LUCAS COUNTY

EMPLOYEE HEALTH BENEFIT PLAN-PARAMOUNT HMO

AS AMENDED AND RESTATED

EFFECTIVE MARCH 1, 2011

Incorporating all changes made through the Third Amendment, effective March 1, 2014.

Board of County Commissioners, Lucas County, Ohio
Employee Benefits
One Government Center, Suite 440
Toledo, Ohio 43604-2259

Paramount Care, Inc.
Schedule of Benefits
For:

LUCAS COUNTY EMPLOYEES

Group Number:	030989	**Effective Date:**	3/1/2014
Benefit Period:	Contract Year (3/1/2014 – 2/28/2015)		
Dependent Child Limiting Age:	See Lucas County Eligibility Rules		

	Paramount HMO Network
Out-of-Pocket Copayment Limit:	$1500 Single, $3000 Family. Co-Payments/Coinsurance for Infertility Services & Visi rebate, **do not** apply toward Out-of-Pocket Coinsurance Limit.
Covered Services:	All Covered Services not listed below are subject to 25% Coinsurance
Primary Care Physician Office Visits:	$10 Copay per Office Visit. Allergy testing is subject to a $25Copay per testing session
Specialist Physician Office Visits:	$15 Copayment per Office Visit. Allergy testing is subject to a $25 Copayment per test session.
Inpatient Hospital:	Inpatient hospital services are subject to a 25% Coinsurance per admission. Inpatient rehabilitation is covered up to 60 days.
Outpatient Surgical Facility:	Outpatient hospital or free-standing surgical facility services are subject to a 25% Coinsurance.
Outpatient Physical/Occupational/Speech Therapy:	Physical/Occupational Therapy: $25 Copay per Visit up to 30 visits. Speech Therapy: S Copay per visit up to 30 visits.
Emergency Room Facility:	$100 Copay. Waived if admitted.
Urgent Care Facility:	$15 Copay
Ambulance:	Emergency – 25% Coinsurance
Skilled Nursing Facility Days:	Up to a maximum of 100 days per Participant-25% Coinsurance.
Mental Illness/Substance Abuse:	Inpatient & Outpatient Mental Illness is covered the same as any physical condition. In and Outpatient chemical dependency and substance abuse treatment is covered the sam any physical condition **subject to** such treatment being provided at a facility approved of the following: Medicare, Medicaid, NCQA or CARF International.
Durable Medical Equipment:	25% Coinsurance, subject to Medicare Part B guidelines and Out-of-Pocket Coinsuran Limit.
Prosthetic Devices:	25% Coinsurance, subject to Medicare Part B guidelines.
Infertility:	25% Coinsurance. Excludes infertility drugs. Not subject to Out-of-Pocket Coinsurance
Contraception Services:	Covered, subject to applicable Copayment.
Foot Orthotics Rider:	Not Covered unless meets Medicare Part B criteria.
Chiropractic Services Rider:	$20 Copay per Visit.
Hearing Aid Rider:	Coverage not available.
Vision Hardware Rider:	$100 Rebate every 24 months toward the purchase of vision hardware with itemized re from any vision or optical provider.
PPACA Defined Preventative Services	100% (no Copay required)

Notice Concerning Coordination of Benefits (COB)

If the Participant or his Family members are covered by more than one health care plan, the Participant may not be able to collect benefits from both plans. Each plan may require the Participan follow its rules or use specific doctors and hospitals, and it may be impossible to comply with both plans at the same time. Participants are urged to read all the rules very carefully, including th Coordination of Benefits section, and compare them with the rules of any other plan that covers the Participant or his Family.

Restrictions on Choice of Providers

All services described in the Summary of Benefits must be provided, arranged or authorized by the Primary Care Physician. Exceptions are Emergency Medical Conditions and services from th following participating providers; OB/GYN, vision, dermatologists, allergists, hematologists, oncologists and pediatric pulmonologists. In the event the Participant is referred to a non-Participa Provider, Prior Authorization must be obtained from Paramount by the Primary Care Physician except for Emergency Medical Conditions.

Plan Administrator and Claims Administrator

This Summary of Benefits is a general overview of the Plan. Although every effort has been made to present important Plan provisions in a fully accurate manner, any inadvertent error, misstat
omission will be disregarded and the actual Plan provisions will be controlling. The Plan Administrator is indicated on page 14 of this document. The Claims Administrator is Paramount Care,
Claims Administrator is solely responsible for the processing and paying of claims and is not a fiduciary under the Plan.

LUCAS COUNTY HEALTH PLAN-PARAMOUNT HMO
AS AMENDED AND RESTATED
EFFECTIVE MARCH 1, 2011

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PURPOSE OF THE PLAN

The Board of County Commissioners, Lucas County, Ohio adopts this document, including any addenda, to maintain a health benefit plan for the exclusive benefit of its Eligible Employees and their Eligible Dependents and the Eligible Employees and their Eligible Dependents of eligible designated entities.

NOT AN ERISA PLAN

This plan is a 'governmental plan' as defined by ERISA Section 29 USC §1002 (32) and is exempt from the provisions of United States Code Title 29, Chapter 18, Subchapter I (29 USC §1001 through 29 USC §1191(c) ("ERISA"). Adoption or use of a term or procedure in the Plan that is identical or substantially similar to a term or procedure contained in 29 USC §1001 through 29 USC 1191(c) shall not cause the plan to lose its 'governmental plan' exemption.

SUMMARY OF PLAN INFORMATION

TYPE OF PLAN:

This is a self-insured managed care plan providing medical benefits. The Plan is administered by the Board of County Commissioners, Lucas County, Ohio.

TYPE OF ADMINISTRATION:

The Plan Administrator is responsible for the operation and management of the Plan; however, the Plan Administrator has retained the services of the Claims Administrator, who is experienced in processing claims, to handle the day-to-day operation of the Plan. The Claims Administrator provides administrative services only and does not insure that any Plan benefits or expenses will be paid. Complete and proper claims will be processed promptly but in the event that there are delays in processing, Participants will have no greater rights to interest or other remedies than otherwise afforded by law.

The Plan's administrative costs are borne by the Plan Sponsor.

GENERAL COMMENTS PERTAINING TO ELIGIBLITY

Non-Bargaining Unit Employees. The Plan Sponsor reserves the right at its sole discretion to modify, suspend, or terminate the eligibility rules contained herein and/or any or all provisions contained herein with or without notice. The Plan Administrator is the sole arbiter of the eligibility rules. The eligibility rules are not a contract, express or implied. No representative of the Plan Sponsor, or any other Lucas County agency, board, department or official, has the authority to enter into an agreement with an employee or employee representative that provides any benefit greater than the benefits set forth in these rules. There is no guarantee of eligibility or coverage for any agreement made contrary to these rules.

Collective Bargaining Unit Employees. The eligibility rules herein shall be subject to labor contract negotiations between the Plan Sponsor and the various unions representing Lucas County, Ohio employees. It is in the best interest of all parties that there be only one health insurance benefit package for all Lucas County, Ohio employees. Therefore, these eligibility rules shall be discussed and reviewed at meetings of the Lucas County Health Care Cost Containment Board.

NOTICE CONCERNING COORDINATION OF BENEFITS (COB)

AN EMPLOYEE-PARTICIPANT AND/OR ANY DEPENDENT-PARTICIPANTS COVERED BY MORE THAN ONE HEALTH CARE PLAN OR PROGRAM MAY NOT BE ABLE TO COLLECT BENEFITS FROM BOTH PLANS. EACH PLAN MAY REQUIRE THE PARTICIPANT TO FOLLOW ITS RULES OR USE SPECIFIC DOCTORS AND HOSPITALS AND IT MAY BE IMPOSSIBLE TO COMPLY WITH BOTH (OR ALL) PLANS AT THE SAME TIME. PARTICIPANTS ARE URGED TO READ THE RULES OF THIS PLAN VERY CAREFULLY, INCLUDING THE COORDINATION OF BENEFITS SECTION, AND COMPARE THEM WITH THE RULES OF ANY OTHER PLAN(S) THAT COVERS THE PARTICIPANTS.

I. DEFINITIONS

The following terms used in this Plan document shall have the following meanings. Use of a term in this document that is identical to, or having substantially the same meaning as, the same term in 29 USC §1002 shall not constitute, or be interpreted as, either a waiver or other revocation of the Plan's status as a 'governmental plan' as defined under 29 USC §1002(32), or a waiver or other revocation of the Plan's 29 USC §1003(b)(1) exemption from the provisions of ERISA contained in United States Code Title 29, Chapter 18, Subchapter I (29 USC §1001 through 29 USC §1191c).

"Actively at Work". An Employee's actual engagement in employment at an Employer's business establishment, or at other locations that the Employer may require the Employee to travel to and work at, for which the Employee is eligible to receive, or actually receiving, Pay.

"Active Pay Status". The conditions under which an Employee is receiving Pay from his Employer.

"Active Work Status". Conditions under which an Employee is employed by an Employer but not actually receiving Pay.

"Adopting Employer". Any of the following entities (other than the Plan Sponsor) which have adopted this Plan for the benefit of their Employees:

Board of Lucas County Commissioners (Human Resources, Support Services, OMB, Administration, Commissioners, Facilities, Building Regulations, Child Support Enforcement Agency, Dog Warden, Emergency Services, Job and Family Services, Maumee River Wastewater Treatment Plant, Sanitary Engineer, Solid Waste Management and Workforce Development.)
Criminal Justice Coordinating Council
Lucas County Auditor
Lucas County Board of Developmental Disabilities
Lucas County Board of Elections
Lucas County Children Services
Lucas County Clerk of Courts
Lucas County Common Pleas Court
Lucas County Coroner
Lucas County Domestic Relations Court
Lucas County Engineer
Lucas County Family Council
Lucas County Juvenile Court
Lucas County Land Bank
Lucas County Law Library
Lucas County Mental Health & Recovery Services Board
Lucas County Probate Court
Lucas County Prosecutor
Lucas County Recorder
Lucas County Sheriff
Lucas County Soil & Water Conservation District
Lucas County Treasurer
Lucas County Veteran Service Commission
Metropolitan Park District of Toledo Area

"**Authorized Medical Leave of Absence".** An Employee's leave of absence for medical reasons as approved by the Employee's Employer. An Authorized Medical Leave of Absence does not include a leave of absence granted for workers' compensation purposes.

"Basic Health Care Services". Providers' services, inpatient hospital services, outpatient medical services, emergency health services, diagnostic laboratory services and diagnostic and therapeutic radiology services, diagnostic and treatment services (other than prescription drug services) for biologically-based mental illnesses, preventative health services including: family planning, infertility services, periodic physical examinations, prenatal obstetrical care and well-child care, all as defined under Ohio Revised Code Section 1715.01.

"Benefit Period". An annual time period commencing on March 1 of each Plan Year. The Benefit Period will terminate on the earliest of the following dates:

(A) the last day of February of the same Plan Year in which the Benefit Period commenced; or

(B) the day the Participant ceases to be a Participant under this Plan.

"Biologically Based Mental Illness". The following conditions defined under Ohio Revised Code Section 1751.01(D): schizophrenia, schizoaffective disorder, major depressive disorder, bi-polar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder and panic disorders as those terms are defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders ("DSM") published by the American Psychiatric Association.

"Center of Excellence". A facility described in the following list, requiring Prior Authorization, that may or may not be a Participating Provider :

Akron Children's Hospital
Arthur James Cancer Center
Cincinnati Children's Hospital
Cleveland Clinic
Doctor's Hospital (Columbus, OH)
Glenbeigh Hospital (Rock Creek, OH)
Grant Medical Center (Columbus, OH)
Karmanos Cancer Center (Detroit, MI)
Mayo Clinic, The
Medical City Dallas Hospital
Nationwide Children's Hospital
Northshore University Hospital
Ohio State University Hospital
Providence Hospital (MI)
Riverside Methodist Hospital (Columbus, OH)
University Hospitals of Cleveland (Includes UHC Rainbow Children's Hospital)
University of Michigan Medical Center (Regents U of M)

University of Pittsburgh Medical Center
Weisburg Cancer Center (Farmington Hills, MI)
Williams County Hospitals and Wellness Centers (Archbold, Montpelier, and Bryan, OH)

"**Child" or "Children".** An individual who is a:

(A) biological child of the Employee;

(B) stepchild of the Employee (except in the case of the child of a domestic partner who is a Spouse);

(C) legally-adopted child of the Employee; or

(D) a child not described in the preceding paragraphs (A), (B) or (C) but for whom the Employee and/or his Spouse is/are the court-ordered guardian(s) or court-ordered custodian(s) provided the court-ordered custody or guardianship has not been granted solely for the purpose of qualifying the child for coverage under the Plan.

The Plan Administrator may require the Employee to submit Documentation demonstrating, to the sole satisfaction of the Plan Administrator, that the individual claimed to be the Employee's and/or Spouse's Child meets the requirements of paragraph (A), (B), (C) or (D), above.

"Claims Administrator". The individual or business entity, if any, selected and retained by the Plan Administrator to supervise the administration, consideration, investigation and settlement of claims, maintain records, submit reports and other such duties as may be set forth in a written administration agreement. If no Claims Administrator is appointed or retained (as a result of the termination or expiration of the administrative agreement or other reason) or if the term is used in connection with a duty not expressly assigned to and assumed by the Claims Administrator in writing, the term will mean the Plan Administrator.

The entity retained by the Plan Administrator to serve as the Claims Administrator of the Plan is:

Paramount Care, Inc.
P.O. Box 928
Toledo, OH 43697-0928
419.887.2525
1.800.462.3589
PHCMbrSvcAppeals@ProMedica.org

"COBRA". The health insurance continuation coverage provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 added to Title XXII of the Public Health Service Act at 42 USC §300bb-1 et. seq., as amended from time to time.

"Cohabitate", "Cohabitating", "Cohabitation". An Eligible Employee or an Employee-Participant and Spouse dwelling together or sharing the same living quarters. Periods of time during which the Eligible Employee or Employee-Participant are not dwelling together or sharing the same living quarters for reasons OTHER THAN Separation, Legal Separation, divorce, annulment of marriage, dissolution of marriage or termination of domestic partnership (e.g. being away on business, vacation or military duty)

shall not be considered in determining whether an Eligible Employee or Employee-Participant and Spouse are no longer Cohabitating.

"Coinsurance". The portion of the cost of Covered Services (a percentage of the allowed provider charges) in excess of any Copayment that is required to be paid by the Participant. For example, the Participant may be responsible for paying 20% of billed charges for authorized Covered Services.

"Copayment" or "Copay". The dollar amount described under the Summary of Benefits that must be paid by a Participant at the time Covered Services are rendered by a provider.

"Covered Service" or "Covered Services". Authorized service(s) rendered by a provider for which the Plan will provide payment. A Covered Service may be subject to a Copayment and/or other limitations.

"Creditable Coverage". The period of prior health plan coverage of a former Participant which may entitle that former Participant reduce the effective time period of a pre-existing conditions exclusion which may be present in future coverage sought by the former Participant with an entity other than an Employer. Upon a Participant's termination of Plan coverage, he is entitled to receive a 'certificate of Creditable Coverage' that provides information regarding prior coverage with the Plan.

"Dependent-Participant". An Eligible Dependent who has met the requirements described under 'Participation Requirements for Eligible Dependents', herein and (if applicable) for whom all required Plan contributions are paid.

"Disability Separated" or "Disability Separation". The voluntary or involuntary termination of an Employee from his Employer due to that Employee's inability to perform the essential functions of his position because of a disabling illness, or injury. Disability Separated or Disability Separation shall be determined by the Employee's Employer; however, for the purposes of a Participant obtaining Employer-paid coverage in the event of unpaid medical leave, layoff or disability described under the section entitled 'Employer-Paid Coverage in the Event of Unpaid Medical Leave, Disability, Layoff' at page 40 herein, the Plan Administrator may, in accordance with the provisions thereunder, overrule an Employer's determination that an Employee has been Disability Separated or undergone 'Disability Separation'.

"Documentation". Written information to be provided by an Employee upon the request of the Plan Administrator, or the Claims Administrator, or their authorized representatives, as may be deemed necessary by the Plan Administrator and/or the Claims Administrator, to ensure compliance with the provisions of the Plan. The type of written information that may be required by the Plan Administrator and/or the Claims Administrator will depend on the situation and/or provision of the Plan in question; however, with respect to the following specific situations, the required written information may include, **but is not limited to**, the following:

> **Evidence an individual is a Spouse:** Photocopy of marriage certificate identifying both the Employee and his Spouse; and/or, photocopy of the page(s) of the Employee's most recently filed Federal Tax Return (Form 1040, 1040-A or 1040-EZ) that identifies the Spouse to the sole satisfaction of the Plan Administrator and/or Claims Administrator. (The submitter may redact the income totals if they choose.)

Evidence an individual is an Employee's dependent Child:

(A) **Employee's Biological or Adopted Child:** Photocopy of a birth certificate identifying the Employee as a birth parent; or, photocopy of the court order or decree finalizing the adoption of the Child by the Employee; or photocopy of the page(s) of the Employee's most recently filed Federal Tax Return (Form 1040, 1040-A or 1040-EZ that identifies that individual as the Employee's dependent Child (according to IRS rules and regulations) to the sole satisfaction of the Plan Administrator and/or the Claims Administrator (the submitter may redact the income totals if they so choose); or, any combination of the above listed information; or any additional documentation requested by the Plan Administrator and/or the Claims Administrator or voluntarily provided by the Employee that adequately evidences dependent Child eligibility.

