Swanton Local School District
Medical, Prescription Drug Card
And Dental Benefits

Administered through
Jefferson Health Plan
Effective June 1, 2015

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Grandfathered Health Plan

Paramount & CVS/Caremark and RxBenefits believe this plan is a “non-grandfathered health plan” under the Patient Protection Affordable Care Act (PPACA). The PPACAA law requires that when there is a significant plan change including Swanton School’s recent employee payroll deduction contribution increase that the plan be categorized as a non-grandfathered health plan. This change in plan status requires that certain benefits be included. In the case of Swanton Schools, the only benefit change to be compliant with PPACA is that preventive/wellness health care services will now be covered at 100% without cost share by the employee. This change is effective February 1, 2012. Previously, the Swanton Schools covered preventive/wellness health care services at 100% with $20 copay.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Paramount Health Care at (419) 887-2525; toll-free 1-800-462-3589. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

This is a new summary of benefits format for the purpose of illustrating consistency with the Affordable Care Act Summary of Benefits & Coverage. This new format describes the plan member's cost share shown in dollars and percentages, rather than a combination of the employee cost share and what the plan pays.

Benefit Provisions	***Paramount***	
	Requires PCP selection	
	In Network**	***Out of Network******
Waiting Period and Eligibility	Coverage begins on date employee satisfies eligibility requirements	
Dependents covered	Spouse, Children to the limiting age of 26 if the child meets the requirements of the Patient Protection Affordable Care Act (PPACA). Coverage ends at the end of the calendar year the child attains either of the ages specified above. Please refer to the Eligibility section for details.	
Deductible *	$100 from September 1 to August 31	$500 with cross application from September 1 to August 31
Family Deductible *	$200 from September 1 to August 31	$1,000 with cross application from September 1 to August 31
Coinsurance Out-of-Pocket Limits	$1,000 per person; $2,000 per family from September 1 to August 31	$3,000 per person; $6,000 per family from September 1 to August 31
Copay Out-of-Pocket Limits	$1,000 per person; $2,000 per family from September 1 to August 31	$1,000 per person; $2000 per family from September 1 to August 31
Medical Out-of-Pocket Limits(OOPL) (includes the medical plan deductible, coinsurance & copays)	$2,100 per person; $4,200 per family from September 1 to August 31	$4,500 per person; $9,000 per family with cross application from September 1 to August 31
Lifetime & Annual Benefit Limits	unlimited	
Coinsurance Levels	20% Paid by plan members, 80% paid by the plan	40% Paid by plan members, 60% paid by the plan
Pre-Certification	Required, doctor's responsibility	Required, patient's responsibility
Member Non-Notification Penalty	Not Applicable	$200 Inpatient***
Inpatient Hospital	20% after deductible, subject to the OOPL	40% after deductible, subject to the OOPL
Surgery	20% after deductible, subject to the OOPL	40% after deductible, subject to the OOPL

Benefit Provisions	Paramount	
	Requires PCP selection	
	In Network**	Out of Network***
Urgent Care	0% after $50 copay, no deductible	0% after $50 copay, no deductible
Emergency Room Visit	0% after $125 copay, no deductible	0% after $125 copay, no deductible
PCP Office Visit	0% after $20 copay not subject to the deductible	Not Covered
Specialist Office Visit	0% after $40 copay not subject to the deductible	40% after deductible, subject to the OOPL
Diagnostic Lab & X-ray	20% after deductible, subject to the OOPL	40% after deductible, subject to the OOPL
Well Child Preventative	0% no copay or other cost share	Not Covered
Adult Preventative Care	0% no copay or other cost share	Not Covered
Screenings for Mammography, Pap Smears & PAP Tests	0% no copay or other cost share	Not Covered
Inpatient Mental Nervous	20% after deductible, subject to the OOPL	40% after deductible, subject to the OOPL
Outpatient Mental Nervous	0% after $20 copay, not subject to deductible	40% after deductible, subject to the OOPL
Inpatient Substance Abuse	20% after deductible, subject to the OOPL	40% after deductible, subject to the OOPL
Outpatient Substance Abuse	0% after $20 copay, not subject to deductible	40% after deductible, subject to the OOPL
Voluntary Sterilization	20% after the deductible, subject to the OOPL	40% after deductible, subject to the OOPL
Ambulance	20% after the deductible, subject to the OOPL	20% after deductible, subject to the OOPL
Home Health Care	20% after the deductible, subject to the OOPL, limited to 100 visits/benefit year, cross applied	40% after the deductible, subject to the OOPL, limited to 50 visits/benefit year, cross applied
	Maximum of 100 combined visits/benefit year	
Durable Medical Equipment	20% after the deductible, subject to the OOPL	40% after deductible, subject to the OOPL
Temporomandibular Joint Dysfunction	20% after the deductible, subject to the OOPL	Not Covered
Skilled Nursing Facility	20% after the deductible, subject to the OOPL, limited to 100 visits/year	40% after the deductible, subject to the OOPL, limited to 50 visits/benefit year, cross applied
Hospice	20% after the deductible, subject to the OOPL	20% after the deductible, subject to the OOPL

Benefit Provisions	Paramount Requires PCP selection	
	In Network	***Out of Network****
Chiropractic Services	0% after $20 copay, limited to 20 visits/benefit year	40% after the deductible, subject to the OOPL, limited to 10 visits/benefit year, cross applied
Eye Exams (Routine)	% no copay or other cost share	Not Covered
Hearing Exams	0% after $20 copay	Not Covered
Radiotherapy	20% after deductible, subject to the OOPL	40% after deductible, subject to the OOPL
Speech Therapy	0% after $20 copay, limited to 20 visits/benefit year	40% after deductible, subject to the OOPL and limited to 10 visits/year, cross applied
Outpatient Physical & Occupational Therapy	0% after $20 copay, limited to 30 visits/year	40% after deductible, subject to the OOPL and limited to 15 visits/benefit year, cross applied
Outpatient Inhalation Therapy	20% after deductible, subject to the OOPL	40% after deductible, subject to the OOPL
Chemotherapy	20% after deductible, subject to the OOPL	40% after deductible, subject to the OOPL
Outpatient Cardiac	20% after deductible, subject to the OOPL	40% after deductible, subject to the OOPL
Human Organ Transplant	0%	Not Covered

Prescription Drugs & Mail Order (administered by Caremark)	Employee pays 10% for generic, 20% for preferred brand, 30% for non-preferred brand and multi-source brand
Prescription Drug Coinsurance Out-of-Pocket Limits (effective June 1, 2015)	$4,000 per person; $8,000 per family from September 1 to August 31

Dental Benefits	There is no dental provider network. Administered by Self-Funded Plans, Inc.	
Calendar Year Deductible	None	
Type I - Preventive Services	0%	
Type II - Minor Restorative Services	20%	
Type III - Major Restorative Services	40%	
Type IV - Orthodontic Services	40%	
Maximum Annual Benefit Per Calendar Year Per Person for Type I, II & III Services	$2,000	
Maximum Annual Benefit Per Calendar Year Per Person for Type IV Services	$1,500	

Special Provisions
**** Cross application or cross applied means that the out-of-network deductible, coinsurance limit and out-of-pocket limit will satisfy the in-network deductible, coinsurance and out-of-pocket limit. However, the in-network deductible, coinsurance and out-of-pocket limit will not satisfy the out-of-network deductible, coinsurance and out-of-pocket limit.***
***** Primary Care Provider (PCP) designation is required to receive In-Network Benefits.***
****** A member must call Utilization Review at 1-800-891-2549 (also shown on your id card) to notify of non-emergency out-of-network hospital admission. Failure to make the call will result in a $200 penalty. When an out-of-network provider is being used for covered services, the member is responsible for call Paramount for pre-notification.***

ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE

New Eligible Employees who are enrolled will be covered on the date they become Eligible Employees. If an Employee fails to enroll within thirty-one (31) days of becoming eligible, he will be treated as a Late Enrollee.

Eligible Employees who return to work following a tour of active duty in a United States Military Reserve Unit will be covered on the date they return to work. Such Eligible Employees will continue to be covered under the Plan as if there had been no break in service, and a new Pre-Existing Condition Limitation will not apply to such Eligible Employees or their Eligible Dependents.

Coverage must be in effect for an Eligible Employee in order for coverage to take effect for an Eligible Dependent.

Eligible Dependents who are enrolled will be covered on the same date as the Eligible Employee or the date such dependent is acquired (whichever is later), subject to the terms described in the following paragraphs. If an Eligible Dependent is not enrolled within thirty-one (31) days of becoming eligible, the Eligible Dependent will be treated as a Late Enrollee upon subsequent enrollment in the Plan, unless he is a Special Enrollee.

If two Eligible Employees are married to each other, and one is covered as an Eligible Dependent of the other, if the Eligible Employee who is carrying the dependent coverage terminates, coverage can be transferred to the Eligible Dependent who is still an Eligible Employee, and no waiting period or new pre-existing condition limitation will apply, provided coverage is continuous. Credit will be given toward maximums, deductible, etc.

If an employee's spouse and adult dependent child are eligible or in the future ever become eligible for a health plan through his/her employer, that spouse must enroll in his/her employer's health plan. You are not required to enroll other family members in the spouse's plan. The spouse and adult dependent child can be covered on this plan as secondary coverage. The appropriate form must be completed. Swanton Local Schools reserves the right to have the employee complete an audit questionnaire.

In accordance with Ohio Revised Code 3313.202 Board of Education members of the school district's board including their spouse and children are eligible to enroll in the health plan. This is at the option of the board member. The member shall pay all premiums (or accrual payments) for the coverage starting in the month prior to the coverage beginning. The board member must submit their request in writing and must be announced and recorded for public record in the minutes of the board. The board member is eligible as of the date they begin their official capacity, which for newly elected or re-elected board member is January 1st. It is possible that a board member is filling vacant board seat at a date other than January 1st. The board member has the same 31-day enrollment period beginning on the date they are first eligible. The board member electing coverage must enroll in medical and prescription drug coverage together. If a board member chooses not to enroll when first eligible, they must wait until the School Board's annual open enrollment period or the date of a qualifying event which causes them to lose their current health coverage.

Coverage will terminate at the end of the month that the board member ceases to hold their position as a board member. In most insistences this date is December 31st. A board member will be afforded, if covered under the plan, the same rights as a regular employee for continuation of coverage under COBRA.

All other provisions of this plan document will also apply to board members and their covered family members as it applies to active employees under the plan.

Open Enrollment Period

In the event that an Eligible Employee or Eligible Dependent is a Late Enrollee, he may complete enrollment paperwork during the annual open enrollment period specified by the Plan Administrator (it is a 30-day period to be announced each year) and coverage will be effective on the September 1st.

Special Enrollee with Respect to Loss of Other Coverage.

An Eligible Employee and/or Eligible Dependent(s) may be enrolled as Special Enrollees if they are eligible (but not enrolled) for coverage under the terms of the Plan and when enrollment in the Plan was previously offered the Eligible Employee declined coverage and stated in writing that coverage under another group health plan or other health insurance coverage was the reason for declining enrollment;

A Special Enrollee described in paragraph above is eligible to enroll in the Plan if, when enrollment in the Plan was declined, the Special Enrollee had COBRA continuation of coverage under another plan and the COBRA continuation of coverage under that other plan has since been exhausted; or if the other coverage that applied to the Special Enrollee when enrollment was declined was not under a COBRA continuation of coverage provision, either the other coverage has been terminated as a result of loss of eligibility for the coverage, the other coverage requires our employee to elect primary coverage under our plan or Employer contributions towards the other coverage have been terminated. For the purposes of this paragraph, "loss of eligibility for coverage" includes a loss of coverage as a result of legal separation, divorce, death, termination of employment, reduction in the number of hours of employment and any loss of eligibility after a period that is measured by reference to any of the foregoing. However, loss of eligibility does not include a loss due to failure of an individual to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or intentional misrepresentation of a material fact in connection with the Plan).

For purposes of this paragraph, exhaustion of COBRA continuation of coverage means that an individual's COBRA continuation of coverage ceases for any reason other than the failure of the individual to pay premiums on a timely basis or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the Plan). An individual is considered to have exhausted COBRA continuation of coverage if such coverage ceases (a) due to the failure of the Employer or other responsible entity to remit premiums on a timely basis, or (b) when the individual no longer resides, lives or works in a service area of an HMO or similar program (whether or not within the choice of the individual) and there is no other COBRA continuation of coverage available to the individual. Proof of Special Enrollee status is required.

In the event of the enrollment of a Special Enrollee as described above, the Eligible Employee is required to enroll himself or his dependents (who are Special Enrollees), not later than thirty-one (31) days after the exhaustion or termination of the other coverage. Coverage for such Special Enrollees will be effective on the day following loss of coverage.

Special Enrollee with Respect to Certain Eligible Dependents.

a. An Eligible Employee may enroll as a Special Enrollee if he is eligible (but not enrolled) for coverage under the terms of the Plan and he would be a Covered Person in the Plan but for a prior election by him not to enroll in the Plan and he acquires an Eligible Dependent through marriage, birth, adoption or Placement for adoption.
b. An Eligible Dependent who is the spouse of the Eligible Employee may enroll as a Special Enrollee if the Eligible Dependent becomes the spouse of the Eligible Employee or the Eligible Employee and the Eligible Dependent are married and a child becomes an Eligible Dependent of the Eligible Employee through birth, adoption or Placement for adoption.
c. An Eligible Employee and an Eligible Dependent who is the Eligible Employee's spouse may enroll as Special Enrollees if the Eligible Employee would be a Covered Person in the Plan but for a prior election by the Eligible Employee not to enroll in the Plan and either the Eligible Dependent and the Eligible Employee become married or the Eligible Employee and Eligible Dependent are married and a child becomes an Eligible Dependent of the Eligible Employee through birth, adoption or Placement for adoption.
d. An Eligible Dependent who is a dependent child of the Eligible Employee may enroll as a Special Enrollee if the Eligible Dependent becomes an Eligible Dependent of the Eligible Employee through marriage, birth, adoption or Placement for adoption.
e. An Eligible Employee and an Eligible Dependent who is a dependent child of the Eligible Employee may enroll as Special Enrollees if the Eligible Employee would be a Covered Person in the Plan but for a prior election by the Eligible Employee not to enroll in the Plan and the Eligible Dependent becomes an Eligible Dependent of the Eligible Employee through marriage, birth, adoption or Placement for adoption.
f. An Eligible Dependent child qualifies under the Ohio Revised Code 1751.14 (State of Ohio Dependent Eligibility Rule) for continued health coverage if certain requirements are met until the dependent child is 28 years of age. Those requirements are as follows: The child must be unmarried. The child must be a natural child, stepchild, or adopted child of the insured. The child is a resident of Ohio or a full-time student at an accredited higher education institution in Ohio or in another state. The child is not eligible for employer-sponsored coverage. The child is not eligible for coverage under Medicaid or Medicare. This continued coverage applies to medical, prescription drug card and dental. A separate premium in addition to the employee's regular payroll premium deduction must be paid for this coverage extension.

