

# **State of Ohio**

## ***Summary Plan Description***

### ***PARAMOUNT HMO PLAN***

**July 1, 2010**

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

## **SUMMARY OF PLAN INFORMATION**

### **TYPE OF PLAN:**

This is a self-insured managed care plan providing medical benefits. The Plan Sponsor, the State of Ohio Department of Administrative Services, has retained the services of an independent Plan Administrator experienced in processing claims.

### **PLAN ADMINISTRATOR:**

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

### **TYPE OF ADMINISTRATION:**

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

## **THE BASICS**

### **How the Paramount HMO Benefit Plan Works**

Your Primary Care Physician is your first contact when you need medical care. (Female Members may receive OB/GYN care from a participating obstetrics/gynecology specialist; see Section 2. Members may also see participating providers without a referral.

### **Your Identification Card**

Every Benefit Plan Member receives a Paramount identification card with his or her name. The name of that person's Primary Care Physician (PCP) is on the card. Each Member's identification number is a unique number assigned to the Subscriber followed by two digits.

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

### **What Are Deductibles?**

A Deductible is the amount you must pay for Covered Services within each Contract Year before benefits will be paid by the Benefit Plan. The single Deductible is the amount each Member must pay, and the family Deductible is the total amount any two or more covered family members must pay. Preventive Health Services and Covered Services requiring a Copayment are not subject to the Deductible. See "Preventive Health Services" for a list of Preventive Health Services.

### **What Are Copayments and Coinsurance?**

Benefit Plan members pay Copayments (copays) or Coinsurance for basic health services: office visits and services, inpatient services (services you receive while a patient in a hospital or other medical facility), outpatient medical services, emergency services, laboratory and radiology services, durable medical equipment, prosthetic devices, home health care, physical/occupational and speech therapy and preventive health services. See your Summary of Benefits for Copayments/Coinsurance on specific services. Copayments are payable at the time you receive services.

The Out-of-Pocket Maximum is the maximum amount of Copayments and Coinsurance including the Deductible you pay every Contract Year. Once the Out-of-Pocket Maximum is met, there will be no additional Copayment and Coinsurance during the remainder of the Contract Year. The Out-of-Pocket Maximum is stated in your Summary of Benefits.

The single and family Out-of-Pocket Maximum is reached when the combined Copayments and Coinsurance of family members reached the limit as defined in the Summary of Benefits.

### **Who to Call for Information**

The Paramount Member Services Department will help you.

#### **Call, if you:**

- Have any questions about your coverage
- Have questions about the providers who participate with Paramount
- Have questions about how to obtain health care services

- Need help understanding how to use your benefits
- Need to change your Primary Care Physician
- Lose your Paramount identification card
- Or have any other health care coverage concerns

## GETTING A DOCTOR'S CARE

### Start with Your Primary Care Physician (PCP)

Your PCP is the doctor you chose to handle your medical care through your HMO Benefit Plan. Each family member can have a different PCP.

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

For doctor appointments, call your PCP's office.

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

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

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

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

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

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

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

All Covered Services must be based on "medically necessary" guidelines, except in case of emergency.

*What are the "medically necessary" guidelines?*

The service you receive must be:

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

**If another doctor is covering** for your Primary Care Physician during off-hours or vacation, you do not need Plan authorization before you see that doctor. But be sure to tell the doctor you are a member of Paramount. Any referrals to specialists should be to physicians participating with the Benefit Plan.

**You may change your Primary Care Physician.** You must notify the Benefit Plan first, before you see any new Primary Care Physician. Call the Paramount Member Services Department. The change can be made effective the day you call. You will receive a new identification card with your new physician's name and number. If you need to see the doctor before your card arrives, your doctor can call Paramount Member Services to check your membership.

If you need specific information about the qualifications of any participating physicians or specialists, you may call the Academy of Medicine. You also can call any of the physicians referral services listed in the *Participating Physicians and Facilities* directory. If you need a current directory, you may request one free of charge by calling the Paramount Member Services Department.

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

### **When You Need OB/GYN Care**

For obstetrical/gynecological care, a female Member may see her Primary Care Physician or a Paramount participating OB/GYN. Simply choose the specialist you wish to see from those listed in the *Participating Physicians and Facilities* directory and make an appointment.

Most of your health care needs can and should be handled by your Primary Care Physician. But when you need a specialist - a cardiologist, orthopedist or others - you do not need a written referral from Paramount to a participating specialist. Simply choose the participating specialist

you wish to see from those listed in the *Participating Physicians and Facilities* directory and make an appointment. You may use the on-line directory under PARAMOUNT DIRECT located on the Paramount website at [www.paramounthealthcare.com](http://www.paramounthealthcare.com)

### **Out-of-Plan Medical Care**

If a medically necessary covered service is not available from any Participating Providers, Paramount will make arrangements for an out of plan referral. Consultations with Participating Specialists will be required before an out of plan referral can be considered. Your Primary Care Physician must request an out of plan referral in advance. If Paramount approves the out of plan referral, written authorization will be sent to you, your PCP and the non-participating provider. All eligible authorized services will be covered subject to appropriate Copayments or Coinsurance.

### **Utilization Management**

Participating physicians and providers have direct access to Paramount’s Utilization Management Department to authorize or pre-determine coverage for certain services based on medical necessity. It is the responsibility of the participating physician or provider to request a pre-determination for service if there is a question about coverage. If you experience an Emergency Medical Condition after normal office hours, you should call 911, an ambulance or rescue squad or go to the nearest medical facility. You do not need to obtain prior approval from your PCP or Paramount. You should notify your Primary Care Physician as soon as reasonably possible that you were treated.

### **Pre-Service, Post-Service and Urgent Care Claims**

Paramount will follow the guidelines below for processing initial requests for pre-service, post-service and urgent care claims:

<b>Type of Initial Request</b>	<b>Paramount Notification/Decision</b>
If request for pre-service approval is incomplete	5 days from receipt of request (24 hours for urgent care claims)
Request for pre-service approval	15 days from receipt of request
Request for urgent care pre-service approval	72 hours for urgent care claims
Request for post-service reimbursement (claim)	30 days from receipt of claim
Additional information is needed for determination of post-service claim	15 day extension – Additional information may be provided at a minimum within 45 days from receipt that additional information is needed

### **Initial Determinations**

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

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

## **Adverse Determinations**

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

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

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

## **Entering the Hospital**

Your Primary Care Physician or Participating Specialist will make the arrangements when you need hospital care. Paramount Participating Hospitals are listed in your *Participating Physicians and Facilities Directory*. Show your Paramount Identification card when you are admitted.

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

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

## **Change in Benefits**

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

## **If a Provider Leaves the Benefit Plan**

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

## **If a Specialist Leaves the Benefit Plan**

If you are regularly visiting a Participating Specialist or a specialty group whose agreement with Paramount has terminated, you and your PCP will be notified.