(B) **Employee's step-child:** A photocopy of a birth certificate, court order or decree identifying the relationship of the Employee or his Spouse, to the child; or photocopy of the page(s) of the Employee's or Spouse's most recently filed Federal Tax Return (Form 1040, 1040-A or 1040-EZ that identifies that individual as the Employee's or the Spouse's Child (according to IRS rules and regulations) to the sole satisfaction of the Plan Administrator and/or Claims Administrator (the submitter may redact the income totals if they so choose); or, any combination of the above listed information; or any additional documentation requested by the Plan Administrator and/or Claims Administrator or voluntarily provided by the Employee that adequately evidences a child's eligibility for Plan participation.

(C) **Child for Whom an Employee is the guardian:** Copy of court order or decree that establishes the Employee's guardianship over the child.

"**Effective Date".** The Plan was originally adopted and effective March 1, 2009. This amendment and restatement is effective March 1, 2011.

"Eligible Dependent". Except as otherwise indicated or described herein, an Eligible Employee's or Employee-Participant's: Spouse; and/or Child; and/or child who is determined by the Plan Administrator (in its sole discretion) to be an 'alternate recipient' entitled to Plan coverage pursuant to a Qualified Medical Child Support Order.

The Plan Administrator reserves the right to require the Eligible Employee or Employee-Participant to submit Documentation satisfactory to the Plan Administrator (in its sole discretion and as it deems necessary) as to an Eligible Dependent's dependency status. This evidence of dependency status includes, but is not expressly limited to, whether a child can be considered an Eligible Dependent.

A person who is covered under this Plan as an individual Participant shall not qualify as an Eligible Dependent. See also the section entitled 'Employee and Spouse Both Employed by an Employer', below.

"Eligible Employee". An Employee or former Employee, who is not an Intermittent Employee.

"Emergency Medical Condition". A medical condition that manifests itself by such acute symptoms of sufficient severity, including severe pain that a prudent layperson with an average knowledge of health

and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:

(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; or

(C) serious dysfunction of any body organ or part.

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

"Emergency Services".

(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 ad 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 center and burn center of the hospital.

"Stabilize". For purposes of the definition of Emergency Services, "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 body functions;

(C) serious dysfunction of any body organ or part.

In the case of a pregnant woman having contractions, "stabilize" means such medical treatment as may be necessary to deliver, including the placenta.

"Employee". An individual employed by the Plan Sponsor or an Adopting Employer.

"Employee-Participant". An Eligible Employee who has met the requirements for Plan participation.

"Employer". The Plan Sponsor and/or an Adopting Employer as the context may require.

"Employer Identification Number" or "EIN". The taxpayer identification number issued to the Plan Sponsor by the Internal Revenue Service. The Plan Sponsor's EIN is 34-6400806.

"**Enrollment Date".** The first day of a Participant's coverage under this Plan or, if earlier, the beginning of any applicable waiting period.

"ERISA". The Employee Retirement Income Security Act of 1974 codified at 29 USC §1001 *et. seq*.

"Experimental". Any treatment, procedure, facility, equipment, drug, device or supply which the Claims Administrator does not recognize as accepted medical practice or which did not have required governmental approval when received by the Participant. This includes treatments and procedures which have

(A) not been approved or accepted by the appropriate review body, or

(B) not been generally accepted by the local medical community as safe, appropriate and effective.

"Family". An Employee-Participant and his Dependent-Participant(s).

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

"Intermittent Employee".

(A) An Employee who is required to work less than one thousand (1000) hours in a calendar year and whose work schedule is generally irregular and fluctuating based on work needs; or

(B) a "seasonal employee" who works for an Employer during a certain regular season or period of each calendar year performing some work or activity limited to that season or period of the calendar year; or

(C) a "temporary Employee" who works for a limited period of time established by the Employer and whose employment is limited to no more than one hundred twenty (120) calendar days unless the reason for hiring the "temporary employee" is due to an Authorized Medical Leave of Absence of another Employee in which case the "temporary Employee" can work for the duration of such Authorized Medical Leave of Absence.

"Legal Separation". 'Separation' (as defined below) pursuant to a decree or order issued by a court of competent jurisdiction.

"Medical Necessity". A service, medicine, or treatment received by the Participant that is:

(A) needed to prevent, diagnose and/or treat a specific condition;

(B) specifically related to the condition being treated or evaluated; and

(C) provided in the most medically appropriate setting (i.e. an outpatient setting must be used rather than a hospital or inpatient facility, unless the services cannot be provided safely in the outpatient setting).

"**Medicare".** The health insurance for the aged program established under Public Law 89-97 as subsequently amended from time to time.

"Newborn". The status of an infant from the time of the infant's birth until the earlier of :

(A) the infant's initial hospital discharge; or

(B) the time at which the infant becomes seven (7) days old.

Non-Biologically Based Mental Illness. A mental illness that is not a Biologically Based Mental Illness.

"Open-Enrollment Period". An annual period of time established by the Plan Administrator during which an:

(A) Eligible Employee who has initially met the Plan's eligibility requirements may enroll in the Plan along with any Eligible Dependents; and/or

(B) Employee-Participant may change Plan coverage for himself and/or his Eligible Dependents; and/or

(C) Employee-Participant may add or drop Eligible Dependents from Plan coverage.

"Other Coverage". Any and all plans, insurance or other scheme that may pay, in whole or in part, for health care provided to a Participant OTHER THAN plans sponsored by the Plan Sponsor. Solely for purposes of the section entitled 'Special Eligibility/Participation Rules Applicable to Spouses' at page 30 (below), 'Other Coverage' shall also include 'single', 'primary' prescription drug coverage, if such coverage offered or provided.

"Out-of-Pocket Coinsurance Limit". The maximum amount of Copayments and Coinsurance paid by or on behalf of a Participant every Plan Year for Basic Health Services. Once an individual Participant has met the 'single' Out-of-Pocket Coinsurance Limit in a given Plan Year, there will be no additional Copayments or Coinsurance required from that Participant for the remainder of that Plan Year. Once a 'family' Out-of-Pocket Coinsurance Limit has been met by a Family in a given Plan Year, there will be no additional Copayments or Coinsurance required from any Participant who is a member of that Family.

Co-Payments/Coinsurance for Infertility Services and the Vision rebate, do not apply toward Out of Pocket Coinsurance Limit.

"Outpatient". Services or supplies provided to an individual who has not been admitted to a hospital as an Inpatient. Observation care is considered an Outpatient service.

“Paramount”. Paramount Care, Inc.
P.O. Box 928
Toledo, OH 43697-0928

"Paramount Member Services" or "Paramount Member Services Department" or "Member Services". The entity that can be contacted by Participants who have questions or problems regarding the Plan at (419)887-2525 or toll-free, 1-800-462-3589. TTY services for the hearing impaired are available at (419) 887-2526 or toll-free 1-800-740-5670.

"Paramount Service Area" or "Service Area". 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 the Service Area. Participants should contact Paramount Member Services for an updated listing of the Paramount Service Area.

“Participant”. An Employee-Participant and/or a Dependent-Participant, as the context may require.

“Participating Hospital”. Any hospital with which Paramount has contracted or established arrangements for Inpatient/Outpatient hospital services and/or Emergency Services.

“Participating Provider”. A provider, hospital or other health professional or facility that has a contract with Paramount to provide Covered Services to Participants.

“Participating Specialist”. A provider who provides Covered Services to Participants within the range of his medical specialty and who has chosen to be designated as a Specialist Provider by Paramount.

“Pay”. The remuneration an Employee receives from an Employer.

“**Plan”.** The Lucas County Employee Health Benefit Plan-Paramount HMO, as amended and restated effective March 1, 2011. The Plan was originally effective March 1, 2009.

“Plan Administrator”. The Plan Sponsor, which is responsible for the day-to-day functions and management of the Plan. The Plan Administrator has engaged the services of the Claims Administrator to process claims and perform other Plan-related services and may engage or utilize the services of other persons or firms to assist in the administration of the Plan, as it may deem necessary.

“Plan Number”. The Plan Number is 030989.

"Plan Sponsor". The Board of County Commissioners, Lucas County Ohio, One Government Center, Suite 800, Toledo, Ohio 43604-2259, (419)213-4500**.**

"Plan Year". The twelve (12) consecutive month period commencing March 1 and ending the immediately following February 28/29.

"Post-Service Claim". Any claim for benefits from this Plan that is not a Pre-Service Claim.

"Pre-Service Claim". Any claim for benefits from this 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 Provider" or "PCP". A provider or a provider who specializes in family general practice, internal medicine or pediatrics and is who is designated by Paramount as a Primary Care Provider and who meets all other requirements as may be established or adopted by Paramount from time-to-time. The Primary Care Provider is responsible for managing and coordinating the full scope of a Participant's medical care including (but not limited to): performing routine evaluations and treatment, ordering laboratory tests and x-ray examinations, prescribing required medication and arranging for a Participant's hospitalization or other services when appropriate.

"Prior Authorization" or "Prior Authorized". Approval from Paramount required for certain procedures or services. **UNLESS OTHERWISE PROVIDED, IT IS THE RESPONSIBILITY OF THE PARTICIPATING PROVIDER TO OBTAIN 'PRIOR AUTHORIZATION' FROM PARAMOUNT IN ADVANCE OF SUCH PROCEDURES OR SERVICES.**

"Prosthetic Device". An artificial substitute that replaces all or part of a missing body part and its adjoining tissues.

"Qualified Medical Child Support Order". A court order, as defined and provided under ERISA Section 609, that directs the Plan to provide, or continue providing benefits, for the Child of a Participant who is the noncustodial parent of the Child, and which order has been deemed 'qualified' by the Plan Administrator. In making its determination as to whether a medical child support order is 'qualified' the Plan Administrator may (if deemed necessary in its sole discretion) seek clarification and/or modification of the order up to and including the right to seek a hearing before the court that issued the order.

"Separation" or "Separated". A determination made by the Plan Administrator in its sole discretion that an Employee-Participant and his Spouse have ceased Cohabitation.

"Specialist Provider". A provider who provides Covered Services to Participants within the range of his medical specialty, who is designated by Paramount as a Specialist Provider, and who meets all other requirements as may be established or adopted by Paramount from time to time.

"Spouse".

(A) Except as otherwise provided in the two Special Rules described later in this definition, an individual who:

(1) is legally married to an Employee-Participant or Eligible Employee; and

(2) is a resident of the United States; and

(3) legally resides in the United States.

(B) A Participant may have only one (1) Spouse at a time.

Special Rules Regarding Spouses in Common Law Marriages.

(1) An individual seeking the status of Spouse through a claim of a common law marriage with an Employee in the state of Ohio on and after October 10, 1991, shall not qualify as a Spouse for purposes of this Plan.

(2) An individual who has entered into a common law marriage in the state of Ohio with an Employee prior to October 10,1991, or who has at any time entered into a common law marriage in any other jurisdiction that allows common law marriages, shall qualify as a Spouse; provided

(a) Documentation of the common law marriage is submitted to the Plan Administrator; and

(b) such Documentation is deemed by the Plan Administrator (in its sole discretion) as satisfactorily substantiating the existence of the common-law marriage; and

(c) the common law marriage is recognized as valid by the state of Ohio.

Special Rule Regarding Domestic Partners. A same-sex, domestic partner of an Employee, who is not otherwise an Eligible Employee, shall be deemed to be the Employee's Spouse provided the Employee and his domestic partner meet the requirements for domestic partnership as described under Lucas County Board of Commissioners Resolution 09-1266.

"Timely Application". An application for initial participation or continued participation in the Plan:

(A) made by an Eligible Employee or (in the case of mandatory re-enrollment) an Employee-Participant on his own behalf and/or on behalf of his Eligible Dependent(s) or (in the case of mandatory re-enrollment) Dependent-Participants; and

(B) that is received and approved by the Plan Administrator:

(1) within thirty-one (31) days (plus any extensions granted by the Plan Administrator) of the date on which the Eligible Employee and/or his Eligible Dependent(s) met the Plan's

participation requirements described under "Participation Requirements for Eligible Employees" and/or "Participation Requirements for Eligible Dependents" at page II-1 herein.

(2) within thirty-one (31) days (plus any extensions granted by the Plan Administrator) of the date on which the Eligible Employee and/or his Eligible Dependent(s) lost 'primary' Other Coverage previously selected in lieu of Plan coverage, as described under "Waiver of Coverage and Subsequent Loss of Other Coverage" at page II-5, herein; or

(3) within thirty-one (31) days (plus any extensions granted by the Plan Administrator) of the date on which the Eligible Employee acquired a new Eligible Dependent, or

(4) on or before such other date established by the Plan or Plan Administrator (plus any extensions of that date granted by the Plan Administrator) as being the deadline for submitting all materials relating to:

(a) an enrollment in the Plan for any reason not listed hereinabove under this definition; or,

(b) a mandatory re-enrollment required by the Plan Administrator.

(C) In the event the Plan Administrator receives an incomplete application (as determined in its sole discretion) during the thirty-one (31) day period described in the immediately preceding paragraphs (B)(1), (2) and (3) above (plus any extensions granted by the Plan Administrator) or before the deadline date (plus any extensions granted by the Plan Administrator) described in immediately preceding paragraph (B)(4), the Eligible Employee or Employee-Participant (as applicable) submitting the application shall be contacted by the Plan Administrator (or its designee) and shall be informed of the corrections that must be made or the missing information that must be supplied in order for the application to be deemed complete along with a deadline date by which the properly completed application must be returned to the Plan Administrator who, upon receipt, will again review the application for completeness and approval.

(D) Failure of the Eligible Employee or Employee-Participant (as applicable) to return an application, completed to the sole satisfaction of the Plan Administrator, by the applicable date (plus any extensions) established by the Plan or the Plan Administrator, shall result in the Eligible Employee or Employee-Participant (as applicable) not being deemed to have made Timely Application.

"Total Disability" or "Totally Disabled". The physical state of a Participant or Eligible Dependent resulting from an illness or injury which wholly prevents

(A) the Participant, from engaging in any and every business or occupation and from performing any and all work for compensation or profit; and/or

(B) an Eligible Dependent, from performing the normal day-to-day living activities of a person of like age and sex in good health; provided, however, the Eligible Dependent is not institutionalized and resides with the Participant at the Participant's residence, as determined by the Plan Administrator in its sole discretion based on Documentation satisfactory to the Plan Administrator. Subsequent to an initial determination of the Plan Administrator that a Participant or Eligible Dependent is Totally Disabled, the Plan Administrator shall have the right to reasonably request, at any time, updated Documentation relating to the Eligible Dependent's or Participant's condition for the purpose of determining whether the Participant or Eligible Dependent continues to be Totally Disabled. If, after reviewing the updated Documentation the Plan Administrator, in its sole

opinion, determines that the Eligible Dependent or Participant is no longer Totally Disabled, the Eligible Dependent or Participant shall lose Total Disability status on the last day of the month following the date such determination made by the Plan Administrator.

The definition of 'Total Disability' or 'Totally Disabled' is separate and distinct from the definition of "Total Disability for Social Security Purposes" described herein at page IX-2.

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

"Urgent Medical Condition". An unexpected illness or injury requiring medical attention soon after the illness or injury appears (e.g. a persistent high fever, lingering colds, sprains, minor cuts where bleeding is controlled etc.) that is not permanently disabling or life-threatening.

II. ELIGIBILITY AND PARTICIPATION

PARTICIPATION REQUIREMENTS FOR ELIGIBLE EMPLOYEES

An Eligible Employee who has been Actively at Work more than twenty (20) hours per week over a period of four (4) consecutive weeks and who has made Timely Application, shall become an Employee-Participant at 12:01 a.m., local time on the thirty-first (31st) calendar day following that Eligible Employee's meeting the foregoing 'Actively at Work' requirement.

Timely Application Not Made: Eligible Employee or Employee-Participant.

In the event an Eligible Employee, or in the case of a mandatory re-enrollment required by the Plan Administrator, an Employee-Participant:

(A) meets the 'Actively at Work' requirement described above in the immediately preceding section entitled 'Participation Requirements for Eligible Employees'; and

(B) does not make Timely Application; or

(C) does not waive participation in the Plan,

the Plan Administrator shall, as soon as administratively possible, and in its sole discretion, enroll that Eligible Employee or Employee-Participant in, and the Eligible Employee or Employee-Participant shall become an Employee-Participant in, the lowest-cost health insurance coverage sponsored by the Plan Sponsor.

Following such enrollment by the Plan Administrator, the Employee-Participant shall be permitted to elect a different coverage option during the Open-Enrollment Period coincident with or immediately following his enrollment by the Plan Administrator.

PARTICIPATION REQUIREMENTS FOR ELIGIBLE DEPENDENTS

(A) An Eligible Dependent who is a Newborn shall become a Dependent-Participant at the moment of birth, following Timely Application by the Employee-Participant.

(B) An Eligible Dependent who is a newly-adopted Child shall become a Dependent-Participant from the moment the Child's adoption is finalized by the court, following Timely Application by the Employee-Participant.

(C) An Eligible Dependent who is a Child for whom the Employee-Participant is the court-ordered guardian or court-ordered custodian shall become a Dependent-Participant at the time the guardianship or custody arrangement becomes effective, following Timely Application by the Employee-Participant.

(D) An Eligible Dependent who is an 'alternate recipient' under a Qualified Medical Child Support Order shall become a Dependent-Participant at the time specified in the order.