In the event of the enrollment of a Special Enrollee described in paragraphs a through e above, the Eligible Employee is required to enroll himself or his dependents (who are eligible to enroll as Special Enrollees), not later than thirty-one (31) days after the date of the marriage, birth, adoption or Placement for adoption. In the event of

the enrollment of a Special Enrollee described in paragraph d above who is a Special Enrollee for the reason of his birth, the Eligible Employee is required to enroll such Special Enrollee not later than one (1) year following the date of birth provided the Eligible Employee was already enrolled for dependent coverage. Proof of Special Enrollee status is required. Coverage for such Special Enrollees will be effective as follows:

i. Special Enrollees who enroll as Special Enrollees due to the birth, adoption or Placement for adoption of an Eligible Dependent will be Covered Persons from the moment of birth, adoption or Placement for adoption of the Eligible Dependent.
ii. Special Enrollees who enroll as Special Enrollees due to marriage of an Eligible Dependent to an Eligible Employee will be Covered Persons from the date of marriage.

If a dependent is acquired other than at the time of his birth, due to a court order or decree, that dependent will be considered an Eligible Dependent of the Eligible Employee from the date of such court order or decree, provided this new dependent is properly enrolled as a dependent of the Eligible Employee within thirty-one (31) days of the court order or decree. However, if a dependent child is acquired as a result of adoption, that child will be covered the day he is placed with the adopting parents during the period before the adoption becomes final.

Michelle's Law for Continued Health Coverage While a Full-Time Student

If a child qualifies as an Eligible Dependent due to being a Full-Time Student (which will typically happen if the child is extending coverage under the Ohio Revised Code 1751.14 [State of Ohio Dependent Eligibility Rule], and such child is forced to take a Medically Necessary Leave of Absence from school due to a serious Illness or Injury, coverage can be continued for such Eligible Dependent. A "Medically Necessary Leave of Absence" is defined as a leave of absence from a post-secondary educational institution (including an institution of higher education as defined in section 102 of the Higher Education Act of 1965) or any other change in enrollment at such an institution that begins while the student is suffering from a serious Illness or Injury; is Medically Necessary; and causes the student to lose student status for purposes of coverage under the terms of the Plan. Coverage will be continued until one year after the first day of the leave of absence or the date coverage would otherwise terminate under the terms of the Plan, whichever comes first. The Plan must receive a written certification by the treating Physician of the dependent child which states that the child is suffering from a serious Illness or Injury and that the leave of absence is Medically Necessary. The child taking the leave described herein is entitled to the same benefits as if the child had continued to be covered as a student who did not take leave. This Plan provides no greater rights than what Michelle's Law requires (nothing in this Plan is intended to expand the rights of any participant beyond the law's requirements). If Michelle's Law is amended, this Plan will follow such legislation

TERMINATION OF COVERAGE

The coverage of any Covered Person shall terminate on the earliest of the following dates:

1. The date of termination of the Plan.
2. if employment terminates due to the death of the Eligible Employee, Dental Benefits will be continued for the family members covered on the date of death, without payment of premiums, until the earliest of the following dates:
   a. remarriage of the surviving spouse, in which case the coverage for all family members terminates;
   b. the date a family member ceases to qualify as an Eligible Dependent for any reason other than lack of primary support by the Eligible Employee;
   c. two years from the date of the Eligible Employee's death.
3. The date all coverage or certain benefits are terminated on a particular class by modification of the Plan.
4. The date the Employee fails to make any required contribution for coverage.
5. With respect to an Eligible Dependent, the date coverage terminates for the Eligible Employee or the date such Dependent no longer meets the qualifications of an Eligible Dependent.
6. Coverage ends for employees and dependents as shown below:

   a. Coverage Ending Date When Employee Terminates Employment: At the end of the month that employment terminated.
   b. Spouse Termination Date: The end of the month that the spouse is no longer considered an eligible spouse.

c. Dependent Children Termination Date: Children will be considered as Eligible Dependents from the end of the calendar year in which they attain age twenty-six (26) and to the end of the calendar year in which they attain age twenty-eight (28) if coverage is being extended under Ohio Revised Code 1751.14.

THE POINT-OF-SERVICE PLAN

The Point-of-Service Plan is a plan that offers you a broad selection of Paramount (In-network) providers through Paramount's Health Maintenance Organization (HMO) under In-Network Coverage. It also offers the flexibility to choose to receive Covered Services from other providers of health care with benefits under Out-of-Network Coverage.

In-Network and Out-of-Network Deductible

The Deductible is the amount you must pay for Covered Services within each Benefit Year before In-Network and Out-of-Network benefits will be paid by Paramount. The single Deductible is the amount each Member must pay; the family Deductible is the amount any two or more covered family members must pay. Covered Services with a fixed dollar Copayment is not subject to the In-Network or Out-of-Network Deductible. The In-Network Deductible applies to all In-Network Covered Services rendered by In-Network Providers and the Out-of-Network Deductible applies to all Out-of-Network Covered Services rendered by Out-of-Network Providers, except where indicated on the Schedule of Medical Benefits.

In-Network and Out-of-Network Copayments or Coinsurance

Benefit Plan members pay Copayments (copays) or Coinsurance for In-Network and Out-of-Network services. See your Schedule of Medical Benefits for In-Network and Out-of-Network Copayments and Coinsurance due for specific services. In-Network Coinsurance is a percentage of Paramount's allowed amount when services are performed by In-Network Providers. **Out-of-Network Coinsurance is a percentage of the Reasonable & Customary (R&C) when services are provided by Out-of-Network Providers.** If the charge billed is greater than the R&C, You are responsible for the difference. Copayments are payable at the time you receive services. If a Coinsurance is applicable, the provider will bill the Member once the claim has been processed.

In-Network and Out-of-Network Medical Coinsurance Limit

The In-Network and Out-of-Network Coinsurance Limit is the maximum amount of Coinsurance you pay every Benefit Year for Covered Services. The single Coinsurance Limit is the amount each Member must pay, and the family Coinsurance Limit is the total amount any two or more covered family members must pay. The expenses incurred for Covered Services received from In-Network Providers apply toward satisfying the In-Network Coinsurance Limit and the expenses incurred for Covered Services received from Out-of-Network Providers apply toward satisfying the Out-of-Network Coinsurance Limit. Copayments, pre-notification penalties and charges in excess of R&C do not apply to the Coinsurance Limits. Once the Coinsurance Limit is met, there will be no additional Coinsurance during the remainder of the Benefit Year**.** The In-Network and Out-of-Network Coinsurance Limit is stated in your Schedule of Medical Benefits.

Out-of-Pocket Maximum for In-Network and Out-of-Network

The In-Network and Out-of-Network benefit each have their own Out-of-Pocket Maximums which is the sum of the deductible, medical coinsurance and medical copays. The Schedule of Benefits section states the Out-of-Pocket Maximum for single and family. Cross application or cross applied means that the out-of-network deductible, coinsurance limit, copays and out-of-pocket limit will satisfy the in-network deductible, coinsurance and out-of-pocket limit. However, the in-network deductible, coinsurance and out-of-pocket limit will not satisfy the out-of-network deductible, coinsurance and out-of-pocket limit. Starting in June 2015, there will be a separate Prescription Drug Out-of-Pocket Maximum. The Aggregate Out-of-Pocket is the sum of the medical out-of-pocket maximum and the prescription drug out-of-pocket maximum.

Lifetime and Annual Dollar Limits

The Essential Health Benefits that may be provided by your Plan have unlimited lifetime and annual dollar limit. Plan benefits that are not defined as Essential Health Benefits may have a lifetime dollar limit. If you have reached a lifetime dollar limit under your Plan before the federal regulation prohibiting lifetime dollar limits for Essential Health Benefits became effective, and you are still eligible under your Plan's terms, and that Plan is still in effect, you will receive a notice that the lifetime dollar limit no longer applies and that you will have an opportunity to enroll or be reinstated under your Plan. If you are eligible for this enrollment opportunity, you will be treated as a special enrollee.

THE BASICS OF IN-NETWORK COVERAGE

Your Primary Care Provider is your first contact when you need medical care. Your PCP will coordinate your medical care with other Participating Providers in the Paramount network. Female Members may get receive OB/GYN care from a participating obstetrics/gynecology specialist without a 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.

WHO TO CALL FOR INFORMATION

The Paramount Member Services Department will help you.

Call, if you:

- Have any questions about your coverage
- Have questions about the providers who participate with Paramount
- Have questions about how to obtain health care services
- Need help understanding how to use your benefits
- Need to change your Primary Care Physician
- Lose your Paramount identification card
- Or have any other health care coverage concerns

GETTING A DOCTOR'S CARE

Start with Your Primary Care Physician (PCP)
Your PCP is the doctor you chose to handle your medical care through your HMO Benefit Plan. Each family member can have a different PCP.

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

For doctor appointments, call your PCP's office.

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

Type of Care Required	Recommended Lead Time
Routine assessments, physicals or new visits	Call 30 days in advance
Routine follow-up visits (for recurring problems related to chronic ailments like high blood pressure, asthma, diabetes, etc.)	Call 14 days in advance
Symptomatic, non urgent (cold, sore throat, rash, muscle pain, headache)	Call 2-4 days in advance
Urgent medical problems (unexpected illnesses or injuries requiring medical attention soon after they appear; urgent care problems are not permanently disabling or life-threatening; an example would be a persistent high fever)	Call 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. Call your physician and/or Paramount within 24 hours, or as soon as possible.

ACCESS STANDARDS for BEHAVIORAL HEALTH CARE SERVICES	
TYPE OF CARE REQUIRED	**RECOMMENDED LEAD TIME**
Routine Care/ Office Visit for new problems upon request of the member or provider	Call 14 days in advance
Routine Care/ Office Follow-Up Visits	Call 30 days in advance
Urgent Care, may not be life-threatening, but requires immediate attention (complex or dual problems)	48 hours in advance
Emergency Care, immediate threat to self or others (acutely suicidal or homicidal)	Immediately call 911 or seek medical treatment. Call your physician and/or Paramount within 24 hours, or as soon as possible.

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

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

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

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

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

What are the "medically necessary" guidelines?

The service you receive must be:

1. Needed to prevent, diagnose and/or treat a specific condition.

2. Specifically related to the condition being treated or evaluated.

3. Provided in the most medically appropriate setting; that is, an outpatient setting must be used, rather than a hospital or inpatient facility, unless the services cannot be provided safely in an outpatient setting.

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

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

If you need specific information about the qualifications of any In-Network physicians or specialists, you may call the Academy of Medicine. You also can call any of the physician's referral services listed in the *Participating Physicians and Facilities* directory available through the Paramount website at: www.paramounthealthcare.com.

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

When You Need OB/GYN Care

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

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

Obtaining Care from a Specialist

Most of your health care needs can and should be handled by your Primary Care Physician. If your Primary Care Provider believes you need a specialist - a cardiologist, orthopedist or others - your Primary Care Physician will recommend a Participating Specialist. Or you may choose the Participating Specialist you wish to see from those listed in the Participating Physicians and Facilities directory (also available on the website) and make an appointment. Remember, it is the patient responsibility to verify if the Specialist participants in the Paramount provider network in order to maximize your benefits and to avoid the out-of-network higher costs.

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

Prior Authorizations

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

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

Utilization Management

Participating physicians and providers have direct access to Paramount's Utilization Management Department to authorize specific procedures and certain other services based on medical necessity. It is the responsibility of the In-Network physician or provider to obtain Prior Authorization when required. If you experience an Emergency Medical Condition after normal office hours, you should call 911, an ambulance or rescue squad or go to the nearest medical facility. You do not need to obtain prior approval from your PCP or Paramount. You should notify your Primary Care Physician as soon as reasonably possible that you were treated.

Utilization management decisions are not subject to incentives to restrict or deny care and services. In fact, Paramount monitors under-utilization of important preventive services, health screening services (immunizations, pap tests, etc.), medications and other services to care for chronic conditions, such as asthma and diabetes. Paramount will send reminder cards to the Member and physician if a claims review suggests that important services were missed.
If you need to discuss the status of a Prior Authorization, you should contact your Primary Care Provider. You may also call the Member Services Department at (419) 887-2525 or toll-free 1-800-462-3589.

In-Network Coverage Available with Prior Approval

In some cases, your In-Network Primary Care Physician may request In-Network Coverage for services from an Out-of-Network Provider (See Special Referrals). Services from Out-of-Network Providers may be covered under In-Network Coverage only with prior written approval from Paramount's Utilization Management Department. Both the Primary Care Physician's request and Paramount's response must be made prior to the services being provided. In-Network Coverage will be available for Out-of-Network Providers for Emergency Medical Conditions and when Paramount has prior approved. If the requested services are available from In-Network Providers, the request for In-Network Coverage will be denied.

Initial Determinations

When Prior Authorization is required, Paramount will make a decision within two (2) working days from obtaining all the necessary information about the admission, or procedure that requires Prior Authorization. Paramount will advise the provider of the decision by telephone within one (1) working day after making the decision. Paramount will send written confirmation of the decision to the provider and the Member within two (2) working days of making the telephone notification.

Paramount will notify the requesting provider by telephone within one (1) working day after making the decision. Paramount will send written confirmation of the decision to the provider and the Member within one (1) working day of the telephone notification. If Paramount does not make a determination within the required timeframe, the Member may request an internal review.