## **Provider Reimbursement**

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

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

## **Non-Covered Services**

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

## **If You Receive a Bill**

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

## **New Technology Assessment**

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

## **Privacy and Confidentiality**

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

## **Insurance Fraud**

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

## WHAT TO DO FOR URGENT CARE OR EMERGENCY MEDICAL CONDITIONS

### Urgent Care Services

URGENT CARE SERVICES means covered services provided for an Urgent Medical Condition. An Urgent Medical Condition is an unexpected illness or injury requiring medical attention **soon** after it appears. It is not permanently disabling or life-threatening. Urgent Medical Conditions include but are not limited to:

- Colds and cough, sore throat, flu
- Earache
- Persistent high fever
- Minor cuts where bleeding is controlled
- Sprains
- Sunburn or minor burn
- Skin rash

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

#### What to do:

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

**Participating providers are listed in your Directory of Participating Physicians and Facilities or the Paramount web site at [www.paramounthealthcare.com](http://www.paramounthealthcare.com).**

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

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

**Follow-up care within the Service Area:** Your Primary Care Physician will decide what care you need after your urgent care services.

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

ANY TIME AN URGENT CARE PHYSICIAN RECOMMENDS ADDITIONAL CARE, such as a return visit, seeing a specialist, additional testing or X-rays, etc., call Paramount

Member Services BEFORE you get the services. Paramount Member Services can tell you if the service will be covered, or if you need to contact your Primary Care Physician.

## **Emergency Services**

“Emergency Services” which are required as the result of an “Emergency Medical Condition” are covered at any medical facility, anytime, anywhere world-wide without prior authorization. The service will be subject to an emergency room, urgent care facility or office visit copay, depending on where you receive treatment and the plan option you selected. Your Copay/Coinsurance may be found in your Summary of Benefits.

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

- a) Placing the health of the individual or, with respect to a pregnant woman, the health of the woman and her unborn child, in serious jeopardy;
- b) Serious impairment to bodily functions; or
- c) Serious dysfunction of any bodily organ or part.

“Emergency Services” mean the following:

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

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

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

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

- a) Due to circumstances beyond the Member’s control, the Member was unable to utilize a participating facility without serious threat to life or health.
- b) A prudent layperson with an average knowledge of health and medicine would reasonably believe that the time required to travel to a participating facility could result in one or more adverse health consequences described under Emergency Medical Condition above.
- c) A Paramount representative refers the Member to an emergency room and does not specify a participating emergency room.
- d) An ambulance takes the Member to a non-participating facility other than at the direction of the Member.

- e) The Member is unconscious.
- f) A natural disaster prevented the use of a participating facility.
- g) The status of a participating emergency facility changed to a non-participating emergency facility, and Paramount did not inform the Member of the change.

The determination as to whether or not an “Emergency Medical Condition” exists in accordance with the definition stated in this section rests with Paramount or its Designated Representative.

Examples of “Emergency Medical Conditions” include:

- Heart attack
- Stroke
- Poisoning
- Loss of consciousness
- Inability to breathe
- Uncontrolled bleeding
- Convulsions
- Paramount may determine that other similarly acute conditions are also “Emergency Medical Conditions”

#### **What to do:**

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

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

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

**Follow-up care within the Service Area:** Your Primary Care Physician will decide what care you may need.

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

#### **Out-of-Area Student Coverage**

Your ProMedica Benefit Plan includes coverage for emergency, urgent, and follow-up care as well as care provided by college or university student health centers while your student Dependent is away at school outside the Paramount HMO Service Area through Paramount’s *Student Coverage 101 Program*. If your Dependent student needs medical care away from home that is not available from the student health center and it is not an

emergency or urgent condition, before seeking services You or Your Dependent student should contact our Utilization Management department to obtain prior authorization. In the event of an Emergency Medical Condition, call 911, an ambulance or rescue squad or go directly to the nearest medical facility.

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

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

### **The Paramount HMO Service Area**

Please refer to the State's eligibility criteria for the availability of this Plan in your specific zip code.

## **YOUR BENEFIT PLAN**

### **What Is Covered - In General**

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

To be covered by the Benefit Plan, the health services you receive must be medically necessary and be from Paramount Participating Providers, except in emergencies or with prior written approval from Paramount.

### **What Is Not Covered - In General**

These services and supplies are not covered:

1. Services by providers chosen only for convenience (for example, if you use a nonparticipating X-ray or lab provider because their offices are nearby).
2. Any service received from any other nonparticipating physician, hospital, person, institution or organization unless:
  - a. Prior special arrangements are made by Paramount or
  - b. Such services are for Emergency Medical Conditions as described in What to Do for Urgent Care or Emergency Medical Conditions.
3. Services received before coverage began or after coverage ended.
4. Any court-ordered testing, treatment or hospitalization, unless determined to be Medically Necessary by Paramount and rendered by a Participating Provider.
5. Care for conditions which state or local laws require to be treated in a public facility or for which a Member is not legally required to pay.
6. Care for disabilities related to military service to which the Member is legally entitled.

7. Care provided to Members by relatives.
8. All charges incurred as a result of a non-covered procedure. (Medically necessary services due to complications of a non-covered procedure are covered.)
9. All charges for completion of reports, transfer of medical records, or missed appointments. Self-help audio cassettes, videos and books.
10. Assisted reproductive technology such as, in vitro fertilization, embryo transplant services, GIFT, ZIFT infertility drugs and related services and any other assisted reproductive technology.
11. Surrogate parenting/pregnancy and related services.
12. Non-Emergency Services from hospital emergency facilities and providers unless prior direction is received from the Primary Care Physician or Paramount.

### **What Is Covered/What Is Not Covered - Specific Services**

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

A list of services follows, in alphabetical order:

**Abortion** Non-therapeutic abortions are not covered. "Non-therapeutic" is defined as an abortion that is performed or induced when the life of the mother would not be endangered if the fetus were carried to term, or when the pregnancy was not the result of rape or incest reported to a law enforcement agency.

**Acupuncture** Not covered.

**Alcoholism treatment** Treatment of alcoholism is administered by **United Behavioral Health**. Please refer to the separate booklet for information about coverage provided by your Plan Sponsor. Alcoholism services are **not covered** under this Plan.

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

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

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

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

**Asthma Supplies** (C/L) the asthma supplies below are covered when obtained from participating DME providers. Asthma supplies are covered in full.

- Peak expiratory flow rate meter (hand-held),

- Spacers for metered dose inhalers, and
- Masks and tubing for nebulizers.

**Biofeedback** Not covered.

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

**Breast Reduction** Not covered except when specifically approved in advance by Paramount as medically necessary.

**Chiropractic services** (C/L) Covered when performed by participating chiropractors. See Summary of Benefits for Copays and limits.