(E) An Eligible Dependent who is a Spouse shall become a Dependent-Participant entitled only to "secondary" coverage under the Plan, at no charge, following Timely Application by the Eligible Employee or Employee-Participant provided the Spouse:

(1) is enrolled in Other Coverage (other than Medicare, Medicaid, Tri-Care or any other federally sponsored plan, program or scheme providing health insurance coverage) that provides 'primary' health insurance coverage; and

(2) is not Separated from the Eligible Employee or Employee-Participant.

An Eligible Employee or Employee-Participant who fails or failed to properly enroll his Spouse in the Plan shall be responsible for any and all claims and costs incurred by and for that Spouse under the Plan. The Plan Administrator shall exercise all rights of recovery for any and all amounts expended by the Plan during the time the Spouse was not properly enrolled in the Plan.

A Spouse who incurred claims or costs under the Plan as a Dependent-Participant, but who was Separated from the Employee-Participant at the time such claims or costs were incurred, shall be responsible for any and all such claims and costs. The Plan Administrator shall exercise all rights of recovery for any and all amounts expended by the Plan during a period of time when such Spouse was Separated from the Employee-Participant.

Waiver of Participation or Failure of Timely Application for Eligible Dependent or Dependent-Participant.

(A) In the event the Employee-Participant does not make Timely Application for his Eligible Dependent upon initially meeting the Plan's participation requirements, the Employee-Participant shall not be permitted to enroll such Eligible Dependent in the Plan until the immediately following Open-Enrollment Period.

(B) In the event of a mandatory re-enrollment required by the Plan Administrator the Employee-Participant fails to make Timely Application for the re-enrollment of his Dependent-Participant, the Dependent-Participant's participation in the Plan shall be terminated as of the March 1 immediately following the mandatory re-enrollment period and the Employee-Participant shall be prohibited from re-enrolling the Dependent–Participant until the immediately following Open-Enrollment Period.

Participation Requirements for Eligible Dependents Losing Coverage under Other Coverage; Eligible Dependents Acquired After Initial or Open Enrollment.

An Employee-Participant:

(A) whose Eligible Dependent (other than a Spouse) lost 'primary' Other Coverage or,

(B) who added a new Eligible Dependent through marriage, birth, adoption or placement for adoption,

shall cause the Eligible Dependent to become a Dependent-Participant as of the date of the Eligible Dependent's loss of such Other Coverage or the date the Eligible Dependent is added to the Employee-Participant's Family, after making Timely Application for that Eligible Dependent. Failure of the Employee-Participant to make Timely Application on behalf of the Eligible Dependent described in the immediately preceding paragraphs (A) and (B), will render that Eligible Dependent ineligible for Plan participation until the next Open-Enrollment Period.

Failure to Properly Enroll Spouse; Dependent-Participant Spouse Separated; Recovery of Amounts Expended for Separated Spouse.

(A) An Employee-Participant who fails or failed to properly enroll his Spouse in the Plan shall be responsible for any and all claims and costs incurred by and for that Spouse under the Plan. The Plan Administrator shall exercise all rights of recovery for any and all amounts expended by the Plan during the time the Spouse was not properly enrolled in the Plan.

(B) A Spouse who incurred claims or costs under the Plan as a Dependent-Participant, but who was Separated from the Employee-Participant at the time such claims or costs were incurred, shall be responsible for any and all such claims and costs. The Plan Administrator shall exercise all rights of recovery for any and all amounts expended by the Plan during a period of time when such Spouse was Separated from the Employee-Participant.

WAIVER OF COVERAGE AND SUBSEQUENT LOSS OF 'OTHER COVERAGE'

As used in this Section, and notwithstanding the definition of "**Eligible Dependent**" on page 20 hereof, the term "Eligible Dependent" shall exclude a "Spouse" as defined herein on page 26.

An Eligible Employee:

(A) who waived, in writing, Plan participation for himself and/or his Eligible Dependent(s) upon attaining initial eligibility for participation in the Plan; and

(B) whose written waiver stated Plan participation was declined because the Eligible Employee and/or Eligible Dependent had obtained Other Coverage on a ‘primary’ basis; and

(C) who subsequently loses the Other Coverage for himself and/or his Eligible Dependent(s);

shall, following Timely Application, become a Participant, along with his Eligible Dependent(s) at 12:01 a.m.(local time) on the day after the Other Coverage was lost, PROVIDED, however, that the Eligible Employee and/or any Eligible Dependent:

(D) was (were) under the Other Coverage’s Consolidated Omnibus Budget Reconciliation Act continuation coverage and such continuation coverage was exhausted; or

(E) was (were) not under such Consolidated Omnibus Budget Reconciliation Act continuation coverage and the Other Coverage was terminated as a result of:

(1) loss of eligibility; or

(2) employer contributions toward such Other Coverage were terminated.

Notwithstanding anything in this Section to the contrary, an Eligible Employee and/or Eligible Dependent who lost the Other Coverage due to nonpayment of premium(s) or for ‘cause’ (e.g., filing fraudulent claims) shall not be permitted to enroll in the Plan pursuant to this Section and shall, instead, be required to satisfy the requirements described in 'Participation Requirements for Eligible Employees' on page II-1 and (if applicable) 'Participation Requirements for Eligible Dependents', on page II-1 hereof.

III. MAINTENANCE OF PARTICIPANT STATUS; LOSS OF PLAN COVERAGE

MAINTENANCE OF PARTICIPANT STATUS.

An Employee-Participant initially hired prior to March 1, 2001 shall maintain coverage under this Plan for himself and his Dependent-Participant(s) for any month or any portion of the month in which the Employee-Participant is in Active Pay Status or Active Work Status. Failure of the Employee-Participant to meet the immediately foregoing 'Active Pay Status' or 'Active Work Status' requirement shall result in the loss of Plan coverage, for the Employee-Participant and any Dependent-Participant, at the end of the last day of the month in which the requirement is not satisfied unless otherwise provided herein.

An Employee-Participant initially hired on or after March 1, 2001 shall maintain coverage under this Plan for himself and his Dependent-Participant(s) provided the Employee-Participant is in Active Pay Status or Active Work Status for a minimum of 80 hours during a calendar month. Failure of the Employee-Participant to meet the immediately foregoing 'Active Pay Status' or 'Active Work Status' requirement shall result in the loss of Plan coverage for the Employee-Participant and any Dependent-Participant and/or Spouse at the end of the last day of the month in which the requirement is not satisfied, unless otherwise provided herein.

SPOUSE'S LOSS OF COVERAGE DUE TO DIVORCE, ANNULMENT, DISSOLUTION, SEPARATION, LEGAL SEPARATION, TERMINATION OF DOMESTIC PARTNERSHIP; LAST DAY OF PLAN COVERAGE; EMPLOYEE-PARTICIPANT DUTY TO NOTIFY PLAN ADMINISTRATOR.

Notwithstanding anything in this Section to the contrary, Plan coverage (except for COBRA coverage, as applicable) for a Spouse who is a Dependent-Participant shall cease on the day the Spouse's divorce, annulment of marriage, dissolution of marriage, Separation, Legal Separation from, or termination of domestic partnership with, the Eligible Employee or Employee-Participant becomes 'final'. For purposes of this Section, a:

(A) Separation is 'final' on the date the Plan Administrator, in its sole discretion, has determined that the Employee-Participant no longer Cohabitate.

(B) Divorce, annulment of marriage, dissolution of marriage or Legal Separation is 'final' on the date the court's order or decree relating to the divorce, annulment of marriage, dissolution of marriage or Legal Separation is journalized by the court.

(C) Termination of a domestic partnership is 'final' on the date a 'Notice of Termination of Domestic Partnership' is filed with the City of Toledo, Ohio in accordance with Toledo Municipal Code Section 114.05 or the Plan Administrator receives written notice of the termination of the domestic partnership.

The Employee-Participant who is a party to the Spouse's divorce, annulment of marriage, dissolution of marriage, Separation, Legal Separation or termination of domestic partnership is required to immediately notify the Plan Administrator of the occurrence of any of the events described in this Section.

LOSS OF COVERAGE DUE TO EMPLOYEE-PARTICIPANT'S TERMINATION OF EMPLOYMENT, RETIREMENT, DEATH, MILITARY SERVICE, PLAN TERMINATION; LAST DAY OF PLAN COVERAGE.

(A) Except as otherwise provided, an Employee-Participant shall lose Plan coverage for himself and any Dependent-Participant at midnight of the last day of the month in which the Employee-Participant's employment with an Employer is terminated.

(B) Except as otherwise provided, an Employee-Participant who retires from an Employer shall lose Plan coverage for himself and any Dependent-Participant on the date that Employee-Participant becomes eligible for benefits under the Ohio Public Employees Retirement System.

(C) Except as otherwise provided, an Employee-Participant shall lose Plan coverage for himself at the time of his death. Coverage for any Dependent-Participant(s) shall continue through the end of the last day of the month in which the Employee-Participant died.

(D) Except as otherwise provided, an Employee-Participant shall lose Plan coverage for himself and any Dependent-Participant on the date the Employee-Participant enters active United States military service.

(E) Coverage for all Employee-Participants and their Dependent-Participants shall cease on the date the Plan is terminated.

LOSS OF COVERAGE DUE TO STRIKE.

Pursuant to Ohio Revised Code Section 4117.15(C), no Employee- Participant (along with any Dependent -Participant) shall be entitled to Lucas County-paid employee benefits (including Employer-paid coverage under this Plan) for the period during which the Employee-Participant is engaged in any strike against his Employer.

If eligible for COBRA coverage, a striking Employee-Participant will be offered COBRA coverage in accordance with this Plan. In the event the striking Employee-Participant returns to Active Work Status after having paid a COBRA premium while on strike, that Employee-Participant will be reimbursed a pro-rata portion of the paid COBRA premium for the portion of the month the Employee-Participant was not on strike PROVIDED the Employee-Participant meets the applicable requirements described under 'Maintenance of Participant Status' at page III-1, above.

SPECIAL RULES REGARDING EMPLOYEES AND WORKERS' COMPENSATION

Special Rule: Employee-Participants Placed on Worker's Compensation before March 1, 2011.

An Employee-Participant who is no longer Actively at Work because he has been placed on a worker's compensation leave of absence from an Employer commencing before March 1, 2011 shall retain Plan coverage for himself and any Dependent-Participant(s) for a period of up to two (2) years following the commencement of such leave of absence.

Special Rule: Employee-Participants Placed on Worker's Compensation On and After March 1, 2011

An Employee-Participant who is no longer Actively at Work because he has been placed on a worker's compensation leave of absence from an Employer on or after March 1, 2011 shall retain Plan coverage for himself and any Dependent-Participants for a period of up to twelve (12) months following the commencement of such leave of absence.

Special Rule: Duration of Coverage for Employee-Participant on Worker's Compensation.

The two (2) year period [twelve (12) month period on and after March 1, 2011] of Employer-paid Plan coverage described in the immediately preceding two Special Rules is a "lifetime" limit that applies per Employee-Participant without regard to:

(A) the number of Employers he is or may have been employed by; or

(B) the number of times he may have been on a worker's compensation leave of absence from an Employer (subject to the limitations of the immediately- following paragraph).

That is, prior to March 1, 2011, a Participant is "credited" with two (2) years of Employer-paid Plan coverage that may be received during workers' compensation leaves of absence from an Employer [on and after March 1, 2011, the two (2) year period is reduced to become twelve (12) months of Employer-paid Plan coverage]. The two (2) year or twelve (12) month period (as applicable) is reduced by number of days during which Employer-paid Plan coverage was provided to the Employee-Participant during any and all workers' compensation leaves of absence from an Employer.

Special Rule: Workers' Compensation Leave of Absence and Employer-Paid Coverage Commencing Before March 1, 2011 and Ending After March 1, 2011; Employer-paid Coverage Offset.

An Employee-Participant whose workers' compensation leave of absence from an Employer and Employer-paid Plan coverage begins prior to March 1, 2011 and continues beyond that date, shall be eligible for Employer-paid Plan coverage during such leave of absence up to the two (2) year limit described under the immediately preceding paragraph (C), notwithstanding the reduction in the duration of the Employer-paid coverage period effective March 1, 2011.

An Employee-Participant:

(A) whose worker's compensation leave of absence from an Employer and Employer-paid Plan coverage commenced prior to March 1, 2011 and ended after March 1, 2011 ("original leave of absence"); and

(B) who, subsequent to the end of the "original leave of absence" described in the immediately preceding sub-paragraph (1), is placed on a new worker's compensation leave of absence from an Employer,

shall be eligible for twelve (12) months of Employer-paid Plan coverage; provided, however, that such twelve (12) month period of coverage shall be reduced by the number of days Employer-paid

Plan coverage was provided to the Employee-Participant under the "original leave of absence" for the period of time on and after March 1, 2011.

LOSS OF COVERAGE BY A CHILD

(A) Plan coverage for a Dependent-Participant who is a Child will terminate the end of the month in which that Dependent-Participant reaches age 26; however, such termination of coverage may be extended to the end of the month in which that Dependent-Participant reaches age 28 under certain circumstances, provided Timely Application is made to the Plan Administrator by the Employee and any Documentation required by the Plan Administrator is timely submitted.

(1) Notwithstanding anything in the immediately foregoing paragraph (A), a Dependent-Participant who is a Child who has been determined to be Totally Disabled may have coverage extended beyond age 26 or age 28 (whichever is applicable) upon Timely Application and timely submission of any Documentation required by the Plan Administrator. Such an extension shall continue until the earlier of the date of the Dependent-Participant's death, the date the Dependent-Participant no longer resides at the Employee-Participant's residence or the last day of the month in which the Plan Administrator has determined that the Dependent-Participant is no longer Totally Disabled.

(B) Plan coverage for a Dependent-Participant who is a Child for whom an Employee and or his Spouse is/are the court-ordered guardians or custodians will terminate at the end of the month in which such Dependent-Participant reaches the State of Ohio's age of majority, unless otherwise provided elsewhere in this Plan document.

LOSS OF PARTICIPANT STATUS AND SUBSEQUENT ELIGIBILITY.

An Employee-Participant who:

(A) loses Employee-Participant status;

(B) has not elected COBRA coverage; and

(C) has had thirty (30) days or less elapse from the time Employee-Participant status was lost,

shall again become an Employee-Participant immediately upon resuming Active Work Status.

An Employee-Participant who has met the conditions of immediately preceding paragraphs (A) and (B), but who has had MORE THAN thirty (30) days elapse before resuming Active Work Status shall be treated as a new Eligible Employee and shall be required to meet the requirements described under 'Participation Requirements for Eligible Employees', hereof.

Special Rule for Employees Receiving OPERS Disability Retirement Benefits

In the event an Employee-Participant:

(A) becomes Disability Separated; and

(B) loses Employee-Participant status; and

(C) qualifies for disability retirement health benefits from the Ohio Public Employees' Retirement System ("OPERS"); and

(D) has his OPERS disability retirement health benefits terminated by OPERS on or before the fifth (5th) anniversary of the date his Disability Separation became effective, and

(E) resumes Actively at Work status,

then, upon resuming Actively at Work Status, that former Employee-Participant shall be treated as an Eligible Employee who shall again become an Employee-Participant on the day after his OPERS disability retirement health benefits ended upon making Timely Application provided:

(F) (in the case of an Eligible Employee whose initial date of hire was before March 1, 2001) the Eligible Employee was Actively at Work for any portion of calendar month in which he resumed employment; or

(G) (in the case of an Eligible Employee whose initial date of hire was on or after March 1, 2001) the Eligible Employee was Actively at Work for an average of twenty (20) hours per week or eighty (80) hours total during the thirty-one (31) consecutive day period commencing with the day he resumes Actively at Work status.

PLAN CONTRIBUTIONS AND PARTICIPATION.

Effective March 1, 2014, 'primary' coverage for a Spouse is eliminated from the Plan; monthly contributions to the Plan for a Spouse's 'primary' coverage will no longer be required, charged or accepted. If a Spouse enrolls in 'secondary' coverage under the Plan, no contribution or premium shall be charged for such coverage.

Deductible for Failure to Complete Annual Health Risk Assessment . Commencing March 1, 2013, and for each Plan Year thereafter, each Employee- Participant shall be required to complete an **annual** health risk assessment in accordance with rules and procedures established by the Plan Administrator or its designate. Failure of the Employee-Participant to complete the assessment before the first day of the immediately following Plan Year in good faith and to the best of their knowledge shall result in the application of a $100 deductible for that Employee-Participant in the Plan Year immediately following the Plan Year in which the health risk assessment was required to be completed.

For example, an Employee-Participant who does **NOT** complete the health risk assessment before March 1, 2014 shall be required to pay a $100 deductible in the Plan Year commencing March 1, 2014. By extension, if that same Employee-Participant subsequently **COMPLETES** the health risk assessment in accordance with the immediately preceding paragraph, during the Plan Year commencing March 1, 201**4**, a $100 deductible will be charged for the 2014 Plan Year but NO deductible shall be charged in the Plan Year commencing March 1, 201**5**.

COVERAGE OPTIONS FOR EMPLOYEE AND SPOUSE BOTH EMPLOYED BY AN EMPLOYER.

An Employee and his Spouse, both of whom are Eligible Employees, will be required to choose between the following Plan coverage options:

(A) separate ‘single’ coverage for each of them; or

(B) sole ‘Family’ coverage covering both of them.