Adverse Determinations

Paramount's written notification will include the principal reason/s for the decision including specific utilization review criteria or benefit provision used in making the determination. Paramount will also include instructions for requesting a written statement of the clinical rationale used to make the decision. Paramount will provide a written statement of the clinical rationale to any Authorized Person making the request and following the instructions.

Leaving the Hospital "Against Medical Advice"

If you discharge yourself from any hospital or facility *"against medical advice"* (AMA), there will be a penalty on all charges related to that admission. Also, if a hospital or facility requires your discharge (a "*disciplinary discharge"*) for any reason, you will be responsible for a penalty on all charges related to that admission. The total of your copays (if any) and the penalty will not exceed 40% of the average cost of covered services on medical admissions and 50% of the average cost of covered services on substance abuse admissions.

If a Provider Leaves the Plan

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

If a Specialist Leaves the Plan

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

Provider Reimbursement

You should always show your Paramount ID card to all providers. You are responsible for paying any office visit Copayments at the time you receive services. Participating Providers must notify Paramount of the services they have rendered within 90 days from the date of service.
If you have received services from a non-participating provider, it is your responsibility to submit a claim for consideration. You must obtain a standard claim form from the provider and send the claim to Paramount at the address below *within 120 days from the date of the service*. Be sure to include your Paramount ID number and a brief explanation of the circumstances related to the service.

Paramount Health Care
P.O. Box 928
Toledo, Oh 43697-0928

Paramount will send reimbursement directly to Participating Providers for Covered Services. In most cases, reimbursement for Covered Services will be sent directly to a non-participating provider, but instead may be paid directly to you. Claims are processed within 30 days from receipt of a fully completed claim. If any claim is denied, Paramount will send you an "Explanation of Benefits" with the reason for the denial. If you receive a denial on a claim and need further explanation or wish to appeal the denial, you may call the Member Services Department for assistance. The appeal process is also described in Section 6 of this Handbook.

Non-Covered Services

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

If You Receive a Bill

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

New Technology Assessment

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

Privacy and Confidentiality

Paramount will keep all documented Member medical and personal information, whether obtained in writing or verbally, in the strictest confidence in accordance with HIPAA Privacy/Security

Standards. Paramount will provide Members with the opportunity to approve or deny the release of identifiable personal information, except when such release is required by law.

Insurance Fraud

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

WHAT TO DO FOR URGENT CARE OR EMERGENCY MEDICAL CONDITIONS

Urgent Care Services

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

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

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

What to do:

During office hours: Call your Primary Care Provider 's office as soon as symptoms persist or worsen. In most cases, your PCP will be able to treat you the same day or the next day. If the office cannot schedule you within a reasonable time, you may seek treatment at a participating urgent care facility or physician's office. The service will be subject to an urgent care facility or office visit copay, depending on where you receive treatment. Your Copay/Coinsurance may be found in your Summary of Benefits.
Participating providers are listed in your Directory of Participating Physicians and Facilities or the Paramount web site at www.paramounthealthcare.com.
After office hours: Call the telephone number of your Primary Care Provider and ask the answering service to have your doctor call you back. When the doctor or a nurse calls back, explain your condition and the doctor or nurse will give you instructions.

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

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

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

Emergency Services

"Emergency Services" which are required as the result of an "Emergency Medical Condition" are covered at any medical facility, anytime, anywhere without prior authorization. The service will be subject to an emergency room, urgent care facility or office visit copay, depending on where you receive treatment. Your copay may be found in your Schedule of Medical Benefits.

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

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

"Emergency Services" mean the following:

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

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

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

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

a. Due to circumstances beyond the Member's control, the Member was unable to utilize a participating facility without serious threat to life or health.

b. A prudent layperson with an average knowledge of health and medicine would reasonably have believed that the time required to travel to a participating facility could result in one or more adverse health consequences described under Emergency Medical Condition above.

c. A Paramount representative refers the Member to an emergency room and does not specify a participating emergency room.

d. An ambulance takes the Member to a non-participating facility other than at the direction of the Member.

e. The Member is unconscious.

f. A natural disaster prevented the use of a participating facility.

g. The status of a participating emergency facility changed to a non-participating emergency facility and Paramount did not inform the Member of the change.

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

What to do:

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

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

Follow-up care within the Service Area: Follow-up medical care must be arranged by your Primary Care Provider with participating providers.

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

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

The Paramount Service Area

The Paramount Service Area includes all of Ashland, Crawford, Defiance, Erie, Fulton, Hancock, Henry, Huron, Lucas, Marion, Morrow, Ottawa, Putnam, Richland, Sandusky, Seneca, Williams, Wood, and Wyandot counties, and portions of Allen, Delaware, Hardin, Knox, Lorain and Paulding counties in Ohio and Monroe and Lenawee counties in Michigan. Paramount may periodically add or remove certain counties from their service area. Benefit Plan Participants should contact Paramount Member Services for an updated listing of the Paramount Service Area.

THE BASICS OF OUT-OF-NETWORK COVERAGE

Under Out-of-Network Coverage, you will have to pay higher Deductibles, Copayments and Coinsurance and call for prior notification on Inpatient admissions.

For Out-of-Network Hospital Providers in Lucas County, Paramount pays for benefits based on the lesser of the Reasonable & Customary Amount that is determined payable by Paramount or the actual charge for the service. For all other Out-of-Network Hospitals, Physicians and Providers, Paramount pays for benefits based on the lesser of the Reasonable & Customary (R&C) charge or the actual charge for the service**.**

Out-of-Network Pre-Notification Requirements

When you are using your In-Network PCP and In-Network Providers for covered services, **the In-Network Providers** are responsible for handling any necessary authorizations from Plan Supervisor, Paramount. **When you use Out-of-Network providers for Out-of-Network Coverage, you are responsible for calling Paramount prior to receiving the services below:**

- All elective Inpatient Hospital admissions including;
  - Maternity
  - Inpatient Rehabilitation
  - Inpatient mental health
  - Inpatient chemical dependency
  - Skilled Nursing Facility admissions

You should call the Paramount Utilization Review Department toll-free at 1-800-891-2549 for pre-notification.

If you do not call Paramount when required, you will have a penalty of $200 per Out-of-Network admission.

WHAT IS COVERED & WHAT IS NOT COVERED

What Is Not Covered under <u>In-Network Coverage</u>

These services and supplies are not covered ***under In-Network Coverage***:

1. Services by providers chosen only for convenience (for example, if you use an Out-of-Network X-ray or lab provider because their offices are nearby, the benefit will be payable under Out-of-Network Coverage).

2. Any service received from any other Out-of-Network physician, hospital, person, institution or organization unless:

   a. Prior special arrangements are made by Paramount or

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

What is Not Covered – <u>In-Network or Out-of-Network</u>

These services and supplies are not covered:

1. Any court-ordered testing, treatment or hospitalization, unless determined to be Medically Necessary by Paramount.

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

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

4. Care provided to Members by relatives.

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

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

7. Assisted reproductive technology such as, artificial insemination, in vitro fertilization, embryo transplant services, GIFT, ZIFT and related services, infertility drugs and related services and any other assisted reproductive technology unless specifically required by state regulation.

8. Surrogate parenting/pregnancy including gestational pregnancy and related services.

9. Services received before coverage began or after coverage ended.

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

What is Covered by the Medical Plan

The list of covered services are subject to copay or a deductible and coinsurance. Refer to the summary of benefit for information.

Abortion: Covered only when performed by In-Network Providers.

Not covered: Abortion by an Out-of-Network Provider

Allergy testing and therapy (injections): Covered.

Ambulance: Covered for Emergency Medical Conditions when medically necessary and to the nearest medically appropriate facility. Ambulance transportation from one Hospital to another Hospital will be covered only if the first Hospital is not equipped to treat the Member's medical condition.

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

Asthma Supplies: 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; and
- Masks and tubing for nebulizers.

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

Chiropractic services: Covered, see your Schedule of Medical Benefits for details

Contraceptive services: All Federal Drug Administration (FDA) approved contraceptive methods for women without cost sharing.

Dental emergency treatment and oral surgery: The Swanton Local Schools dental plan will be primary coverage for these services. Refer to that section of this document for further information on dental services and benefits. However, the following services are covered ONLY for the following limited oral surgical procedures when you have 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) only when performed by an In-Network Provider. Bite plates, retainers, snore guards, splints or any appliance or device which is fitted to the mouth.

Diagnostic services: Covered for medically necessary outpatient diagnostic testing by an In-Network Provider. Covered Services include:

- X-rays
- Laboratory tests
- EKGs, EEGs
- Hearing tests
- Pre-admissions tests
- Mammograms, pap smears and PSA tests. Screening mammograms, pap smears and PSA tests are covered In-Network only. Mammograms, pap smears and PSA tests for diagnostic purposes are covered both In-Network and Out-of-Network.

  Not covered: Court-ordered testing and treatment unless determined to be Medically Necessary by Paramount.

Drugs and other medicines: Covered when given during a hospital stay. Retail drugs, mail order drugs and specialty drugs are covered under the prescription drug card benefit.

Drug abuse and addiction treatment: (See Substance Abuse Services)

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

Not covered:

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

Emergency services: Covered for facility and physician services for Emergency Medical Conditions meeting the definition in this document. The facility (hospital) charge will be subject to the emergency room Copayment noted in your Schedule of Medical Benefits. The emergency room copay will be waived if the Member is admitted as a hospital inpatient.

Foot Care: Covered, including treatment of the skin of the foot or toenails related to a diabetic condition.

Not covered:

- Trimming and/or scraping of bunions, calluses, corns and nails.
- Foot orthotics including shoes, shoe molds and inserts, unless condition meets Medicare Part B criteria.

Gastric stapling, by-pass, diversion: (See Morbid Obesity Surgery)

Home health care: Covered. Services include:

- Physician services
- Intermittent skilled nursing care
- Physical, occupational and speech therapy
- Other medically necessary services
- Infusion therapy from an In-Network Provider

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
- Infusion therapy from an Out-of-Network Provider

Hospice services: Covered when medically necessary for terminally ill patients.

Hospital and other facility services:

Inpatient services: Covered for inpatient room, board and general nursing care in non-private rooms. ***Elective admissions to Out-of-Network Hospitals require pre-notification.***

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

Outpatient Surgery: Covered for outpatient surgical procedures.

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

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

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

Not covered:

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

Kidney disease treatments: Covered for:

- Hemodialysis
- Peritoneal dialysis
- Kidney transplant services (see Transplants)
- 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.

Maternity care and family planning: Covered for:

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

- Voluntary sterilization.

Mental Health Services: Services for a Biologically Based and Non-Biologically Based Mental Illness are covered for inpatient and outpatient care subject to the same Deductible, Copayments and/or Coinsurance as any other physical disease or condition. See your Summary of Benefits for further details.

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 and behavioral modification

Office visits: Covered for:

- Primary Care Physician services
- Participating OB/GYN specialist for OB/GYN conditions
- 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)

Physical exams: Covered if exams are periodic physical exams as considered medically necessary by the physician.

Not covered when requested for:

- Obtaining or maintaining employment or governmental licensure
- Employer-requested physical exams
- Court-ordered or forensic evaluations unless determined to be Medically Necessary by the Plan Supervisor
- Physicals and immunizations required for travel

Preventive Health Services/Benefits:

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

Members who have current symptoms or have been diagnosed with a medical condition are not considered to require preventive care for that condition but instead, benefits will be considered under the diagnostic services benefit.

Preventive Care Services in this section shall meet requirements as determined by federal and state law. Many preventive care services are covered by this Handbook with no deductible, copayments or coinsurance from the member when provided by a participating provider. That means we pay 100% of the maximum allowed amount. These services fall under four broad categories as shown below:

1. Services with an "A" or "B" rating from the United States Preventive Services Task Force.

   Examples of these services are screenings for:
   A. Breast cancer
   B. Cervical cancer
   C. Colorectal cancer
   D. High Blood Pressure
   E. Type II Diabetes Mellitus
   F. Cholesterol
   G. Child and Adult Obesity

2. Immunizations for children, adolescents and adults recommended by the Advisory Committee on immunization practices of the Centers for Disease Control and Prevention.

3. Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.

4. Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration. You may call member services using the number on your ID card for additional information about these services or by viewing the following federal government's web sites.

   http://www.healthcare.gov/center/regulations/prevention.html
   http://www.ahrq.gov/clinic/uspstfix.htm;
   http://www.cdc.gov/vaccines/recs/acip

Private Duty Nursing: Covered, when Medically Necessary and from an In-Network Provider

Not Covered:

- Private duty services from an Out-of-Network Provider

Prosthetic devices: Covered, subject to coverage by Medicare Part B. In addition, the first wig following chemotherapy is covered. Refer to your Schedule of Medical Benefits for further Coinsurance or limits. A Prosthetic Device is an artificial substitute that replaces all or part of a missing body part and its adjoining tissues.

Not Covered:

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

Reconstructive surgery: Covered when required for:

- Repair of anatomical impairment to improve or correct functional disability within 2 years

of accident or injury.

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

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

Not covered:

- Cosmetic surgery
- Breast reduction/augmentation
- Staged procedures and surgeries when performed in preparation of a non-covered reconstructive surgery

Skilled nursing facility: Covered when medically necessary with prior authorization from Paramount.

Not covered: Custodial care

Sleep Studies: Coverage is available for certain clinical indications of obstructive sleep apnea, narcolepsy and seizure disorder when approved in advance by the Plan Supervisor.

Not covered: Sleep studies for sexual dysfunction

Substance Abuse Services (alcohol and drug abuse/addiction): 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 Deductible, 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. Partial hospitalization care 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
- Residential treatment
- Long-term rehabilitation

Therapy services: Covered for:

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

Not covered:

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

- Physical/occupational therapy beyond benefit limits
- Speech therapy beyond benefit limits
- Speech therapy for development or language disorders in children (aphasia, stuttering, hyperkinesia and extreme mental retardation).
- Equestrian therapy.

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

When Paramount selects a Center of Excellence for transplant services outside the Service Area, Paramount will reimburse IRS allowance on mileage for car travel or coach commercial air travel. Reasonable lodging and meals (not to exceed $30.00 per day excluding alcohol) for the transplant candidate only during Medically Necessary, approved visits to the institution will be reimbursed. Any eligible reimbursement will be made following receipt of itemized statements. Paramount does not cover travel, lodging or meal expenses for donors or family members.

