

PARAMOUNT CARE OF MICHIGAN, INC.
GROUP MEDICAL AND HOSPITAL SERVICE AGREEMENT
3-TIER
MULTI ACCESS PLAN

2010

**IMPLEMENTATION PAGE
DECLARATION**

The Agreements and Riders (the "Documents") checked and initialed below shall become effective and binding agreements of Paramount Care of Michigan, Inc. ("Health Plan") and _____ ("Group") on _____, 2010 ("Effective Date"); provided however, that Group may cancel such agreements upon written notice delivered to Health Plan within seven (7) calendar days of the date of receipt by Group of the Documents.

_____ This is a _____ year Agreement effective from _____, 2010 through _____, 20__, and subject to the term and termination provisions set forth in Section XII.

The second year renewal rate increase is guaranteed not to exceed _____%.

- _____ Ohio HMO Group Medical and Hospital Service Agreement
- _____ Ohio Flex and Flex Plus Group Medical and Hospital Service Agreement
- _____ Michigan HMO Group Medical and Hospital Service Agreement
- _____ Michigan Flex Group Medical and Hospital Service Agreement
- _____ Michigan MAP Large Group Medical and Hospital Service Agreement
- _____ Michigan MAP Small Group Medical and Hospital Service Agreement
- _____ PIC Flex Plan with PCP Certificate of Insurance
- _____ PIC Flex Plan without PCP Certificate of Insurance
- _____ PIC Traditional Plan Certificate of Insurance
- _____ PIC 3 Level PPO Plan Certificate of Coverage
- _____ PIC 2 Level PPO Plan Certificate of Coverage (__ PPO __ PPC)
- _____ PIC Small Group Policy (__ Flex __ Flex Plus __ Traditional __ PPO __ PPC)
- _____ PIC Large Group Policy (__ Flex __ Flex Plus __ Traditional __ PPO __ PPC)
- _____ Ohio Administrative Services Agreement Health Benefits
- _____ Michigan Administrative Services Agreement Health Benefits
- _____ PHC HMO Enrollment Application
- _____ PHC Flex Enrollment Application
- _____ Flex Plus Enrollment Application
- _____ Michigan HMO Enrollment Application
- _____ Michigan Flex Enrollment Application
- _____ PIC Enrollment Application (__ PPO __ PPC)
- _____ Ohio Prescription Drug Rider
- _____ Michigan Prescription Drug Rider
- _____ Medicare Prescription Drug Rider Addendum
- _____ Limited Medical Supply Rider
- _____ Specialty Drug Rider
- _____ Prestige Rider
- _____ Domestic Partner Rider (Not available to HMO Small Group)
- _____ Morbid Obesity Surgery Rider (Not available to HMO Small Group)
- _____ PIC Prescription Drug Rider
- _____ PIC Hearing Aid Rebate Rider
- _____ PIC Infertility Rider
- _____ PIC Vision Hardware Rebate Rider
- _____ Endorsement Page (__ HMO __ Flex __ Flex Plus __ Traditional __ PPO __ PPC)
- _____ Rate Page (__ HMO __ Flex __ Flex Plus __ Traditional __ PPO __ PPC)

By: _____
Title: _____
Date: _____

Paramount Care of Michigan, Inc.

By: _____
Title: _____
Date: _____

**PARAMOUNT CARE OF MICHIGAN, INC.
GROUP MEDICAL AND HOSPITAL SERVICE AGREEMENT**

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ATTACHMENT A: In-Network and PPO Schedule of Benefits
ATTACHMENT B: Out-of-Network Schedule of Benefits

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

I. INTRODUCTION

1.1 Paramount Care of Michigan, Inc. Paramount Care of Michigan, Inc. (hereinafter referred to as the "Health Plan") is a corporation licensed as a Health Maintenance Organization (HMO) in the State of Michigan. Under the HMO concept, all care, including hospitalization, must be provided, prescribed, or authorized by a Health Plan Physician. *Except for certain Emergency and Urgent Care Conditions (see Part II-E-1, Attachment A) Members will not receive any benefits under this Agreement unless provided, arranged or authorized by a Health Plan Physician.*

1.2 Coverage. Group agrees to offer Health Plan's prepaid health care plan to its employees subject to the terms of this Agreement and on at least the substantially similar terms and conditions, as it provides any Alternative Health Benefits Plan for its employees. Health Plan agrees to cover Members in accordance with the Schedule of Benefits set forth in Attachment A and B, and the Endorsement Page(s) to this Agreement, subject to all exclusions therein. This Agreement is issued in consideration of each Member's application for Health Plan coverage and receipt of the Group's payment of required prepayments.