In the case of

(C) an Employee and Spouse, BOTH of whom are employed by an Employer;

and

(D) EITHER of whom has their employment with their Employer terminated (whether voluntarily or involuntarily),

the following rules regarding coverage shall apply. Solely for purposes of this Section, ‘terminated individual’ shall mean the Employee or Spouse whose employment with their Employer was terminated and ‘employed individual’ shall mean the Employee or Spouse who continues employment with their Employer:

Status prior to termination:	**Action required from 'employed individual' to maintain Plan coverage for the 'terminated individual':**
Employee and Spouse each carry their own 'single' coverage.	'Employed individual may request a change from 'single' coverage to 'family' coverage. The 'terminated individual' shall become, and shall be treated as, a Spouse seeking 'secondary' coverage under the Plan.
Employee and Spouse covered under 'family' coverage held by 'terminated individual'.	'Employed individual' may request a change to 'family' coverage, effective as of the date the 'terminated individual' would otherwise have lost coverage. The 'terminated individual' shall become, and shall be treated as, a Spouse seeking 'secondary' coverage under the Plan.
Employee and Spouse covered under 'family' coverage held by the 'employed individual'.	The 'terminated individual' shall become, and shall be treated as, a Spouse seeking 'secondary' coverage under the Plan.

EMPLOYER-PAID COVERAGE IN THE EVENT OF UNPAID MEDICAL LEAVE, DISABILITY, LAYOFF.

(A) An Employee-Participant who has:

(1) exhausted his/her paid sick leave and is awarded an unpaid Authorized Medical Leave of Absence; or

(2) been laid off and is not, or does not become, eligible for

(a) Medicare; or

(b) any other group health insurance coverage by reason of new employment, retirement, disability retirement or social security retirement;

or

(3) has become Disability Separated

is eligible for continued Employer-paid Plan coverage for himself and any Dependent-Participant for up to twelve (12) months following the otherwise-scheduled expiration of such coverage provided that Employee-Participant has been in Active Pay Status for the twelve (12) consecutive calendar month period immediately preceding the effective date of the unpaid Authorized Medical Leave of Absence, layoff or Disability Separation.

Twelve (12) Month Period of Coverage is Lifetime Limit.

The twelve (12) month period of Employer-paid Plan coverage described in the immediately foregoing section is a "lifetime" limit that applies per Employee-Participant without regard to:

A. the number of Employers he is or may have been employed by; or

B. the number of times he may have been awarded an Authorized Medical Leave of Absence or Disability Separation, or was laid off.

That is, upon becoming a Participant, each Employee-Participant is "credited" with twelve (12) months of Employer-Paid Plan coverage. This twelve (12) month period is reduced by each period of time Plan coverage was provided to the Employee-Participant under this benefit.

Nothing about this twelve (12) month period of Employer-paid coverage shall limit, or be interpreted as limiting, an Employee's right to continued benefits under the Family Medical Leave Act. Additional coverage beyond the twelve (12) month period of Employer-paid Plan coverage shall be provided if and as required under the Family Medical Leave Act.

Maximum Amount of Employer-Paid Plan Coverage.

(A) The twelve (12) month period of Employer-paid Plan coverage described hereof shall be reduced by periods of Employer-paid coverage (not to exceed a total of six (6) months) provided under the provision entitled "Extended Disability and Lay-Off" under the Lucas County Employee Health Benefit Plan (Revised March 1, 2007) as it existed prior to the Effective Date of this Plan (the "prior plan").

(B) In the event an Employee-Participant was receiving Employer-paid Plan coverage under the "Extended Disability and Lay-Off" provision of the "prior plan" and such coverage continued beyond the Effective Date, the Employee-Participant shall be

entitled to a maximum of six (6) months of Employer-paid Plan coverage from the date such coverage began under the "prior plan" (i.e. the fact that the Employee-Participant's continuous period of disability or layoff began prior to the Effective Date of the Plan and continued after the Effective Date of the Plan would not entitle that Employee-Participant to a maximum additional six (6) months of Employer-paid Plan coverage). However, if:

(1) the Employee-Participant's Authorized Leave of Absence, Disability Separation or layoff began prior to March 1, 2011; and

(2) the Employee-Participant's Authorized Leave of Absence, Disability Separation or layoff ended on or after March 1, 2011; and

(3) the Employee-Participant was Actively at Work after the end of his Authorized Leave of Absence, Disability Separation or layoff; and

(4) the Employee-Participant subsequently incurred a new Authorized Leave of Absence, Disability Separation, or layoff

that Employee-Participant shall be entitled to twelve (12) months of Employer-paid Plan coverage LESS the amount of time he received Employer-paid Plan coverage for Authorized Leave of Absences, Disability Separations or layoffs that began and ended before March 1, 2011 and/or that began prior to March 1, 2011 and ended after March 1, 2011.

COBRA Coverage after Exhaustion of Employer-Paid Coverage.

An Employee-Participant who has exhausted the twelve (12) month period of Employer-paid coverage described earlier in this Section shall be eligible for COBRA coverage as described under 'Continuation Coverage' at page 74 herein.

Plan Administrator's Disagreement With Award of Authorized Medical Leave of Absence and/or Disability Separation and Right to Require Independent Examination of Employee-Participant.

The Plan Administrator shall have the right to challenge the award of an Authorized Medical Leave of Absence or Disability Separation for purposes of an Employee-Participant seeking the Employer-paid coverage described earlier in this Section. In challenging the award of an Authorized Medical Leave of Absence or Disability Separation, the Plan Administrator shall have the right to require that the Employee-Participant be examined by an independent medical examiner of the Plan Administrator's choosing, at the expense of the Plan Administrator, for the purpose of determining whether, for Plan purposes and in the Plan Administrator's sole opinion, the Authorized Medical Leave of Absence or Disability Separation is warranted by the Employee-Participant's medical condition(s). Failure of the Employee-Participant to submit to the independent medical examination required by the Plan Administrator shall result in a denial of the additional Employer-paid coverage to the Employee-Participant and his Dependent-Participant.

Each Employee-Participant is deemed, through his participation in the Plan, to authorize the Plan Administrator to review the results of the independent medical examination. If, in the Plan Administrator's sole opinion, the results of the examination do not support the award of the Authorized Medical Leave of Absence or Disability Separation, the Plan Administrator may, in its

sole discretion, deny the twelve (12) month Employer-paid coverage. The Plan Administrator's decision shall be final and binding.

'OUT OF AREA' COVERAGE FOR ELIGIBLE DEPENDENT CHILD(REN)

In the event an Employee-Participant has:

(A) a Child who does NOT reside within the Paramount Service Area for reasons other than attending school (but who is otherwise eligible for Plan participation); and

(B) been ordered to provide medical insurance coverage for that Child under a Qualified Medical Child Support Order,

the Plan shall not deny enrollment of that Child as a Dependent-Participant solely on the basis that the Child does not live within the Paramount Service Area; however, the Plan shall in no way be responsible for any denial of service or refusal to pay claims that were incurred by the Employee-Participant and/or his Dependent-Participant at providers outside the Service Area.

FAMILY AND MEDICAL LEAVE ACT.

All provisions relating to Plan coverage and participation are intended to be in compliance, and shall comply, with the Family and Medical Leave Act of 1993 (FMLA). To the extent the FMLA applies to an Employer, group health benefits may be maintained during certain leaves of absence at the level and under the conditions that would have been present as if employment had not been interrupted. Employee eligibility requirements, the obligations of the Employer and Employee concerning conditions of leave, and notification and reporting requirements are specified in the FMLA. Any Plan provision that conflicts with the FMLA is superseded by the FMLA to the extent such provision conflicts with the FMLA. A Participant with questions concerning any FMLA rights and/or obligations should contact his Employer.

MILITARY LEAVES OF ABSENCE.

Employee-Participants and/or Dependent-Participants on approved military leaves will have Plan benefits provided in accordance with the Uniformed Services Employment and Re-employment Rights Act ("USERRA") and any policy or provisions enacted by the Plan Sponsor.

IV. PCP AND PRIOR AUTHORIZATION; IDENTIFICATION CARD; COPAYMENTS/COINSURANCE; QUESTIONS

PRIMARY CARE PROVIDER AND PRIOR AUTHORIZATION

The Primary Care Provider is the Participant's first contact when medical care is needed. The PCP will coordinate the Participant's medical care with other Participating Providers in the Paramount network. Female Participants may receive OB/GYN care from a participating obstetrics/gynecology specialist without Prior Authorization from the Primary Care Provider (PCP). Prior Authorization is required for certain procedures or services. It is the responsibility of the Participating Provider to obtain Prior Authorization from Paramount in advance of these procedures or services:

(A) Ophthalmologists, Retinologists and other vision-related providers,

(B) Dermatologists

(C) Allergists

(D) Pediatric Pulmonologists

(E) Hematologists

(F) Oncologists

(G) Other Participating Providers as required by Paramount.

(H) Outpatient surgeries not performed in a Participating Provider's office and Outpatient surgeries not performed in the office in which the Participating Provider routinely sees his patients, and for which a 'facility' or similar fee will be charged.

IDENTIFICATION CARD

Every Plan Participant receives a Paramount identification card with his name. The name of that Participant's Primary Care Provider is on the card. Each Participant's identification number is a unique number followed by two digits.

A STOLEN/LOST IDENTIFICATION CARD OR AN IDENTIFICATION CARD CONTAINING INCORRECT INFORMATION SHOULD BE REPORTED IMMEDIATELY TO PARAMOUNT MEMBER SERVICES.

COPAYMENTS AND COINSURANCE

Participants pay Copayments (Copays) or Coinsurance for Basic Health Services: office visits and services, inpatient services (services received while a patient in a hospital or other medical facility), outpatient medical services, emergency services, laboratory and radiology services, services for the treatment Biologically Based Mental Illness, substance abuse and preventive health services. The Schedule of Benefits defines the Copayments/Coinsurance for specific services. Copayments are payable at the time services are received by the Participant.

The Out-of-Pocket Coinsurance Limit is the maximum amount of Copayments and Coinsurance paid by the Participant every Plan Year. Once the Out-of-Pocket Coinsurance Limit is met, there will be no additional Copayments and Coinsurance on Basic Health Services during the remainder of the Plan Year**.** The Out-of-Pocket Coinsurance Limit is stated in the Schedule of Benefits. The 'single' Out-of-Pocket Coinsurance Limit is the applicable amount that must be paid by each individual Participant, and the 'family' Out-of-Pocket Coinsurance Limit is the applicable amount that must be paid for two or more Family members covered under the plan. Co-Payments/Coinsurance for Infertility Services & Vision rebate, **do not** apply toward Out-of-Pocket Coinsurance Limit. There is no Out-of-Pocket Coinsurance Limit for services rendered by a non-Participating Provider.

QUESTIONS REGARDING THE PLAN; INFORMATION.

Participants seeking further information or who:

(A) have questions about coverage;

(B) have questions about the providers who participate with Paramount;

(C) have questions about how to obtain health care services;

(D) need help understanding how to use the Plan's benefits;

(E) need to change a Primary Care Provider;

(F) lost their Paramount identification card,

or have any other health care coverage concerns should call Paramount Member Services.

V. GETTING MEDICAL CARE

THE PRIMARY CARE PHYSICIAN

Paramount requires each Participant to designate a Primary Care Provider. The Participant has the right to designate any PCP who participates in the Paramount network as a PCP and who is available to accept the Participant or his Family members. For children, a pediatrician may be designated as the PCP. Information on how to select a PCP, and a list of participating PCPs, can be obtained from Paramount Member Services. A directory of Participating Providers is also available at: www.paramounthealthcare.com.

The PCP is the doctor chosen by the Participant to handle his medical care through the Plan. PCPs are family practitioners, internists and pediatricians participating in the Paramount network. Each Family member can have a different PCP.

A Participant who has chosen an available doctor whom the Participant has not seen before should make an appointment and get to know the doctor and his staff. The more comfortable the Participant is with the PCP--and the better the PCP gets to know the Participant--the more effective the Participant's health care can be.

Participants are encouraged to call as far in advance as possible for an appointment. The following tables serve as guides for lead times that should be allowed when calling to schedule appointments for certain conditions:

Access Standards for Medical Health Care Services	
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 1-2 days in advance.
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. The PCP and/or Paramount should be called within 24 hours, or as soon as possible.

Access Standards for Behavioral Health Care Services	
Type of Care Required	**Recommended Lead Time**
Routine Care/ Office Visit for new problems upon request of the member or provider	Call 14 days in advance.
Routine Care/ Office Follow-Up Visits	Call 30 days in advance.
Urgent Care, may not be life-threatening, but requires immediate attention (complex or dual problems)	Call 1-2 days in advance.
Emergency Care, immediate threat to self or others (acutely suicidal or homicidal)	Immediately call 911 or seek medical treatment. Call your provider and/or Paramount within 24 hours, or as soon as possible.

In the event a Participant is unable to keep an appointment, the provider should be called as soon as possible so the time can be made available for other patients. The Plan will not cover claims associated with missed appointments.

A Participant can reach his Primary Care Provider 24 hours a day, seven (7) days a week. If medical advice is needed after hours, on weekends or holidays, the Participant should call his PCP's office number. The answering service will take the call at which time the Participant should leave a message for the PCP to return the call.

When the PCP, the doctor who is covering for the Primary Care Provider or a nurse returns the call, the Participant should explain the problem clearly. The Participant will then be advised on what to do.

A treatment or test recommended by a doctor will, in most cases, be covered; however, some treatments may not be covered or are covered only when authorized in advance by Paramount. The Participant's doctor may be working with several Paramount plans; plans are often different from one company to the next. The service recommended by the doctor for the Participant may be covered under some similar plans, but not under this Plan.

A Participant who is unsure whether a particular test or service is covered by the Plan is encouraged to ask Paramount Member Services.

If another doctor is covering for the Participant's Primary Care Provider during off-hours or during vacation, the Participant does not need Prior Authorization to see that doctor; however, the Participant should tell the doctor he is a Participant in a Paramount plan.

A Participant may change Primary Care Providers but must first notify Paramount Member Services before seeing any new Primary Care Provider. The change can be made effective the day Paramount Member Services is called call. A new identification card with the new PCP's name will be issued to the Participant. If the Participant needs to see a doctor before the card arrives, the doctor can call Paramount Member Services to check the Participant's Plan status.

Participants may call the Toledo Academy of Medicine or any of the providers' referral services listed in the *Participating Providers and Facilities* directory if specific information about the qualifications of any

Participating Providers or Participating Specialists is needed. Current directories can be received free of charge by calling the Paramount Member Services Department.

PARTICIPANTS HAVING QUESTIONS ABOUT WHETHER A SERVICE IS COVERED CAN FIND OUT BY CALLING PARAMOUNT MEMBER SERVICES. A PARTICIPANT'S FAILURE TO OBTAIN PRIOR AUTHORIZATION BEFORE RECEIVING SERVICES MAY RESULT IN THAT PARTICIPANT BEING HELD RESPONSIBLE FOR TOTAL PAYMENT.

WHEN OB/GYN CARE IS NEEDED

Prior Authorization from Paramount or from any other person (including the PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in the Paramount network who specializes in obstetrics or gynecology, is not required. The health care professional, however, may be required to comply with certain procedures, including obtaining Prior Authorization for certain services or following a pre-approved treatment plan. A list of participating health care professionals who specialize in obstetrics or gynecology can be obtained from Paramount Member Services. A directory of Participating Providers is also available at: www.paramounthealthcare.com.

If more specialized OB/GYN care is needed, the Participant's gynecologist may recommend another Participating Specialist.

REFERRAL TO A SPECIALIST

Most of health care needs can and should be handled by the Participant's Primary Care Provider. If the Primary Care Provider believes the Participant needs to see a specialist--a cardiologist, orthopedist or others--he will recommend a Participating Specialist, or, the Participant may choose, and make an appointment with, the Participating Specialist he (the Participant) wishes to see from those listed in the *Participating Providers and Facilities* directory (also available on the website).

Newly-enrolled Participants in the Plan who are already seeing a specialist should verify that their specialist is participating with Paramount.

PRIOR AUTHORIZATIONS

If a Medically Necessary Covered Service is not available from any Participating Providers, Paramount will make arrangements for an "out of plan Prior Authorization". The Primary Care Provider must request an "out of plan Prior Authorization" in advance. Consultations with Participating Specialists will be required before an "out of plan Prior Authorization" can be considered. If Paramount approves the "out of plan Prior Authorization", written confirmation will be sent to the Participant, his PCP and the non-participating provider. All eligible authorized services will be covered subject to appropriate Copayments/Coinsurance.

Participants having a life-threatening, degenerative or disabling condition that requires the services of a Participating Specialist over a long period of time should discuss their condition with their Primary Care Provider. If the Primary Care Provider and the Participating Specialist agree that the Participant's condition requires the coordination of a Participating Specialist, the PCP will contact Paramount. Together, the Participant, his Primary Care Provider, the Participating Specialist and Paramount will agree on a treatment plan. Once this is approved, the Participating Specialist will be authorized to act as the

Participant's Primary Care Provider in coordinating the Participant's medical care.

UTILIZATION MANAGEMENT

Participating Providers and providers have direct access to Paramount's Utilization Management Department to obtain Prior Authorization for specific procedures and certain other services based on Medical Necessity. It is the responsibility of the Participating Provider or provider to obtain Prior Authorization when required. **A Participant who experiences an Emergency Medical Condition after normal office hours should call 911, an ambulance or rescue squad or go to the nearest medical facility; the Participant does not need to obtain prior approval from his PCP or Paramount.** The Participant should notify his Primary Care Provider as soon as reasonably possible that he was treated for the Emergency Medical Condition.

A Participant needing to discuss the status of a Prior Authorization should contact his Primary Care Provider or Paramount Member Services.

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:

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

INITIAL DETERMINATIONS

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

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 Participant.

