or regular Hospital bed; and
  - B. Home care services provided by the hospice either directly or under arrangements with other licensed Providers.

## SECTION SIX: TRANSPLANT BENEFITS

Benefit levels for transplants will depend on where Your care is obtained. Pre-authorization for transplant services is required to avoid a denial in payment of benefits. The Plan will cover transplant services as follows:

1. **Transplant Procedures Covered.** The Plan will pay for Covered Services for heart, lung, kidney, heart-lung, liver, pancreas, kidney-pancreas, bowel, bone marrow and cornea transplants. Benefits will not be provided for any organ or tissue transplant procedures not specifically covered under the Plan, or for any transplants that do not meet the established criteria determined by Paramount.
2. **General Description of Transplant Covered Services.** Covered Services include any Hospital, medical-surgical, and other service related to the transplant, including blood and blood plasma.

The Plan will pay for Covered Services for organ transplants, subject to Deductibles, Coinsurance, benefit maximums or other limits as indicated in Your Schedule of Benefits. The organ transplant must be Medically Necessary, medically appropriate, and not experimental or investigational for the medical condition for which the transplant is recommended. These determinations must be made by a Plan-approved external independent review organization specializing in transplant services, such as the Ohio Solid Organ Transplant Consortium or the Ohio Bone Marrow Transplant Consortium.

3. **Specified Covered Services.**
  - A. **Hospital Care:** All Inpatient and Outpatient care.
  - B. **Organ Procurement:** The tissue typing, surgical procedure, storage expense, and transportation costs directly related to the donation of an organ or other human tissue used in Your transplant procedure will be covered as follows:
    1. If the donor is covered under another health care benefit plan which includes coverage for donations used in the covered transplant procedure, then the donor's plan will be primary and this Plan will be secondary; and
    2. If the donor is not covered by any health care benefit plan or is covered by a health care benefit plan which excludes from coverage donation benefits, this Plan will be primary.
  - C. **Operative Care and Post-Operative Care:** Benefits paid will vary depending on where You obtain care.

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

The following operative and post-operative care Covered Services:

- Hospital room, board, and general nursing in semi-private rooms and/or special care units;
- Medically Necessary Hospital ancillaries while You are an Inpatient;
- Physician's services for surgery, surgical assistance, administration of anesthetics, and



- Inpatient medical care;
- Acquisition, preparation, transportation and storage of a human heart, lung, kidney, heart-lung, liver, pancreas, kidney-pancreas, bowel, bone marrow or cornea;
- Diagnostic X-rays and other radiology services; laboratory and pathology services; and EKGs, EEGs and radioisotope tests.

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

4. **Transplant Benefit Providers.** Benefit levels for transplants will depend on where Your care is obtained. See your Schedule of Benefits. Note, Transplant services not obtained at a Paramount approved Center of Excellence will not cover. A facility is a “Center of Excellence” when it appears on Paramount’s list of centers for the specific transplant being performed or other facility pre-approved by Paramount.
5. **Pre-authorization Required.** You, or someone on Your behalf, must call Paramount at (419) 887-2520 or toll-free 1-800-891-2520 to obtain pre-authorization for Inpatient Transplant Services (except for Emergency Services). If you obtain pre-authorization, these services, procedures and equipment will be covered at the appropriate benefit level indicated in Your Schedule of Benefits. Pre-authorization is required to avoid a denial in payment of benefits.
6. **Limitation.** In accordance with and to the extent permitted by applicable law, reimbursement to You under this Plan will be secondary to any and all governmental or institutional sources of funding that will offset the cost of Covered Services. No benefits are provided for an artificial organ.

## SECTION SEVEN: MOTHER AND NEWBORN CARE

The level of benefits for maternity and newborn care will depend on whether care is obtained through UT Network, Paramount/ First Health Network or Non-Network Providers. Paramount will cover such services as follows:

1. **Medical Services.** Covered Services include the full range of obstetrical services at a Physician’s office, including prenatal visits and postnatal visits and all other services set forth in Section Two, Medical Services, with respect to pregnancy.  
  
During any period of covered hospitalization, Covered Services include obstetrical services for the termination of a pregnancy by delivery of a baby, or miscarriage, and the initial examination of a covered newborn child performed by a Physician other than the delivery Physician. Payment for maternity care includes payment for all the Medically Necessary care related to the pregnancy. The Copayment for prenatal and postnatal obstetrical services, when provided by UT Network and Paramount/ First Health Network Providers, will be waived.
2. **Hospital Services.** Coverage for Inpatient care for a covered mother and her newborn pursuant to Section Three, Paragraph 2, Inpatient Care in a Hospital, shall extend for 48 hours following normal vaginal delivery or 96 hours following a cesarean delivery or until a Physician or nurse-midwife determines that an earlier discharge is warranted after conferring with the mother or person responsible for the mother or newborn (e.g. parent, guardian or other person with authority to make medical decision for the mother or newborn). You are not required to stay in the Hospital for the above specified period of time, and if Medically Necessary, longer stays will be covered by The Plan. See Section Three: Hospital Care.
3. **Follow-up Care.** The following Physician-directed services provided after discharge from Inpatient care are covered as follow-up care:
  - A. Physical assessment of the mother and newborn;
  - B. Parent education, assistance, and training in breast and bottle feeding;
  - C. Assessment of the home support system;
  - D. Performance of any Medically Necessary clinical tests; and
  - E. Performance of any other services that are consistent with the follow-up care recommended in the

protocols and guidelines developed by national organizations that represent pediatric, obstetric, and nursing professionals.

If the mother or newborn is discharged prior to the expiration of the applicable number of Inpatient hours specified in paragraph 2 of this section, all follow-up care provided within 72 hours after discharge is covered. If the mother or newborn receive at least the number of Inpatient hours specified in paragraph 2 of this section, all such care determined to be Medically Necessary by the Physician or nurse-midwife responsible for discharge is covered. Follow-up care may be provided in a Physician's office or during a home health visit if the health care professional conducting the home visit is knowledgeable and experienced in maternity and newborn care.

## SECTION EIGHT: EXCLUSIONS

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

Benefits for the following will not be provided.

1. **Admission to a Hospital Before You Became Covered Under this Plan:** Services provided at a Hospital or Skilled Nursing Facility as a registered Inpatient before the Effective Date of this Plan.
2. **Bariatric Treatment/Surgery:** Medical services or supplies (such as weight loss or weight maintenance programs), dietary counseling programs are not covered.
3. **Breast Reduction Surgery:** Medical services, supplies or surgical procedures for breast reduction.
4. **Cardiac Rehab:** Services provided as part of Cardiac Rehabilitation, Phase III and IV.
5. **Care Provided by a Family Member:** Care provided by an individual who normally resides in Your household or is a member of Your immediate family or the family of Your spouse. Immediate family is defined as parents, siblings, spouses, children, grandparents, aunts, uncles, nieces, and nephews.
6. **Care Rendered in Certain Non-Hospital Institutions:** Care or supplies in convalescent homes or similar institutions, facilities providing primarily custodial or rest care or domiciles, care or supplies in health resorts, spas, sanitariums, tuberculosis Hospitals, or infirmaries at schools, colleges or camps.
7. **Charges in Excess of UCR:** Charges for Non-Network services that are in excess of the Usual, Customary and Reasonable (UCR) charges.
8. **Complementary Treatments:** Acupuncture, Acupressure, Hypnotherapy, Massotherapy, Aroma Therapy, Chelation therapy, Rolfing, Biofeedback training, neurofeedback training and related diagnostic tests and other forms of alternative treatments including but not limited to non-prescription drugs or medicines, vitamins, nutrients and food supplements are not Covered Services. This limitation applies even if the service or item is prescribed by or administered by a Physician.
9. **Contraceptive Supplies or Drugs:** Over-the-counter contraceptive condoms, sponges, foams, jellies and ointments.
10. **Convenience Items:** Items that are primarily for Your convenience and personal comfort. These are items that are not directly related to the provision of Covered Services. Such items include, but are not limited to, telephone, television, barber or beauty service, guest service, private rooms (except as Medically Necessary) in a Hospital or Skilled Nursing Facility, housekeeping services and meal services as part of Home Health care, travel, transportation, or living expenses, rest cures, recreational or diversional therapy.
11. **Cosmetic or Plastic Surgery:** This limitation applies to any procedures, services, equipment, or supplies provided in connection with cosmetic or plastic surgery which is intended primarily to improve appearance

or to treat a mental or emotional condition through a change in body form. In addition, the Plan will not cover procedures, services, equipment or supplies for any disease or condition resulting from a cosmetic or plastic surgery excluded under this Section. This limitation does not apply to the repair of anatomical impairment to improve or correct functional disability, breast reconstruction following a covered mastectomy or plastic surgery after an accidental injury.