II. DEFINITIONS

2.1 Alternative Health Benefits Plan means the health benefits plan or plans which Group offers as an alternative to the plan set forth in this Agreement.

2.2 Authorized Person is a person, including a spouse, other relative or provider, who has been authorized in writing by the Member to represent the Member in a request for an Internal or External Review.

2.3 Basic Health Services set forth in MCL 500.3501, b, shall include but not be limited to; inpatient hospital services, physician services, outpatient medical services, Emergency health services, urgent care services, laboratory and radiology services, home health services and preventive health services.

2.4 Child means natural children, legally adopted children, stepchildren, and children under legal custody (i.e., official court appointed guardianship or custody) of Subscriber or Subscriber's spouse for whom the Subscriber or the Subscriber's spouse has the financial responsibility to provide for health care needs at the time Covered Services are provided.

2.5 Contract Year means the period of time specified in the "Benefit Period" on the Endorsement Page(s). This may be a calendar year or the anniversary date of the Group.

2.6 Copayment means an amount required under this Agreement to be paid by a Member as a condition of the receipt of Covered Services. The Copayment may be a flat fee or it may be a percentage of provider charges. Copayments are described in the Attachment A and B and Endorsement Page(s) to this Agreement.

2.7 Cosmetic or Plastic Procedures are those procedures that improve physical appearance or treat a mental or emotional condition through a change in body form, but do not correct or materially improve a physiological function.

2.8 Covered Group. A Group consisting of employees, retirees or Dependents receiving Covered Services pursuant to this Agreement.

2.9 Covered Services means the services and benefits provided under this Agreement as set forth in Attachment A hereto that are provided, prescribed or authorized by an In-Network Provider and as set forth in Attachment B for services and benefits provided by a PPO or Out-of-Network Provider.

2.10 Dependent means any member of a Subscriber's family who meets all the applicable eligibility requirements of Article III of this Agreement, who has enrolled in accordance with the Article, and for whom the payment required by this Agreement actually has been received by Health Plan.

2.11 Designated Representative means any entity appointed by Health Plan to administer managed care and/or cost containment programs for this Group Medical and Hospital Service Agreement.

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

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

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

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

2.14 Experimental Drugs and Services means those drugs and services determined by Health Plan to fall outside of generally accepted medical practice. This determination is made based on the recommendation of the Medical Advisory Committee, the most recent HAYES Medical Technology Directory and on current evidenced-based medical/scientific publications.

2.15 Group means a company employing two or more full-time eligible employees.

2.16 Health Plan Physician means any physician duly licensed to practice in either Ohio and/or Michigan, depending upon where the physician engages in the practice of medicine and who is under contract with Health Plan to provide Covered Services to Members. Health Plan Physicians are comprised of Primary Care Physicians and Specialist Physicians.

2.17 HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended, and Michigan regulations promulgated thereunder.

2.18 In-Network or Participating Hospital means any hospital with which Health Plan has contracted or established arrangements to provide Covered Services to Members.

2.19 In-Network or Participating Provider means a Health Plan Physician, Participating Hospital, or other licensed health professional or facility who or which, at the time care is rendered to a Member, has a contract in effect with Health Plan to furnish Covered Services to Members.

2.20 In-Network Benefits are payments made by Health Plan for Covered Services when (1) the Member chooses a Primary Care Physician at the time of enrollment, (2) receives Covered Services from In-Network or Participating Providers and (3) follows the terms and conditions of this Agreement. A Member may not receive In-Network, PPO and Out-of-Network benefits for the same services. All In-Network, PPO and Out-of-Network Benefits are combined to apply toward the maximum benefit limit for a particular service.

2.21 Legal Representative is a person who has been named through legal process as guardian or who has Durable Power of Attorney for Health Care for a Member and is thereby authorized to act on behalf of the Member.

2.22 Medically Necessary means those services determined by Health Plan or its Designated Representative to be (i) preventive, diagnostic and/or therapeutic in nature, and (ii) specifically related to the condition which is being treated/evaluated, and (iii) rendered in the least costly medically appropriate setting, (e.g., inpatient, outpatient, office), based on the severity of illness and intensity of service required, and (iv) not solely for the Member's convenience or that of his or her physician, and (v) is supported by evidence-based medicine.