ADVERSE DETERMINATIONS

If a Participant's claim is denied, Paramount will provide the Participant with written or electronic notification of the determination. The notification will detail:

(A) the specific reason(s) for the adverse determination,

(B) the specific Plan provisions on which the determination is based,

(C) the right of the Participant to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Participant's claim for benefits; a statement describing any additional appeal procedures offered by the Plan; and the Participant's right to obtain the information about those procedures.

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

(For additional appeal information see 'Questions, Complaints or Appeals' beginning on page 80.)

HOSPITAL ADMISSION

The Primary Care Provider or Participating Specialist will make the arrangements when a Participant needs hospital care. Paramount Participating Hospitals are listed in the *Participating Provider and Facilities Directory*. The Participant should show his Paramount identification card when he is admitted.

If a Participant is already in the hospital on his Enrollment Date or when this Plan becomes effective, shall have his coverage begin on his Enrollment Date. (The health plan covering the Participant when he was initially admitted should cover his hospital stay up to his Enrollment Date.)

Paramount must be notified of an emergency admission to a non-Participating Hospital within twenty-four (24) hours (or as soon as reasonably possible) or the hospital care may not be covered. If and when the Participant's medical condition allows, his Primary Care Provider and Paramount may arrange for the Participant's transfer to a Participating Hospital.

Leaving the Hospital "Against Medical Advice"; Disciplinary Discharge

A Participant who discharges himself from any hospital or facility *"against medical advice"* (AMA), will be assessed a penalty on all charges related to that admission. Also, if a hospital or facility requires the Participant's discharge (a "*disciplinary discharge"*) for any reason, the Participant will be assessed a penalty on all charges related to that admission.

PARTICIPATING HOSPITAL LEAVING THE PLAN

If the Participant's Primary Care Provider or any Participating Hospital can no longer provide medical services because its agreement with Paramount has terminated, the Claims Administrator will notify the Participant of that fact in writing within thirty (30) calendar days of the contract termination date. The 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.

PARTICIPATING SPECIALIST LEAVING THE PLAN

If the Participant is regularly visiting a Participating Specialist or a specialty group whose agreement with Paramount has terminated, the Participant and his PCP will be notified. The Participant may then contact a different Participating Specialist for an appointment.

PROVIDER REIMBURSEMENT

A Participant should always show his Paramount ID card to all providers. The Participant is responsible for paying any office visit Copayments at the time services are received. Participating Providers will notify the Plan of the services rendered. The Plan will send reimbursement directly to Participating Providers for Covered Services. In most cases, reimbursement for Covered Services will be sent directly to a non-participating provider, but instead may be paid directly to the Participant. The Claims Administrator will send the Participant a notice if any service is not covered. If a Participant receives a denial notice and needs further explanation or wishes to appeal, he 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 Participants receive appropriate and timely access to qualified providers. Through contracts with Participating Providers, Paramount obtains discounts and rebates. When copayments are charged as a percentage of Covered Services, the amount paid by the Participant 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

A Participant receiving care for services that are not covered by this Plan is responsible for full payment to the provider of those services.

PARTICIPANTS RECEIVING A BILL

With the exception of Copayments and non-Covered Services, Participating Providers may not bill Participants for Covered Services. If a Participant receives a bill or statement, it is usually just a summary of the activity on his account. A Participant having any questions about any amount(s) shown on the bill or statement should 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 provider advisors.

PRIVACY AND CONFIDENTIALITY

Paramount will keep all documented Participant medical and personal information, whether obtained in writing or verbally, in the strictest confidence in accordance with HIPAA Privacy Standards. Paramount will provide Participants 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 Participants to report any questions or concerns about Paramount providers and/or the services received to Member Services for confidential handling. Participants may also contact the ProMedica Health System Compliance Hotline for confidential investigation at (419) 824-1815 or toll-free 1-800-807-2693.

VI. URGENT CARE OR EMERGENCY MEDICAL CONDITIONS

URGENT CARE SERVICES

Urgent Medical Conditions should be treated by the Participant's Primary Care Provider (PCP) or, in the event the PCP is not available, in a participating urgent care facility. The Participant 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 the PCP, a Participating Provider or Paramount are not covered.

Urgent Care Services needed during normal office/business hours. The Participant should call his Primary Care Provider's office as soon as symptoms persist or worsen. In most cases, the PCP will be able to treat the Participant the same day or the next day. If the PCP's office cannot schedule the Participant within a reasonable time, the Participant may seek treatment at a participating urgent care facility or provider's office. The service will be subject to an urgent care facility or office visit Copay or Coinsurance, depending on the treatment received. The Copay/ Coinsurance may be found in the Schedule of Benefits.

Urgent Care Services needed after normal office/business hours. The Participant should call the number of his Primary Care Provider and ask the answering service to have the doctor call the Participant back. When the doctor or a nurse calls back, the Participant should explain his condition and the doctor or nurse will provide guidance.

Urgent Care Services needed outside the Service Area: The Participant should call his Primary Care Physician first and explain his condition. If the Participant cannot call his PCP, he should go to the nearest urgent care facility or walk-in clinic. The service will be subject to a Copay/ Coinsurance, depending on where the Participant receives treatment. The Copay/Coinsurance may be found in the Schedule of Benefits.

Follow-up care within the Service Area: The Primary Care Provider will decide what care the Participant needs after the urgent care services are rendered.

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

Any time an urgent care provider recommends additional care, such as a return visit, seeing a specialist, additional testing or X-rays, etc., the Participant must call Paramount Member Services BEFORE receiving the services. Paramount Member Services can tell the Participant if the service will be covered, or if the Participant needs to contact his Primary Care Provider.

EMERGENCY SERVICES

Emergency Services which are required as the result of an Emergency Medical Condition are covered at any medical facility, anytime, anywhere world-wide without Prior Authorization. The service will be subject to an emergency room, urgent care facility or office visit Copay, depending on where treatment is received. The Copay/Coinsurance may be found in the Schedule of Benefits at the beginning of this document.

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

(A) Due to circumstances beyond the Participant's control, the Participant 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 constituting an Emergency Medical Condition.

(C) A Paramount representative suggests that the Participant go to an emergency room and does not specify a participating emergency room.

(D) An ambulance takes the Participant to a non-participating facility other than at the direction of the Participant.

(E) The Participant 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 Participant of the change.

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

Emergency Medical Condition Inside the Service Area: In the event of an Emergency Medical Condition inside the services area, the Participant should call 911, an ambulance or rescue squad or go directly to the nearest medical facility. In the event that the Participant is unsure about whether a condition is an Emergency Medical Condition, he may contact his Primary Care Provider for instructions. Medical care is available through Paramount providers seven (7) days a week, twenty-four (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.

The Participant must contact his Primary Care Provider or Paramount within twenty-four (24) hours after the emergency has occurred (or as soon as possible thereafter).

Emergency Medical Condition Outside the Service Area: In the event of an Emergency Medical Condition outside the Service Area, **t**he Participant should call 911, an ambulance or rescue squad or go to the nearest emergency facility for treatment. Upon arriving for treatment the Participant should show his Paramount identification card. In some cases, the Participant may be required to make payment and seek reimbursement from the Plan. The Plan will cover Emergency Services from non-Participating Providers outside the Paramount Service Area related to Emergency Services. Appropriate Copays will be applicable.

Follow-up care within the Service Area: Follow-up medical care for an Emergency Medical Condition inside the Service Area must be arranged by the Participant's Primary Care Provider with Participating Providers.

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

OUT-OF-AREA STUDENT COVERAGE

The Plan includes coverage for emergency, urgent, and follow-up care as well as care provided by college or university student health centers while a full-time student who is a Dependent-Participant is away at school outside the Paramount Service Area through Paramount's *Student Coverage 101 Program*. If a student Dependent-Participant 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 the Employee-Participant or the Dependent-Participant should contact Paramount's Utilization Management Department to obtain Prior Authorization. In the event of an Emergency Medical Condition, the Participant should 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 Participants in locating providers outside of the Paramount Service Area. Paramount's Utilization Management Department may be contacted at (419) 887-2520 or 1-800-891-2520.

A student Dependent-Participant admitted to a hospital outside the Paramount Service Area, 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 the Participant's Primary Care Provider.

VII. COVERAGE UNDER THE PLAN

PLAN COVERAGE-GENERAL

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

Deductible for Center of Excellence. Notwithstanding anything in this Plan document herein to the contrary, a $500 per Participant annual Plan Year deductible shall apply for use of any Inpatient or Outpatient services at a Center of Excellence. This $500 per Participant deductible shall apply towards the Participant's Out-of-Pocket Maximum. The $500 per Participant deductible shall **NOT** apply to:

(A) a Participant whose treatment at a Center of Excellence began before March 1, 2013 and whose treatment was continuous on and after that date until that treatment is concluded (as determined by the Medical Management Company); and

(B) a Participant seeking only a Physician's opinion at an initial visit at a Center of Excellence.

This $500 per Participant deductible shall apply towards the Participant's Out-of-Pocket Coinsurance Limit.

WHAT IS NOT COVERED-IN GENERAL

The following services and supplies are not covered:

(A) Services by providers chosen only for convenience (for example, a Participant uses a non-participating X-ray or lab provider because their offices are nearby).

(B) Any service received from any other non-Participating Provider, non-Participating Hospital, person, institution or organization unless:

(1) Prior special arrangements are made by Paramount or

(2) Such services are for Emergency Medical Conditions.

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

(D) Non-Emergency Services from non-Participating Providers without Prior Authorization from Paramount.

(E) Non-Emergency Services from a non-Participating Provider without Prior Authorization from a Primary Care Provider and authorization from Paramount.

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

(G) Care for conditions which state or local laws require to be treated in a public facility or for which a Participant is not legally required to pay.

(H) Care for disabilities related to military service to which the Participant is legally entitled, and for any services received at a military, veteran or other federal health care facility.

(J) Care provided to Participants by relatives.

(K) All charges incurred as a result of a non-covered procedure.

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

(M) Assisted reproductive technology such as, artificial insemination, in vitro fertilization, embryo transplant services, GIFT, ZIFT infertility drugs and related services and any other assisted reproductive technology.

(N) Surrogate parenting/pregnancy and related services.

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

(P) Services received in a hospital emergency room for an Urgent Medical Condition without prior direction from the PCP, a Participating Provider or Paramount.

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

(R) Screenings or treatments associated with learning disabilities, mental retardation and autism.

COVERED SERVICES; SPECIFIC NON-COVERED 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 Plan's benefits. Benefit limits for certain services may be day or visit limits or a maximum benefit limit each Plan Year. At the start of a new Plan Year, benefits with limitations will renew. **Consult the Schedule of Benefits for Copay requirements and specific limitations on services.**

A list of services follows, in alphabetical order:

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

Acupuncture. Not covered.

Alcoholism and drug addiction treatment. (See Substance Abuse Services.)

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

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

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

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

Asthma supplies (C/L). The asthma supplies below are covered subject to the durable medical equipment Coinsurance and limits:

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

Biofeedback. Not covered.

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

Breast augmentation or reduction. Not covered.

Chiropractic services (C/L). Covered, from participating chiropractors. Consult the Schedule of Benefits Copay and Limits. **Copayment/Coinsurance for chiropractic services will not be applied to the annual Out-of-Pocket Coinsurance Limit.**

Clinical trials (i.e. research studies using consenting human subjects that test the effectiveness and safety of a treatment, diagnostic tool, or a prophylactic intervention). Not covered.

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

Corrective/remedial procedures. Not covered, including, but not limited to: revisions to, correction of and/or treatment of complications arising directly or indirectly from any procedure or treatment not specifically covered under this Plan regardless of whether such procedure or treatment was covered during a time when the Participant was not covered under this Plan.

Cosmetic surgery. Not covered. Cosmetic therapy or surgery is a procedure primarily for the purpose of altering or improving appearance. 'Cosmetic surgery' includes, but is not limited to:

Skin tag removal.

Sclerotherapy for spider angiomas (veins).

Breast reduction/augmentation.

Face lifts, tummy tucks, panniculectomy and liposuction.

Blepharoplasty (eyelid lift) unless medically necessary.

Scar revision and correction.

Torn pierced ear lobes.

Chemical face peels and dermabrasion.

Custodial care. Not covered.

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

First aid received within forty-eight (48) hours of an accidental injury to sound natural teeth, the jaw bones or surrounding tissues. This includes only extraction of teeth, emergency treatment of teeth and repair of soft tissue. **Not covered**: Replacement or restoration of teeth.

Medically necessary orthognathic (jaw) surgery, as determined by Paramount.

Treatment for tumors and cysts (including pathological examination) of the jaws, cheeks, lips, tongue, roof and floor of the mouth.

Medically necessary oral surgery to repair fractures and dislocations only.
Medical treatment for temporomandibular joint syndrome or dysfunction (TMJ).

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

Treatment on or to the teeth, bridges or crowns.

Extraction of teeth, including impacted wisdom teeth.

Treatment of granuloma.

Dental treatment including splints and oral appliances for temporomandibular joint syndrome or dysfunction ("TMJ").

Placement, removal or replacement or implants of the teeth and alveolar ridge including preparatory oral and maxillofacial surgery (bone grafts).

Treatment of periodontal (gum) disease and abscesses.

Root canals.

Bite plates, retainers, snore guards, splints or any appliance or device that is fitted to the mouth.

Any other dental products or services.

Treatment required for an injury as a result of chewing or biting.

Upper and lower jawbone surgery except as required for direct treatment of acute traumatic injury or cancer, or as necessary to safeguard a Member's health due to a non-dental physiological impairment.

Diabetic supplies (C/L). The diabetic supplies below are covered subject to the Coinsurance and limits of the durable medical equipment rider:

Needles with syringes (1cc or less).

Tubing for insulin pumps.
Blood glucose monitor, test strips and control solutions, and lancing devices, lancets.

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

X-rays.

Laboratory tests.

EKGs, EEGs.

Hearing tests.

Pre-admissions tests.

Mammograms and pap smears. Screening mammograms and pap smears are covered when ordered by the PCP or Participating Specialist.

Imaging/Nuclear cardiology studies when preauthorized by PCP or Participating Specialist.

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

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

Not covered:

Growth hormones or steroids used for growth and development.

Retail prescription drugs.

Specialty Drugs.

Drug addiction treatment. (See Substance Abuse services)

Durable medical equipment (C/L). Covered from Participating Providers if the item serves a medical purpose only and can withstand repeated use. The Plan covers medical equipment and supplies that are covered by Medicare Part B and meet Medicare Part B criteria. This includes but is not limited to: oxygen, crutches, wheelchairs, hospital beds, ostomy supplies, etc. **Coinsurance for durable medical equipment will not be applied to the annual Out-of-Pocket Coinsurance Limit.**

Not covered:

Medical equipment and supplies not covered by Medicare Part B.

Disposable supplies (except for ostomy supplies), test kits etc.).

Exercise equipment, air conditioners.

Hearing aids.

Penile implants, erectile devices.

Wigs.

Bite plates, retainers, snore guards, splints or any appliance or device which is fitted to the mouth.

Emergency services (C/L). Covered for facility and provider 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 the Participant's Paramount identification card. The emergency room Copay will be waived if the Participant is admitted as a hospital Inpatient.

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

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

Foot care (C/L). Covered when Prior Authorized to a Participating Specialist.

Not covered:

Trimming and/or scraping of calluses, corns and nails except for services with a diagnosis of diabetes or other conditions causing loss of sensation.

Foot orthotics including shoes, shoe molds and inserts, unless the Participant's condition meets Medicare Part B criteria.

Extra Corporeal Shock Wave Therapy (ESWT)

Growth hormones/growth steroids Not covered.

Home health care (C/L). Covered when properly authorized to a Participating Provider. **Coinsurance will not be applied to the annual Out-of-Pocket Coinsurance Limit.** Services include:

Provider services;

Intermittent skilled nursing care;

Physical, occupational and speech therapy;

Other medically necessary services.

Not covered:

Personal comfort and convenience items and services such as meals, housekeeping, bathing and grooming;

Any services or supplies furnished by a non-eligible institution, which is any institution other than a hospital or skilled nursing facility (for example, custodial, convalescent, domiciliary and intermediate or day care);

Care provided by family members;

Trimming of calluses, corns and nails;

Custodial or respite care.

Hospice services (C/L). Covered when Medically Necessary for terminally ill patients and when Prior Authorized to Participating Providers.

Hospital and other facility services.

Inpatient services (C/L): Covered for Inpatient room, board and general nursing care in non-private rooms. (See 'Hospital Admission' at page 47.)

"Observation stay" (C/L): Charges for an "observation stay". "Observation stay" means active, short-term medical and/or nursing services rendered at a facility other than a clinic, physician's office, urgent care center or mental health/substance abuse treatment facility for the purpose of monitoring a patient's condition for a period of time not exceeding seventy-two (72) hours in order to determine whether Inpatient care is appropriate. An "observation stay" cannot be used for a planned or elective admission and is reimbursed as an Outpatient service. An "observation stay" of less than twenty-four (24) hours shall not require Prior Authorization. An "observation stay" of twenty-four (24) hours or more shall require

Outpatient services (C/L): Covered; including surgery, observation care and diagnostic testing. Outpatient emergency room care is covered under certain conditions. (See Urgent Care or Emergency Medical Conditions at page 50.)

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

Professional services (C/L): The services of providers and other professionals are covered when related to eligible Inpatient and Outpatient hospital services. Covered Services include:

Surgery;

Medical Care;

Newborn Care;

Obstetrical Care;

Anesthesiology;

Radiology and pathology.

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

Services and supplies: Covered when Medically Necessary if the Participant is 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 CONSULT THE SCHEDULE OF BENEFITS FOR INPATIENT AND OUTPATIENT LIMITATIONS.