Not covered:

- Services related to a Benefit Plan organ/bone marrow donor for a non-Benefit 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 an Out-of-Network transplant facility or by Out-of-Network Providers.

In addition to any standard transplant benefit set forth in this booklet, a Special Transplant Benefit may be available when a Covered Person participates in the Special Transplant Program. The Special Transplant Benefit provides enhanced transplant benefits and participation in the Program is voluntary. Additional information regarding the Special Transplant Program may be obtained through Paramount Health Care.

The Special Transplant Benefit provides the following benefits in addition to any transplant benefits available under this plan:

1. Access to Centers of Excellence Transplant Facilities throughout the United States;

2. Reimbursement, up to a total of $5,000, for expenses incurred by the {*Covered Person*} and one companion, or both parents if Covered Person is a minor child:

   (a) for travel to and from the Centers of Excellence facility when that travel is related to the actual transplant occurrence; and

   (b) for lodging expenses related to such travel and occurring prior to and following the the actual transplant occurrence; and

3. Waiver of the Covered Person's deductible and co-payments up to $1,500 during the year in which the transplant occurs.

The Special Transplant Benefit is only available when a Covered Person participates in the Special Transplant Program and satisfies all of the following requirements:

1. Notification of the transplant procedure must be provided to Paramount Health Care in accordance with its guidelines;

2. The Covered Person or Covered Person's representative or whomever the Employer or TPA designates must call the Special Transplant Program at 1-888-4ORGANS or call the number on the back of your insurance identification card as soon as the Covered Person is identified as a potential transplant candidate to notify the Special Transplant Program of the impending transplant and;

3. The Covered Person or Covered Person's representative or whomever the Employer or TPA designates} must call the Special Transplant Program at 1-888-4ORGANS {or call the number on the back of your insurance identification card} as soon as the {Covered Person} is identified as a potential transplant candidate to notify the Special Transplant Program of the

All transplant services must be rendered at a Centers of Excellence Transplant Facility which participates in this Program for the specific organ or tissue transplant required. A current list of participating Centers of Excellence facilities for each type of transplant is available from Paramount Health Care.

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

Vision care: Covered as needed for treatment related to a medical condition or disease of the eyes. One routine vision exam by an In-Network Provider every twelve (12) months to monitor refractory disorders of the eyes will be covered

Not covered:

- Routine vision exams more often than every twelve (12) months
- Orthoptic/vision training
- Contact lenses, eyeglasses and other corrective lenses except following cataract surgery and as specified in the Schedule of Medical Benefits
- Routine vision exam from an Out-of-Network Provider

What is Not Covered by the Medical Plan

Acupuncture: Not covered.

Alcohol abuse and drug addiction treatment: (See Substance Abuse Services)

Biofeedback: Not covered.

Breast Augmentation or Reduction: Not covered

Candela Laser Treatment for rosacea and port wine stains: Not covered.

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

Including but not limited to:

- Skin tags
- Sclerotherapy for spider angiomas (veins)
- Breast reduction/augmentation
- Face lifts, tummy tucks, panniculectomy and liposuction. Blepharoplasty (eyelid lift) unless medically necessary.
- Scar revision and correction.
- Removal of pigmentation, tattoo removal
- Torn pierced ear lobes.
- Chemical face peels and dermabrasion
- Candela laser for rosacea and port wine stains

Custodial Care: Not covered.

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, or medical or surgical procedures: Not covered

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

Hearing Aids: Not covered, unless hearing loss is the result of an accidental injury or a surgical procedure

Infertility Services: Not covered

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

Morbid Obesity Surgery: Surgery for the purpose of weight reduction or control is not covered. Not covered:

- Surgery for the treatment of morbid obesity that does not meet the criteria in Paramount's Morbid Obesity Surgery medical policy and/or was not prior authorized by Paramount.
- Morbid Obesity Surgery, and related services, that are not performed by Participating Providers authorized by paramount to perform morbid obesity surgery.
- Cosmetic procedures, including but not limited to tummy tuck or panniculectomy following morbid obesity surgery.

Penile implants: Not covered.

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

Sclerotherapy for spider angiomas (veins): Not covered

Surrogate Parenting and Pregnancy and related services: Not covered.

Transsexual surgery and related services: Not covered.

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 Physician furnishes supporting documentation to the Plan Supervisor. The benefits will be limited to those conditions where the formula is the primary source of nutrition as certified by the treating physician by diagnosis.

PRESCRIPTION DRUG BENEFIT

BENEFITS ADMINISTERED BY RxBenefits

Retail Drug Benefit (up to a 30-day supply)

The percentage that a participant will pay for each prescription is 10% for generic, 20% for preferred brand and 30% for non-preferred brand and multi-source brand.

The Prescription Drug Benefit covers:

- medically Necessary drugs that may be lawfully dispensed only upon the written prescription of a Physician licensed to practice medicine.
- contraceptives except Levonorgestrel (Norplant),
- impotence medications;
- diabetic supplies;
- injectable insulin;
- legend smoking cessation drugs;
- oral fluoride supplements;
- topical dental products;
- legend vitamins, including prenatal vitamins.

Each Covered Person will receive a CVS/Caremark identification card. When a Covered Person presents the card to a member pharmacy, he need only pay the pharmacist the amount shown as the co-payment in the Schedule of Medical Benefits for any prescription, filled or refilled. If a Physician prescribes a Brand Name Drug and a Generic Drug is available, then the Covered Person must pay the difference in cost between the Brand Name Drug and the Generic Drug (in addition to the co-pay per prescription). If the Physician indicates “dispense as written” on the prescription, the Covered Person will not have to pay the difference in cost between the Brand Name Drug and the Generic Drug. If the Covered Person is not in possession of his identification card, the Covered Person and the pharmacist must complete a Prescription Drug Claim Form. The Employer may choose to administer the prescription drug program on a reimbursement basis, without the use of Caremark. If this is the case, the employee will submit drug expenses on a medical claim form and be reimbursed by the Plan for eligible prescription drug expenses at the rate of 100%, after the prescription drug co-payment, per prescription (filled or refilled), has been satisfied.

Mail Order Drug Benefit

The percentage that a participant will pay for each prescription is 10% for generic, 20% for preferred brand and 30% for non-preferred brand and multi-source brand.

The Mail Order Drug program will be provided by CVS/Caremark caremark.com and administered by RxBenefits. This benefit covers a 90-day supply of many maintenance medications, subject to the co-payment per prescription that is specified in the Schedule of Medical Benefits.

Prescription Drug Exclusions

The following charges are excluded under this benefit:

- anabolic steroids

- anti-wrinkle agents
- cosmetic hair removal products
- growth hormones
- hair growth stimulants
- immunization agents
- blood or blood plasma
- infertility medications
- levonorgestrel (Norplant)
- mineral and nutrient supplements
- pigmenting/depigmenting agents
- anti-obesity drugs
- non-legend vitamins
- therapeutic devices or appliances other than as specified herein
- charges for the administration or injection of any drug
- diabetic pumps and other durable medical equipment (they are covered by the medical portion of the plan)
- drugs labeled “Caution - limited by federal law to investigational use,” or Experimental/Investigational drugs, even though a charge is made to the Covered Person
- medication which is to be taken by or administered to a Covered Person, in whole or in part, while he is a patient in a licensed Hospital, rest home, sanitarium, Convalescent Facility, nursing home or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals

DENTAL BENEFIT

SCHEDULE OF DENTAL BENEFITS

BENEFITS ADMINISTERED BY SELF-FUNDED PLANS, INC.

CALENDAR YEAR DEDUCTIBLE	NONE
BENEFIT PERCENTAGES	
TYPE I PREVENTIVE SERVICES	100% OF REASONABLE CHARGE
TYPE II MINOR RESTORATIVE SERVICES	80% OF REASONABLE CHARGE
TYPE III MAJOR RESTORATIVE SERVICES	60% OF REASONABLE CHARGE
TYPE IV (ORTHODONTIC) SERVICES	60% OF REASONABLE CHARGE
MAXIMUM BENEFIT PAYABLE PER CALENDAR YEAR	
TYPE I, II & III SERVICES COMBINED	$2,000
MAXIMUM LIFETIME BENEFIT	
TYPE IV (ORTHODONTIC) SERVICES All members	$1,500

DENTAL EXPENSE BENEFIT

Percentage Payable
Benefits are payable at the percentage rate applicable to the type of service, which is specified in the Schedule of Dental Benefits.

Maximum Benefit
The maximum benefit payable for each person in any calendar year for Type I, II, and III Services combined is specified in the Schedule of Dental Benefits. The maximum lifetime benefit payable for each person for Type IV (Orthodontic) Services is specified in the Schedule of Dental Benefits.

Pre-Determination of Benefits
Each Covered Person can take advantage of a Pre-Determination of Benefits. Under this provision, the Covered Person files with Self-Funded Plans, Inc. a Dentist's diagnosis, proposed course of treatment, and expected charges. The Dentist may complete this information on a dental claim form. When a Pre-Determination of Benefits has been made, Self-Funded Plans, Inc. will inform the Covered Person, in advance of treatment, as to the estimated amount of any benefits payable under this Plan with respect to the proposed course of treatment.

Benefits for Temporary Work
Benefits for temporary dental service will be considered a part of the final dental service. Benefits paid for temporary service will be deducted from the benefits otherwise payable for the final service.

Alternate Treatment

If alternate services or supplies may be employed to treat a dental condition, Covered Dental Expenses will be limited to the Reasonable and Customary charge for those services or supplies which are customarily employed nationwide in the treatment of the disease or Injury and are recognized by the profession to be appropriate methods of treatment in accordance with broadly accepted national standards of dental practice, taking into account the current total oral condition of the covered family member.

Covered Dental Expenses

Covered Dental Expenses are the Reasonable and Customary Charges of a Dentist which the Employee is required to pay for services and supplies listed below; but only to the extent that the Plan determines that the services rendered and supplies furnished are:

a. appropriate and meet professionally recognized national standards of quality; and
b. are necessary for the treatment of a non-occupational disease or a non-occupational Injury and are customarily employed nationwide for the treatment of the dental condition;

taking into account the current total oral condition of the covered family member.

The following is a complete list of those dental services which will be considered as Covered Dental Expenses; however, expenses that are incurred for the performance of any dental service not listed below will be considered a Covered Dental Expense only if the Plan Administrator agrees in writing to accept such expenses as Covered Dental Expenses. If the Plan Administrator so agrees, the benefits that are payable will be consistent with a payment for such similar Covered Dental Expenses that would provide the least costly professionally adequate treatment.

Type I Services

1. Oral examination, but not more than two (2) examinations in any consecutive twelve (12) month period.
2. Prophylaxis (routine or periodontal), but not more than twice in any consecutive twelve (12) month period.
3. Topical application of sodium or stannous fluoride. Such charges will be covered once every twelve (12) months.
4. Emergency palliative treatment.
5. Space maintainers, including all adjustments within six (6) consecutive months of installation.
6. Topical application of sealants (limited to the four [4] back molars), but only if the Covered Person has not yet attained the age of fourteen (14) years.
7. Dental x-rays required in connection with the diagnosis of a specific condition requiring treatment; also other dental x-rays, but not more than one (1) full mouth x-ray or series in any period of thirty-six (36) consecutive months.
8. Tests and lab exams.

Type II Services

1. Fillings (amalgams, silicate, acrylic).
2. Endodontic treatment, including root canal therapy.
3. Treatment of periodontal and other diseases of the gums and tissues of the mouth.
4. Repair or recementing of crowns, inlays, bridgework, or dentures; or relining of dentures.
5. Extractions and oral surgery (excluding any charges which are covered under the medical benefits plan).
6. General anesthesia.

Type III Services

1. Inlays, onlays, gold fillings or crowns (including precision attachments for dentures).
2. Initial installation of fixed bridgework (including inlays and crowns to form abutments).
3. Initial installation (including adjustments for the six [6] month period following installation) of partial or full removable dentures to replace one (1) or more natural teeth extracted while the family member is covered under the Employer's Plan.
4. Replacement of an existing partial or full removable denture or fixed bridgework by a new partial or full removable denture, or addition of teeth to an existing partial denture, provided such expense is not excluded herein.

Type IV (Orthodontic) Services

Orthodontic Services are covered for the use of active appliances to move teeth, to correct faulty position of teeth (malposition); or abnormal bite (malocclusion). This includes charges for appliances to control harmful habits and retention appliances. An Orthodontic Treatment Plan means a Dentist's report, on a form approved by the Plan, that states the class of malocclusion or malposition; recommends and describes needed treatment by orthodontic

procedures; estimates the duration of the treatment; estimates the total charge for the treatment; and includes cephalometric x-rays, study models and any other supporting evidence that the Plan may reasonably require.

When Expenses Are Deemed to be Incurred

Expenses are deemed to be incurred as of the date dental care is performed, except as provided below:

1. Expenses for restorations shall be deemed incurred on the first date of preparation of the tooth or teeth involved, provided the person remains continuously covered during the course of treatment.
2. Expenses or charges for endodontic services shall be deemed incurred on the date the specific root canal procedure commenced, provided the person remains continuously covered during the course of treatment.
3. Expenses for fixed bridgework, crowns, inlays or restorations shall be deemed incurred on the first date of preparation of the tooth or teeth involved, provided the person remains continuously covered during the course of treatment.
4. Expenses for full or partial dentures shall be deemed incurred on the date the final impression is taken, provided the person remains continuously covered during the course of treatment.
5. Expenses for rebase of an existing partial or complete denture shall be deemed incurred on the first day of preparation of the rebase of such denture, provided the person remains continuously covered during the course of treatment.
6. The orthodontia benefit will be divided equally over the number of months of treatment planned.