2.23 Member means any Subscriber or Dependent as defined herein.

2.24 Out-of-Network Benefits are payments for Covered Services when the Member receives Covered Services from Out-of-Network or non-participating Providers and follows the terms and conditions of Attachment B. A Member may not receive In-Network or PPO and Out-of-Network Benefits for the same services. All In-Network, PPO and Out-of-Network Benefits are combined to apply toward the maximum benefit limit for a particular service.

2.25 Out-of-Network Provider means a physician, hospital or other health professional or facility that does not have a contract with Paramount In-Network or the PPO Network to provide Covered Services to Members.

2.26 Out-of-Pocket Copayment Limit is the maximum amount of Copayments including the Deductible, if any, the Member will pay every Contract Year on Basic Health Services. Once the Out-of-Pocket Copayment Limit is met, there will be no additional Copayments on Basic Health Services during the remainder of the Contract Year. Specific dollar Copayments, Copayments for Supplemental Health Services and any penalties do not count toward the Out-of-Pocket Copayment Limit. The single Out-of-Pocket Copayment Limit is the amount each Member must pay; the family Out-of-Pocket Copayment Limit is the total amount any two or more covered family members must pay.

2.27 Participating Hospital means any hospital with which Health Plan has contracted or established arrangements to provide Covered Services to Members.

2.28 Participating Provider means a Health Plan Physician, Participating Hospital, or other licensed health professional or facility who or which, at the time care is rendered to a Member, has a contract in effect with Health Plan to furnish Covered Services to Members.

2.29 Preferred Provider Organization (PPO) Covered Services are authorized services in the list of services covered and applies when the Member receives Covered Services from PPO Participating Providers. PPO Covered Service are subject to a Deductible, Copayment or other limitations.

2.30 Preferred Provider Organization (PPO) Covered Hospital and Provider means a hospital, primary care or specialist physician or other health care professional or facility that has a contract with the Multi Access Plan PPO Network to provide Covered Services to Members.

2.31 Preventive Health Services means Covered Services that are being provided: 1) to a Member who has developed risk factors (including age and gender) for a disease for which the Member has not yet developed symptoms, and 2) as an immunization to prevent specific diseases. However, any service or benefit intended to treat an existing illness, injury or condition does not qualify as Preventive Health Services. See Preventive Health Services in Attachment A.

2.32 Primary Care Physician means a Health Plan Physician who is designated by Health Plan as a Primary Care Physician responsible for managing and coordinating the full scope of a Member's medical care, including but not limited to performing routine evaluations and treatment, arranging for all necessary referrals to specialists, ordering laboratory tests and x-ray examinations, prescribing required medications, and arranging for a Member's hospitalization or other services when appropriate and who meets all the requirements for Primary Care Physicians contained in Primary Care Physician's Agreement with Health Plan and such other requirements adopted by Health Plan from time to time.

2.33 Schedule of Benefits means the benefits and coverage applicable to a Member which appears in Attachment A and B or which hereafter may be made a part of this Agreement.

2.34 Service Area means Monroe and Lenawee counties in Michigan and such other areas in which Health Plan may from time to time extend its services.

2.35 Specialist Physician means a Health Plan Physician who provides Covered Services to Members within the range of his or her medical specialty, who is designated by the Health Plan as a Specialist Physician, and who meets all the requirements for Specialist Physicians contained in the Specialist Physician's agreement with Health Plan and such other requirements adopted by Health Plan from time to time.

2.36 Subscriber means a person who meets all applicable eligibility requirements of Article III of this Agreement, who enrolls in accordance with that Article, and for whom the payment required by this Agreement actually has been received by Health Plan.

2.37 Supplemental Health Services shall include but not be limited to; inpatient mental health, inpatient substance abuse, durable medical equipment, prosthetic devices, vision care services and outpatient prescription drugs.

2.38 Urgent Medical Condition means a medical condition, other than an Emergency Medical Condition, that requires medical attention soon after it appears that is not permanently disabling or life-threatening.

2.39 Urgent Care Services means Covered Services that are provided for an Urgent Medical Condition.

2.40 Usual, Customary and Reasonable means the schedule established by Health Plan and updated periodically.

2.41 Value of Medical Benefits Paid is the amount paid by Health Plan to the provider, or in the absence of a cash payment for a specific visit, the fee-for-service equivalent, plus administrative costs and legal fees as permitted by law.