Infertility services (C/L). Covered for the Medically Necessary diagnosis and treatment of infertility conditions. **Copay/Coinsurance will not be applied to the annual Out-of-Pocket Coinsurance Limit.**

Not Covered:

Infertility drugs.

Any assisted reproduction technology ("ART") such as:

Artificial insemination;

In vitro fertilization and related services;

Embryo transplant services, GIFT, ZIFT, zygote transfer;

Reversal of voluntary sterilization;

Cost of donor sperm or donor egg; and

Services and supplies related to ART procedures.

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

Hemodialysis.

Peritoneal dialysis.

Kidney transplant services.

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

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

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

Prenatal and postnatal care (office visit Copay does not apply to prenatal and postnatal visits).

Delivery including complications of pregnancy, hospitalization and anesthesia. A minimum hospitalization of forty-eight (48) hours will be allowed for normal vaginal delivery and ninety-six (96) hours for cesarean delivery unless the Participant and his provider determine otherwise. If the Participant is 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.

Outpatient self-administered prescription drugs.

Mental health services (Services for a Biologically and Non-Biologically Based Mental Illness) (C/L). Covered for Inpatient and Outpatient care subject to the same Copayments and/or Coinsurance as any other physical disease or condition. Consult the Schedule of Benefits for further details.

Partial hospitalization (comprehensive outpatient treatment) and intensive outpatient programs (comprehensive and primarily educational programs for chemical dependency and some mental health conditions) are available. Services must be approved in advance by Paramount. Partial hospitalization and intensive outpatient care is included in the Inpatient benefit.

Not covered:

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

Testing and treatment for learning disabilities, and mental retardation.

Residential Treatment.

Marriage or relationship counseling.

Hypnosis and biofeedback.

Social skills classes, behavioral modification and other training programs including but not limited to, Applied Behavioral Analysis (ABA) programs.

Morbid obesity surgery/weight-loss procedures. Not covered, including but not limited to: All charges for treatment of obesity and/or weight loss procedures including, but not limited to: gastric reservoir reduction, gastric stapling or diversion for weight loss, corrective or remedial surgery for previously-performed gastric bypasses (or other gastric procedures) performed for the purposes of treatment of obesity or weight-loss.

Office visits (C/L). Covered for:

The Participant's Primary Care Provider.

Participating OB/GYNs and other Participating Specialists.

Eligible services provided during each visit, may include:

Periodic physical exams;

Well-baby/child exams;

Gynecological exams;

Immunizations;

Diagnostic procedures;

Medical/surgical procedures.

Not covered:

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

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

Plastic surgery. (See Reconstructive surgery)

Penile implants. Not covered.

Physical exams (C/L). Covered if exams are periodic physical exams as considered Medically Necessary by the provider.

Not covered when requested for:

Obtaining or maintaining employment or governmental licensure.

Employer-requested physical exams.

Court-ordered or forensic evaluations unless determined to be Medically Necessary by Paramount and rendered by a Participating Provider; and

Physicals and immunizations required for travel.

Preventive health services (C/L).

Initial mammography starting at age 35,

Annual screening for cervical cancer, and

Child health supervisions.

Additional covered preventative health services include but are not limited to the following:

Well baby care from birth and newborn screenings.

Periodic health evaluations, health screenings (obesity, type 2 diabetes, osteoporosis) and physical examinations for children and adults.

Routine adult and pediatric immunizations.

Breast and pelvic exams and Pap smears for women.

Routine eye examinations for children.

Routine hearing examinations.

Genetic risk assessment and BRCA mutation testing for breast and ovarian cancer susceptibility.

Colorectal cancer screening (fecal occult blood testing, sigmoidoscopy, or colonoscopy).

Abdominal aortic aneurysm (AAA) testing.

Aspirin therapy counseling for the prevention of cardiovascular disease.

Blood pressure screening.

Routine screenings during pregnancy (screening for asymptomatic bacteriuria, hepatitis B virus, RH (D) incompatibility.

Screening for sexual transmitted infections (Chlamydia, gonorrhea, syphilis).

Human immunodeficiency virus (HIV) screening.

Depression screening, substance abuse/chemical dependency screening.

Nutritional counseling including diabetes self-management and diet behavioral counseling.

Tobacco cessation classes.

Private duty nursing Not covered.

Prosthetic Devices (C/L). Covered from a Participating Provider subject to coverage by Medicare Part B. Consult the Schedule of Benefits for Copayment details. Repair and replacement of a Prosthetic Device is covered subject to meeting Medicare Part B criteria. **Coinsurance for Prosthetic Devices will not apply to annual Out-of-Pocket Coinsurance Limit.**

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

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

Reconstructive surgery Covered when required for:

Repair of anatomical impairment to improve or correct functional disability within 2 years of accident or injury.

Breast reconstruction following a mastectomy; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas in accordance with the Women's Health and

Cancer Rights Act of 1998.

Plastic surgery following an accidental injury 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 reduction/augmentation.

Sclerotherapy for spider angiomas (veins). Not covered.

Skilled nursing facility (C/L). Covered when Medically Necessary up to a maximum of 100 days with Prior Authorization from Paramount. Services must be rendered at a participating facility approved by Paramount.

Not covered: Custodial care.

Skin tag removal. Not covered.

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

Not covered: Sleep studies for sexual dysfunction.

Smoking cessation classes. Covered at Participating Hospitals.

Specialty Drugs. Not covered.

Substance abuse services (alcohol and drug abuse/addiction) (C/L). Covered for Inpatient and Outpatient care, for diagnosis, crisis intervention and short-term treatment of substance abuse services. Covered Services are subject to the same Copayments and/or Coinsurance as any other physical disease or condition. Partial hospitalization (comprehensive Outpatient treatment) and intensive Outpatient programs comprehensive and primarily educational programs for substance abuse and some mental health conditions) are available when approved in advance by Paramount.

Not covered:

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

Residential treatment.

Long-term rehabilitation.

Surrogate Parenting and Pregnancy and related services. Not covered.

Therapy services (C/L). Covered for:

Chemotherapy, radiotherapy and radiation therapy.

Outpatient physical/occupational therapy. Consult the Schedule of Benefits for limitations. **Copay/Coinsurance for Outpatient/physical therapy will not be applied to the annual Out-of-Pocket Coinsurance Limit.**

Speech therapy. Consult the Schedule of Benefits for limitations. **Copay/Coinsurance for speech therapy will not be applied to the annual Out-of-Pocket Coinsurance Limit.**
Not covered:

Non-medical services such as vocational rehabilitation and employment counseling.

Testing, training and educational therapy for learning disabilities including developmental delays in children.

Physical/occupational therapy beyond benefit limits.

Speech therapy beyond benefit limits.

Speech therapy for development or language disorders in children (aphasia, stuttering, hyperkinesia and extreme mental retardation). Equestrian therapy.

Extra Corporeal Shock Wave Therapy (ESWT) for conditions of the feet, elbows and shoulders.

Transplants (C/L). Covered for certain clinical indications with written Prior Authorization at a Paramount approved Center of Excellence for heart, lung, liver, pancreas, heart-lung, kidney-pancreas, bowel and bone marrow transplants. Participants must notify Member Services as soon as possible after being recommended for a transplant. This will enable a Paramount Nurse Case Manager to work with the Participant, the Participant's PCP and Specialist to coordinate the Participant's care.

When Paramount selects a Center of Excellence for transplant services outside the Service Area, Paramount will reimburse up to the 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 or Family members.

Not covered:

Services related to a Paramount organ/bone marrow donor for a non- Plan recipient.

Any transplant not approved by the Ohio Solid Organ Transplant Consortium or the Ohio Bone Marrow Transplant Consortium.

Coverage of non-Benefit Plan donor unless no other coverage exists.

Any services rendered at a non-Paramount Center of Excellence transplant site.

Transsexual surgery and related services. Not covered.

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

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

Not covered:

Services received in a hospital emergency room for an Urgent Medical Condition without prior direction from the Participant's PCP, a Participating Provider or Paramount.

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

There is an additional benefit allowance every twenty-four (24) months toward the purchase of vision hardware with an itemized receipt from any vision or optical provider. Consult the Schedule of Benefits for details. **Charges above the vision care benefit allowance will not apply to annual Out-of-Pocket Coinsurance Limit.**

Not covered:

Routine vision exams more often than every twelve (12) months.

Orthoptic/vision training.

Contact lenses, eyeglasses and other corrective lenses in excess of the additional benefit allowance, 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 Provider, and the Participating Provider 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 provider by diagnosis.

Any non-covered procedures including (but not limited to), surgeries, services, tests and/or treatments. Not covered.

Inpatient and Outpatient services provided by or at a facility not approved by Medicare, Medicaid, NCQA or CARF International. Not covered.

VIII. COORDINATION OF BENEFITS

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

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

DEFINITIONS

For purposes of this Coordination of Benefits Section:

(A) A “plan” is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same "plan" and there is no COB among those separate contracts.

(1) "Plan" includes: group and non-group insurance contracts, health insuring corporation (HIC) contracts, "closed panel plans" or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

(2) "Plan" does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; supplemental coverage as described in Ohio Revised Code §§ 3923.37 and 1751.56; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

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

(B) “This plan” means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of the other plans. Any other part of the contract providing health care benefits is separate from "this plan". A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only similar benefits, and may apply another COB provision to coordinate other benefits.

(C) The order of benefit determination rules determine whether "this plan" is a "primary plan" or "secondary plan" when the person has health care coverage under more than one "plan".

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

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

The following are examples of expenses that are not "allowable expenses":

(1) The difference between the cost of a semi-private hospital room and a private hospital room is not an "allowable expense", unless one of the "plans" provides coverage for private hospital room expenses.

(2) If a Participant is covered by two or more "plans" that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an "allowable expense".

(3) If a Participant is covered by two or more "plans" that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an "allowable expense".

(4) If a Participant is covered by one "plan" that calculates its benefits or services on the basis of usual or customary fees or relative value schedule reimbursement methodology or similar reimbursement methodology and another "plan" that provides its benefits or services on the basis of negotiated fee or payment amount is different than the "primary plan’s" payment arrangement and if the provider’s contract permits, the negotiated fee or payment shall be the "allowable expense" used by the "secondary plan" to determine its benefits.

(5) The amount of any benefit reduction by the "primary plan" because a Participant has failed to comply with the "plan" provisions is not an "allowable expense". Examples of these types of provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

(E) "Closed panel plan" is a "plan" that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the "plan", and that excludes coverage for services provided by other providers, except in cases of emergency or prior authorization by a panel member.

(F) "Custodial parent" is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

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

(A) The "primary plan" pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other "plan".

(B) (1) Except as provided in immediately following subparagraph (2), a "plan" that does not contain a coordination of benefits provision that is consistent with this regulation is always the "primary plan" unless the provisions of both "plans" state that the complying "plan" is the "primary plan".

(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the "plan" provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a "closed panel plan" to provide out-of-network benefits.

(C) A "plan" may consider the benefits paid or provided by another "plan" in calculating payment of its benefits only when it is the "secondary plan" to that other "plan".

(D) Each "plan" determines its order of benefits using the first of the following rules that apply:

(1) Non-Dependent or Dependent. The "plan" that covers the Participant other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the "primary plan" and "plan" that covers the Participant as a dependent is the "secondary plan". However, if the Participant is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the "plan" covering the Participant as a dependent; and primary to the "plan" covering the Participant other than as a dependent (e.g. a retired employee); then the order of benefits between the two "plans" is reversed so that the "plan" covering the Participant as an employee, member, policyholder, subscriber or retiree is the "secondary plan" and the other "plan" is the "primary plan".

(2) Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a dependent Child is covered by more than one "plan" the order of benefits is determined as follows:

(a) For a dependent Child whose parents are married or are living together, whether or not they have ever been married:

(i) The "plan" of the parent whose birthday falls earlier in the calendar year is the "primary plan"; or

(ii) If both parents have the same birthday, the "plan" that has covered the parent the longest is the "primary plan".

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

(b) For a dependent Child whose parents are divorced or separated or not living together, whether or not they have ever been married:

i. If a court decree states that one of the parents is responsible for the dependent Child's health care expenses or health care coverage and the "plan" of that parent has actual knowledge of those terms, that "plan" is

primary. This rule applies to Plan Years commencing after the "plan" is given notice of the decree;

ii. If a court decree states that both parents are responsible for the dependent Child's health care expenses or health care coverage, the provisions of immediately preceding subparagraph (2)(a) shall determine the order of benefits;

iii. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent Child, the provisions of immediately preceding subparagraph (2)(a) shall determine the order of benefits;

iv. If there is no court decree allocating the responsibility for the dependent Child's health care expenses or health care coverage, the order of benefits for the Child are as follows:

- The "plan" covering the "custodial parent";
- The "plan" covering the spouse of the "custodial parent";
- The "plan" covering the non-"custodial parent"; and then
- The "plan" covering the spouse of the non-"custodial parent".

(c) For a dependent Child covered under more than one "plan" of individuals who are not the parents of the Child, the provisions of immediately preceding subparagraph (2)(a) or (2)(b) shall determine the order of benefits as if those individuals were the parents of the Child.

(3) Active Employee or Retired or Laid-off Employee. The "plan" that covers a Participant as an active employee, that is, an employee who is neither laid off nor retired, is the "primary plan". The "plan" covering the same Participant as a retired or laid off employee is the "secondary plan". The same would hold true if a Participant is a dependent of an active employee and that same Participant is a dependent of a retired or laid off employee. If the other "plan" does not have this rule, and as a result, the "plans" do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule in immediately preceding subparagraph (D)(1) can determine the order of benefits.

(4) COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another "plan", the "plan" covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber, or retiree is the "primary plan" and the COBRA or state or other federal continuation coverage is the "secondary plan". If the other "plan" does not have this rule, and as a result, the "plans" do not agree on the order of benefits, this rule is ignored. This rule does not apply if the immediately preceding subparagraph (D)(1) can determine the order of benefits.

(5) Longer or Shorter Length of Coverage. The "plan" that covered the Participant as an employee, member, policyholder, subscriber or retiree longer is the "primary plan" and the "plan" that covered the Participant the shorter period of time is the "secondary plan".

(6) If the immediately preceding subparagraphs (D)(1) through (D)(5) do not determine the order of benefits, the "allowable expenses" shall be shared equally between the "plans" meeting the definition of "plan". In addition, "this plan" will not pay more than it would have paid had it been the "primary plan".

EFFECT ON PLAN BENEFITS

(A) When "this plan" is secondary, it may reduce its benefits so that the total benefits paid or provided by all "plans" during a Plan Year are not more than the total "allowable expenses". In determining the amount to be paid for any claim, the "secondary plan" will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any "allowable expense" under its "plan" that is unpaid by the "primary plan". The "secondary plan" may then reduce its payment by the amount so that, when combined with the amount paid by the "primary plan", the total benefits paid or provided by all "plans" for the claim do not exceed the total "allowable expense" for that claim. In addition, the "secondary plan" shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

(B) If a Participant is enrolled in two or more "closed panel plans", and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one "closed panel plan", COB shall not apply between that "plan" and the other "closed panel plans".

RIGHT TO RECEIVE AND RELEASE INFORMATION

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

FACILITY OF PAYMENT

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

RIGHT OF RECOVERY

If the "amount of the payments made" by the Claims Administrator is more than it should have paid under this COB provision, it may recover the excess from one or more of the Participants it has paid or for

whom it has paid; any other person or organization that may be responsible for the benefits or services provided for the Participant. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

COORDINATION DISPUTES

If a Participant believes that the Claims Administrator has not paid a claim properly, he should first attempt to resolve the problem by contacting the Claims Administrator at (419) 887-2525 or refer to 'Questions, Complaints and Appeals' at page X-1. If still not satisfied, the Participant may call the Ohio Department of Insurance (1-800-686-1526) or visit the Department’s website at http://insurance.ohio.gov for instructions on filing a consumer complaint.

WORKERS' COMPENSATION CLAIMS AND SETTLEMENTS

If an Employee-Participant or a Dependent-Participant receives health care services due to an injury which may be covered by Workers’ Compensation, the Participant must notify Paramount Member Services as soon as possible.

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

SUBROGATION AND REIMBURSEMENT

Where a Participant has benefits paid by the Plan for the treatment of sickness or injury caused by a third party or the Participant, these are conditional payments that must be reimbursed by the Participant if the Participant receives compensation, damages or other payment as a result of the sickness or injury from any person, organization or insurer, including the Participant'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 Participant, the Plan may subrogate to the Participant's rights of recovery and remedies by joining in the Participant's lawsuit, assigning its rights to the Participant to pursue on the Plan‘s behalf, or bringing suit in the Participant's name as subrogee.

The Plan’s reimbursement and subrogation rights are equal to the value of medical benefits paid for Covered Services provided to the Participant. The Plan’s subrogation rights are a first priority claim against any recovery and must be paid before any other claims, including claims by the Participant for damages. This means the Participant must reimburse the Plan in full, in an amount not to exceed the total recovery, even when the Participant's settlement or judgment is for less than the Participant's total damages and must be paid without any reductions for attorney’s fees, costs or other expenses incurred by the Participant. The Plan is always a 'secondary' payor when there are no fault and/or personal injury protection benefits available to the Participant.

IX. CREDITABLE COVERAGE; CONTINUATION COVERAGE

CERTIFICATE OF CREDITABLE COVERAGE

A Participant whose coverage with the Plan ends for any reason will receive a Certificate of Creditable Coverage indicating the length of time he was covered by the Plan without a sixty-three (63) day lapse in coverage. This certificate may help the Participant obtain health insurance through another insurance carrier without having to worry about a pre-existing condition exclusion.