Dental Plan Limitations and Exclusions

Dental Expense Benefits do not cover expenses incurred for any of the following:

1. Charges for dental care which is provided solely for the purpose of improving appearance, when form and function of the teeth are satisfactory and no pathological condition exists, including charges for personalization or characterization of dentures.
2. Charges for replacement of a bridge or denture which meets or can be made to meet commonly held dental standards of functional acceptability.
3. Charges made by other than a Dentist, except that cleaning or scaling of teeth may be performed by a licensed Dental Hygienist, if such treatment is rendered under the supervision and direction of the Dentist.
4. Charges for dental care which does not meet the standards of dental practice accepted by the American Dental Association.
5. Charges for the replacement of a lost or stolen prosthetic device.
6. Charges for a spare or duplicate prosthetic device or appliance.
7. Charges for sealants (except for dependent children under the age of 14), for oral hygiene and dietary instruction, implantology and a plaque control program.
8. Charges for appliances or restorations, other than full dentures, whose primary purpose is to increase vertical dimension or stabilize periodontally involved teeth (splinting) or to restore the occlusion (unless as a Type IV Service).
9. Charges which were incurred prior to the effective date of coverage under the Plan, or after coverage is terminated.
10. Charges for replacement of a bridge or denture within five years following the date of its installation unless (a) such replacement is made necessary by the placement of an original opposing full denture or the extraction of natural teeth; or (b) the bridge or denture, while being worn, has been damaged beyond repair as a result of an accidental Injury received while the patient is covered for Dental Expense Benefits.
11. Charges excluded under the Medical Plan Limitations and Exclusions, other than item 19 in the list of Medical Plan Limitations and Exclusions.
12. Charges for diagnosis or treating conditions or dysfunction of the temporomandibular joint.
13. Charges for porcelain or acrylic veneers of crowns or pontics on or replacing the upper and lower first, second and third molars.
14. Charges for bite registrations.
15. Charges for precision attachments.
16. Charges, if any, that are included as covered medical expenses.
17. Charges for appointments not kept, or for the completion of claims forms

TERMS AND DEFINITIONS

Annual Benefit Limit: The Plan provides unlimited annual Essential benefits for each Member.

Benefit Year: It is the twelve (12) month period September 1 through August 31 for determining when your deductible, out-of-pocket limit and any other annual benefit limits, if applicable.

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

Board and Room: Means any charges made by a Hospital on its own behalf for necessary medical services and supplies actually administered during any Hospital Confinement.

Body Organ: Means 1) kidney; 2) heart; 3) lung; 4) heart and lung together; 5) liver; 6) pancreas (when the condition is not treatable by use of insulin therapy); 7) bone marrow; 8) kidney - pancreas; or 9) cornea.

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

Clinical Peer: Means a Physician who may evaluate the clinical appropriateness of services provided by another Physician. If services are provided by a provider who is not a Physician, it means a Physician or provider holding the same license as the provider of the services.

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

Coinsurance Limit: is the maximum amount of Coinsurance you pay every Benefit Year. Once the Coinsurance Limit is met, there will be no additional Coinsurance during the remainder of the Benefit Year**.** The single Coinsurance Limit is the amount each Member must pay, the family Coinsurance Limit is the total amount any two or more covered family members must pay.

Contract Plan Year: It is the twelve (12) month period June 1 through May 31 for maintaining plan fiscal records and compliance with certain government regulations at the beginning of the plan year.

Copayment/Copay: is your share of the cost of some Covered Services. This is a specific dollar amount, such as $10.00 or $20.00. Copayments that are for specific dollar amounts are due and payable at the time services are provided.

Covered Person: means an individual (employee, spouse and child) covered by this Plan.

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

Deductible: is the amount the Member must satisfy each Benefit Year before receiving benefits for Covered Services. Only costs incurred during the Benefit Year for Covered Services count toward satisfying your Deductible. Any amount by which a Provider's billed charges exceed the R & C amount will not be counted toward satisfying the Member's Deductible.

Dependent: The Eligible Employee's spouse, unless divorced, and all children from birth to twenty-six (26) years of age. The term "children" will include only natural children; stepchildren; legally adopted children (including children Placed with the adopting parents during the period before the adoption becomes final); or children for whom the Eligible Employee or his spouse has been appointed as legal guardian or Custodian.

Such children do not need to live with the Eligible Employee or to be financially dependent upon the Eligible Employee for support. Such children do not need to be Full-Time Students, and they are also eligible if they are married and/or employed; however, prior to January 1, 2014, if they are eligible to receive benefits under an employer sponsored health plan (other than a group health plan sponsored by the employer of either parent), they will not be eligible for this coverage (on or after January 1, 2014, they will be eligible for this coverage). Dependents of such children will not be eligible for coverage.

A child who is physically or mentally incapable of self-support upon attaining the age of twenty-six (26) may be considered a Dependent while remaining incapacitated, unmarried and continuously covered under the Plan. To continue a child under this provision, proof of incapacity may be required from time to time.

The term "Dependent" shall not include any dependent that is covered as an Employee. Also, if both parents are employed by the Employer, children will be covered only as Dependents of one parent. This Dependent Eligibility Rule applies to the dental as well as the medical and prescription drug benefits.

Durable Medical Equipment: Means equipment which is: 1) prescribed by a Physician as essential in the treatment of the Injury or Sickness; 2) able to withstand repeated use; 3) not useful generally to an individual in the absence of an Injury or Sickness; 4) manufactured or sold by a medical supply company; and 5) meets Medicare Part B guidelines. The term does not include: artificial aids; hearing aids; exercise equipment; bite plates, dental braces or retainers for TMJ treatment; or disposable medical supplies except for diabetic supplies.

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

Eligible Employee: all employees who work at least 30 hours per week are eligible to be covered by the Plan. Certain collective bargaining agreement(s) may establish different number of hours per week requirement. Employees who begin employment after the effective date of the Plan will be covered after they have satisfied the requirements of the Eligibility and Effective Date of Coverage provisions of this Plan. Please read the section titled “Eligibility and Effective Date of Coverage” for specific information.

Employer: The Swanton Local School District

Essential Benefits: As defined by the Patient Protection and Affordable Care Act (PPACA) lists 10 essential benefit categories. The 10 categories are ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health/substance abuse/behavioral health, prescription drugs, rehabilitative/habilitative services and devices, laboratory services, preventive/wellness/chronic disease management services and pediatric services including oral and vision care.

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

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

Extended Care or Skilled Nursing Facility: Means an institution or a distinct part thereof, including an intermediate nursing facility, which:

1. is licensed pursuant to state and local laws;
2. is operated primarily for the purpose of providing skilled nursing care and treatment for individuals convalescing from Injury or Sickness;
3. is approved by and is a participating facility with Medicare;
4. has organized facilities for medical treatment;
5. provides 24-hour-a-day nursing service under the full-time supervision of a Physician or Registered Nurse;
6. maintains daily clinical records on each patient;
7. has available the services of a Physician under an established agreement;

8. provides appropriate methods for dispensing and administering drugs and medicines;
9. has transfer arrangements with one or more Hospitals; a utilization review plan in effect; and operational policies developed with the advice of and reviewed by a professional group including at least one Physician; and
10. is not an institution which is mainly a rest home; a home for the aged; a place for drug addicts; a place for alcoholics; or a place for the treatment of mental illness.

Extension of Adult Child Coverage to Age 28 (effective at the first group renewal after September 23, 2010)

In accordance with ORC 1751.14, and upon the written request of the Subscriber, Paramount will cover an unmarried child under the employer's health plan until the child reaches age 28, if all of the following is true;

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

The child is a resident of Ohio, within the Paramount Service Area or a full-time student at an accredited public or private institution of higher learning;

The child is not employed by an employer that offers any health benefit plan under which the child is eligible for coverage; and

The child is not eligible for coverage under Medicaid or Medicare.

A child may be enrolled:

1. When the child reaches the dependent [or student] limiting age.

2. When the child experiences a change in circumstances. Change in circumstance includes moving back to the Paramount Service Area or the child losing employer-sponsored coverage.

3. During the Annual Open Enrollment Period of the Employer.

Within 30 days of one of the above events, the Subscriber must certify in writing that the child is eligible under the above conditions. The Subscriber must pay the full cost of the child's coverage to the employer. To obtain the form required to apply for extension of child coverage to age 28, the Subscriber should contact Swanton Local Schools administration office. Paramount will require certification of eligibility and proof of residency or full-time student status if living out of state and continued eligibility certification annually until the child reaches age 28.

If the Dependent does not meet these requirements, he or she may be eligible for continuation coverage under the employer group's health benefit plan or individual conversion coverage. See your benefits officer with questions.

Free-Standing Surgical Facility: Means a legally operated institution which:

1. has permanent operating rooms;
2. has at least one recovery room;
3. has all necessary equipment for use before, during and after surgery;
4. is supervised by an organized medical staff, including Registered Nurses available for care in an operating or recovery room;
5. has a contract with at least one nearby Hospital for immediate acceptance of patients who require Hospital care following care in the Free-Standing Surgical Facility;
6. is other than: a) a private office or clinic of one or more Physicians; or b) part of a Hospital; and
7. requires that admission and discharge take place within the same working day.

Home Health Care: Means services provided by a public or private agency that provides skilled nursing functions or activities in the Member's home. The services must be provided by an agency that is licensed as such (or if no license is required, approved as such) by a state department or agency having authority over home health agencies.

Hospice: Means a facility operated by a Hospital or other licensed health care institution. It is not a convalescent home; a nursing home; or an Extended Care or Skilled Nursing Facility or similar institution. Its purpose is to provide an alternative environment with palliative and supportive care for terminally ill patients either directly or on a consulting basis with the patient's Physician or another community agency, such as a visiting nurses' association. For purposes hereof, a terminally ill patient is any patient whose life expectancy, as determined by a Physician, is not greater than 6 months.

Hospital: Means an institution which:

1. is legally operated in the jurisdiction where it is located;
2. is engaged mainly in providing inpatient medical care and treatment for Injury and Sickness in return for compensation;
3. has organized facilities for diagnosis and major surgery on its premises;
4. is supervised by a staff of at least two Physicians;
5. has 24-hour-a-day nursing service by Registered Nurses; and
6. is not a facility specializing in dentistry; or an institution which is mainly a rest home; a home for the aged; a place for drug addicts; a place for alcoholics; a convalescent home; a nursing home; or an Extended Care or Skilled Nursing Facility or similar institution.

Injury: Means accidental bodily Injury of a Member.

In-Network Coverage: applies when: 1) the Member sees the Paramount PCP for treatment and obtains Prior Authorizations, and 2) the Member receives In-Network Covered Services from In-Network Providers.

In-Network Provider: means a physician, hospital or other health professional or facility that has a contract with Paramount to provide Covered Services to Members.

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

Intensive Care Unit: Means a section, ward or wing within the Hospital which:

1. is separated from other Hospital facilities;
2. is operated exclusively for the purpose of providing professional care and treatment for critically ill patients;
3. has special supplies and equipment necessary for such care and treatment available on a standby basis for immediate use;
4. provides Board and Room; and
5. provides constant observation and care by Registered Nurses or other specially trained Hospital personnel.

Maximum Lifetime Benefit: The Plan provides unlimited lifetime Essential benefits for each Member.

Medically Necessary: Means any health care treatment, service or supply determined by Paramount to be: 1) preventive, diagnostic, or therapeutic in nature; 2) specifically related to the condition that is being treated or evaluated; 3) rendered in the least costly medically appropriate setting (e.g.; inpatient, outpatient, office), based on the severity of Sickness or Injury and intensity of service required; and 4) not solely for the Member's convenience or that of his or her Physician, and is supported by evidence-based medicine.

Medicare: Means Parts A and B of the United States Social Security Act, Title XVIII, including amendments.

Member: means any Covered Person.

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

Out-of-Network Covered Services: are authorized services described in herein and applies when the Member receives Out-of-Network Covered Services from Out-of-Network Providers. Out-of-Network Covered Services are subject to a Deductible, Copayment/Coinsurance or other limitations.

Out-of-Network Provider: means a physician, hospital or other health professional or facility that does not have a contract with Paramount to provide Covered Services

Out-of-Pocket Maximum Limit and Aggregate Out-of-Pocket: The Out-of-Pocket Maximum is the sum of the medical deductible, medical coinsurance limit and medical copays that a covered person pays. There are separate in-network and out-of-network out-of-pocket maximum limits. Starting in June 2015, prescription drug coinsurance limits will have a out-of-pocket maximum limit. The Aggregate Out-of-Pocket which is the sum of the Medical out-of-pocket maximum and the prescription drug out-of-pocket maximum.

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

Paramount Service Area: means all of Ashland, Crawford, Defiance, Erie, Fulton, Hancock, Henry, Huron, Lucas, Marion, Morrow, Ottawa, Putnam, Richland, Sandusky, Seneca, Williams, Wood, and Wyandot counties, and portions of Allen, Delaware, Hardin, Knox, Lorain and Paulding counties In Ohio and Monroe and Lenawee counties in Michigan. Paramount may periodically add or remove certain counties from their service area. Benefit Plan Participants should contact Paramount Member Services for an updated listing of the Paramount Service Area.

Plan Sponsor: means the Swanton Local School District.

Plan Supervisor: means Paramount Health Care.

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

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

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

Reasonable and Customary Charge (R & C): The Reasonable and Customary Charge for services is based on a relative value system for the types of services performed, taking into consideration the geographic areas where the services are performed, as well as the fees being charged within those geographic areas. The Reasonable and Customary Charge for supplies is based on a relative value system for the types of supplies provided, taking into consideration the geographic areas where the supplies are provided, as well as the fees being charged within those geographic areas. The calculation for the Reasonable and Customary Charge takes into consideration any unusual circumstances or complications which require additional time, skill or experience in connection with the particular service or procedure. If services are rendered by a PPO Provider, the allowable amount established by the PPO will be considered the Reasonable and Customary Charge.

Registered Nurse: Means a professional nurse who has the right to use the title Registered Nurse (R.N.) in the state in which services are provided.

Semiprivate Room Rate: In the case of a Hospital which does not have semiprivate accommodations: the standard daily Semiprivate Room Rate will, for purposes of this benefit, be 80% of the daily charges for regular Hospital services at its lowest rate for private accommodations.

Sickness: Means illness or a disease of a Member. Sickness will include congenital defects or birth abnormalities.

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

Urgent Care Claim: means any claim for medical care or treatment where the non-urgent timeframes:

1) Could seriously jeopardize the life or health of the Member to regain maximum function, or
2) In the opinion of a physician with knowledge of the claimant's medical condition, would subject Member to severe pain that cannot be adequately managed without care or treatment that is the subject of the claim.