12. **Custodial or Convalescent Care:** Services for Hospital care, nursing home or Skilled Nursing Facility care, home care, respite care or any other setting which is determined to be custodial. Custodial care means (1) non-health related services, such as assistance in activities of daily living, or (2) health-related services which do not seek to cure or which are provided during periods when the medical condition of the patient is not changing, or (3) services which do not require continued administration by trained medical personnel. Custodial care includes, but is not limited to, help in eating, getting out of bed, bathing, dressing, toileting and supervision in taking medications.
13. **Dental Care:** Dental work, treatment, supplies or x-rays including but not limited to, treatment of cavities and extractions; bridges, crowns, root canals; replacement or restoration of the teeth; care of gums or bones supporting the teeth; treatment of periodontal abscess; removal of impacted teeth; orthodontia (including braces, retainers and bite plates); false teeth; non-medical treatment of temporomandibular joint syndrome (TMJ) and orthognathic surgery; or any other dental service.

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

- a. initial first aid treatment received within 72 hours of an accidental Injury to sound natural teeth, the jaw bones, or surrounding issues, to the extent of extraction of teeth and repair of soft tissue;
  - b. treatment for tumors and cysts (including pathological examination) of the jaws, cheeks, lips, tongue, roof and floor of the mouth; or
  - c. repair of fractures and dislocations.
14. **Designated Blood Donation:** If You choose to designate another person to be a blood donor so that You may receive the designated blood at a future time, the Plan will not cover storage of such donated blood or any extra charges associated with designated blood donation.
15. **Diabetic and Asthmatic Equipment and Supplies.** The following Diabetic and Asthmatic equipment and supplies are not covered under this Plan:
- Needles and syringes (1cc or less)
  - Blood glucose monitor, test strips, batteries and control solutions
  - Lancing Devices, lancets
  - Peak expiratory flow rate meter (hand-held)
  - Spacers for metered dose inhaler

However, benefits for such supplies are available under the Plan's Prescription Drug Plan administered by the pharmacy benefit manager (PBM). Refer to the Prescription Drug Plan for details.

16. **Donor Searches:** Searches for organ and tissue transplants, including compatibility testing of potential donors who are not immediate, blood related family members (parent, child, and sibling).
17. **Elective Abortion:** Only an abortion necessary to save the life of the mother will be covered under this Plan.
18. **Enteral Nutrition:** All services and supplies associated with enteral nutrition. However, the Plan will cover these services and supplies if You have a disease or malfunction of the structures that normally permit food to reach the gastrointestinal tract. In this case, coverage will be provided when it is required to maintain Your weight and/or prevent clinical deterioration.
19. **Equipment:** Items not eligible under Medicare Part B guidelines including but not limited to: hypoallergenic pillows, central or unit air conditioners, breast pumps, humidifiers, dehumidifiers, air purifiers, water purifiers, mattresses, waterbeds, commodes, exercise equipment, common first aid supplies, adhesive removers, cleansers, underpads or ice bags. Charges relating to the purchase or rental of household fixtures, including but not limited to, escalators, elevators, handrails, ramps, stair glides, adjustments to a

vehicle and swimming pools are also not covered.

20. **Experimental and Investigational Procedures, Treatments, Drugs or Medicines:** Treatments, procedures, drugs or medicines that are determined to be experimental or investigational. This means that one or more of the following is true:
  - a. the device, drug or medicine cannot be lawfully marketed without approval of the U. S. Food and Drug Administration and approval for marketing has not been given at the time the device, drug or medicine is furnished.
  - b. reliable evidence shows that the treatment, procedure, device, drug or medicine is the subject of ongoing phase, I, II, or III clinical trials or is under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis.
  - c. reliable evidence shows that the consensus of opinion among experts regarding the treatment, procedure, device, drug or medicine is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis. Reliable evidence means only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same treatment, procedure, device, drug or medicine; or the written informed consent used by the treating facility or by another facility studying substantially the same treatment, procedure, device, drug or medicine.
  - d. A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational or for research purposes.
21. **First Aid Supplies:** Common first aid supplies.
22. **Fraudulent or Misrepresented Claims:** Services related to fraudulent or misrepresented claims.
23. **Free Care:** Care furnished without charge or care that would normally be furnished without charge. This exclusion also applies if the care would have been furnished without charge if You were not covered under this Plan or under any other health care benefit plan or other insurance.
24. **Genetic Testing:** Genetic testing services other than fetal screenings. Services for potential illnesses that may result from genetic predisposition or family history are not covered in the absence of signs or symptoms.
25. **Government Expense and Programs:** Services where care is provided at the Government's expense. This includes charges for Covered Services that are payable under Medicare or any other federal, state or local government program. The Plan will not cover treatment of disabilities from diseases contracted or injuries sustained as a result of military service or war, declared or undeclared, or any act of war. This exclusion does not apply if You are legally obligated to pay for such treatment or service in the absence of insurance or where the law prohibits it.
26. **Growth Hormone Therapy:** All services, drugs, and procedures associated with growth hormone therapy.
27. **Hair Loss Treatment:** Services and supplies for the treatment of hair loss.
28. **Hearing Care:** Hearing examinations, hearing aid evaluations, hearing aids, cochlear implants, bone anchored hearing aids (BAHA) and other hearing care services and supplies except Covered Services required for newborn hearing screening and the diagnosis and treatment of diseases of, or injury to, the ears.
29. **Home Monitoring Equipment:** Charges for services and supplies used for home monitoring, including but not limited to blood pressure equipment, hydrospray jet injectors, bed wetting alarms, home pregnancy, ovulation, HIV and any other home testing kits.
30. **Illegal Activities:** Any loss to which a contributing cause was the insured's commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal occupation.

31. **Infertility Services:** Diagnosis and treatment of the underlying cause of infertility by Out-of-Network Providers. Any procedure intended to induce pregnancy, such as in vitro fertilization, infertility drugs, embryo or ovum transplant or transfer services, gamete intrafallopian transfer (GIFT) procedures, zygote intrafallopian transfer (ZIFT) procedures, experimental and investigational infertility services, donor ovum, and semen related costs, including collection and preparation, storage of eggs and sperm, cryogenics, sperm banking, surrogate parenting, reversal of voluntary sterilization and any related procedures, and associated counseling.
32. **Injuries During Riots:** Services for injuries sustained while You participated in an insurrection or riot.
33. **Insulin.** Insulin, insulin injections, or other insulin therapy.
34. **Mandated or Court Ordered Care:** Any medical, psychological, alcohol and drug abuse, or psychiatric care which is solely the result of court order or otherwise mandated by a third party (such as a licensing board).
35. **Marriage-related Services:** Marriage relationship counseling and charges relating to premarital laboratory work required by any state or local law.
36. **Medical Reports:** Special medical reports not directly related to treatment; appearances at hearings and court proceedings.
37. **Mental Health / Substance Abuse Services:** Covered Services do not include the following conditions and treatments for mental health and substance abuse:
  - a. Special or remedial education, including testing and services for learning and behavioral disabilities. This limitation applies whether or not associated with manifest Mental Illness or other disturbances.
  - b. Services which are extended beyond the period necessary for the evaluation and diagnosis of mental retardation, or pervasive developmental disorders, including but not limited to Autism, hyperkinetic syndrome, mental retardation, Rett's, Asperger's Disorder, Childhood Disintegrative Disorder, Atypical Autism or Pervasive Developmental Disorder Not Otherwise Specified;
  - c. Structured sexual therapy programs;
  - d. Services for narcotic maintenance therapy in which an agonist, antagonist, or agonist/antagonist drug is used for chronic administration, as well as detoxification services related to such chronic drug maintenance use;
  - e. Testing for ability, aptitude, intelligence or interest;
  - f. Vocational and recreational activities or coma stimulation therapy;
  - g. Treatment in a specialized facility or program for a patient who has not been or would not be responsive to therapeutic management or who has not been or is not motivated;
  - h. Continuation in a course of treatment for patients who are disruptive, unruly, abusive or non-cooperative;
  - i. Inpatient treatment for codependency or environmental changes;
  - j. Halfway houses;
  - k. Cognitive rehabilitation therapy;
  - l. Family counseling;
  - m. Social skills classes;
  - n. Sleep disorders; or
  - o. Positron Emission Tomography (PET scans) for Mental Illness.