CONTINUATION COVERAGE-COBRA DEFINITIONS

For purposes of the provisions of 'Continuation Coverage' and with respect to any reference to COBRA benefits throughout the Plan document, the following definitions shall apply in addition to those described under the DEFINITIONS section at the beginning of this document.

"Code". The Internal Revenue Code of 1986, as amended.

"Continuation Coverage". The Plan coverage elected by a Qualified Beneficiary following a Qualifying Event.

"Covered Employee". An individual defined under 42 USC §300bb-8(2).

"Group Health Plan". Has the same meaning as that term is defined in COBRA and the regulations thereunder.

"Qualified Beneficiary".

(A) An Employee-Participant whose employment terminates (other than for gross misconduct) or whose hours are reduced, rendering him/her ineligible for coverage under the Plan;

(B) A Dependent-Participant who becomes eligible for coverage under the Plan due to a Qualifying Event; and/or

(C) A Newborn or newly adopted Child of a Participant who is continuing coverage under COBRA.

"Qualifying Event". Any of the following events that may permit a Qualified Beneficiary to elect Continuation Coverage:

(A) termination of the Qualified Beneficiary's employment with his Employer (other than for gross misconduct) or reduction in the Qualified Beneficiary's hours of employment;

(B) the death of a Qualified Beneficiary who was employed by an Employer;

(C) the divorce or Legal Separation of the Qualified Beneficiary;

(4) the Qualified Beneficiary who is an Employee-Participant becoming entitled to Medicare coverage; or

(D) a Child ceasing to be Dependent-Participant.

"Totally Disabled for Social Security Purposes" or "Total Disability for Social Security Purposes". A determination made by the Social Security Administration that the Participant is totally and permanently disabled under Title II or Title XVI of the Social Security Act.

RIGHT TO ELECT CONTINUATION COVERAGE.

If a Qualified Beneficiary loses coverage under the Plan due to a Qualifying Event, he may elect to continue coverage under the Plan in accordance with COBRA upon payment of the monthly premium specified from time to time by the Plan Administrator. A Qualified Beneficiary must elect the coverage by no later than the sixtieth (60_{th}) day following the later of:

(A) the date of the Qualifying Event triggering the right to elect Continuation Coverage; or

(B) the date the Qualified Beneficiary was notified of his right to elect Continuation Coverage.

NOTIFICATION OF QUALIFYING EVENT.

In the event of a Qualifying Event resulting from divorce, Legal Separation or a dependent Child's ineligibility under the Plan, the Qualified Beneficiary must notify the Employer of the Qualifying Event within sixty (60) days of the Qualifying Event in order for coverage to continue. In addition, a Qualified Beneficiary who is Totally Disabled for Social Security Purposes must notify the Employer in accordance with the provisions under "Total Disability for Social Security Purposes", below, in order for Plan coverage to continue.

DURATION OF CONTINUATION COVERAGE.

(A) The maximum period of time a Qualified Beneficiary may maintain Continuation Coverage for himself (and, if applicable, any Dependent-Participants) as a result of the Qualified Beneficiary's loss of Plan coverage due to a reduction in hours of employment or termination of employment (other than for gross misconduct) is:

(1) eighteen (18) months from the date of the Qualifying Event; or

(2) (regardless of the date of the Qualifying Event), twenty-nine (29) months from the date of the Qualifying Event if the Qualified Beneficiary is determined to be Totally Disabled for Social Security Purposes within sixty (60) days of the Qualifying Event, PROVIDED the Qualified Beneficiary notifies the Plan Administrator of the Social Security Administration's determination of his Total Disability for Social Security Purposes before the end of the original eighteen (18) month period of Continuation Coverage and no later than sixty (60) days following the date of such determination.

(B) A Qualified Beneficiary (other than an Employee-Participant) who loses coverage due to the Employee-Participant's death, divorce or entitlement to Medicare, and a Dependent-Participant who is a Child who has become ineligible for Plan coverage, is eligible for Continuation Coverage for up to thirty-six (36) months from the date of the Qualifying Event or for such period as prescribed by the Internal Revenue Code, ERISA, and the regulations and administrative pronouncements promulgated thereunder.

TERMINATION OF CONTINUATION COVERAGE.

Continuation Coverage will automatically end earlier than the applicable eighteen (18) twenty-nine (29) or thirty-six (36) month period for a Qualified Beneficiary provided:

(A) the required monthly premium is not received by the Plan Administrator within thirty (30) days following the date it is due;

(B) the Qualified Beneficiary becomes covered under any other group medical insurance plan as an employee or otherwise. If the other group medical insurance plan contains an exclusion or limitation relating to a pre-existing condition, and such exclusion or limitation applies to the Qualified Beneficiary, then the Qualified Beneficiary shall be eligible for the remaining balance of the Continuation Coverage period specified above under this Plan as long as the exclusion or limitation relating to the pre-existing condition limitation or exclusion applies to the Qualified Beneficiary;

(C) (for a Qualified Beneficiary who is Totally Disabled for Social Security Purposes and continuing coverage for up to twenty nine (29) months) the last day of the month coinciding with or immediately following the thirtieth (30_{th}) day following the date of a final determination by the Social Security Administration that such Qualified Beneficiary is no longer Totally Disabled for Social Security Purposes;

(D) the Qualified Beneficiary becomes entitled to Medicare benefits; or

(E) the Employer ceases to offer any group medical insurance plan.

MULTIPLE QUALIFYING EVENTS

If a Qualified Beneficiary maintains Continuation Coverage due to a Qualifying Event for which the maximum Continuation Coverage is eighteen (18) or twenty-nine (29) months, and a second Qualifying Event occurs during the eighteen (18) or twenty-nine (29) month period, that Qualified Beneficiary may elect, in accordance with the foregoing provisions, to maintain Continuation Coverage for up to thirty-six (36) months from the date of the first Qualifying Event. In addition, if a Qualified Beneficiary who was an Employee-Participant becomes entitled to benefits under Medicare (whether or not this triggers a Qualifying Event), a Qualified Beneficiary (other than the Employee-Participant) may elect Continuation Coverage for a maximum of thirty-six (36) months from the date of the initial Qualifying Event, to the extent another period of Continuation Coverage is not required by law under COBRA.

TOTAL DISABILITY FOR SOCIAL SECURITY PURPOSES.

(A) In a case of a Qualified Beneficiary who is determined to be Totally Disabled for Social Security Purposes within sixty (60) days of a Qualifying Event (if the Qualifying Event is termination of employment or reduction in hours), that Qualified Beneficiary may continue coverage (including coverage for Dependent-Participants who were covered under the Continuation Coverage) for a total of twenty-nine (29) months PROVIDED the Qualified Beneficiary notifies the Plan Administrator:

(1) prior to the end of eighteen (18) months of Continuation Coverage that he was disabled as of the date of the Qualifying Event; and

(2) within sixty (60) days of the determination of Total Disability for Social Security Purposes.

(B) The Plan Administrator will charge the Qualified Beneficiary an increased premium for Continuation Coverage extended beyond eighteen (18) months.

(C) If during the period of extended coverage for Total Disability for Social Security Purposes (i.e. Continuation Coverage in excess of eighteen (18) months and less than or equal to twenty-nine (29) months) a Qualified Beneficiary is determined to be no longer Totally Disabled for Social Security Purposes:

(1) The Qualified Beneficiary shall notify the Plan Administrator of this determination within thirty (30) days of the Qualified Beneficiary receiving notice of the determination; and

(2) Continuation Coverage shall terminate the last day of the calendar month that is at least thirty (30) days after the date of the final determination under the Act that the Qualified Beneficiary is no longer Totally Disabled for Social Security Purposes.

CONTINUATION COVERAGE SUBJECT TO PLAN TERMS

The Continuation Coverage elected by a Qualified Beneficiary is subject to all of the terms, conditions, limitations and exclusions which are applicable to the Group Health Plan offered to similarly situated Employee-Participants and Dependent-Participants. The Continuation Coverage is also subject to the rules and regulations under COBRA. If COBRA permits Qualified Beneficiaries to add dependents for Continuation Coverage, such dependents must meet the definition of Eligible Dependent under the Plan.

CARRYOVER OF PLAN MAXIMUMS

If Continuation Coverage elected by a Qualified Beneficiary, expenses already credited to the Plan's applicable Co-payment features for the Plan Year will be carried forward into the Continuation Coverage.

Similarly, amounts applied toward any maximum payments under the Plan will also be carried forward into the Continuation Coverage. Coverage will not be continued for any benefits for which Plan maximums have been reached.

PAYMENT OF PREMIUM

(A) The Plan Administrator will determine the amount of premium to be charged for Continuation Coverage for any period. Such premium will be a reasonable estimate of the cost for providing coverage for such period for similarly situated individuals, determined on an actuarial basis and considering such factors as the Secretary of Labor may prescribe.

(1) The Plan may require a Qualified Beneficiary to pay a premium for coverage that does not exceed one hundred two (102) percent of the applicable contribution for that period.

(2) For Qualified Beneficiaries whose coverage is continued pursuant to the foregoing provisions of this section, the Plan may require the Qualified Beneficiary to pay a premium for coverage that does not exceed one hundred fifty (150) percent of the applicable premium for Continuation Coverage in excess of eighteen (18) months but less that or

equal to twenty-nine (29) months.

(3) Premiums for coverage may, at the election of the payor, be paid in monthly installments.

(4) Premiums for Continuation Coverage shall not be paid through the Lucas County Flexible Benefits Plan, as amended and restated effective March 1, 2008.

(B) If Continuation Coverage is elected, the first monthly premium for coverage must be made within forty-five (45) days of the date of election.

(C) Without further notice from the Plan Administrator, the Qualified Beneficiary must pay the monthly premium for coverage by the first day of the month for which coverage is to be effective. If payment is not received by the Employer within thirty (30) days of the payment's due date, Continuation Coverage will terminate as of the last day of paid Continuation Coverage.

(D) No claim will be payable under this provision for any period for which the premium for coverage is not timely received from or on behalf of the Qualified Beneficiary.

BANKRUPTCY UNDER TITLE XI

(A) For purposes of this Section only:

(1) "Qualified Beneficiary" means:

(a) An Employee-Participant who retired on or before the date of the Qualifying Event and who was covered as a retiree under the Plan;

(b) An individual who was covered under the Plan as a surviving Spouse of a deceased retiree on the day before the date of the Qualifying Event; and

(c) A dependent of (1)(a) or (1)(b) above who was covered under the Plan on the day before the date of the Qualifying Event.

(2) "Qualifying Event" means the substantial elimination of coverage under the Plan within one year before or after the Employer files a petition in bankruptcy under Title XI of the United States Code.

(B) If a Qualified Beneficiary experiences a Qualifying Event, he may elect to continue coverage under the Plan if he pays the monthly premium specified from time to time by the Plan Administrator, and makes his election in accordance with the foregoing provisions.

(C) Continuation Coverage elected under this section will automatically end earlier than the periods specified above if the required contribution for coverage is not paid on a timely basis or if the Employer ceases to offer any group health plans.

X. QUESTIONS, COMPLAINTS OR APPEALS

Participants with questions, complaints or comments may contact Paramount's Member Services Department from 8:00 A.M. to 5:00 P.M., Monday through Friday.

Participants calling Member Services after hours, may leave a message and their call will be returned the next working day. Participants may also E-mail Paramount through the Paramount web site at: www.paramounthealthcare.com.

Member Services' goal is to help Participants with any questions about procedures, benefits, Participating Providers, payment for services, enrollment, etc. Participants are encouraged to call Paramount with any questions. Paramount provides a TTY number for Participants who are hearing impaired. Paramount will also provide translation services for Participants who don't speak English. If a Participant needs foreign language translation services, they should call Member Services. Participants with suggestions for improving service or Participants wishing to recommend changes in procedures or benefits are encouraged to write or call Member Services. Participants are also encouraged to develop a good relationship with their provider so that they fully understand the diagnosis and treatment prescribed.

RECONSIDERATION OF A UTILIZATION REVIEW DECISION

Under Ohio Revised Code Section1751.82 a provider has the right to request reconsideration on behalf of a Participant 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 the Participant's 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 Participant his legal representative, an authorized person, the provider or health care facility acting on the Participant's behalf may request an internal review under Ohio Revised Code Section 1751.83.

MAKING A COMPLAINT

Participants who are dissatisfied with any aspect of Paramount service may file a complaint with the Paramount Member Services Department. 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. The Participant making the complaint will be advised of the disposition of his complaint by telephone call or in writing. If a complaint is not resolved to the Participant's satisfaction, he will be advised of his right to appeal.

APPEALS OF ADVERSE BENEFIT DETERMINATIONS

A Participant has the right to appeal decisions made by the Claims Administrator that deny or limit his health care benefits. Participants' rights are explained below. Solely for the purposes of any appeal to Paramount of an Adverse Benefit Determination, the following definitions shall apply:

"Adverse Benefit Determination". A decision made by the Claims Administrator:

(A) declining to provide or pay for any item or service (in whole or in part);

(B) not to issue Plan coverage to the Participant; or

(C) to rescind a Participant's Plan coverage.

"Appeal Request Form". The form provided by the Claims Administrator that must be completed by the Participant or his Authorized Representative in order to commence any appeal of an Adverse Benefit Determination under the Plan's appeal process.

"Appeals Committee". The entity formed by the Claims Administrator to review appeals of Adverse Benefit Determinations whose contact information is:

Paramount Care, Inc.
Member Service Dept - Appeals Committee
P.O. Box 928
Toledo, Ohio 43697-0928
(419) 887-2525
1.800.462.3589
PHCMbrSvcAppeals@ProMedica.org

"**Authorized Representative".** An individual authorized by law or designated by the Participant (including, but not limited to, the Participant's treating physician) to act on, or appeal, an Adverse Benefit Determination on the Participant's behalf. To be valid, the Participant's Authorized Representative must be identified in writing on the Appeal Request Form.

"External Review". The process that allows the Participant or his Authorized Representative to request a review of an Adverse Benefit Determination (circumstances permitting) by the Ohio Department of Insurance or an IRO.

"Independent Review Organization" or "IRO". An accredited and qualified entity selected at random, to conduct an External Review (based on the type of health care service involved with an Adverse Benefit Determination) by the Ohio Department of Insurance from its secure web-based system.

"Urgent". A situation or condition in which the:

(A) Participant's health or life may be in serious jeopardy; or

(B) Participant may not be able to regain maximum function if treatment is delayed; or,

(C) Participant may experience pain that cannot be adequately controlled while he waits for a decision on his appeal.

Adverse Benefit Determination Appeal-Procedure

The Participant or his Authorized Representative shall have the right to appeal any Adverse Benefit Determination through an Internal Appeal Review, an External Review, or both, depending upon the circumstances.

Requesting an Internal Appeal Review. The request for an Internal Appeal Review must be made in writing on an Appeal Request Form requested from and provided by the Claims Administrator. The Appeal Request Form must be submitted by the Participant or his Authorized Representative to the Claims Administrator in writing, within 180 days after receiving notice of an Adverse Benefit Determination. The Participant or Authorized Representative may request and obtain an Appeal Request Form by contacting the Claims Administrator by phone, facsimile, regular U.S. Mail or e-mail at PHCMbrSvcAppeals@ProMedica.org .

Internal Appeal Review decision process. Once an Internal Appeal Review is timely requested and a complete Appeal Request Form is received by the Claims Administrator, the Claims Administrator shall forward the Appeal Request Form to the Appeals Committee. The Appeals Committee shall then review the documentation and evidence relating to the appeal. A written decision containing the Appeals Committee's findings will be provided to the Participant or his Authorized Representative initiating the appeal within:

(A) thirty (30) days of the Appeals Committee's receipt of a complete request for an Internal Appeal Review of an Adverse Benefit Determination involving a non-Urgent medical condition for which services have not yet been rendered; or

(B) sixty (60) days of the Appeals Committee's receipt of a complete request for an Internal Appeal Review of an Adverse Benefit Determination involving services already received by the Participant.

If the appeal is denied or a decision is not rendered in the thirty (30) or sixty (60) period described hereof, the Participant or his Authorized Representative may request an External Review.

"Expedited" Internal Appeal Review. The Participant or his Authorized Representative may request an "expedited" Internal Appeal Review upon the Participant's treating Physician certifying to the Appeals Committee in writing on the Appeal Request Form that the Participant has an Urgent medical condition.

The Participant or his Authorized Representative may also submit a request for an "expedited" Internal Appeal Review by facsimile or e-mail at PHCMbrSvcAppeals@ProMedica.org by completing an Appeal Request Form, checking the appropriate box(es) on the Form and providing any necessary certifications.

Requests for "expedited" Internal Appeal Reviews may also be made orally by a Participant or his Authorized Representative by calling the Appeals Committee's 'Appeals Team' at (419) 887.2525 and asking for a member of the 'Appeals Team' because of a Participant's Urgent condition. Written

confirmation of the oral request, Urgent condition and any required certifications must be submitted by the individual making the request to the Appeals Committee no later than five (5) days after the request for an "expedited" Internal Appeal Review is made.

Upon receiving a complete request for an "expedited" Internal Appeal Review, the Appeals Committee shall review the evidence and documentation relating to the Adverse Benefit Determination being appealed and shall issue its decision, in writing, to the Participant or his Authorized Representative requesting the appeal within seventy-two (72) hours of receiving the complete "expedited" Internal Appeal request.