Urgent Care Services: mean covered services provided for an unexpected illness or injury requiring medical attention ***soon*** after it appears (a persistent high fever, colds, sprains, etc.). It is not permanently disabling or life-threatening.

GENERAL PROVISIONS

CONTINUATION OF COVERAGE PROVISION (COBRA)

Under certain circumstances (as outlined in this section), an Eligible Employee or Eligible Dependent may elect to continue certain benefits under this Plan, at the Covered Person's own expense, after that person is no longer eligible for coverage. This Plan provides no greater COBRA rights than what COBRA requires (nothing in this Plan is intended to expand the rights of any participant beyond COBRA's requirements).

ELIGIBILITY FOR CONTINUATION. A person who is eligible for continuation coverage is called a "Qualified Beneficiary." The events making a person eligible for continuation coverage are called "Qualifying Events."
For a covered employee to become a Qualified Beneficiary, the employee must become ineligible for group coverage because of a Qualifying Event consisting of a termination of the employee's employment (other than because of gross misconduct) or because of a reduction in the number of hours worked.
For a covered spouse or covered child to become a Qualified Beneficiary, the spouse or child must become ineligible for group coverage because of one of the following Qualifying Events:

1. Death of the Eligible Employee;
2. Termination of the Eligible Employee's employment (other than because of the Employee's gross misconduct) or reduction in the number of hours of employment;
3. Divorce or legal separation of the Eligible Employee from the Eligible Employee's spouse. Also, if the Eligible Employee reduces or eliminates coverage for a spouse in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event for the Eligible Dependent spouse and/or children even though their coverage was reduced or eliminated before the divorce or legal separation;
4. The Eligible Employee becoming entitled to Medicare; or
5. A dependent child ceasing to meet the definition of "Eligible Dependent." Provided the Eligible Employee has elected and is covered by continuation coverage, newborn children of the Eligible Employee and children Placed for adoption with the Eligible Employee on or after the date of the Qualifying Event that are properly enrolled as Eligible Dependents will be considered Qualified Beneficiaries.

TYPE OF COVERAGE TO BE CONTINUED. A Qualified Beneficiary is entitled to the same coverage that is available to other similarly situated persons covered under this Plan who have not experienced a Qualifying Event. Proof of good health will not be required.

PERIOD OF CONTINUATION. A Qualified Beneficiary may elect to continue the group coverage beyond the Qualifying Event until the earliest of the following:

1. The end of:
   a. eighteen (18) months, in a case where the Qualifying Event was a termination of employment or a reduction in hours; or
   b. thirty-six (36) months, for other Qualifying Events;
2. The date on which the Employer ceases to provide any group health plan to any Eligible Employee;
3. The date on which coverage ceases under the Plan due to the Qualified Beneficiary's failure to make timely payment of any required premium;
4. The date on which the Qualified Beneficiary first becomes, after the date of election:
   a. a covered person under any other group health plan. If the other group health 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 continuation coverage as long as the exclusion or limitation relating to the pre-existing condition has not been satisfied or deemed to have been satisfied; or

b. entitled to benefits under Medicare (under Part A, Part B, or both).

5. In the case of a Qualified Beneficiary who is determined by the Social Security Administration (hereinafter SSA) to be disabled, then continuation coverage may continue for up to twenty-nine (29) months for all Qualified Beneficiaries. This extension is available only for Qualified Beneficiaries who are receiving COBRA coverage because of a Qualifying Event that was the Eligible Employee's termination of employment or reduction of hours. The disability must have started at some time before the sixty-first (61st) day after the covered employee's termination of employment or reduction of hours, and must last at least until the end of the period of COBRA coverage that would be available without the disability extension. The disability extension is available only if the Qualified Beneficiary notifies the Plan in writing of the SSA determination of disability (based on the Notification of Qualifying Event procedures outlined herein) within sixty (60) days after the latest of (1) the date of the SSA disability determination; (2) the date of the covered employee's termination of employment or reduction of hours; (3) the date on which the Qualified Beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered employee's termination of employment or reduction of hours; or (4) the date on which the Qualified Beneficiary is informed, through the Plan's summary plan description or the general COBRA notice, of his or her obligation to provide notice and the procedures for providing such notice. The Qualified Beneficiary must also provide this notice within eighteen (18) months after the covered employee's termination of employment or reduction of hours in order to be entitled to a disability extension. Required notification procedures are outlined in the section entitled "Notification of Qualifying Event." The Employer is authorized to charge the Qualified Beneficiary an increased premium for continuation coverage extended beyond eighteen (18) months pursuant to this provision. In the event that the Qualified Beneficiary is determined by SSA to be no longer disabled, the Qualified Beneficiary shall notify the Employer of this determination within thirty (30) days. This notification shall be satisfied by sending a copy of the SSA letter stating that the Qualified Beneficiary is no longer considered to be disabled by SSA.

If during extended coverage for disability (continuation of coverage months nineteen [19] - twenty-nine 29]) a Qualified Beneficiary is determined to be no longer disabled under The Act, continuation coverage shall terminate the last day of the month following thirty (30) days from the date of SSA's final determination that the Qualified Beneficiary is no longer disabled.

PREMIUM FOR CONTINUATION. The Employer will determine the amount of premium which will be charged for continuation coverage. Premium may, at the election of the payer, be made in monthly installments. Without further notice from the Employer, the Covered Person must pay the monthly premium by the last day of the period before the period for which coverage is to be effective. A thirty (30) day grace period is available before coverage will be retroactively terminated. If election of continuation coverage is made after the Qualifying Event, payment must be made (in an amount that is current, when taking the grace period into account) within forty-five (45) days of the date of election. No claim will be payable under this provision until the premium is received from, or on behalf of, the Covered Person.

If mailed, the premium is considered to have been made on the date that it is postmarked. If hand-delivered, the premium is considered to have been made when it is received by the COBRA department at the Plan Supervisor's office. If the check is returned for insufficient funds, the premium will be deemed to be unpaid

ELECTION PERIOD. A Qualified Beneficiary may elect continuation coverage during the Election Period. The Election Period means the period which:

1. Begins not later than the date on which coverage terminates under the group plan because of the Qualifying Event;
2. Is of at least sixty (60) days duration; and
3. Ends not earlier than sixty (60) days after the later of:
   a. the date coverage terminates under this Plan because of the Qualifying Event; or
   b. the date of the notice offering the election of continuation of coverage.

MULTIPLE QUALIFYING EVENTS. If during continuation coverage a Qualified Beneficiary experiences a subsequent Qualifying Event and the original Qualifying Event was termination of the Eligible Employee's employment (other than for gross misconduct) or reduction in the number of hours of the Eligible Employee's employment, then that Qualified Beneficiary may be eligible to participate in continuation coverage for up to thirty-six (36) months from the date of the original Qualifying Event.

When Plan coverage is lost due to the end of employment or reduction of the Eligible Employee's hours of employment, and the Eligible Employee became entitled to Medicare benefits less than eighteen (18) months before the Qualifying Event, COBRA coverage for the Qualified Beneficiaries (other than the Eligible Employee) who lose coverage as a result of the Qualifying Event can last up to thirty-six (36) months after the date of Medicare entitlement. For example, if an Eligible Employee becomes entitled to Medicare eight (8) months before the date on which his employment terminates, COBRA coverage for his spouse and children who lost coverage as a result of his termination can last up to thirty-six (36) months after the date of Medicare entitlement, which is equal to twenty-eight (28) months after the date of the Qualifying Event (thirty-six [36] months minus eight [8] months). This COBRA coverage period is available only if the Eligible Employee becomes entitled to Medicare within eighteen (18) months before the termination or reduction of hours.
To report a subsequent Qualifying Event, the Qualified Beneficiary must send written documentation of the second Qualifying Event to the Employer within sixty (60) days of the later of (a) the occurrence of such Qualifying Event, or (b) the date on which the Qualified Beneficiary loses (or would lose) coverage as a result of the Qualifying Event, or (c) the date on which the Qualified Beneficiary is informed, through the Plan's summary plan description or the general COBRA notice, of his or her obligation to provide notice and the procedures for providing such notice.
Required notification procedures are outlined in the section entitled "Notification of Qualifying Event." If the required notification procedures are not followed, then there will be no extension of COBRA due to a second Qualifying Event.

NOTIFICATION OF QUALIFYING EVENT. The Covered Person is responsible for notifying the Employer of the occurrence of the following Qualifying Events:

- divorce or legal separation of the Eligible Employee from the Eligible Employee's spouse;
- a dependent child ceasing to be an Eligible Dependent,
- second qualifying events, entitling certain Qualified Beneficiaries to an extension of the COBRA maximum coverage period for up to thirty-six (36) months;
- a Qualified Beneficiary's disability, entitling Qualified Beneficiaries to an eleven (11) month extension of the COBRA maximum coverage period for up to twenty-nine (29) months; and
- the end of a disabled Qualified Beneficiary's disability (such that the eleven [11] month disability extension is no longer available).

Such notification must be made within sixty (60) days of the later of (a) the occurrence of such Qualifying Event; (b) the date on which there is a loss of coverage; (c) in the case of a Qualified Beneficiary's disability, the date of the SSA disability determination; or (d) the date on which the Qualified Beneficiary is informed, through the Plan's summary plan description or the general COBRA notice, of his or her obligation to provide notice and the procedures for providing such notice. To report such Qualifying Events, the Covered Person must submit written documentation of the change to the Treasurer within the time period noted in this paragraph. The Covered Person must include copies of the relevant paperwork (i.e. the paperwork outlining the Medicare determination of disability, a copy of the divorce decree, etc). If the notification is deficient, the Employer will request more complete information; if this request for information is not responded to within the required time period, the Notification will be rejected.

TRADE ADJUSTMENT ASSISTANCE OR ALTERNATIVE TRADE ADJUSTMENT ASSISTANCE. Special COBRA rights apply to certain employees and former employees who are eligible for federal trade adjustment assistance (TAA) or alternative trade adjustment assistance (ATAA). These individuals are entitled to a second opportunity to elect COBRA for themselves and certain family members (if they did not already elect COBRA) during a special second election period. This special second election period lasts for 60 days or less. It is the 60-day period beginning on the first day of the month in which an Eligible Employee or former Eligible Employee becomes eligible for TAA or ATAA, but only if the election is made within the six months immediately after the individual's group health plan coverage ended. Employees or former employees who believe they qualify or may qualify for TAA or ATAA should contact the Employer promptly after qualifying for TAA or ATAA.

FMLA. if an Eligible Employee takes FMLA leave and does not return to work at the end of the leave, the Eligible Employee (and the Eligible Employee's Eligible Dependents, if any) will be entitled to elect COBRA if (1) they were covered under the Plan on the day before the FMLA leave began (or became covered during the FMLA leave); and (2) they will lose Plan coverage within 18 months because of the employee's failure to return to work at the end of the leave. (This means that some individuals may be entitled to elect COBRA at the end of an FMLA leave even if they were not covered under the Plan during the leave). COBRA coverage elected in these circumstances will begin on the last day of the FMLA leave, with the same 18-month maximum coverage period (subject to extension or early termination) generally applicable to the COBRA qualifying events of termination of employment and reduction of hours.

ELECTION PROCEDURES. To elect COBRA, the Qualified Beneficiary must complete the Continuation Coverage Election Form and submit it to the Plan Supervisor. Under federal law, the Qualified Beneficiary must have sixty (60) days after the date of the COBRA election notice provided to the Qualified Beneficiary at the time of his Qualifying Event to decide whether he wants to elect COBRA under the Plan. The Continuation Coverage Election Form must be completed in writing and mailed or hand-delivered to the address shown on the form. If mailed, the election must be postmarked (and if hand-delivered, the election must be received by the individual at the Plan Supervisor's office) no later than sixty (60) days after the date of the COBRA election notice provided to the Qualified Beneficiary at the time of the Qualifying Event. If the election is not submitted within these time periods, the individual will lose his right to elect COBRA. The following are not acceptable as COBRA elections and will not preserve COBRA rights: oral communications regarding COBRA coverage, including in-person or telephone statements about an individual's COBRA coverage; and electronic communications, including e-mail. If COBRA is rejected before the due date, the Qualified Beneficiary may change his mind as long as he furnishes a completed Election Form before the due date.

THE FAMILY AND MEDICAL LEAVE ACT OF 1993

In the event that the Employer approves a leave under The Family and Medical Leave Act of 1993 (FMLA) for an Eligible Employee, that Eligible Employee may receive up to twelve (12) work weeks of continued benefits under this Plan while on such leave (provided that required contributions, if any, are made by or on behalf of that Eligible Employee). An Eligible Employee returning from an approved leave under the FMLA who did not continue benefits under this Plan during such leave, will not be required to satisfy a new Waiting Period upon returning from the leave. In addition, such persons will continue to be covered under the Plan as if there had been no break in service. In the event that an Eligible Employee does not continue benefits under this Plan throughout an approved FMLA leave, the Continuation of Coverage Provision (COBRA) outlined in the Plan will apply to such Eligible Employee in accordance with the following paragraph. The Continuation of Coverage Provision (COBRA) outlined in the Plan will apply on the earlier of:

1. The date that the Eligible Employee informs the Employer of his intent not to return from such leave; or
2. The date that the Eligible Employee does not return from such leave after the leave is over.

NON-PAYMENT OF CLAIMS

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

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 PROVISION

If an Eligible Employee who is enrolled in the Plan is absent from work by reason of service in the uniformed services, the Eligible Employee and his Eligible Dependents, if any, who are enrolled in the Plan may elect to continue coverage under the Plan for a maximum period equal to the lesser of (i) the 24-month period beginning on the date on which the Eligible

Employee's absence begins, or (ii) the day after the date on which the Eligible Employee fails to apply for or return to a position of employment as determined by the Employer under the federal Uniformed Services Employment and Reemployment Rights Act of 1994, as may be amended from time to time (the "USERRA"). A person who is eligible to elect to continue health-plan coverage under this provision and who so elects, is required to pay 102 percent of the cost to participate in the Plan (determined in the same manner as the cost to participate in COBRA continuation coverage), except that in the case of an Eligible Employee who performs service in the uniformed services for less than thirty-one (31) days, such person shall pay the employee contribution, if any, for such coverage. Except in the case of any Illness or Injury determined by the Secretary of Veterans' Affairs to have been incurred in, or aggravated during, the performance of service in the uniformed services, in the case of an Eligible Employee whose coverage under the Plan was terminated by reason of service in the uniformed services, any otherwise applicable exclusion or Waiting Period under the Plan shall not be imposed in connection with the reinstatement of such coverage upon reemployment under the USERRA if that exclusion or Waiting Period would not have been imposed under the Plan had coverage of such Eligible Employee by the Plan not been terminated as a result of such service. This paragraph applies to the Eligible Employee and to his Eligible Dependents, if any. "Service in the uniformed services" for purposes of this provision shall mean the performance of duty on a voluntary or involuntary basis in a uniformed service under competent authority and includes active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty, and a period for which a person is absent from a position of employment for the purpose of an examination to determine the fitness of the person to perform any such duty.