38. **Natural Disaster or Uncontrolled Event:** Benefit coverage may be limited due to the extent that a natural disaster, war, riot, civil uprising or any other Emergency or similar event not within the control of Paramount, results in the inability to provide health care services in accordance with the Plan. Paramount will make a good faith effort to continue operations, taking into account the severity of the event.
39. **Not Medically Necessary Services:** Services and supplies which, as determined by the Plan, are not Medically Necessary. The exclusion of coverage in such cases is solely a benefit determination and not a medical treatment determination or recommendation. You or Your Provider may elect to proceed with the Planned treatment, at Your expense, and appeal the denial of claim for such services in accordance with the Plan's appeal procedure.
40. **Nutrition Counseling:** Nutrition counseling and related services, except when provided as part of diabetes education.
41. **Organ Donation Services:** Organ transplant services related to donation of an organ by a Covered Person; artificial organs and services related to the implantation thereof, and other related services, except as specified in Section Six, Transplant Benefits.
42. **Orthopedic Devices:** Orthopedic devices not eligible under Medicare Part B guidelines.
43. **Paternity Testing:** Testing to establish paternity is not covered.
44. **Penile Implants:** Penile implants for the treatment of impotence.
45. **Prescription Drugs and Non-Prescription Drugs:** Outpatient Prescription Drugs, non-prescription medications, vitamins, nutrients, infant formula and food supplements even if prescribed by a Physician. However, benefits for such Prescription Drugs are available under the Plan's Prescription Drug Plan administered by the pharmacy benefits manager (PBM). Refer to the Prescription Drug Plan for details.
46. **Private Room:** If You occupy a private room, You will have to pay the difference between the Hospital's charges for a private room and the Hospital's most common charge for semi-private accommodations, unless Paramount determines that it was Medically Necessary for You to have a private room or if the Hospital only provides private rooms.
47. **Reports:** Services relating to telephone consultations, care plan oversight in the absence of the patient, missed appointments, completion of claim forms, copies of medical records or special medical reports not directly related to treatment; appearances at hearings and court proceedings.
48. **Required Examinations:** Examinations specifically for the purpose of obtaining or maintaining employment, obtaining insurance and/or professional or other licenses; examinations precedent to engaging in athletic or recreational activities or attending camp, school or other program, unless obtained in the context of the periodic examination described in Section Two, paragraph 2.i, Preventive Health Services and services for other than therapeutic purposes such as custody evaluations, adoption, research and judicial proceedings.
49. **Reversal of Sterilization:** Any procedures or related care to reverse previous voluntary sterilization.
50. **Routine Foot Care:** Any services, supplies, or devices used to improve comfort or appearance including but not limited to trimming and/or scraping of calluses, bunions (except capsular and bone surgery), toenails, subluxations.
51. **Self-Inflicted Injuries:** Charges for the diagnosis, care, or treatment of any condition arising from self-inflicted injuries or attempted suicide, unless the result of an underlying medical condition such as depression.
52. **Services After Termination of Coverage:** Services after Your coverage under this Plan ends.
53. **Services Normally Considered Non-Covered:** Services and supplies which are normally considered non-covered when another health care benefit plan has the primary Coordination of Benefits obligation, and/or services for which no charge would be made if the individual had no health care benefit.

54. **Services Not Recommended by a Physician:** Services not recommended and approved by a Physician. Also excluded are services not completed in accordance with the attending Physician's orders.
55. **Services Not Specified as Covered:** Any services not specifically described as covered in this Certificate of Coverage.
56. **Services Not Within Provider's Scope:** Services and supplies that are not performed or provided within the scope of the Provider's license.
57. **Sex-related Disorders:** Not covered unless Medically Necessary for services and supplies related to sex transformation and/or the reversal thereof, or male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This Exclusion includes sexual therapy and counseling. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, Prescription Drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related Diagnostic Testing. Evidence based and nondiscriminatory criteria will be used to determine Medical Necessity
58. **Skilled Nursing Facility:** Stays for the treatment of psychiatric conditions and senile deterioration, or facility services during a temporary leave of absence from the facility.
59. **Stand-by Charges:** Physician stand-by charges.
60. **Therapy Services:** Speech therapy except as specified under Section Two: Medical Services, 2, E. Group speech therapy, group physical therapy or recreational therapy which includes but is not limited to sleep, dance, arts, crafts, aquatic, gambling, horseback riding (equestrian therapy) and nature therapy.
61. **Third Party Liability (Subrogation) Exclusion:** Any Plan benefits to the extent You have recovered payment from any other person on account of the illness or injury for which such benefits were paid. See Section Twelve, Subrogation, for further information concerning Your obligations to cooperate with and reimburse Paramount.
62. **Topical Anesthetics:** Topical anesthetics are not covered.
63. **Transplant Services:** Any Transplant not pre-authorized by the Plan. Any Transplant provided by Non-Network Providers. The transportation and/or lodging costs of the transplant recipient or individuals traveling with him or her are not covered. Transplants using artificial organs or non-human donors, or any transplant which is not specifically listed in Section Six, Transplant Benefits.
64. **Travel Related Immunizations and Services:** Immunizations for the purpose of fulfilling requirements for international travel are not covered when provided by Non-Network Providers. Charges for confinement, treatment, services or supplies received outside the United States. This limitation only applies if the services are not of the type and nature available in the United States.
65. **Vision Care:** Orthoptic training, eyeglasses, contact lenses, contact lens evaluation and fittings, sunglasses of any type, and surgery including but not limited to: eye surgery to correct refractory errors, LASIK surgery, Keratomileusis, excimer laser, photo refractory keratectomy (interwave technology), radial keratotomy, and other vision care services and supplies, except Covered Services required for the diagnosis and treatment of diseases of, or injury to, the eyes and one annual routine eye exam.
66. **Work-Related Injuries:** Care for treatment of a work or occupational related injury or illness. This includes charges for injury or illness arising out of or in the course of past or current work for pay, profit, or gain, unless workers' compensation or benefits under similar law are not required or available.
67. **X-Rays:** Diagnostic x-rays performed in connection with a research project are not covered.

#### **SECTION NINE: COORDINATION OF BENEFITS**

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

The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary plan. The Primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary plan is the Secondary plan. The Secondary plan may reduce the benefits it pays so that payments from all Plans 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 non-group 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 2 or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.

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

(4) If a person is covered by one Plan that calculates its benefits or services on the basis of usual or



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

- (5) The amount of any benefit reduction by the Primary plan because a covered person has failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.
- E. Closed panel plan is a Plan that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.
- F. Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding temporary visitation.

### **Order of Benefit Determination Rules**

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

- A. The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.
- B. (1) Except as provided in Paragraph (2), a Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying plan is primary.  
(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide out-of-network benefits.
- C. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.
- D. Each Plan determines its order of benefits using the first of the following rules that apply:
- (1) Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary plan and Plan that covers the person as a dependent is the Secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person other than as a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.
  - (2) Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:
    - (a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:
      - The Plan of the parent whose birthday falls earlier in the in the calendar year is the Primary plan;or
      - If both parents have the same birthday, the Plan that has Covered the parent the longest is the Primary plan.
      - However, if one spouse's plan has some other coordination rule (for example, a "gender rule" which says the father's plan always primary), This plan will follow the rules of that plan.
    - (b) For a dependent child whose parents are divorced or separated or not living together, whether

or not they have ever been married:

- (i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the decree;
  - (ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;
  - (iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits;
  - (iv) If there is no court decree allocating the responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
    - The Plan covering the Custodial parent;
    - The Plan covering the spouse of the Custodial parent;
    - The Plan covering the non-custodial parent; and then
    - The Plan covering the spouse of the non-custodial parent.
- (c) For a dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.
- (3) Active Employee or Retired or Laid-off Employee. The Plan that covers a person as an active employee, that is, as employee who is neither laid off nor retired, is the Primary plan. The Plan covering the same person as retired or laid off employee is the Secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D (1) can determine the order of benefits.
  - (4) COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, The Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber, or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D (1) can determine the order of benefits.
  - (5) Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary plan and the Plan that covered the person the shorter period of time is the Secondary plan.
  - (6) If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This plan will not pay more than it would have paid had it been the Primary plan.