If the appeal is denied or a decision is not rendered in the seventy-two (72) hour period described hereof, the Participant or Authorized Representative may request an External Review.

Requesting an External Appeal Review. A Participant is entitled to an External Appeal Review conducted by either the Ohio Department of Insurance or an Independent Review Organization.

The Ohio Department of Insurance will conduct the External Appeal Review in cases where the Adverse Benefit Determination:

(A) is based on a contractual issue that does not involve a medical judgment or any medical information; or

(B) indicates that emergency medical services did not meet the definition of an Emergency Medical Condition AND the Adverse Benefit Determination has already been upheld through an External Review by an IRO.

An Independent Review Organization will conduct the External Appeal Review only in cases where the Adverse Benefit Determination:

(A) involves a medical judgment or is based on any medical information; or

(B) indicates the requested service is Experimental or investigational and the treating physician certifies that:

(1) standard health care services have not been effective in improving the condition of the Participant; or

(2) standard health care services are not medically appropriate for the Participant; or

(3) no available standard health care service covered by the Plan is more beneficial than the requested health care service.

An External Appeal Review may be of the **"standard"** or **"expedited"** type. A **"standard" External Appeal Review** must be requested by the Participant or his Authorized Representative, in writing on an Appeal Request Form requested from, and provided by, the Claims Administrator and filed with the Appeals Committee within 180 days of the date an Adverse Benefit Determination is issued.

If a "standard" External Appeal Review request is complete. If an External Appeal Review request is complete and eligible for review, the Appeals Committee will initiate the External Appeal Review and shall so notify the Participant or his Authorized Representative making the request, in writing. The notification shall also:

(A) include the name and contact information for the assigned IRO or the Ohio Department of Insurance (whichever is applicable) for the purpose of submitting additional information; and

(B) inform the Participant or Authorized Representative making the request that, within ten (10) business days after receipt of the notice, additional information in writing may be submitted to the IRO or the Ohio Department of Insurance (as applicable) for consideration in the Review.

The Appeals Committee will forward all documents and information used to make its Adverse Benefit Determination to the IRO or the Ohio Department of Insurance (as applicable).

If the External Appeal Review is being conducted by an IRO, upon receipt, the IRO must forward any additional information it receives from the Participant or his Authorized Representative to the Appeals Committee. The Appeals Committee may, at any time, reconsider and reverse the Adverse Benefit Determination; however, reconsideration will NOT delay or terminate the External Appeal Review. If the Adverse Benefit Determination is reversed, the Appeals Committee shall notify the Participant or his Authorized Representative, the assigned IRO and the Ohio Department of Insurance within one business (1) day of making the decision. Upon receiving notice of the reversal from the Appeals Committee, the IRO will terminate the Review.

In addition to all documents and information considered and/or used in making the Adverse Benefit Determination, the IRO shall take into consideration factors such as: the Participant's medical records, the treating physician's recommendation, consulting reports from appropriate health care professionals, the Plan's terms and conditions and the most appropriate practice guidelines.

Written decisions in "standard" External Appeal Reviews are normally provided to the Participant or his Authorized Representative within thirty (30) days of the Appeal Committee's receipt of a complete request for a "standard" External Appeal Review; however, a "standard" External Appeal Review decision made by an IRO shall be sent to the Appeals Committee and the Ohio Department of Insurance and shall include the following information:

(1) a general description of the reason for the request of the "standard" External Appeal Review;

(2) the date the IRO was assigned to conduct the "standard" External Appeal Review;

(3) the dates over which the "standard" External Appeal Review was conducted;

(4) the date on which the IRO's decision was made;

(5) the rationale for the IRO's decision; and

(6) references to the evidence or documentation (including any evidence-based standards) that the IRO used or considered in reaching its decision.

If a "standard" External Appeal Review request is NOT complete. The Appeals Committee will inform the Participant or his Authorized Representative that a "standard" External Appeal Review request is not complete, in writing, and shall specify what information is needed to complete the request.

"Expedited" External Appeal Review. An "expedited" External Appeal Review due to an Urgent medical condition may be requested on an Appeal Request Form requested from the Claims Administrator and submitted to the Appeals Committee within 180 days of an Adverse Benefit Determination being issued, if any of the following apply**:**

(A) the Participant's treating physician certifies to the Appeals Committee on the Appeal Request Form that the Adverse Benefit Determination involves the Participant's Urgent medical condition;

(B) the Adverse Benefit Determination involves an admission, availability of care, continued stay or health care service for which the Participant received treatment for an Emergency Medical Condition, but has not yet been discharged from a facility;

(C) an "expedited" Internal Appeal Review is in process for an Adverse Benefit Determination of an Experimental or investigational treatment and the Participant's treating physician certifies to the Appeals Committee in writing that the recommended health care service or treatment would be significantly less effective if not promptly initiated.

The Participant or his Authorized Representative may also submit a request for an "expedited" External Appeal Review by facsimile or e-mail at PHCMbrSvcAppeals@ProMedica.org , by completing an Appeal Request Form, ensuring the appropriate box(es) relating to the "expedited" External Appeal Review request are checked and providing the Appeals Committee with any necessary certifications relating to the Participant's Urgent condition.

Requests for "expedited" External Appeal Reviews may also be made orally by a Participant or his Authorized Representative by calling the Appeals Committee and asking to speak to a member of the 'Appeals Team' due to an Urgent situation. Written confirmation of the oral request, the Participant's Urgent condition and any other certifications relating to the "expedited" External Appeal Review request must be submitted to the Appeals Committee no later than five (5) days after the oral request is made.

The Appeals Committee will initiate the External Appeal Review and notify the Participant, Authorized Representative or treating physician making the request, in writing, if the 'expedited' External Appeal Review request is complete and eligible for review. The notification shall also:

(A) include the name and contact information for the assigned IRO or the Ohio Department of Insurance (whichever is applicable) for the purpose of submitting additional information; and

(B) inform the Participant or his Authorized Representative that, within ten (10) business days after receipt of the notice, additional information in writing may be submitted to the IRO or the Ohio Department of Insurance (as applicable) for consideration in the review.

The Appeals Committee will forward all documents and information used in making the Adverse Benefit Determination to the IRO or the Ohio Department of Insurance (as applicable).

If the 'expedited' External Appeal Review is being conducted by an IRO:

(A) Upon receipt, the IRO must forward any additional information it receives from the Participant or his Authorized Representative to the Appeals Committee. The Appeals Committee may, at any time, reconsider and reverse the Adverse Benefit Determination; however, reconsideration will NOT delay or terminate the "expedited" External Appeal Review. If the Adverse Benefit Determination is reversed, the Appeals Committee shall notify the Participant or his Authorized Representative, the assigned IRO and the Ohio Department of Insurance within one (1) business day of making the decision. Upon receiving notice of the reversal from the Appeals Committee,

the IRO will terminate the Review.

(B) In addition to all documents and information considered and/or used in making the Adverse Benefit Determination, the IRO shall take into consideration factors such as: the Participant's medical records, the treating physician's recommendation, consulting reports from appropriate health care professionals, the Plan's terms and conditions and the most appropriate practice guidelines.

Written decisions in "expedited" External Appeal Reviews are normally provided to the Participant, Authorized Representative or treating physician making the request within seventy-two (72) hours of the Appeals Committee's receipt of a complete request for the "expedited" External Appeal Review. The decision made by an IRO shall be sent to the Appeals Committee and the Ohio Department of Insurance and shall include the following information:

(A) a general description of the reason for the request of the "expedited" External Appeal Review;

(B) the date the IRO was assigned to conduct the "expedited" External Appeal Review;

(C) the dates over which the "expedited" External Appeal Review was conducted;

(D) the date on which the IRO's decision was made;

(E) the rationale for the IRO's decision; and

(F) references to the evidence or documentation (including any evidence-based standards) that the IRO used or considered in reaching its decision.

Adverse Benefit Determination not eligible for External Appeal Review by IRO. If the Appeals Committee determines that the Adverse Benefit Determination is not eligible for External Appeal Review by an IRO, it shall so notify the Participant or his Authorized Representative, in writing. The notification shall provide the reason for the denial along with a statement that the denial may be appealed to the Ohio Department of Insurance.

The Ohio Department of Insurance may, in accordance with the terms of the Plan document and all applicable provisions of the law, determine that the Adverse Benefit Determination is eligible for External Appeal Review regardless of the Appeals Committee's decision and can require that the External Appeal Review take place.

Concurrent "expedited" Internal Appeal Review and "expedited" External Appeal Review. A Participant or his Authorized Representative may request an "expedited" Internal Appeal Review and an "expedited" External Appeal Review be conducted concurrently in cases where:

(A) the Participant has an Urgent medical condition; or

(B) in the judgment and expertise of the Participant's treating physician a proposed Experimental or investigational treatment must begin promptly.

The Participant or his Authorized Representative may submit the request for the concurrent "expedited" Reviews by requesting and completing a Appeal Request Form, **making sure the section relating to a concurrent "expedited" Internal Appeal Review and "expedited" External Appeal Review are**

properly completed and the Participant's treating physician has completed the "Treating Physician Certification Form for Internal Appeal and/or External Review".

The request for the concurrent "expedited" Reviews may be made in person, by mail or by facsimile or e-mail at PHCMbrSvcAppeals@ProMedica.org. The request may also be made orally by calling the Appeals Committee and asking to be transferred to a member of the 'Appeals Team' due to an Urgent situation. Written confirmation of the oral request and Urgent condition and any certifications must be submitted to the Appeals Committee no later than five (5) days after such a request is made.

Upon receiving a complete request for a concurrent "expedited" Reviews the Appeals Committee and the IRO will issue their decisions in accordance with the procedures described hereof in the sections captioned "**Expedited Internal Appeal Review**" and "**Expedited External Appeal Review**" within seventy-two (72) hours of the Appeals Committee receiving the complete request for the concurrent "expedited" Reviews.

Submitting additional information about a Participant's claim. A Participant may supply additional information regarding his claim for consideration during the appeal review. Any such information along with a copy of the 'explanation of benefits' must be sent to the Appeals Committee by regular mail, courier service (e.g. FedEx) or by facsimile.

Requesting copies of information relevant to the Participant's claim. The Participant or his Authorized Representative may request copies of information relevant to the Participant's claim free of charge. If a coding error is suspected of having caused the claim to be denied, the Participant or his Authorized Representative has the right to have billing and diagnosis codes provided to them. Copies of such information can be requested and obtained by contacting the Appeals Committee by mail, phone, facsimile or e-mail.

Binding nature of External Appeal Review decision. Any External Appeal Review decision, whether "standard", "expedited" or "concurrent", is binding on the Plan except to the extent the Plan has other remedies available under Ohio law. The decision is also binding on the Participant except to the extent the Participant has other remedies available under applicable Ohio or federal law.

A Participant may not file a subsequent request for any kind of External Appeal Review involving the same Adverse Benefit Determination that was previously reviewed unless new medical or scientific evidence is submitted to the Appeals Committee.

Further information about appeal rights. Further information regarding appeal rights and/or additional assistance regarding Plan appeals may be obtained from:

Ohio Department of Insurance
ATTN: Consumer Affairs
50 West Town Street, Suite 300, Columbus, OH 43215
800-686-1526 / 614-644-2673
614-644-3744 (fax)
614-644-3745 (TDD)
https://secured.insurance.ohio.gov/ConsumServ/ConServComments.asp

Consumer complaints may be filed at:
http://insurance.ohio.gov/Consumer/OCS/Pages/ConsCompl.aspx

APPEAL OF ELIGIBILITY OR PARTICIPATION ISSUES

An Eligible Employee who has been denied participation in the Plan or whose Eligible Dependents have been denied participation in the Plan may appeal the denial to the Plan Administrator (or the person or entity designated by the Plan Administrator to review and rule on appeals of denial of participation) by written application submitted to the Plan Administrator within sixty (60) days following the date of the denial of participation. Written appeals should be sent to: Board of Lucas County Commissioners, ATTN: Employee Benefits Manager, One Government Center, Suite 440, Toledo, OH 43604. The Eligible Employee may review pertinent documents related to the determination and submit issues and comments in writing to the Plan Administrator.

The Plan Administrator shall make a decision on the appeal within sixty (60) days of the date the written appeal is received by the Plan Administrator unless special circumstances require a sixty (60) day extension of the original sixty (60) day limit, in which case the Participant shall be notified of the extension. Within this period, the Plan Administrator or its designee shall notify the Participant of its decision, the reasons for it, and the provisions of the Plan which form the basis of the decision. In conducting its review, Plan Administrator may request Documentation from the Participant and/or provider. If the Plan Administrator fails to make a decision within the time provided, the appeal shall be deemed to be denied.

LIMITATION ON LEGAL ACTIONS

A Participant may not bring action in court against the Plan until all the applicable appeals procedures described above have been exhausted. In no event may a Participant 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.

XI. MISCELLANEOUS PROVISIONS

PLAN ADMINISTRATOR RESPONSIBILITIES

The Plan Administrator may delegate responsibilities for the operation and administration of the Plan as it, in its sole discretion, may deem necessary and/or proper. The Plan Administrator's responsibilities include those delegated to the Claims Administrator as set forth in an administration agreement and any addenda thereto.

CLAIMS ADMINISTRATOR, PLAN ADMINISTRATOR DISCRETION

The Claims Administrator alone shall be the sole judge of the standards of proof required in any matter hereunder other than matters regarding eligibility and/or participation. The Plan Administrator alone shall be the sole judge of the standards of proof regarding matters of eligibility and/or participation. The decisions of the Plan Administrator and/or the Claims Administrator shall be final and binding on the Participants, and all other persons and/or entities. The Plan Administrator shall have the full and exclusive power and authority, in its sole discretion, to determine all questions of Plan participation and eligibility and may demand such Documentation from the Employee as it deems reasonable and/or necessary to make its determination. The Claims Administrator shall have the full and exclusive power and authority to determine all questions regarding eligibility for benefits, methods of providing or arranging for benefits, payment of benefits and all other related benefit matters and may demand such Documentation from the Participant as it deems reasonable and/or necessary to make its determination. The Plan Administrator shall have the full power and authority, in its sole discretion, to construe and interpret the provisions and terms of this Plan document and all other written documents. Any such determination and any such construction adopted by the Plan Administrator in good faith shall be binding upon all the parties hereto and the beneficiaries thereof.

FAILURE TO ENFORCE

Failure of the Plan Sponsor, Claims Administrator or Plan Administrator or their designate(s) to enforce any provisions of this Plan does not constitute a waiver or otherwise affect the Plan Administrator's right to enforce such a provision at another time, nor will such failure affect the right to enforce any other provision.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

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

FACILITY OF PAYMENT

Whenever payments which should have been made under the Plan in accordance with its terms and conditions have been made under any other plan, the 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 Plan and, to the extent as such, payments for Covered Services, for which the Plan shall be fully discharged from liability.

RIGHTS OF RECOVERY

Whenever payments have been made by the 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 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 Plan shall determine: any Participants to whom or 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 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.

ASSIGNMENT OF MEDICAL BENEFITS

Participants may not assign benefits under this Plan, except by consent of the Plan Administrator, to other than suppliers of medical services.

EXAMINATION

The Plan Sponsor shall have the right and opportunity to have the Participant 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.

WORKER'S COMPENSATION NOT AFFECTED

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

PLAN MODIFICATION AND AMENDMENT

The Plan Sponsor reserves the right, subject to Federal Law, to terminate, change or amend the Plan by a written instrument.

PLAN IS NOT A CONTRACT

The Plan shall not be deemed to constitute a contract between an Employer and any Employee or be a consideration for, or an inducement or condition of, the employment of an Employee. Nothing in the Plan shall be deemed to give an Employee the right to be retained in the service an Employer or to interfere with the right of an Employer to discharge any Employee or 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 Plan Sponsor with the bargaining representatives of any Employee.

HEADINGS

The heading of articles and sections herein are included solely for convenience of reference and shall not affect the meaning of any of the provisions of the Plan.

NOTICE

Any notice required to be given under this 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 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 Participant has received Covered Services from a non-Participating Provider, the proof of the claim must be submitted to the Plan ***within one year*** after the date such claim is incurred. Proof of claims includes the following:

(A) An itemized bill for the service or supply must be furnished to the 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.

(B) If the Claims Administrator requests information from the Participant, the Participant must furnish such information as requested.

(C) If the Claims Administrator requests information from a provider and the provider does not furnish the requested information, the Participant will be required to obtain the requested information and furnish it to the Claims Administrator.

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

The Claims Administrator, on behalf of the Plan, will make decisions on initial claims no later than:

(D) 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 processed within 48 hours.

(E) 15 days for pre-service claims.

(F) 30 days for post-service claims.

(G) One 15-day extension for pre- and post-service claims is provided due to circumstances beyond the 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 Plan does not ultimately pay medical expenses which are eligible for payment under the Plan for any reason, Participants covered under the Plan may be liable for such expenses.

ACTIONS

No action at law or in equity shall be brought to recover from the Plan prior to the expiration of 60 days after proof of loss has been filed in accordance with the requirements of the 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 Plan.

SEVERABILITY

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

PLAN CONSTRUCTION

This Plan shall be construed in accordance with applicable state and federal law.

Whenever any words are used herein in the masculine, they shall be construed as though they were in the feminine in all cases where they would so apply; and whenever any words herein are used in the singular, they shall be construed as though they were used in the plural in all cases where they would so apply.

If any provision of this Plan is contrary to any state or federal law to which it is subject, such provision is hereby amended to conform thereto.

GOVERNING LAW

This Plan shall be governed in all respects by the laws of the State of Ohio or where applicable, federal law.