MEDICARE PROVISION

For those Eligible Employees (who have Plan coverage by virtue of their current employment status as defined in Medicare) or spouses of Eligible Employees (who have Plan coverage by virtue of the Eligible Employee's employment status as defined in Medicare), who are age sixty-five (65) or older and who are entitled to benefits under Medicare, this Plan will pay primary benefits, unless the Eligible Employee or spouse refuses coverage under this Plan. If such Eligible Employee or spouse refuses coverage under this Plan, Medicare will be the sole source of benefits. Eligible Employees or spouses of Eligible Employees who have enrolled in this Plan are deemed to have accepted coverage under this Plan until the Plan Administrator receives a written election indicating that an Eligible Employee or spouse of an Eligible Employee refuses coverage under this Plan. Any charges which are not paid under this Plan should be submitted to Medicare as secondary payor. For COBRA Qualified Beneficiaries who are age sixty-five (65) or older and who are entitled to benefits under Medicare, this Plan will pay secondary benefits.

For those Eligible Employees (who have Plan coverage by virtue of their current employment status as defined in Medicare), or Eligible Dependents (who have Plan coverage by virtue of a family member's current employment status as defined in Medicare), who are entitled to benefits under Medicare because of total disability (and who are not or could not be entitled to benefits under Medicare on the basis of End Stage Renal Disease), this Plan will pay primary benefits, unless the Eligible Employee or Eligible Dependent refuses coverage under this Plan. If such Eligible Employee or Eligible Dependent refuses coverage under this Plan, Medicare will be the sole source of benefits. Eligible Employees or Eligible Dependents who have enrolled in this Plan are deemed to have accepted coverage under this Plan until the Plan Administrator receives a written election indicating that an Eligible Employee or Eligible Dependent refuses coverage under this Plan. Any charges which are not paid under this Plan should be submitted to Medicare as secondary payor. For COBRA Qualified Beneficiaries who are entitled to benefits under Medicare because of total disability (and who are not or could not be entitled to benefits under Medicare on the basis of End Stage Renal Disease), this Plan will pay secondary benefits.

For the purpose of this paragraph, the time that a person is an Eligible Employee or Eligible Dependent is added to the time that a person is a COBRA Qualified Beneficiary to determine whether the Plan pays primary benefits or secondary benefits. For those Eligible Employees or Eligible Dependents who are entitled to benefits under Part A of Medicare solely on the basis of End Stage Renal Disease the following will apply:

For items and services furnished on or after August 5, 1997, with respect to Eligible Employees or Eligible Dependents who become entitled to benefits under Part A of Medicare on or after February 5, 1996. The Plan will pay primary benefits during the 30-month period beginning on the earlier of: the first month in which the Eligible Employee or Eligible Dependent becomes entitled to benefits under Part A of Medicare; or the first month in which the Eligible Employee or Eligible Dependent would have been entitled to benefits under Part A of Medicare if such person had filed an application for such benefits. After the expiration of such 30-month period, Medicare benefits will be primary and this Plan will pay secondary benefits.

Otherwise, the Plan will pay primary benefits during the 18-month period beginning on the earlier of: the first month in which the Eligible Employee or Eligible Dependent becomes entitled to benefits under Part A of Medicare; or the first month in which the Eligible Employee or Eligible Dependent would have been entitled to benefits under Part A of Medicare if such person had filed an application for such benefits. After the expiration of such 18-month period, Medicare benefits will be primary and this Plan will pay secondary benefits.

For those Eligible Employees or Eligible Dependents who are entitled to benefits under Medicare solely on the basis of End Stage Renal Disease and who subsequently become entitled to benefits under Medicare for the reason of attaining age sixty-five (65) or for a disability other than End Stage Renal Disease, the Plan will pay in accordance with the End Stage Renal Disease provisions stated above.

For those Eligible Employees or Eligible Dependents who are entitled to benefits under Medicare on the basis of attaining age sixty-five (65) or because of disability (other than End Stage Renal Disease), and who subsequently become entitled to benefits under Medicare on the basis of End Stage Renal Disease, the End Stage Renal Disease provisions stated above will apply but only if, prior to such entitlement to benefits under Medicare on the basis of End Stage Renal Disease, the Plan was to pay primary benefits and Medicare was to pay secondary benefits under other provisions of the Plan.

For those Eligible Employees or Eligible Dependents who are not entitled to benefits under Medicare on the basis of attaining age sixty-five (65) or because of disability (other than End Stage Renal Disease), and who become entitled to benefits under Medicare on the basis of attaining age sixty-five (65) or because of disability (other than End Stage Renal Disease) and, simultaneously, End Stage Renal Disease, the End Stage Renal Disease provisions stated above will apply.

COORDINATION OF BENEFITS

The Coordination of Benefits provision is intended to prevent payment of benefits which exceed expenses. It applies when any person who is covered under this Plan is also covered by any other plan or plans. When more than one coverage exists, one plan normally pays its benefits in full and the other plans pay a reduced benefit. This Plan will always either pay its benefits in full or a reduced amount which, when added to the benefits payable by the other plan or plans, will not exceed 100% of allowable expenses. Only the amount paid by the Plan will be charged against the Plan maximums. All benefits contained in the Plan Document are subject to this provision. When any person is eligible for coverage under two (2) or more plans, it is necessary to determine which plan is primary and which plan is secondary. The following rules are used to determine the primary carrier:

1. A plan which does not have a non-duplication of benefits or coordination of benefits provision will be the primary carrier;

2. If all the plans have Coordination of Benefits provisions, a plan is primary if it covers the person as an employee, and secondary if it covers the person as a dependent;

3. The primary plan is the plan that covers the person as an active, full-time employee, or that employee's dependent. The secondary plan is the plan that covers that person in a status other than as an active, full-time employee, or that employee's dependent;

4. If a person is covered as a dependent child under more than one (1) plan:
   a. the plan of the parent whose birthday falls earlier in the year is the primary plan;
   b. if the father and mother have the same birthday, the plan covering the parent longer is the primary plan;
   c. if the other plan's provisions for coordination of benefits does not follow the rule of this plan (as stated in 4a & b), then the rules for coordination of benefits of the other plan shall determine the order of benefits;
   d. if more than one plan covers a person as a dependent child of divorced or separated parents, benefits for the child will be determined by the specific terms of the Court decree. If the Court decree states which parent is responsible for the health care expenses of the child then that parent's plan shall be primary. If there is no Court decree or the Court decree is silent as to which parent is responsible for the health care expenses of the child, or if the Court decree is not being followed by the parent who is supposed to be providing coverage, then the plan that will pay primary benefits will be determined in the following order:
      i. the plan of the parent with custody of the child;
      ii. the plan of the spouse of the parent with custody of the child;
      iii. the plan of the parent without custody of the child.

5. When the above rules do not establish an order of benefit determination, the benefits of a Plan which has covered the person for the longer period of time shall be determined before the benefits of a Plan which has covered the person the shorter period of time.

This Plan will coordinate benefits with any of the following types of coverage:

1. Group, blanket, franchise or individual insurance coverage;
2. Hospital services payment plans, medical services prepayment plans, health maintenance organizations, or other group prepayment coverage;
3. Any coverage under labor-management trustee plans, union welfare plans, employee organization plans, or employee benefit organization plans;
4. Any coverage provided by automobile "No Fault" legislation or any coverage provided by the Social Security Act or any other statute, including but not limited to Medicare;
5. Any Employer-sponsored non-insured employee benefit plans; and

The term "Allowable Expense" means any necessary item of expense, the charge for which is Reasonable and Customary and is a covered expense under this Plan. When a Plan provides benefits in the form of services rather than cash payments, then the reasonable cash value of each service rendered will be deemed to be both an allowable expense and a benefit paid. The term "Claim Determination Period" means a calendar year or that portion of a calendar year during which the Covered Person for whom claim is made has been covered under this Plan.

SUBROGATION

In the event of any payment under the Plan, the Plan Administrator shall, to the extent of such payment, be subrogated to all the rights of recovery of a Covered Person which arise out of the acts or omissions of any person or entity, including the Covered Person or which arise under any no-fault coverage, uninsured motorist coverage, underinsured motorist coverage or any other type of first party coverage including Medical Payment Coverage (for the purposes of this provision, collectively referred to as “Other Coverage”). In the event the Plan has a subrogated interest or right of recovery, no Covered Person shall release any party, person, corporation, entity, insurance company, insurance policies or funds that may be liable or obligated to the Covered Person for the acts or omissions of any person or entity, without the written approval of the Plan. In the event a Covered Person pursues a claim against a third party or Other Coverage, the Covered Person agrees to include the Plan’s subrogated interest and rights of recovery in that claim, and if there is a failure to do so, the Plan shall be legally presumed to be included in such claim. In the event a Covered Person does not pursue a claim against a third party or Other Coverage, the Plan shall have the right to pursue, sue, compromise or settle any such claims in the Covered Person’s name and to execute any and all documents necessary to pursue said claims in the Covered Person’s name. Each Covered Person hereby agrees to reimburse the Plan, for any benefits paid by the Plan, out of any monies recovered from any person, entity, or Other Coverage as the result of judgment, settlement or otherwise, regardless of how those monies are classified. In the event a Covered Person settles, recovers or is reimbursed by any third party or Other Coverage, the Covered Person shall hold any such monies in trust for the benefit of the Plan and reimburse the Plan for any benefits so paid hereunder on a first priority basis, regardless of whether or not the Covered Person has been made whole. If a Covered Person fails to reimburse the Plan in accordance with this provision, the Covered Person shall be liable to the Plan for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such monies from the Covered Person. Each Covered Person also agrees to execute and deliver all necessary instruments, to furnish such information and assistance, and to take any action the Plan Administrator may require to facilitate enforcement of its rights. The Plan will not pay or be responsible for, without the written consent of the Plan Administrator, any fees or costs including attorney’s fees associated with a Covered Person pursuing a claim against a third party or any other coverage. For purposes of this provision, the term "Covered Person" will include anyone acting for, or on behalf of, a Covered Person when the Covered Person is referred to as taking an action. This Plan is always a secondary payor when there are no fault and/or personal injury protection benefits available to the Covered Person.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

The Plan may, without the consent of or notice to any person, release to or obtain from any insurance company or any other party, any information which the Plan deems relevant for the purpose of applying and implementing the terms of the Plan. Any person claiming benefits under the Plan shall furnish to the Plan such information as may be necessary to implement this provision.

FACILITY OF PAYMENT

Whenever payments that should have been made under this Plan were made by another plan, this Plan shall have the right, exercisable alone and at its sole discretion, to reimburse the other plan in the amount that would have been paid by

this Plan. Such reimbursement shall be deemed payment for covered services and the Plan shall be fully discharged from liability.

RIGHTS OF RECOVERY
Whenever payments have been made by the Plan in an amount which exceeds the maximum amount of payment allowed under the Plan at that time, the Plan shall have the right to recover such payment irrespective of to whom paid, to the extent of such excess from among one (1) or more of the following parties: any persons to whom or with respect to whom such payments were made, any insurance companies, or any other organizations or persons.

DISCRETIONARY AUTHORITY
The Plan Administrator shall have the discretionary power and authority to: determine eligibility for benefits; interpret or construe the terms of the Plan and any other writing affecting the establishment or operation of the Plan; determine questions of fact which arise in connection with the Plan; and decide all matters arising under the Plan, based on the applicable facts and circumstances.

DECLARATORY JUDGMENT
In the event that a question of coverage is presented to a court of competent jurisdiction through a declaratory judgment, and the court rules that the Plan is responsible for providing coverage, then the Plan will cover the expense to the extent permitted by all other Plan provisions.

PLAN MODIFICATION AND AMENDMENT
The Plan Sponsor may modify or amend the Plan from time to time at its sole discretion and the amendments or modifications which affect the Plan Members will be communicated to them. Any Plan amendment shall be by a written instrument signed by a representative or representatives of the company who have been authorized by resolution or other appropriate authority to amend The Swanton Local School District Medical and Dental Benefits Plan and shall become effective as of the date specified in the instrument. A copy of such instrument shall be furnished to the Plan Administrator and any outside provider of Plan administration services.

PLAN TERMINATION
The Plan Sponsor may terminate the Plan at any time. Any termination of the Plan will be communicated to plan members.

ASSIGNMENT OF BENEFITS
In the event a Covered Person has executed an Assignment of Benefits, the Plan shall pay benefits directly to the provider of service. If the Plan receives notification from a provider that the provider has the Covered Person's authorization to assign benefits on file, then that shall be acceptable notice to the Plan that an Assignment of Benefits has been executed.

PROOF OF CLAIMS (Filing of Claims)
Written proof of claims must be furnished to the Plan by or on behalf of the Covered Person or the provider within fifteen (15) months 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). Proof of claims includes the following:
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 code (ICD 9 CM) and a CPT code (Current Procedural Terminology) for each service provided.
The Eligible Employee must complete one (1) Employee Statement on a frequency to be determined by the Plan Administrator.
If the Plan Administrator or Plan Supervisor requests information from the Eligible Employee, the Eligible Employee must furnish such information as requested.
If the Plan Administrator or Plan Supervisor requests information from a provider and the provider does not furnish the requested information, the Eligible Employee will be required to obtain the requested information and furnish it to the Plan Administrator or Plan Supervisor.
All of the above requirements must be met within the fifteen (15) month time period in order for the claim to be considered.