#### **Effect on the Benefits of this Plan**

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

that Plan and the other Closed panel plans.

### **Right to Receive and Release Needed Information**

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

### **Facility of Payment**

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

### **Right of Recovery**

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

### **Coordination Disputes**

If You believe that Paramount has not paid a claim properly, You should first attempt to resolve the problem by contacting Paramount at (419) 887-2525 or refer to Section Thirteen: 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>

## **SECTION TEN: MEDICARE AND YOUR COVERAGE**

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

1. An active employee who is age 65 and over;
2. An active employee’s spouse age 65 or over;
3. An active employee under age 65 entitled to Medicare because of disability;
4. An active employee’s covered dependent(s) under age 65 entitled to Medicare because of disability; or
5. Up to 30 months after Your treatment for end stage renal disease begins.

If You do not fall into any of the categories 1 through 5 above, the Plan will pay benefits secondary to Medicare. If You do not elect Part B coverage, the payment to be made by the Plan will be made as if You had elected Part B. When the Plan is secondary, You must first submit the claim to Medicare. After Medicare makes payment, You may submit the claim to the Plan for payment.

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

## SECTION ELEVEN: COMPLAINTS & APPEALS

**Claims Determination Procedure:** The timeframe within which an initial claim determination will be made depends upon the type of claim involved. If the claim is for urgent care, you will receive notice of Paramount's benefit determination as soon as possible, but not later than 72 hours after receipt of the claim by Paramount. The initial notification may be provided to you orally, if a written notification is provided to you not later than three (3) days after the oral notification. A claim involving "urgent care" is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations (a) could seriously jeopardize your life or health or your ability to regain maximum function; or (b) in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

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

- (1) To reduce or terminate an ongoing course of treatment (other than by Plan amendment or termination) before the end of a previously approved period of time or number of treatments, at a time sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination or review of the Adverse Benefit Determination before the benefit is reduced or terminated; and
- (2) With respect to a request to extend a course of treatment involving urgent care beyond the previously approved period of time or number of treatments, within 24 hours after receipt of the claim by Paramount, provided that such claim is made to Paramount at least 24 hours before the expiration of the previously approved period of time or number of treatments.

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

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

If a claim is denied, in whole or in part, the claimant and the provider will be notified in writing. The written denial will give the specific reason or reasons for the denial. In order to obtain information regarding a claim, an Insured Person may call the Company at 1-800-462-3589 or write to Paramount Insurance Company, 1901 Indian Wood Circle, Maumee, OH 43537, Attention: Member Services, or email: [Paramount.memberservices@promedica.org](mailto:Paramount.memberservices@promedica.org).

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

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

[PHCMbrSvcAppeals@ProMedica.org](mailto:PHCMbrSvcAppeals@ProMedica.org).

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

us or call us. We also encourage you to develop a good relationship with your physician so that you fully understand the diagnosis and treatment prescribed.

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

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

### **How to Handle a Complaint**

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

### **Appeal to Paramount**

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

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

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

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

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

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

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

## Instructions for Requesting an Internal Appeal

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

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

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

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

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

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

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

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

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

### Full and Fair Review

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

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

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

### **Concurrent Internal Appeal and External Review**

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

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

### **If Your Appeal is Denied**

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

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

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

### **Your Right to an Additional Appeal**

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

- (1) You are entitled to an external review by an Independent Review Organization (IRO) if:
  - a. the Adverse Benefit Determination involves a medical judgment or is based on any medical information (this includes a decision that a covered person sought services at an emergency room for a condition that did not meet the prudent layperson definition of an emergency); or
  - b. the Adverse Benefit Determination indicates the requested service is experimental or investigational, is not specifically listed as an excluded benefit, and the treating physician certifies one of the following:
    - i. Standard health care services have not been effective in improving your condition;
    - ii. Standard health care services are not medically appropriate for you;
    - iii. No available standard health care service covered by Paramount is more beneficial than the requested health care service.
- (2) You are entitled to an external review by the Department of Insurance if:
  - a. the Adverse Benefit Determination is based on a contractual issue that does not involve medical judgment or any medical information; or

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

### **Exhaustion Requirements**

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

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

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

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

### **Instructions for Requesting External Review**

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

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

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

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

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

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



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

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

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

### **Expedited External Review**

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

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

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

### **External Review of Experimental or Investigational Health Care Services**

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

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

### **External Review Determination:**

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

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

For appeals to the Department of Insurance, if the Department notifies Paramount that making a decision requires the resolution of a medical issue, Paramount will initiate an external review with an IRO. If the Department determines that the health service

is a covered service, Paramount will cover the service. If the Department determines that the health care service is not a covered service, Paramount is not required to cover the service or afford you further external review.

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

## SECTION TWELVE: REIMBURSEMENT/SUBROGATION

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

1. Subrogation. Where a covered person has benefits paid by Plan as a result of sickness or injury caused by a third party and/or the covered person, the rights of the covered person to claim or receive compensation, damages, first party benefits, medical payments coverage, any excess, umbrella, uninsured and/or underinsured motorist insurance or any other payment from any person, organization, insurer or any other source, including the covered person's own insurer and/or the party causing such sickness or injury, are assigned and transferred to Plan to the extent of the value of medical benefits paid for Covered Services provided to the covered person.
2. Reimbursement. Where a covered person has benefits paid by the Plan for the treatment of sickness or injury caused by a third party and/or the covered person, these are conditional payments that must be reimbursed by the covered person to the extent that the covered person receives, as a result of the sickness or injury, compensation, damages, first party benefits, medical payments coverage, any excess, umbrella, uninsured and/or underinsured motorist insurance or any other payment from any person, organization, insurer or any other source, including the covered person's own insurer and/or the party causing such sickness or injury.
3. Equitable Lien. The Plan's subrogation and reimbursement rights are a first party lien against any recovery and must be paid before any other claims, including claims by the covered person for damages (with the exception of claims by the covered person pursuant to the property damage provisions of any insurance policy). This lien is not offset or reduced in any way by the covered person's attorney fees or costs incurred in obtaining the recovery. The "common fund doctrine", "made whole" rule, or similar common law doctrines do not reduce or affect the Plan's subrogation and reimbursement rights. This means the covered person must reimburse the Plan, in an amount not to exceed the total recovery, even when the covered person's settlement or judgment is for less than the covered person's total damages and must be paid without any reductions for attorney fees. Covered person agrees that Plan has the right to obtain injunctive relief prohibiting the covered person from accepting or receiving any settlement or other recovery relating to the expenses paid by the Plan until the Plan's right of subrogation and reimbursement are fully satisfied and covered person consents to such injunctive relief.
4. Plan Assets. If a covered person receives compensation, damages, first party benefits, medical payments coverage, any excess, umbrella, uninsured and/or underinsured motorist insurance or any other payment, as a result of the sickness or injury, from any person, organization, insurer or any other source, including the covered person's own insurer and/or the party causing such sickness or injury, such amounts shall be considered a Plan asset to the extent of the value of medical benefits paid for Covered Services provided to the covered person. The covered person is, therefore, a fiduciary of the Plan with respect to such amounts.
5. Secondary Payor. The Plan is always a secondary payor when there are no fault and/or personal injury protection benefits available to the covered person.