**Contraceptive services** (C/L) Covered for injections, devices and implants.

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

Cosmetic therapy/surgery includes but is not limited to:

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

**Custodial Care** Not covered. (See Home Health Care)

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

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

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

- Treatment on or to the teeth, bridges or crowns
- Extraction of teeth
- Treatment of granuloma
- Dental treatment including splints and oral appliances for temporomandibular joint syndrome or dysfunction (TMJ)
- Placement, removal or replacement or implants of the teeth and alveolar ridge including preparatory oral and maxillofacial surgery (bone grafts)

- Treatment of periodontal (gum) disease and abscesses
- Root canals
- Bite plates, retainers, snore guards, splints or any appliance or device that is fitted to the mouth.
- Any other dental products or services
- Treatment required for an injury as a result of chewing or biting
- Upper and lower jawbone surgery except as required for direct treatment of acute traumatic injury or cancer, or as necessary to safeguard a Member's health due to a non-dental physiological impairment.

**Diabetic Supplies** (C/L) Not Covered under the medical Benefit Plan. Covered under the Catalyst Rx pharmacy benefit.

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

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

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

**Dietician services** (C/L) Services of a registered dietician is covered when medically necessary for the following conditions, limited to two (2) visits per Member per condition per Contract Year.

- Obesity management
- Diabetes
- Heart patients with high cholesterol

**Drugs, other medicines and supplies** All prescription drug services and supplies from pharmacies are covered by Catalyst Rx. Members obtaining such services will not be covered by the Plan, except for those medications prescribed in an inpatient hospital setting and covered supplies obtained from participating DME providers.

**Drug addiction treatment** Treatment of drug addiction is administered by **United Behavioral Health**. Please refer to the separate booklet for information about coverage provided by your Plan Sponsor. Drug addiction services are **not covered** under this Plan.

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

Not covered:

- Medical equipment and supplies not covered by Medicare Part B
- Disposable supplies (except for ostomy supplies), test kits etc.

- Exercise equipment, air conditioners
- Penile implants, erectile devices
- Wigs
- Bite plates, retainers, snore guards, splints or any appliance or device which is fitted to the mouth

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

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

**Foot Care** (C/L) Covered from a Participating Specialist.

Not covered:

- Trimming and/or scraping of calluses, corns and nails for all conditions except for diabetic conditions approved in advance by Paramount.
- Foot orthotics including shoes, shoe molds and inserts, unless condition meets Medicare Part B criteria.
- Extra Corporeal Shock Wave Therapy (ESWT)

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

**Hearing Aids** (C/L) Covered when required due to natural hearing loss, accident, injury or illness. See Your Summary of Benefits for Coinsurance and limit details.

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

- Physician services
- Intermittent skilled nursing care
- Physical, occupational and speech therapy
- Private-duty nursing in the home
- Other medically necessary services

Not covered:

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

**Hospice services** (C/L) Covered when medically necessary for terminally ill patients and from Participating Providers. Hospice services are covered in full.

**Hospital and other facility services**

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

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

*Outpatient Surgery:* (C/L) Outpatient surgical facilities or hospital surgical treatment rooms are used for surgical procedures and other procedures including but not limited to endoscopic procedures such as colonoscopy and laparoscopy. See your Summary of Benefits.

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

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

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

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

Not covered:

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

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

**Infertility Services** (C/L) Covered for the medically necessary diagnosis and treatment of infertility conditions.

Not Covered

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

**Kidney disease treatments** (C/L) Covered for:

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

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

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

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

Not covered:

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

**Mental Health services** Treatment of mental health disorders is administered by **United Behavioral Health**. Please refer to the separate booklet for information about coverage provided by your Plan Sponsor. Mental health services are **not covered** under this Plan.

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

**Office visits** (C/L) Covered for:

- Your Primary Care Physician or participating OB/GYN specialist for OB/GYN conditions
- Participating Specialists
- Eligible services provided during each visit, may include:
  - Periodic physical exams
  - Well-baby/child exams
  - Gynecological exams
  - Immunizations
  - Diagnostic procedures
  - Medical/surgical procedures

Not covered:

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

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

**Osseous surgery on the jaw** (C/L) Typically, your dental plan will provide benefits for this type of surgery and will be the primary payer for these charges. This Plan will pay for this service in the same manner as any other surgical procedure only if you are not covered by any dental plan. If you are covered by any dental plan, this Plan will not pay as secondary insurer.

**Plastic surgery** (See Reconstructive surgery)

**Penile implants** Not covered.

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

Not covered when requested for:

- Obtaining or maintaining employment or governmental licensure
- Employer-requested physical exams
- Physical exams and immunizations for travel
- Court-ordered or forensic evaluations unless determined to be Medically Necessary by Paramount and rendered by a Participating Provider

**Prescription Drugs** Covered by Catalyst Rx

### Preventive Health Services

The following services are covered at **no Copayment, Coinsurance or Deductible.**

#### Preventive Care Guidelines

Procedure	\$0 Co-Pay Guideline
Well-baby, well-child exam	Various for birth to 2 years; then annual to age 18
Well-person exam (annual physical)	1/plan year
Hemoglobin, hematocrit, or CBC	1/plan year
Urinalysis	1/plan year
Lipid profile or total and HDL cholesterol	1/plan year
Glucose	1/plan year
Stool for occult blood	1/plan year
Pre-natal office visits	As needed; based on physician's ability to code claims separately from other maternity-related services
GYN exam	1/plan year
Clinical breast exam	1/plan year
Pap	1/plan year
Mammogram	1 base line between ages 35-39; 1/plan year for 40+
PSA	1/plan year starting at age 40
Flexible sigmoidoscopy	Every 10 years starting at age 50
Colonoscopy	Every 10 years starting at age 50

## Immunization Guidelines

Procedure	\$0 Co-Pay Guideline
Hepatitis B (HepB)	Birth; 1-2 mos; 6-18 mos
Rotavirus (Rota)	2/4/6 mos
Diphtheria, tetanus, pertussis (DTaP)	2/4/6/15-18 mos; 4-6 yr
Tetanus, diphtheria, pertussis (Td/Tdap)	11-12 yrs; Td booster every 10 yrs, 18 and older
Haemophilus influenzae b (Hib)	2/4/6/12-15 mos
Pneumococcal	2/4/6 mos; 12-15 mos; annually at age 65 and older; high risk groups
Poliovirus (IPV)	2 and 4 mos; 6-18 mos; 4-6 yrs
Seasonal flu and H1N1	All flu and H1N1 vaccines at \$0 copay. 1/plan year
Measles, mumps, rubella (MMR)	12-15 mos, then at 4-6 yrs; adults who lack immunity
Varicella (Chickenpox)	12-15 mos; 4-6 yrs; 2 doses for adult susceptibles
Hepatitis A (HepA)	2 doses b/w 1-2 yrs
Meningococcal (MCV4)	1 dose between 11-12 years or start of high school or college
Human Papillomavirus (HPV)	3 doses for females age 9 through age 26 years
Zoster (shingles)	1 dose for age 60+

**Note:** Additional services are covered at more frequent intervals and are subject to normal copays, coinsurance and deductible.