PAYMENT OF CLAIMS
All Plan benefits are payable to the Eligible Employee, unless the Eligible Employee has assigned such benefits to the provider of services. If the Plan Administrator determines that any Eligible Employee entitled to Plan Benefits is incompetent, the Plan Administrator may cause all Plan benefits thereafter becoming due to such Eligible Employee to be made to any other person for his benefit, without the responsibility to follow the application of amounts so paid. Any benefits otherwise payable to an Eligible Employee following the date of death of such Eligible Employee shall be paid to

his or her spouse, or, if there is no surviving spouse, to his or her estate. Payments made pursuant to this section shall completely discharge the Plan and the Plan Administrator.

ACTIONS
No action at law or in equity shall be brought to recover on the Plan prior to the expiration of sixty (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 three (3) years from the expiration of the time within which proof of loss is required by the Plan.

CONFORMITY OF LAW
If any provision of this Plan is contrary to any law to which it is subject, such provision is hereby amended to conform thereto.

CHANGE IN PLAN PROVISIONS
Any change in Plan provisions will apply only to expenses incurred on or after the effective date of the Plan change. If, on the effective date of a Plan change, a Covered Person is confined in a Hospital, the Plan provisions in force before the effective date of the change will continue in force until, in the case of the Eligible Employee, the Eligible Employee returns to work for one full day, or, in the case of an Eligible Dependent, the Eligible Dependent is released from the Hospital.

PLAN IS NOT A CONTRACT
The Plan shall not be deemed to constitute a contract between the Plan Sponsor and any Employee or to 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 of the Plan Sponsor or to interfere with the right of the Plan Sponsor to discharge any Employee at any time; provided, however, that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreements which may be made by the Plan Sponsor with the bargaining representatives of any Employee.

EXAMINATION
The Plan Administrator, at the Plan's expense, shall have the right and opportunity to have the Covered Person examined whose Injury or Illness is the basis of a claim hereunder when and so often as it may reasonably require during the pendency of claim hereunder. If the Plan requires that the Covered Person be examined by a Physician of the Plan's choice, and the Covered Person does not comply with this request, the Plan has the right to deny benefits for the claim in question. The Plan Administrator also has the right and opportunity to have an autopsy performed in case of death where it is not forbidden by law.

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

MEDICAL CHILD SUPPORT ORDERS
The Plan will follow the applicable state requirements, if any, for orders issued by: (1) a court of competent jurisdiction, or (2) through an administrative process established under state law that has the force and effect of law under applicable state law, that establishes a parent’s obligation to provide health coverage to children who are Eligible Dependents and who are the subject(s) of such order, provided such order does not require the Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan.

MEDICAID PROVISION
Payments for benefits will be made in accordance with any assignment of rights made by or on behalf of a Covered Person as required by a State plan for medical assistance approved under title XIX of the Social Security Act pursuant to section 1912(a)(1)(A) of such Act as in effect on August 10, 1993. The fact that an Eligible Employee or Eligible Dependent is eligible for or is provided medical assistance under a State plan for medical assistance approved under title XIX of the Social Security Act will not be taken into account for determining eligibility or determining or providing benefits under this Plan. To the extent that payment has been made under a State plan for medical assistance approved under title XIX of the Social Security Act and this Plan would provide a benefit for those items or services constituting such assistance, payment for benefits under this Plan will be made in accordance with any State law which provides that the State has acquired the rights with respect to the Covered Person to such payment for such items or services.

CLAIM PROVISIONS, REVIEW AND APPEAL PROCEDURES

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

If you call the Member Services Department after hours, you may leave a message and we will call you back on the next working day. You may also Email us through the Paramount web site at: www.paramountinsurancecompany.com.

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

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

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

How to Handle a Complaint

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

Appeal to Paramount

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

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

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

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

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

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

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

Instructions for Requesting an Internal Appeal

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

You must request an internal appeal in writing, unless the claim involves urgent care, in which case the appeal may also be requested orally. A claim involving “urgent care” is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations (a) could seriously jeopardize your life

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

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

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

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

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

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

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

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

Full and Fair Review

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

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

(3) The review will be conducted by an appeal representative of Paramount in consultation with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate;
(4) The review will be conducted in a manner designed to avoid conflicts of interest by ensuring the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual will not be made based upon the likelihood that the individual will support the denial of benefits and;

(5) There will be no reduction or termination of an ongoing course of treatment without advance notice from Paramount or an opportunity for advance review.

Concurrent Internal Appeal and External Review

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

(1) Your treating physician certifies in writing that you have a medical condition where the time frame for completion of an expedited review of an internal appeal involving the Adverse Benefit Determination would seriously jeopardize your life or health or your ability to regain maximum function; or

(2) In the case of experimental or investigational treatment that otherwise meets the criteria for an external review, you may request an expedited review orally or by electronic means, if your treating physician also certifies in writing that the requested health care service would be significantly less effective if not promptly initiated.

If Your Appeal is Denied

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

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

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

Your Right to an Additional Appeal

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

(1) You are entitled to an external review by an Independent Review Organization (IRO) if:

a. the Adverse Benefit Determination involves a medical judgment or is based on any medical information (this includes a decision that a covered person sought services at an emergency room for a condition that did not meet the prudent layperson definition of an emergency); or

b. the Adverse Benefit Determination indicates the requested service is experimental or investigational, is not specifically listed as an excluded benefit, and the treating physician certifies one of the following: i. Standard health care services have not been effective in improving your condition;
ii. Standard health care services are not medically appropriate for you;
iii. No available standard health care service covered by Paramount is more beneficial than the requested health care service.

(2) You are entitled to an external review by the Department of Insurance if:

a. the Adverse Benefit Determination is based on a contractual issue that does not involve medical judgment or any medical information; or

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

Exhaustion Requirements

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

(1) Paramount agrees to waive the exhaustion requirement;

(2) You did not receive a written decision on your internal appeal within the required time frame; (3) Paramount fails to meet all of the requirements of the internal appeal process unless the failure:

a. was de minimis;
b. does not cause or is not likely to cause you prejudice or harm;
c. was for good cause and beyond Paramount's control; and
d. is not reflective of a pattern or practice of non-compliance.

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

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

Instructions for Requesting External Review

You may request an external review at any time within 180 days of the date of the Final Adverse Benefit Determination. When filing a request for external review, you will be required to authorize the release of your medical records as necessary to conduct the review. An authorization for the release of your medical records will be provided to you with the Final Adverse Benefit Determination. The completed authorization form must be returned with your request for external review or confirmation of your request for an expedited external review.

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

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

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

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

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

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

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

Expedited External Review

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

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

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

External Review of Experimental or Investigational Health Care Services

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

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

External Review Determination:

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

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

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

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

Limitation on Legal Actions

No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

GENERAL & CONTACT INFORMATION

1. **NAME OF PLAN:** The Swanton Local School District Medical and Dental Benefits Plan

2. **NAME & ADDRESS OF PLAN SPONSOR:**
   Swanton Local School District
   108 N. Main St.
   Swanton, Ohio 43558

   Jefferson Health Plan
   Jefferson County Board of Education
   2023 Sunset Boulevard
   Steubenville, Ohio 43952

3. **EFFECTIVE DATE OF PLAN:** Medical and prescription drug benefits are effective June 1, 2002. Dental benefits were originally effective on April 1, 2000. This plan document reflects amended and restated benefits which are effective June 1, 2002.

4. **EMPLOYER IDENTIFICATION NUMBER:** 34-6401381

5. **GROUP ACCOUNT NUMBER:**

   Paramount Health Care (medical) 030810
   Self-Funded Plans, Inc. (dental) 506-776
   CVS/Caremark (prescription drug card) RX2155

6. **TYPE OF PLAN:** This is a welfare plan providing medical, prescription drug and dental benefits.

7. **TYPE OF ADMINISTRATION:** Certain administrative services are provided by a contract administrator retained by the Employer. Self-Funded Plans, Inc., Paramount Health Care and Caremark have been retained as contract service administrators.

8. **NAME, BUSINESS ADDRESS & TELEPHONE NUMBER OF THE PLAN ADMINISTRATOR:**
   Swanton Local School District
   108 N. Main St
   Swanton, Ohio 43558
   (419) 826-7085

9. **NAME OF THE DESIGNATED AGENT FOR SERVICE OF LEGAL PROCESS & ADDRESS AT WHICH PROCESS MAY BE SERVED ON SUCH AGENT:** Same as above

10. **FINANCING OF BENEFITS:** Classified and part-time Employees will contribute toward the cost of employee and dependent coverage in such amounts as shall be determined from time to time by the Employer. The Employer will contribute the balance of the cost of employee and dependent coverage solely from the general assets of the Employer.

11. **THE DATE OF THE END OF THE YEAR FOR THE PURPOSES OF MAINTAINING THE PLAN'S FISCAL RECORDS:** Plan year ending May 31st of each year.

Claims and Services Administrators

The following is a list of the claims administrators. Should you have questions or problems reading the Plan's benefits you can contact the appropriate administrator. This information also appears on your ID cards.

Medical: Paramount health Care
Group Number 030810
Members Services Department
P.O. Box 928
Toledo, Ohio 43697-0928
Telephone: (419) 887-2525
Toll Free: 1-800-462-3589
Facsimile: (419) 887-2037
Website: paramounthealthcare.com

Dental: Self-Funded Plans
Group Number 506-776
Members Services Department
1432 Hamilton Ave
Cleveland, Ohio 44114-1146
Toll Free: 1-800-772-7475
Facsimile: (216) 566-1505

Prescription Drug Card: CVS/Caremark
Group Number RX2155
Members Services Department
3700 Colonnade Pkwy, Suite 600
Birmingham, AL 35243
Toll Free: 1-800- 334-8134
Facsimile: (216) 566-1505
Employees can register with CVS/Caremark's website www.caremark.com to obtain plan information and to manage their medication information.

Plan Addendums

ADDENUM TO PLAN DOCUMENT

NAME OF PLAN: Swanton Local School District Medical, Prescription Drug Card and Dental Benefits

ADDENDUM NUMBER: Twenty-seven

EFFECTIVE DATE: September 1, 2015

ADDENDUM:

New Vision Plan to Schedule of Benefits administered by Self-Plans, Inc. for the classification of Superintendent only. The products and services covered are prescription eyewear including frames, lenses, optional lenses features such as scratch resistance coating, contact lenses and prescription sunglasses. The maximum benefit is $500 per member per benefit year. The benefit year is September 1st through August 31st, which is the same as medical, prescription drug and dental benefits.

Eye exam is excluded since this service is covered by the medical portion of the plan.

Upon acceptance, the undersigned, on behalf of Swanton Local School District,
Certifies that the undersigned has read the Addendum, reviewed it with the appropriate parties, found it to include all requested provisions, understood it and agreed to accept all of its provisions.

NAME OF EMPLOYER: SWANTON LOCAL SCHOOL DISTRICT

SIGNATURE_____

TITLE_____

DATE_____

ADDENDUM TO PLAN DOCUMENT

NAME OF PLAN: The Swanton Local School District Medical and Dental Benefits Plan

ADDENDUM NUMBER: Twenty-Eight

EFFECTIVE DATE: September 1, 2015

ADDENDUM:

The Ohio Revised Code (ORC) is receding Section 1751.14, regarding the extension of coverage for dependents at age 26 up to age 28. The Swanton Local School District under ORC Section 9.833 operates a joint health benefits plan (consortium health plan) and as stated in this section the consortium is exempt for mandates from the Ohio Department of Insurance.

Upon acceptance, the undersigned, on behalf of Swanton Local School District,
Certifies that the undersigned has read the Addendum, reviewed it with the appropriate parties, found it to include all requested provisions, understood it and agreed to accept all of its provisions.

NAME OF EMPLOYER: SWANTON LOCAL SCHOOL DISTRICT

SIGNATURE_____

TITLE_____

DATE_____

ADDENUM TO PLAN DOCUMENT

NAME OF PLAN: Swanton Local School District Medical, Prescription Drug Card and Dental Benefits

ADDENDUM NUMBER: Twenty-nine

EFFECTIVE DATE: August 1, 2016

ADDENDUM:

New Vision Plan to Schedule of Benefits administered by Self-Plans, Inc. for the classification of Superintendent and Treasurer only. The products and services covered are prescription eyewear including frames, lenses, optional lenses features such as scratch resistance coating, contact lenses and prescription sunglasses. The maximum benefit is $500 per member per benefit year. The benefit year is September 1st through August 31st, which is the same as medical, prescription drug and dental benefits.

Eye exam is excluded since this service is covered by the medical portion of the plan.

This addendum expands the vision hardware benefit from the Superintendent only to the Superintendent and Treasurer.

Upon acceptance, the undersigned, on behalf of Swanton Local School District,
Certifies that the undersigned has read the Addendum, reviewed it with the appropriate parties, found it to include all requested provisions, understood it and agreed to accept all of its provisions.

NAME OF EMPLOYER: SWANTON LOCAL SCHOOL DISTRICT

SIGNATURE_____

TITLE_____

DATE_____

DRAFT ADDENUM TO PLAN DOCUMENT

NAME OF PLAN: Swanton Local School District Medical, Prescription Drug Card and Dental Benefits

ADDENDUM NUMBER: Thirty

EFFECTIVE DATE:

ADDENDUM:

If an employee's spouse and adult dependent child are eligible or in the future ever becomes eligible for a health plan through his/her employer, that spouse or adult dependent child must enroll in his/her employer's health plan. You are not required to enroll other family members in the spouse's plan. The spouse and adult dependent child can be covered on this plan as secondary coverage. In addition, the plan has a monthly payroll qualified in which the spouse or adult dependent child must adhere too when enrolling in their employer's health coverage. This monthly payroll deduction qualifier can change from time to time and can be referenced in the Swanton Local School District respective collective bargaining agreements and the fringe benefit packet (for non-union). The appropriate form must be completed. Swanton Local Schools reserves the right to have the employee complete an audit questionnaire.

Upon acceptance, the undersigned, on behalf of Swanton Local School District,

Certifies that the undersigned has read the Addendum, reviewed it with the appropriate parties, found it to include all requested provisions, understood it and agreed to accept all of its provisions.

NAME OF EMPLOYER: SWANTON LOCAL SCHOOL DISTRICT

SIGNATURE_____

TITLE_____

DATE_____