**Plan Interpretation Clause: The Plan Sponsor has sole discretion to interpret the terms of the Subrogation and Reimbursement provision and reserves the right to make changes as it deems necessary.**

6. Cooperation by Covered Persons. By enrolling in this Plan, You and Your covered dependents agree to execute and deliver all assignments or other documents as may be required and do whatever is necessary to effectuate and protect fully the rights of the Plan or its nominee. You may not do anything which might limit, waive or release the Plan's subrogation or reimbursement rights. The covered person shall give the Plan written notice of any claim against a third-party as soon as the covered person becomes aware that the covered person may recover damages from a third-party. The covered person will be deemed to be aware that the covered person may recover damages from a third-party upon the date the covered person retains an attorney or the date written notice of the claim is presented to the third-party or the third-party's insurer by covered person, covered person's insurer or covered

person's attorney, whichever is earlier. The covered person will not compromise or settle a claim without prior written consent of the Plan. If covered person fails to provide the Plan with written notice of a claim as required or if covered person compromises or settles a claim without prior written consent, the Plan will deem the covered person to have committed fraud or misrepresentation in a claim for benefits and will terminate the covered person's participation in the Plan.

7. **Workers' Compensation/Non-Duplication.** The benefits which You are entitled to receive under the Plan do not duplicate any benefit to which You are entitled under Workers' Compensation laws or similar Plan Sponsor liability laws. All sums paid for services provided to any Covered Person pursuant to Workers' Compensation are deemed to be assigned to the Plan.

### SECTION THIRTEEN: MISCELLANEOUS PROVISIONS

1. **No Assignment.** You may not assign any benefits or monies under this Plan to any person, corporation, organization, or other entity. Any such assignment will be void and have no effect. Assignment means the transfer to another person, corporation, organization, or other entity of a right to the benefits provided under this Plan. The Plan will not prevent a Provider from receiving payment for eligible charges for Covered Services rendered under a valid assignment. Paramount will determine whether an assignment of benefits to a Provider is a valid assignment.
2. **Notice.** Any notice which the Plan Sponsor or Paramount gives to You will be in writing and mailed to You at the address as it appears on the records. If You have to give the Plan Sponsor or Paramount any notice, it should be in writing and mailed to the address set forth in the Summary of Plan Information section of this Benefit Description.
3. **Medical Records.** For the purposes of determining the applicability of and implementing the terms of this provision of this Plan or other Plan, the 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 Plan shall furnish to the Plan such information as may be necessary to implement this provision – subject to the confidentiality provisions.
4. **Genetic Testing.** The Plan Sponsor will not seek or use genetic screening or test results for the purpose of determining eligibility for enrollment.
5. **Recovery of Overpayments.** On occasion, a payment may be made to or for You when You are not covered, for a service which is not covered, or which is more than is appropriate for that service. When this happens, the Plan will explain the problem, and You must return to the Plan within 60 calendar days the amount of the mistaken payment, or provide the Plan with written notice stating the reasons why You may be entitled to such payment. In accordance with and to the extent permitted by applicable law, the Plan may reduce future payments to You in order to recover any mistaken payment. Overpayments and mistaken payments made to Providers will be recovered directly from them.
6. **Confidentiality.** Medical records, which Paramount receives from Providers, are confidential. Paramount will use Your individually identifiable personal health information only in performance of treatment, payment or health care operations in accordance with Paramount's Notice of Privacy Practices. See Paramount's Notice of Privacy Practices for further details.
7. **Right to Develop Guidelines.** The Plan reserves the right to develop or adopt criteria which set forth in more detail the instances and procedures when the Plan will make payments of benefits under the Plan. Examples of the use of the criteria are: to determine whether care was Medically Necessary, whether Emergency Services in the Outpatient department of a Hospital were Medically Necessary, or whether certain services are skilled care. These criteria will be interpretive and illustrative only and will not be contrary to any term or provision of the Plan. If You have a question about the criteria which applies to a particular benefit, You may contact Paramount for further information.
8. **Review.** If a claim for benefits is denied, a review of the denial may be obtained through the appeal procedure described in Section Eleven, Complaints & Appeals.
9. **Limitation on Benefits of This Plan.** No person or entity other than the Plan Sponsor, Paramount, and

Covered Persons hereunder is or shall be entitled to bring any action to enforce any provision of the Plan against the Plan Sponsor, Paramount, or Covered Persons hereunder, and the covenants, undertakings and agreements set forth in the Plan Sponsor's Contract with Paramount and this Benefit Description shall be solely for the benefit of, and shall be enforceable only by the Plan Sponsor, Paramount, and the Covered Persons covered under this Plan.

10. **Action at Law.** No action at law or in equity may be brought to recover under this Plan prior to the expiration of 60 calendar days after a claim for benefits has been filed as required by this Benefit Description. Also, no such action may be brought after 3 years from the expiration of the time within which a claim for benefits is required by this Benefit Description.
11. **Certification.** Paramount will automatically issue certification of Creditable Coverage under this Plan to You under certain conditions. A Paramount Member Services Representative (419-887-2531 or toll-free 1-800-452-6128) can assist You if You need to obtain certification of Creditable Coverage under this Plan.
12. **Applicable Law.** The Plan, the rights and responsibilities of the Plan Sponsor and Covered Persons under the Plan, and any claims or disputes relating thereto, shall be governed by and construed and administered in accordance with the laws of the State of Ohio and any applicable federal law.
13. **Qualified Medical Child Support Orders.** The Plan will comply with all valid medical child support orders (QMCSOs) that are determined by the Plan to meet the requirements of the Employee Retirement Income Security Act of 1974, as amended.
14. **Facility of Payment.** If a Covered Person dies while benefits under the Plan remain unpaid, the Plan Sponsor may, at its option, make direct payment to the Provider on whose charges the claim is based; or to the surviving spouse of the Covered Person; or if none, to his or her surviving child or children (including legally adopted child or children) share and share alike; or if none, to the executors or administrators of the Covered Person's estate.
15. **Time Effective.** The effective time for any dates used is 12:01 A.M. at the address of the Covered Person.
16. **Incontestability.** In the absence of fraud, any statement made by the Covered Person in applying for coverage under the Plan will be considered a representation and not a warranty. After the Plan has been in force for 2 years, its validity cannot be contested except for nonpayment of premiums or fraudulent misstatement. After a Covered Person's coverage has been in force for 2 years during his or her lifetime, its validity cannot be contested due to misstatement other than a fraudulent misstatement. Only statements that are in writing and signed by the Covered Person can be used in a contest.
17. **Misstatement of Age.** If the age of any person insured under the Plan has been misstated and if benefits are affected by a change in age, benefits will be corrected accordingly.

#### **SECTION FOURTEEN: ELIGIBILITY, FUNDING, OPEN ENROLLMENT, EFFECTIVE DATE AND TERMINATION PROVISIONS**

A Plan Participant should contact the Plan Administrator to obtain additional information, free of charge, about Plan coverage of a specific benefit, particular drug, treatment, test or any other aspect of Plan benefits or requirements.

#### **ELIGIBILITY**

**Eligible Classes of Employees.** All Active Benefit Eligible Employees of the Employer.

(a) Exempt employee is defined as are those who are exempt from certain wage and hour laws, i.e. overtime pay.

(b) Non-exempt employee is defined as employees receiving hourly wages; subject to wage and hour laws, i.e. overtime pay.

**Eligibility Requirements for Employee Coverage.** A person is eligible for Employee coverage from the first day that he or she:

- (1) is a Full-Time, Active Benefit Eligible Employee of the Employer. An Employee is considered to be

Full-Time if he or she is in a position budgeted for at least 40 hours per week.

- (2) is a Part-Time, Active Benefit Eligible Employee of the Employer. An Employee is considered to be Part-Time if he or she is in a position budgeted for at least 20 hours per week.

**Eligible Classes of Dependents.** A Dependent is any one of the following persons:

- (1) A covered Employee's eligible dependents age 19-26. (Can remain on the plan until the end of the year in which they turn age 26.)

Existing covered Dependents who have turned age 26 prior to January 1, 2017 are eligible to remain on the plan until end of month in which they turn age 28. Dependents who have turned age 26 after January 1, 2017 are eligible to remain on the plan until the end of the year in which they turn age 26.

If it is medically necessary for a dependent student to take a leave of absence from school due to a serious illness or injury, coverage will continue for 12 months from the last day of attendance in school or until the dependent reaches an age at which coverage would otherwise terminate, whichever period is shorter. Certification in writing from the dependent's attending physician will be required.