**Private Duty Nursing** Not Covered.

**Prosthetic devices** (C/L) Covered from a Participating Provider subject to coverage by Medicare Part B. Refer to your Summary of Benefits for further Copayment or limits. Repair and replacement of a prosthetic device is covered subject to meeting Medicare Part B criteria. Replacement is covered when due to normal growth or when medically required because of a change in the physical condition of the Member. A Prosthetic Device is an artificial substitute that replaces all or part of a missing body part and its adjoining tissues.

Not covered:

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

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

**Reconstructive surgery** Covered when required for:

- Repair of anatomical impairment to improve or correct functional disability within 2 years of accident or injury.
- Breast reconstruction following a covered mastectomy within 2 years of a mastectomy.
- Plastic surgery following an accidental injury within 2 years of the accident or injury or up to age 18 if a congenital anatomical functional impairment.
- A malignant or non-malignant neoplasm within 2 years following initial surgery for neoplasm.

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

Not covered:

- Cosmetic surgery
- Breast augmentation

**Sclerotherapy for spider angiomas (veins)** Not covered

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

Not covered: Custodial care

**Skin Tag Removal** Not covered.

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

Not covered: Sleep studies for sexual dysfunction

**Smoking cessation classes** Covered at Participating Hospitals.

**Surrogate Parenting and Pregnancy and related services** Not covered.

**Therapy services (C/L)** Covered for:

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

Not covered:

- Non-medical services such as vocational rehabilitation and employment counseling
- Testing, training and educational therapy for learning disabilities including developmental delays in children
- Physical/occupational therapy beyond benefit limits
- Speech therapy beyond benefit limits
- Speech therapy for development or language disorders in children (aphasia, stuttering, hyperkinesia and extreme mental retardation). Equestrian therapy.
- Extra Corporeal Shock Wave Therapy (ESWT) for conditions of the feet, elbows and shoulders

**Transplants (C/L)** Covered for certain clinical indications with prior written authorization at a Paramount approved Center of Excellence for heart, lung, liver, pancreas, heart-lung, kidney-pancreas, bowel and bone marrow transplants. Please notify Member Services as soon as possible after you are recommended for a transplant. This will enable a Paramount Nurse Case Manager to work with you, your PCP and Specialist to coordinate your care.

When Paramount selects a Center of Excellence for transplant services outside the Service Area, Paramount will reimburse IRS allowance on mileage for car travel or coach commercial air travel. Reasonable lodging and meals (not to exceed \$30.00 per day excluding alcohol) for the

transplant candidate only during medically necessary, approved visits to the institution will be reimbursed. Any eligible reimbursement will be made following receipt of itemized statements. Paramount does not cover travel, lodging or meal expenses for donors. Expenses related to the search for an unrelated bone marrow donor are subject to a lifetime limit of \$20,000 per Member.

Not covered:

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

**Transsexual surgery and related services** Not covered.

**Trimming of nails, calluses and corns** Not covered for all conditions except for diabetic conditions approved in advance by Paramount.

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

Not covered:

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

**Vision care** (C/L) Covered as needed for treatment related to a medical condition or disease of the eyes. Service must be rendered by a Participating Specialist.

Not covered:

- Routine vision exams
- Orthoptic/vision training
- Contact lenses, eyeglasses and other corrective lenses except following cataract surgery

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

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

## **ELIGIBILITY**

### **Beginning Date of Coverage Following Open Enrollment**

Plan Sponsor employees and their eligible family dependents who enroll with Paramount during an open enrollment period will be effective for coverage as of the first day of the contract effective period, typically July 1.

### **New Employees' Beginning Date of Coverage**

Plan Sponsor employees and their eligible family dependents may enroll with Paramount within the employee's initial thirty-one (31) days of employment and will be accepted for coverage as of the first day of the month following the date of hire.

## **ELIGIBILITY REQUIREMENTS**

### **Employee Eligibility**

You are eligible for health care benefits if you are a permanent full-time or permanent part-time employee, which includes established-term regular, established-term irregular, a judge or other elected or appointed official.

State of Ohio employee health plans do not contain pre-existing condition exclusions; therefore, coverage is available to you and your eligible dependents regardless of current health or health history.

### **Married State Employees**

When a husband and wife are both employed by the state, both employees cannot carry family coverage for medical, dental or vision. You have the following options:

- Both may carry single coverage
- Both may be covered by one family plan
- One employee may carry family coverage and the other single, but the spouse with single coverage may not be listed as a dependent under the family plan

### **Examples of Employees NOT Eligible for Coverage**

- Temporary
- Seasonal
- Intermittent
- Interim
- Student or college intern

### **Dependent Eligibility**

Family members as described below may be eligible for coverage under your medical benefits. (Please go to: [das.ohio.gov/eligibilityrequirements](http://das.ohio.gov/eligibilityrequirements) for the Definitions and Required Documents checklist for documentation required to enroll a dependent.)

1. Spouse. Your current legal spouse as recognized by Ohio law.

2. Unmarried Children under Age 19 including:

- Your biological children
- Your legally adopted children: adopted children have the same coverage as children born to you or your spouse, whether or not the adoption has been finalized. Coverage begins upon placement/custody for adoption.
- Your dependent stepchildren: stepchildren must live with you 50% or more of the time
- Foster children who normally reside with you
- Children for whom either you or your spouse has been appointed legal guardian and who normally reside with you
- Children for whom the plan has received a Qualified Medical Child Support order: the child must be named as your alternate recipient in the QMCSO

3. Unmarried Children Age 19 through 22 - Student Status

Your unmarried children age 19 or older, who are attending an accredited school full-time or part-time, are eligible until the end of the month in which they either reach age 23 or cease being a student - whichever occurs first.

Student coverage is not automatic. The State will annually request proof of school enrollment along with a completed Affidavit of Student Status (ADM 4729) form (available at: [das.ohio.gov/eligibilityrequirements](http://das.ohio.gov/eligibilityrequirements)). When you provide this proof, your dependent will continue to be covered. If the requested proof is not provided to the State, their coverage ends on the last day of their birthday month.

Michelle's Law prohibits health plans from terminating coverage for a dependent child who is a student at a postsecondary institution and who is on a medically necessary leave of absence from school that started July 1, 2010 or later.