The term "Spouse" shall mean the person recognized as the covered Employee's husband or wife. The Plan Administrator may require documentation proving a legal marital relationship.

The term "children" shall include natural children, step children, adopted children or children placed with a covered Employee in anticipation of adoption.

If a covered Employee is the Legal Guardian of a child or children, these children may be enrolled in this Plan as covered Dependents provided they meet the eligibility requirements.

The phrase "child placed with a covered Employee in anticipation of adoption" refers to a child whom the Employee intends to adopt, whether or not the adoption has become final, who has not attained the age of 19 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

Any child of a Plan Participant who is an alternate recipient under a qualified medical child support order shall be considered as having a right to Dependent coverage under this Plan.

A participant of this Plan may obtain, without charge, a copy of the procedures governing qualified medical child support order (QMCSO) determinations from the Plan Administrator.

The Plan Administrator may require documentation proving dependency, including birth certificates, tax records or initiation of legal proceedings severing parental rights.

- (2) A covered Dependent child who reaches the limiting age and is Totally Disabled, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Employee for support and maintenance and unmarried. The Plan Administrator may require, at reasonable intervals during the two years following the Dependent's reaching the limiting age, subsequent proof of the child's Total Disability and dependency.

After such two-year period, the Plan Administrator may require subsequent proof not more than once each year. The Plan Administrator reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

These persons are excluded as Dependents: other individuals living in the covered Employee's home, but who are not eligible as defined; the legally separated or divorced former Spouse of the Employee; any person who is on active duty in any military service of any country; or any person who is covered under the Plan as an Employee.

If a person covered under this Plan changes status from Employee to Dependent or Dependent to Employee, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for deductibles and all amounts applied to maximums.

If both mother and father are Employees, their children will be covered as Dependents of the mother or father, but not of both.

**Eligibility Requirements for Dependent Coverage.** A family member of an Employee will become eligible for Dependent coverage on the first day that the Employee is eligible for Employee coverage and the family member satisfies the requirements for Dependent coverage.

Employees who elect coverage through the University may also elect coverage for their Dependents who are age 19-26. (Can remain on the plan until the end of the year in which they turn age 26.)

For eligible dependents age 26-28 as long as they are:

- existing dependents between the age of 26 and 28 prior to January 1, 2017; **and**
- unmarried; **and**
- the employee's natural child, stepchild, or adopted child; **and**
- a resident of Ohio or a full-time student at an accredited institution of higher education; **and**
- not employed by an employer that offers any health benefit under which the child is eligible for coverage; **and**
- not eligible for coverage under any Medicare or Medicaid plan

Existing covered Dependents who have turned age 26 prior to January 1, 2017 can remain on the plan until end of month in which they turn age 28 by annually completing a Dependent Verification Affidavit. Persons who are Dependents to Employees because of disability may be covered under the Employee's health plan as a Dependent regardless of age or student status. Dependents who have turned age 26 after January 1, 2017 are eligible to remain on the plan until the end of the year in which they turn age 26.

**Spousal Eligibility.** If a Spouse has accessibility to health insurance through their employer, they must enroll in that plan as primary for a minimum of single coverage and may stay on the UT Plan as secondary. If the Spouse makes \$25,000 or less per year annually and the employee contribution for health insurance through their employer would cost them more than \$75 per month for a single plan, they may be carried on the UT Plan as primary.

No employee may be simultaneously covered as an employee and a dependent / spouse on the University's health care plan; nor can an individual be covered as a dependent/spouse on more than one (1) university plan.

An Eligible Employee who desires to enroll his/her Spouse for coverage under this Plan must annually complete and submit to the Plan Administrator a Spousal Healthcare Eligibility Affidavit (subject to discipline for falsification) identifying whether such Employee's Spouse is currently employed, and if so, the name, address and telephone number of his/her employer, whether such Spouse is eligible for and has enrolled for health care coverage benefits under such employer's plan and if so, the type of coverage provided or selected.

At any time, the Plan may require proof that a Spouse, or a child qualifies or continues to qualify as a Dependent as defined by this Plan.

## **ENROLLMENT**

**Enrollment Requirements.** An Employee must enroll for coverage by completing the enrollment process along with the appropriate payroll deduction authorization. The covered Employee is required to enroll any Dependents they wish to have on the Plan.

### **Enrollment Requirements for Newborn Children.**

A newborn child of a covered Employee who has Dependent coverage is not automatically enrolled in this Plan. Charges for covered nursery care will be applied toward the Plan of the covered parent. If the newborn child is required to be enrolled and is not enrolled in this Plan on a timely basis, as defined in the section "Timely Enrollments" following this section, there will be no payment from the Plan and the covered parent will be responsible for all costs.

Charges for covered routine Physician care will be applied toward the Plan of the covered parent if the newborn of a covered Employee is enrolled. If the newborn child is required to be enrolled and is not enrolled in this Plan on a timely basis, there will be no payment from the Plan and the covered parent will be responsible for all costs.

If the child is required to be enrolled and is not enrolled within 30 days of birth, the enrollment will be considered a

Late Enrollment.

## **TIMELY ENROLLMENT**

- (1) **Timely Enrollment** - The enrollment will be "timely" if the completed data is received by the Plan Administrator no later than 30 days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period.

If two Employees (husband and wife) are covered under the Plan and the Employee who is covering the Dependent children terminates coverage, the Dependent coverage may be continued by the other covered Employee with no Waiting Period as long as coverage has been continuous.

- (2) **Late Enrollment**- An enrollment is "late" if it is not made on a "timely basis" or during a Special Enrollment Period. Late Enrollees and their Dependents who are not eligible to join the Plan during a Special Enrollment Period may join only during open enrollment.

If an individual loses eligibility for coverage as a result of terminating employment or a general suspension of coverage under the Plan, then upon becoming eligible again due to resumption of employment or due to resumption of Plan coverage, only the most recent period of eligibility will be considered for purposes of determining whether the individual is a Late Enrollee.

The time between the dates a Late Enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period. Coverage begins on the date of eligibility.

## **OPEN ENROLLMENT**

During the annual open enrollment period, covered Employees and their covered Dependents will be able to change some of their benefit decisions based on which benefits and coverages are right for them.

Benefit choices made during the open enrollment period will become effective January 1<sup>st</sup> and remain in effect through December 31<sup>st</sup> unless there is a change in family status during the year (birth, death, marriage, divorce, adoption) or loss of coverage due to loss of a Spouse's employment. To the extent previously satisfied coverage Waiting Periods will be considered satisfied when changing from one plan to another plan.

Benefit choices for Late Enrollees made during the open enrollment period will become effective January 1<sup>st</sup>. Plan

Participants will receive detailed information regarding open enrollment from their Employer.

## **SPECIAL ENROLLMENT**

If an eligible employee declines enrollment for themselves or their dependents (including their spouse) because of other health insurance coverage, the employee may in the future be able to enroll themselves or their dependents in this plan, provided that the employee requests enrollment within 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, and moving out of an HMO's service area. Loss of eligibility for coverage does not include loss due to the individual's failure to pay premiums or termination of coverage for cause, such as fraud.

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

In addition, if the employee has a new dependent as a result of marriage, birth, adoption, or placement for adoption, the employee may be able to enroll themselves and their dependents, provided that the employee requests enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

## **EFFECTIVE DATE**

**Effective Date of Employee Coverage.** An Employee will be covered under this Plan as of the first day that the Employee satisfies all of the following:

- (1) The Eligibility Requirement.
- (2) The Active Employee Requirement.
- (3) The Enrollment Requirements of the Plan.

**Active Employee Requirement.**

An Employee must be an Active Employee (as defined by this Plan) for this coverage to take effect.

**Effective Date of Dependent Coverage.** A Dependent's coverage will take effect on the day that the Eligibility Requirements are met; the Employee is covered under the Plan; and all Enrollment Requirements are met.