To qualify for coverage under this federal provision, the dependent child must be enrolled in the plan, on the basis of student status, immediately prior to the first day of the leave. The leave must begin while the student is suffering from a serious illness or injury, be medically necessary and cause the dependent child to lose student status for purposes of coverage under the plan. Additionally, the student must present written certification from his or her physician indicating that he or she is suffering from a serious illness or injury that necessitates the leave.

Coverage under Michelle's Law continues until either one year after the first day of the medically necessary leave or the day that the student's coverage would have otherwise ended, whichever is earlier.

4. Unmarried Children Incapable of Self-Care

Unmarried children who are incapable of self-support due to mental retardation, severe mental illness, or physical handicap, whose disability began before age 23 and who are primarily dependent upon you are eligible for coverage. When there is an unsuccessful attempt at independent living, a child covered pursuant to this provision may be re-enrolled for coverage, provided that the application is submitted within five (5) years following loss of coverage.

This coverage is not automatic. You must complete the applicable form for this plan. The form can be found at [das.ohio.gov/healthplanforms](https://das.ohio.gov/healthplanforms)

The form must be completed and sent to this plan no later than 31 days prior to the dependent's 19th birthday, or upon being diagnosed with a disabling condition between the ages of 19 and 23. Periodically, but not more than once a year, proof of continued incapacity and dependence must be provided upon request.

## 5. HB1 Child

Ohio House Bill 1 of the 128th General Assembly created a new category of eligibility for the state medical plan. HB1 coverage is available for medical (including pharmacy and mental health) coverage only.

HB1 Child requirements:

- Your unmarried child, age 19 through 27, and who is not a student status child aged 19 through 22, as described above; and
- Child is your natural child, stepchild or adopted child; and
- Child is a resident of Ohio or a full time student at an accredited public or private institution of higher education; and
- Child is not employed by an employer that offers any health benefit plan under which the child is eligible for coverage; and
- Child is not eligible for state Medicaid or federal Medicare

A special rate applies for these children.

You can enroll your HB1 Child with the Annual Affidavit of House Bill 1 Child (available at: [das.ohio.gov/eligibilityrequirements](https://das.ohio.gov/eligibilityrequirements)).

When you enroll your HB1 Child, you must indicate on the applicable form whether the child qualifies as an IRS tax dependent or a child (within the meaning of 26 USC 152(f)(1)) who has not attained age 27 as of the end of the taxable year. You may wish to consult with an independent tax advisor as to your HB1 child's status under the Internal Revenue Code and IRS regulations. If your HB1 child qualifies as an IRS tax dependent or as a child (within the meaning of 26 USC 152(f)(1)) who has not attained age 27 as of the end of the taxable year, the deduction for coverage will occur before adjusted gross income is calculated (pre-tax dollars). If your HB1 child does not meet one of these qualifications, the deduction for coverage will occur after adjusted gross income is calculated.

An employee may enroll or disenroll an HB1 Child during open enrollment, when the child reaches the plan's limiting age, or when a child experiences a change in circumstances. Examples of a change in circumstance (Ohio Administrative Code 3901-8-13) include moving back to Ohio or the child's loss of employer-sponsored coverage.

To enroll or disenroll an HB1 Child, the employee must notify the State's DAS HCM Customer Service within 30 days of the change in circumstance. You may notify DAS HCM Customer Service by sending an email to [dashrd.hcmOAKSsupport@das.state.oh.us](mailto:dashrd.hcmOAKSsupport@das.state.oh.us) or by calling 614.466.8857 or 1.800.409.1205. Upon receiving your request, your child will be offered the opportunity to enroll in HB1 coverage within thirty days. If eligible, coverage will be effective at the beginning of the plan year for open enrollment enrollees, and within 30 days of receiving notice of the election and the required documentation.

## **Examples of Persons NOT Eligible for Coverage as a Dependent:**

- A spouse from whom the employee is legally divorced or legally separated
- Children who are age 28 or older
- A spouse or child currently in the military service, eligible for coverage under a federal health plan
- Married children
- Same-sex partners
- Live-in boyfriends or girlfriends
- Parents or parents-in-law
- Grandchildren (unless employee is the court-appointed legal guardian)
- Adults who are not the employee's or spouse's child under guardianship of employee (brother, sister, aunt, uncle, etc.)
- Common law spouse in which the relationship began in Ohio after October 10, 1991
- A child who is eligible for coverage as an employee of the state or who receives health care coverage through their own employment
- Stepchildren not living with the employee at least 50% of the time
- Any other members of your household who do not meet the definition of an eligible dependent

It is your responsibility to disenroll a family member who is no longer eligible for coverage.

Knowingly providing false or misleading dependent eligibility information may result in any or all of the following actions by the State of Ohio: 1) loss of coverage; 2) disciplinary action, up to and including removal; 3) collection action to recoup payments of benefits and claims paid for individuals determined to be ineligible dependents; and/or 4) civil and/or criminal prosecution.

## **Changes in Family Status**

Under normal circumstances, you cannot change or drop your health benefits coverage unless you experience a qualifying event. Any changes outside of open enrollment must be in compliance with the applicable rules of the Internal Revenue Code Section 125 which may include but not be limited to the following:

1. After marriage, death of a spouse, divorce, legal separation, or annulment, in which case coverage becomes effective the first day of the month following the month of the event.
2. Birth, adoption, placement for adoption, or death of a dependent, in which case coverage becomes effective with the birth, adoption, or placement of a child or date of death.
3. Termination or commencement of employment by the employee, spouse or dependent, in which case coverage becomes effective the first day of the month following the month of the event.

4. Reduction or increase in hours of employment by the employee (including layoff or reinstatement from layoff), spouse, or dependent, including a switch between part-time and full-time, strike, lockout, or commencement, return to work from an unpaid absence, or change in work site in which case coverage becomes effective the first day of the month following the month of the event.
5. Return to work through order of arbitration or settlement of a grievance, or any administrative body with authority to order the return to work of an employee.
6. The employee's dependent satisfies or fails to satisfy the requirement of the definition of dependent due to attainment of age, student status or any similar circumstance as provided in the Health Plan under which the employee receives coverage.
7. If the plan receives a Qualified Medical Child Support Order (QMCSO) pertaining to an employee's dependent, the employee may elect to add or drop the child to the plan depending upon the requirement of the QMCSO.
8. If an employee, spouse, or dependent who is enrolled in a health plan becomes entitled to coverage (i.e., enrolled) under Part A or Part B of Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines).
9. If an employee, spouse, or dependent is no longer entitled to coverage (i.e., enrolled) under Part A or Part B of Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines).

Requests for changes pursuant to Sections (1) through (9) must be supported by proper documentation. Documentation must be submitted within 31 days of the event.

10. An employee may change health plans if the employee either no longer resides or no longer works in the service area of the employee's current health plan.

## **WHAT HAPPENS WITH YOUR PLAN**

### **When You Have Other Coverage**

#### **Coordination of Benefits - How Coordination of Benefits Works**

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

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

**This Benefit Plan pays for health care only when you follow the Benefit Plan rules and procedures. If this Benefit Plan's rules conflict with those of another plan, it may be impossible to receive benefits from both plans, and you must follow the Coordination of Benefits provisions in this Benefit Plan.**

### **Benefit Plans That Do Not Coordinate**

This Benefit Plan will pay benefits without regard to benefits paid by the following kinds of coverage:

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

### **How This Benefit Plan Pays as Your Primary Benefit Plan**

When this Benefit Plan is primary, the Benefit Plan will pay the full benefit allowed by your contract as if you had no other coverage.

### **How This Benefit Plan Pays as a Secondary Benefit Plan**

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

### **Which Benefit Plan Is Primary?**

To decide which plan is primary, this Benefit Plan will consider both the coordination provisions of the other plan and which member of your family is involved in a claim. The primary plan will be determined by the first of the following factors which applies:

1. **Non-Coordinating Plan** If you have another group plan, which does not coordinate benefits, it will always be primary.
2. **Employee** The plan that covers you as an employee (neither laid off nor retired) is always primary.
3. **Children** (parents divorced or separated) If the court decree makes one parent responsible for health care expenses, that parent's plan is primary. If the court decree gives joint custody and does not mention health care, this Benefit Plan will follow the birthday rule. (See item 4 below.)

If neither of those rules applies, the order will be determined in accordance with the Ohio

Department of Insurance rule on coordination of benefits.

4. **Children and the birthday rule** When your children's health care expenses are involved, this Benefit Plan will follow the "birthday rule": The plan of the parent with the first birthday is always primary for the children. For example, if your birthday is in January and your spouse's birthday is in March, your plan will be primary for all of your children.

If both parents have the same birthday, the benefits of the Benefit Plan that covered one parent longer are determined before those of the Benefit Plan that has covered the other parent for a shorter period of time.

However, if your spouse's plan has some other coordination rule (for example, a "gender rule" which says that the father's plan is always primary), their Benefit Plan will follow the rules of that plan.

5. **No fault and/or person injury** This Benefit Plan is always a secondary payor when there are no fault and/or personal injury protection benefits available to the Member.
6. **Other situations** For all other situations not described above, the order of benefits will be determined in accordance with the Ohio Department of Insurance rule on "Coordination of Benefits."

### **Coordination Disputes**

If you believe that this Benefit Plan has not paid a claim properly, you should first attempt to resolve the problem by contacting Paramount Member Services. Please refer to What to Do When You Have Questions, Complaints or Appeals for the appeal procedures.

### **When You Qualify for Workers' Compensation**

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

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

### **When Someone Else Is Liable (Subrogation and Reimbursement)**

Where a Member has benefits paid by the Benefit Plan for the treatment of sickness or injury caused by a third party, these are conditional payments that must be reimbursed by the Member if the Member receives compensation, damages or other payment as a result of the sickness or injury from any person, organization or insurer, including the Member's own insurer, medical payments coverage, excess umbrella, and any uninsured and/or underinsured motorist insurance, or any other source (including the party causing sickness or injury). As an alternative to reimbursement by the Member, the Benefit Plan may subrogate to the Member's rights of recovery and remedies by joining in the Member's lawsuit, assigning its rights to Member to pursue on the Benefit Plan's behalf, or bringing suit in the Member's name as subrogee.

The Benefit Plan's reimbursement and subrogation rights are equal to the value of medical benefits paid for Covered Services provided to the Member. The Benefit Plan's subrogation rights are a first priority claim against any recovery and must be paid before any other claims, including claims by the Member for damages. This means the Member must reimburse the Benefit Plan in full, in an amount not to exceed the total recovery, even when the Member's

settlement or judgment is for less than the Member's total damages and must be paid without any reductions for attorney's fees, costs or other expenses incurred by the Member. The Benefit Plan is always a secondary payor when there are no fault and/or personal injury protection benefits available to the Member.

## **WHEN YOU LEAVE YOUR JOB**

### **Certificate of Creditable Coverage**

If your coverage with the Benefit Plan ends for any reason, you will receive a Certificate of Creditable Coverage indicating the length of time you were covered by the Benefit Plan without a sixty-three (63) day lapse in coverage. If you buy health insurance through another insurance carrier, this certificate may help you obtain coverage without a pre-existing condition exclusion.

### **How You May Continue Group Coverage**

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

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

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

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

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

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

- 1) The covered Subscriber and Dependents may continue coverage for up to eighteen (18) months.
- 2) Covered Dependents may continue coverage for up to thirty-six (36) months if any of the following events occur during the eighteen-month period:
  - a. The death of the reservist.
  - b. The divorce or separation of the reservist from the reservist's spouse.
  - c. A covered Dependent child's eligibility under this coverage ends.

- 3) The continuation period begins on the date coverage would have terminated because the reservist was called to active duty.
- 4) The Subscriber and/or Dependent must complete and return to the Plan Sponsor an election form within thirty-one (31) days of the date coverage would terminate.
- 5) The Subscriber and/or Dependent must pay any required contribution to the Plan Sponsor, not to exceed 102% of the group rate.
- 6) Continuation Coverage will end on the date any of the following occurs:
  - a. The Subscriber or Dependent becomes covered by another group plan without any pre-existing condition restriction.
  - b. The period of eighteen (18) months, twenty-nine (29) months or thirty-six (36) months expires.
  - c. The Subscriber or Dependent does not make the required payment.
  - d. The group contract with the Plan Sponsor is terminated.

### **How to Convert to Individual Coverage (When Group Coverage Is No Longer Available)**

If your Plan coverage or continuation coverage ends, you and/or your eligible Dependents can convert to individual membership without providing evidence of insurability. You may call Paramount's Member Services Department and they will send you a summary of conversion benefits available and a payment schedule. A Member who meets the definition of a Federally Eligible Individual will have the option to convert to a basic or standard plan.

To obtain individual membership, you must meet all of the following conditions:

- You must live in the Service Area (except for court-ordered Dependents)
- You must submit a complete application for conversion to an individual policy within thirty-one (31) days after the date your Plan coverage ends
- You must submit any prepayment required. Details of the current prepayment rates will be sent to you at your request for conversion information.

Please be aware that an individual plan may not offer all the same benefits as Plan Sponsor coverage.