**TERMINATION OF COVERAGE**

**When coverage under this Plan stops, Plan Participants will receive a certificate that will show the period of coverage under this Plan. Please contact the Plan Administrator for further details.**

**When Employee Coverage Terminates.** Employee coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Employee may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled COBRA Continuation Options):

- (1) The date the Plan is terminated.
- (2) The last day of the month that the covered Employee ceases to be in one of the Eligible Classes. This includes death or termination of Active Employment of the covered Employee. (See the COBRA Continuation Options.)
- (3) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

**Continuation During Periods of Employer-Certified Disability, Leave of Absence or Layoff.** A person may remain eligible for a limited time if Active, full-time work ceases due to disability, leave of absence or layoff. This continuance will end as follow:

- For disability leave only:** the end of the 6 month calendar month period that next follows the month in which the person last worked as an Active Employee.
- For leave of absence or layoff only:** the end of the 6 month calendar month period that next follows the month in which the person last worked as an Active Employee.

While continued, coverage will be that which was in force on the last day worked as an Active Employee. However, if benefits reduce for others in the class, they will also reduce for the continued person.

**Continuation During Family and Medical Leave.** This Plan shall at all times comply with the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor.

During any leave taken under the Family and Medical Leave Act, the Employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Employee and his or her covered Dependents if the Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the



same extent that it was in force when that coverage terminated. For example, Pre-Existing Conditions limitations and other Waiting Periods will not be imposed unless they were in effect for the Employee and/or his or her Dependents when Plan coverage terminated.

**Rehiring a Terminated Employee.** A terminated Employee who is rehired will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements. However, if the Employee is returning to work directly from COBRA coverage, this Employee does not have to satisfy any employment waiting period.

**Employees on Military Leave.** Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act under the following circumstances. These rights apply only to Employees and their Dependents covered under the Plan before leaving for military service.

- (1) The maximum period of coverage of a person under such an election shall be the lesser of:
  - (a) The 24 month period beginning on the date on which the person's absence begins; or
  - (b) The day after the date on which the person was required to apply for or return to a position or employment and fails to do so.
- (2) A person who elects to continue health plan coverage may be required to pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.
- (3) An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

**When Dependent Coverage Terminates.** A Dependent's coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Dependent may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled COBRA Continuation Options):

- (1) The date the Plan or Dependent coverage under the Plan is terminated.
- (2) The date that the Employee's coverage under the Plan terminates for any reason including death. (See the COBRA Continuation Options.)
- (3) The date a covered Spouse loses coverage due to loss of dependency status. (See the COBRA Continuation Options.)
- (4) On the first date that a Dependent child ceases to be a Dependent as defined by the Plan. (See the COBRA Continuation Options.)
- (5) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

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

- (1) Do not make any required premium contribution; or
- (2) Perform any act or practice that constitutes fraud or an intentional misrepresentation of material fact under the terms of coverage, including without limitation:
  - a. Allowing the use of Your Paramount Identification card by any other person using another Covered Person's card;
  - b. Providing untrue, incorrect, or incomplete information on behalf of Yourself or another Covered Person in

the application for this Plan, which constitutes a material misrepresentation. You will be responsible for paying charges for all Covered Services provided to You through Paramount that are related to such untrue, incorrect, or incomplete information; and

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

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

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

## **COBRA CONTINUATION OPTIONS**

A federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), requires that most employers sponsoring a group health plan ("Plan") offer Employees and their families covered under their health plan the opportunity for a temporary extension of health coverage (called "COBRA continuation coverage") in certain instances where coverage under the Plan would otherwise end. This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of the rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator to Plan Participants who become Qualified Beneficiaries under COBRA.

Note: Special COBRA rights apply to employees who have been terminated or experienced a reduction of hours and who qualify for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 1974. These employees must have made petitions for certification to apply for TAA on or after November 4, 2002.

The employees, if they do not already have COBRA coverage, are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members, but only within a limited period of 60 days or less and only during the six months immediately after their group health plan coverage ended.

Any employee who qualifies or may qualify for assistance under this special provision should contact his or her Plan Administrator for further information.

**What is COBRA continuation coverage?** COBRA continuation coverage is group health plan coverage that an employer must offer to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at group rates for up to a statutory-mandated maximum period of time or until they become ineligible for COBRA continuation coverage, whichever occurs first. The right to COBRA continuation coverage is triggered by the occurrence of one of certain enumerated events that result in the loss of coverage under the terms of the employer's Plan (the "Qualifying Event"). The coverage must be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

**Who is a Qualified Beneficiary?** In general, a Qualified Beneficiary is:

- (i) Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent child of a covered Employee. If, however, an individual is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

- (ii) Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage. If, however, an individual is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.
- (iii) A covered Employee who retired on or before the date of substantial elimination of Plan coverage which is the result of a bankruptcy proceeding under Title 11 of the U.S. Code with respect to the Employer, as is the Spouse, surviving Spouse or Dependent child of such a covered Employee if, on the day before the bankruptcy Qualifying Event, the Spouse, surviving Spouse or Dependent child was a beneficiary under the Plan.

The term "covered Employee" includes not only common-law employees (whether part-time or full-time) but also any individual who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan (e.g., self-employed individuals, independent contractor, or corporate director).

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a qualified beneficiary, then a Spouse or Dependent child of the individual is not considered a Qualified Beneficiary by virtue of the relationship to the individual.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

**What is a Qualifying Event?** A Qualifying Event is any of the following if the Plan provided that the Plan participant would lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

- (i) The death of a covered Employee.
- (ii) The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.
- (iii) The divorce or legal separation of a covered Employee from the Employee's Spouse.
- (iv) A covered Employee's enrollment in the Medicare program.
- (v) A Dependent child's ceasing to satisfy the Plan's requirements for a Dependent child (e.g., attainment of the maximum age for dependency under the Plan).
- (vi) A proceeding in bankruptcy under Title 11 of the U.S. Code with respect to an Employer from whose employment a covered Employee retired at any time.

If the Qualifying Event causes the covered Employee, or the Spouse or a Dependent child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event (or in the case of the bankruptcy of the Employer, any substantial elimination of coverage under the Plan occurring within 12 months before or after the date the bankruptcy proceeding commences), the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of the COBRA law are also met. Any increase in contribution that must be paid by a covered Employee, or the Spouse, or a Dependent child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993 ("FMLA") does not constitute a Qualifying Event. A Qualifying Event occurs, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the covered Employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the employee portion of premiums for coverage under the Plan during the FMLA leave.

**What is the election period and how long must it last?** An election period is the time period within which the Qualified Beneficiary can elect COBRA continuation coverage under the Employer's Plan. A Plan can condition availability of COBRA continuation coverage upon the timely election of such coverage. An election of COBRA continuation coverage is a timely election if it is made during the election period. The election period must begin no later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and must not end before the date that is 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage.

**Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event?** In general, the Employer or Plan Administrator must determine when a Qualifying Event has occurred. However, each covered Employee or Qualified Beneficiary is responsible for notifying the Plan Administrator of the occurrence of a Qualifying Event that is:

- (i) A Dependent child's ceasing to be a Dependent child under the generally applicable requirements of the Plan.
- (ii) The divorce or legal separation of the covered Employee.

The Plan is not required to offer the Qualified Beneficiary an opportunity to elect COBRA continuation coverage if the notice is not provided to the Plan Administrator within 60 days after the later of: the date of the Qualifying Event, or the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event.

**Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights?** If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Employer or Plan Administrator, as applicable.

**When may a Qualified Beneficiary's COBRA continuation coverage be terminated?** During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

- (i) The last day of the applicable maximum coverage period.
- (ii) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.
- (iii) The date upon which the Employer ceases to provide any group health plan (including successor plans) to any Employee.
- (iv) The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.
- (v) The date, after the date of the election, that the Qualified Beneficiary first enrolls in the Medicare program (either part A or part B, whichever occurs earlier).
- (vi) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:
  - (a) (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or
  - (b) The end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

**What are the maximum coverage periods for COBRA continuation coverage?** The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below.

- (i) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.
- (ii) In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered Employee ends on the later of:
  - (a) 36 months after the date the covered Employee becomes enrolled in the Medicare program; or
  - (b) 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.
- (iii) In the case of a bankruptcy Qualifying Event, the maximum coverage period for a Qualified Beneficiary who is the retired covered Employee ends on the date of the retired covered Employee's death. The maximum coverage period for a Qualified Beneficiary who is the Spouse, surviving Spouse or Dependent child of the retired covered Employee ends on the earlier of the date of the Qualified Beneficiary's death or the date that is 36 months after the death of the retired covered Employee.
- (iv) In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.
- (v) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.
- (vi) In the case of employees on military leave, the 24 month period beginning on the date on which the person's absence begins.