### **Conditions of Individual Conversion**

- Conversion to individual coverage will be available to Members who live in the Paramount Service Area, are not eligible for Medicare benefits or any other policy of insurance or health care plan providing comparable benefits, and have lost eligibility due to termination of employment conditions or Dependent eligibility requirements explained in the Eligibility Section.
- Your former Plan Sponsor's Agreement must be in effect at the time of conversion in order to be eligible for this option.
- If a Member chooses to apply for conversion, the conversion will be effective retroactively from the date group or continuation coverage ended. If a Member chooses not to apply for conversion and receives health services or benefits during the 31-day decision period, that Member must pay for those services.
- The Member is responsible for the required payment according to the plan's prepayment schedule as detailed in the individual plan document ("Individual Medical and Hospital Service Agreement").

For details call Member Services.

## **WHAT TO DO WHEN YOU HAVE QUESTIONS, SUGGESTIONS, COMPLAINTS or APPEALS**

Paramount's Member Services Department is available to assist you with any questions from 8:00 A.M. to 5:00 P.M., Monday through Friday, phone (419) 887-2525 or toll-free 1-800-462-3589.

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 us through the Paramount web site at: [www.paramounthealthcare.com](http://www.paramounthealthcare.com).

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 members who are hearing impaired. Paramount will also provide translation services for members who don't speak English. If a Member needs foreign language translation services, they should call the Member Services Department. If you have any suggestions for improving our service or if you wish to recommend changes in procedures or benefits, please write 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.

### **Reconsideration of a Utilization Review Decision**

A provider has the right to request reconsideration on your behalf when Paramount has made an adverse determination (denial) on a prospective or concurrent utilization review of an admission, availability of care, continued stay or other health care service. The provider or health care facility may not request reconsideration without your prior written consent. Paramount will reconsider a non-urgent care precertification request within two (2) working days from receipt of the provider's written request for reconsideration. Reconsideration of a denial for care currently in process (previously authorized by Paramount) is conducted within 24 hours from receipt of the request for reconsideration. Reconsideration of a denial for services that have already been received is conducted within 25 calendar days from receipt of the request for reconsideration. The reconsideration will be conducted between the provider and the Paramount reviewer who made the adverse determination. If the reconsideration process does not resolve the difference of opinion, the Member (you), your Legal Representative, an Authorized Person, or the provider or health care facility acting on your behalf may request an Internal Review.

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

A complaint is when you are dissatisfied with any aspect of Paramount service. If you have a complaint, call the Member Service Department at (419) 887-2525 or, toll-free at 1-800-462-3589. A Member Service representative will try to resolve the complaint within two (2) working days for urgent clinical issues and thirty (30) working days for other complaints. You will be advised of the disposition of your complaint by telephone call or in writing. If a complaint is not resolved to your satisfaction, you will be advised of your right to appeal.

### **Appeal to Paramount**

As a member of Paramount, you have the right to appeal decisions that deny or limit your health care benefits. Your rights are explained below.

### **Internal Review**

If a service is denied, reduced, or terminated, you may ask Paramount to review the request for the service again. You must make this request in writing. You may contact us at:

Paramount Health Care

Member Service Appeals  
Mailing address: P.O. Box 928, Toledo, OH 43697-0928  
Office location: 1901 Indian Wood Circle, Maumee, OH 43537  
Phone: (419) 887-2525 or toll-free 1-800-462-3589

This is called an internal review. You must request an internal review *within one year* from the denial, reduction or termination. You (the member), your Legal Representative, an Authorized Person, the provider, or the health care facility may request the review. The provider and health care facility must have the member's authorization to request a review. You do not need the authorization of the provider. You may request free of charge from Paramount, reasonable access to and copies of, all pertinent documents, records and other information regarding the appeal. You will receive an acknowledgement from Paramount within five (5) working days from receipt of your request. 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.

If the service is being denied, reduced or terminated because of contract benefit limits, because the service is not covered under the contract or the case involves a membership or enrollment issue, the review will be conducted by administrative staff. Paramount will use a clinical peer for this review if it involves a clinical issue. A clinical peer is a physician or provider who has the same license as the provider who will perform the service. The clinical peer will review your medical records and determine if the covered service is medically necessary. If the clinical peer determines that the covered service is medically necessary, Paramount must pay for the service; if the clinical peer determines that the covered service is not medically necessary, Paramount may continue to deny payment for the services. If payment for the services are denied, you have the right to ask for another review.

From the date Paramount receives your written request for an internal review, we will provide you with a written response indicating the decision within 30 calendar days for pre-service appeals and within 60 calendar days for post-service appeals. If your medical condition requires a faster review (called an expedited review), Paramount must provide you with a response ***within 72 hours***. If Paramount does not respond to your request for an Internal Review within 60 calendar-days or within 7 calendar days for Expedited Reviews, it is considered a denial, and you have the right to appeal further.

### **Additional Appeals**

If Paramount continues to deny payment for the service, you will be informed of your right to ask for another review. You may appeal denials for any of the reasons listed below:

- a) They are not covered services.
- b) They are not medically necessary
- c) They are experimental and you have a terminal illness

### **Denial Because Services are Not Covered**

If Paramount denies the service because it is not a covered service under the terms of your Plan, you may request a review from the Department of Administrative Services (DAS). You should write promptly to:

Department of Administrative Services  
Paramount Benefit Appeal  
Benefits Administration Services  
30 East Broad St., 27<sup>th</sup> Floor  
Columbus, OH 43215

The DAS will review your Plan and the type of service requested. If the DAS determines that the service is not a covered benefit, the Plan will not pay for the service. If the DAS determines that the service is a covered benefit, the Plan will pay for the service.

### **Denial Because the Services are not Medically Necessary**

If Paramount denies, reduces or terminates the service because it is not medically necessary and the service and the related expenses will cost you more than \$500 if it is not covered by the Plan (the \$500 does not apply in cases of expedited reviews), you may request an external review from an independent review organization (IRO). The IRO is not affiliated with Paramount.

You must contact Paramount and request this review *within sixty (60) calendar days* of receiving notice that your claim was denied by the clinical peer. Your request must be in writing and include a certification from the provider that the services will *cost you more than \$500*. You (the member), your Legal Representative, an Authorized Person, the provider, or the health care facility may request the review. The provider and health care facility must have the member's authorization to request a review. You do not need the authorization of the provider. You will receive an acknowledgement from Paramount within five (5) working days from receipt of your request.

The IRO will review your medical records and determine if the recommended service is medically necessary. If the IRO determines that the service is medically necessary, the Plan must pay for the service according to the terms of the contract. If the IRO determines that the service is not medically necessary, the Plan does not have to pay for the service.