**Under what circumstances can the maximum coverage period be expanded?** If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event.

**How does a Qualified Beneficiary become entitled to a disability extension?** A disability extension will be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage.

**Can a Plan require payment for COBRA continuation coverage?** Yes. For any period of COBRA continuation coverage, a Plan can require the payment of an amount that does not exceed 102% of the applicable premium except the Plan may require the payment of an amount that does not exceed 150% of the applicable premium for any period of COBRA continuation coverage covering a disabled qualified beneficiary that would not be required to be made available in the absence of a disability extension. A group health plan can terminate a qualified beneficiary's COBRA continuation

coverage as of the first day of any period for which timely payment is not made to the Plan with respect to that qualified beneficiary.

**Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments?** Yes. The Plan is also permitted to allow for payment at other intervals.

**What is Timely Payment for payment for COBRA continuation coverage?** Timely Payment means payment that is made to the Plan by the date that is 30 days after the first day of that period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered Employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, a Plan cannot require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is sent to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of \$50 or 10% of the required amount.

**Is a qualified beneficiary eligible for a conversion health plan at the end of the maximum coverage period for COBRA continuation coverage?** No, a conversion health plan is not available.

## DEFINITIONS

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

**Allowable Expense** - Any necessary, Usual, Customary and Reasonable item of expense covered under this Plan.

**Balance Billing** – The practice of a Provider charging full fees in excess of covered amounts and billing the patient for the portion of the bill that the Plan does not pay. UT Network Providers, Paramount Network Providers and First Health Network Providers located outside of the Paramount Service Area cannot balance bill for covered services. Non-Network Providers, however, can balance bill.

**Benefit Description** - This document, which includes the Schedule of Benefits.

**Benefit Eligible Employee** – An Employee in a classification that is eligible for health care benefits as determined by Plan Sponsor.

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

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

**Coinsurance Out-of-Pocket Maximum** - After that amount has been paid, there will be no additional payments required for Coinsurance during the remainder of that calendar year. The Coinsurance Out-of-Pocket Maximum includes all Deductibles and Coinsurance incurred by a Covered Person in a calendar year.

The single Out-of-Pocket Maximum is the amount each Covered Person must pay, and the single +1 and the family Out-of-Pocket Maximum is the total amount any two or more Covered Persons must pay.

**Copayment** - The fixed dollar amount You must pay each time You receive certain Covered Services. See Your Schedule of Benefits for a list of those services that require Copayments.

**Covered Person** - An eligible employee and/or his or her eligible dependents who elect coverage, become covered, and remain covered under this Plan, continuing to meet the Plan's eligibility requirements.

**Covered Services** - The health care services and items described in this Benefit Description and updated in the Schedule of Benefits, for which the Plan provides benefits to You.

**Creditable Coverage** - Coverage under one or more of the following: an Plan Sponsor or union sponsored health benefit plan, a health insurer, a health maintenance organization, Medicare, Medicaid, a medical and dental plan for members (and certain former members) of the uniformed services, a medical program of the Indian Health Service or a tribal organization, a state health benefits risk pool, the Federal Employees Health Benefits Program, a public health plan, or a health plan through the Peace Corps.

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

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

**Effective Date** - The first day You are covered under the Plan.

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

**Emergency or Emergency Medical Condition** - A medical condition that manifests itself by such acute symptoms of sufficient severity, including severe pain, that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following: (1) placing the health of the individual or, with respect to a pregnant women, the health of the woman or her unborn child, in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

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

**Employer** - The definition of Employer to include The University of Toledo and the University of Toledo Physicians, LLC.

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

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

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

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

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

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

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

- (1) It is provided by a Physician, Hospital, or other Provider under the Plan and is consistent with the diagnosis or treatment of the patient's sickness or injury. Certain routine and preventive health care services and supplies will be considered needed and appropriately provided for medical care only if they are included in the list of Covered Services and supplies;
- (2) The prevailing opinion within the appropriate specialty of the United States medical profession is that it is safe and effective for its intended use, and that its omission would adversely affect the patient's medical condition;
- (3) It is furnished by a Provider with appropriate training, experience, staff and facilities for the administering of the particular service or supply;
- (4) It must be the appropriate supply or level of service which can be safely provided to the patient; and with regard to a person who is an Inpatient, it must mean the patient's illness or injury requires that the service or supply cannot be safely provided to that person on an Outpatient basis; (5)

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

- (6) It must not be scholastic, vocational training, educational or developmental in nature, or experimental or investigational; and
- (7) It must not be provided primarily for the purpose of medical or other research.

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

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

Paramount has the discretionary authority to determine medical necessity under the Plan. The fact that a patient's Physician has ordered a particular treatment or supply does not make it Medically Necessary under terms of the Plan.

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

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



**Non-Network Physician/Provider** - Any Physician, Hospital or health services Provider who is not an UT Network Provider, Paramount Network Provider or First Health Network Provider who is located within Lenawee, Monroe, Williams, Fulton, Lucas, Ottawa, Defiance, Henry, Wood, Sandusky, Erie, Paulding, Putnam, Hancock, Seneca, Huron, Crawford, Richland, Ashland counties or within the remainder of the Paramount Service Area.

**Open Enrollment Period** - The annual period of time during which a Benefit Eligible Employee and/or his or her dependents may select or turn down coverage under a Plan Sponsor-sponsored health care benefit plan. A Benefit Eligible Employee and/or his or her eligible dependents may also change from one Plan Sponsor sponsored health care benefit plan to another at this time.

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

**Paramount/ First Health Network** - A group of Providers who participate in the Paramount HMO Network and/or a group of Providers located outside of the Paramount Service Area who participate in the First Health Network to provide Covered Services, as set forth in this Benefit Description.

**Paramount/First Health Network Physician/Provider** - Any Physician, Hospital, or other health services Provider who participates with the Paramount HMO Network and/or the First Health Network (excluding Lenawee, Monroe, Williams, Fulton, Lucas, Ottawa, Defiance, Henry, Wood, Sandusky, Erie, Paulding, Putnam, Hancock, Seneca, Huron, Crawford, Richland, Ashland counties) to provide Covered Services to Covered Persons.

**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.

**Physician** - A legally qualified person acting within the scope of his or her license and holding the degree of Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.).

**Plan** - The plan of health benefits described in this Benefit Description and the Schedule of Benefits.

**Plan Administrator** – Means Paramount Health Care.

Plan Interpretation – The Plan Sponsor has sole discretion to interpret the terms of the Medical Benefit Plan Document and reserves the right to make changes as it deems necessary.

**Plan Sponsor** – Means the University of Toledo.

**Prior-Authorization** – The process of obtaining authorization prior to the Covered Person receiving services. The purpose of the pre-authorization function is for Paramount to determine member eligibility, benefit coverage, medical necessity, location and appropriateness of services.

**Pre-Notification** – Advanced notice that is given by the Covered Person or the Provider on behalf of the Covered Person to Paramount prior to the member receiving specific services. The purpose of pre-notification is to make Paramount aware of services that the Covered Person is about to receive. This is different from pre-authorization where permission needs to be granted prior to the services being rendered.

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

**Schedule of Benefits** – The insert included with this Benefit Description that provides information on the limits and maximums of the Plan and Deductible, Copayment, and Coinsurance amounts that You must pay.

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

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

**Usual, Customary and Reasonable (UCR) Charges** - Charges for medical services and/or supplies that do not exceed the amount charged by most Providers of like and/or similar services and supplies in the locality where the services and/or supplies are received. Determination of whether or not a charge is Usual, Customary and Reasonable will be made by Paramount.

**UT Network** – A group of Providers, as determined by UT, who participate as tier 1 Providers to provide Covered Services to Covered Persons.

**UT Provider** - Any Physician, Hospital, or other health services Provider who is deemed by the University of Toledo as a participant in the UT Network.

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

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