### **Denial Because the Services are Experimental**

If you have a terminal illness you may also request an external review when the services are denied because they are experimental or investigative. To qualify for this review you must meet *all* of the following criteria:

1. You have a terminal condition that according to the current diagnosis has a high probability of causing death within two years.
2. You request an external review *not later than sixty (60) calendar days* after receipt of notice of the result of your internal review.
3. Your physician certifies that one of the following situations applies to your condition:
  - Standard therapies have not been effective in improving your condition
  - Standard therapies are not medically appropriate for you
  - There is no standard therapy covered by Paramount that will benefit you more than the therapy requested by either you or your physician.
4. Your physician has recommended a drug, device, procedure, or other therapy that he or she certifies in writing is likely to benefit you more than standard therapies or you have requested a therapy that has been found in a preponderance of peer-reviewed published studies to be associated with effective clinical outcomes for the same condition.
5. You have exhausted the internal review process.
6. The drug, device, procedure, or other therapy would be covered if it were not considered to be experimental or investigative.

### **Instructions for Requesting an External Independent Review**

You must contact Paramount and request an external independent review in writing *within sixty (60) calendar days* of receiving notice of the denial from Paramount's internal review. You (the member), your Legal Representative, an Authorized Person, the provider, or the health care facility may request the review. The provider and health care facility must have the member's authorization to request a review. You do not need the authorization of the provider. You will receive an acknowledgement from Paramount within five (5) working days from receipt of your request. You cannot be required to pay for the review. The review is paid for by the Plan.

The independent review organization must provide a response within thirty (30) calendar days. The decision must include:

- A description of the patient's condition
- The principal reasons for the decision
- An explanation of the clinical rationale for the decision

### **Expedited Reviews**

When the review must be completed quickly because of your medical condition, you may request an external review by phone, fax or e-mail. However, you must follow up this request with a written request within five (5) calendar days. The independent review organization (IRO) must provide you with a response to an expedited review within seven (7) calendar days of your initial request.

You may request an expedited review if delaying the review will do any of the following:

- Place the health of the patient or unborn child in serious jeopardy
- Cause serious impairment to bodily functions
- Cause serious dysfunction of any body organ or part

### **Department of Administrative Services (DAS) Appeal**

If both levels of appeals have been exhausted and you disagree with the decision, you can file a complaint and/or request a benefit determination from the Department of Administrative Services (DAS). Submit a written request within 60 days of receiving the final written decision and supply the documentation from earlier appeals. Send your request and documentation to:

Paramount Benefit Appeal  
Benefits Administration Services  
30 East Broad St., 27<sup>th</sup> Floor  
Columbus, OH 43215

- A written decision will be given within 60 days after you submitted your request.

### **Limitation on Legal Actions**

You may not bring action in court against the Benefit Plan until you have exhausted all the applicable procedures described above. In no event may you bring an action in court against the Plan more than two (2) years after the occurrence upon which the legal action is based. If the occurrence that is the basis for the legal action concerns a denial of a claim, the occurrence will be the date of service if the service was in fact received.

### **TERMS AND DEFINITIONS**

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

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

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

**Contract Year** for the State of Ohio begins each July 1st through June 30th of the following year.

**Copayment** is your share of the cost of some Covered Services. This is a specific dollar amount, such as \$20.00. Copayments are due and payable at the time services are provided.

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

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

**Creditable Coverage** is the period of prior health plan coverage of a Covered Person which may entitle the Covered Person to reduce the effective time period of a pre-existing condition exclusion which may be present in future coverage sought by the individual. Upon termination of your coverage with the Benefit Plan, you are entitled to receive a Certificate of Creditable Coverage that provides information regarding prior coverage with the Benefit Plan.

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

**Dependent** means any member of a Subscriber's family who is primarily dependent on Subscriber for support and maintenance and qualifies as a Dependent under IRS guidelines.

**Designated Representative** means a provider appointed by Paramount to administer managed care and/or cost containment programs for this coverage.

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

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

**Employee** means anyone who is employed by the Plan Sponsor.

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

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

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

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

**Emergency Services** means the following:

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

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

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

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

**Experimental** is any treatment, procedure, facility, equipment, drug, device or supply which Paramount does not recognize as accepted medical practice or which did not have required governmental approval when you received it. This includes treatments and procedures which:

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

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

**Member** means any Subscriber or Dependent.

**Out-of-Pocket Maximum** is the maximum amount of Copayment and Coinsurance you pay every Contract Year on basic health services. Once the Out-of-Pocket Maximum is met, there will be no additional Copayment and Coinsurance during the remainder of the Contract Year. The single Out-of-Pocket Maximum is the amount each Member must pay, the family Out-of-Pocket Maximum is the total amount any two or more covered family members must pay.

**Outpatient** refers to services or supplies provided to someone who has not been admitted as an inpatient to a hospital. Observation care is considered an Outpatient service.

**Paramount Service Area** means all of Ashland, Crawford, Defiance, Erie, Fulton, Hancock, Henry, Huron, Lucas, Marion, Morrow, Ottawa, Putnam, Richland, Sandusky, Seneca, Williams, Wood, and Wyandot counties, and portions of Allen, Delaware, Hardin, Knox, Lorain and Paulding counties in Ohio and Monroe and Lenawee counties in Michigan. Paramount may periodically add or remove certain counties from their service area. Benefit Plan Participants should contact Paramount Member Services for an updated listing of the Paramount Service Area. **Note** – Please refer to the State's eligibility criteria for the availability of this Plan in your specific zip code.

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

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

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

**Plan Sponsor** means the State of Ohio.

**Plan Administrator** means Paramount Health Care.

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

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

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

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

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

**Urgent Medical Condition** is an unexpected illness or injury requiring medical attention soon after it appears (a persistent high fever, colds, sprains, etc.). It is not permanently disabling or life-threatening.

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

## **MISCELLANEOUS PROVISIONS**

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

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

## **Facility of Payment**

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

## **Rights of Recovery**

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

## **Change in Benefits**

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

## **Assignment of Medical Benefits**

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

## **Examination**

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

## **Workers' Compensation Not Affected**

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

## **Qualified Medical Child Support Orders**

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

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

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

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

QMCSO means a MCSO that meets the following requirements:

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

### **Plan Modification and Amendment**

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

### **Plan is not a Contract**

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

### **Notice**

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

## **Proof of Claims**

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

- An itemized bill for the service or supply must be furnished to the Benefit Plan. An itemized bill for all professional services must include a diagnosis (ICD 9 CM) and a CPT code (Current Procedural Terminology) for each service provided.
- If Paramount as Benefit Plan Administrator requests information from the Member, the Member must furnish such information as requested.
- If Paramount as Benefit Plan Administrator requests information from a provider and the provider does not furnish the requested information, the Member will be required to obtain the requested information and furnish it to Paramount.

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

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

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

## **Non-Payment of Claims**

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

## **Actions**

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

## **Severability**

If any provision of this Benefit Plan, on its effective date or thereafter, is determined to be in conflict with Ohio law, or applicable Federal rules or regulations, the provision is hereby amended to conform to the applicable rules or regulations.

**Conformity of Law**

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

(Rev. July 1, 2010)

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