III. ELIGIBILITY

3.1 Subscriber Eligibility. To be eligible as a Subscriber, a person must be eligible under the Group's eligibility rules, reside in the Health Plan's Service Area or be employed in the approved Service Area and:

- A. (1) For Groups with fewer than 50 employees, the person must be in the active employment of Group and works on a full-time basis with a normal workweek of 30 hours. Eligible employee includes an employee who works on a full-time basis with a normal workweek of 17.5 to 30 hours, if an employer so chooses and if this eligibility criterion is applied uniformly among all of the employer's employees and without regard to health status-related factors (MCL 500.3701, (h)). For Groups with greater than 50 employees, the person must be in the active employment of Group and working a minimum average of 20 hours per week or such other minimum average that is approved by Health Plan; or
- (2) Be a retired employee, non-Medicare eligible, drawing retirement benefits from Group pension or profit-sharing plan(s), but only if Group is obligated to provide health benefits to all retired employees in the covered group prior to the effective date of this Agreement; or
- (3) Be an eligible employee on company paid sick leave or disability not to exceed 6 months if, prior to sick leave or disability, the employee worked a minimum average of 20 hours per week for the preceding 26 weeks; or
- (4) Be an eligible former employee or Dependent under group continuation (COBRA) status; or
- (5) If the Group has elected to offer a Prestige Rider, to be eligible to enroll as a subscriber thereunder, the subscriber must be an actively working or retired employee of Group, enrolled in and eligible for Medicare Part A and B, Medicare must be primary in accordance with Medicare Coordination of Benefits rules, and the Group must maintain active employee benefits through Health Plan; and , in order to be eligible for coverage under a Prestige Prescription Drug Rider, the subscriber must also be enrolled in Medicare Part D through Paramount Insurance Company.
- B. Be entitled to participate in the medical and hospital care benefits program arranged by Group; and
- C. Submit a completed and signed enrollment application form or electronic enrollment, including all requested information on all Dependents for whom coverage is requested to the Health Plan within 31 days of the effective date of this Agreement.

3.2 Dependent Eligibility. To be eligible as a Dependent, a person must be eligible under the Group's eligibility rules, must reside in the Health Plan's Service Area (or in a county contiguous to the Service Area),

and must submit (or the Subscriber must submit on the Dependent's behalf) a completed and signed enrollment application, and must be:

- A. The legal spouse of the Subscriber (excluding divorce[e]s); or
- B. An unmarried dependent Child of the Subscriber or Subscriber's spouse who is:
 - i. under the limiting age or between the limiting ages specified on the Endorsement Page(s),
 - ii. not employed full-time, and
 - iii. if applicable to Group, attending a recognized college or university, trade or secondary school on a full-time.

As used herein, full time basis for the purposes of attending a college or university means carrying a minimum of 12 credits for undergraduates or 9 credit hours for graduate students.

If it is medically necessary for a Dependent student to take a leave of absence from college, university, trade or secondary school due to a serious illness or injury, dependent eligibility will continue for a period of 12 months from the last day of full time attendance, at such school, or until the Dependent student reaches an age at which coverage would otherwise terminate, whichever period is shorter. Continuation of Dependent Eligibility due to a medically necessary leave of absence is subject to certification of the medical necessity due to a serious illness or injury in writing from the Dependent student's attending physician, within 31 days from the last day of full time attendance at such school; or

- C. An unmarried Child who has reached the limiting age specified on the Endorsement Page(s), is unable to work to support himself or herself and who is primarily dependent on Subscriber for support and maintenance because of mental retardation or physical handicap. Appropriate medical documentation of the incapacity and dependency must be furnished to Health Plan by the Subscriber within 31 days of reaching the limiting age specified on the Endorsement Page (s), and thereafter, at least annually, and the documentation must be satisfactory to Health Plan. In addition, Health Plan may periodically check whether such Child is, and continues to qualify as, a Dependent.

3.3 Newborn Children. A newborn child of a Subscriber or the Subscriber's spouse is covered for the first thirty-one (31) days following birth. To continue coverage beyond this 31-day period, the Subscriber must submit an enrollment application for the newborn child to Health Plan within this 31-day period. A newborn child of a Dependent is not eligible unless otherwise considered a Child under Section 2.4.

3.4 Adopted Children. To receive coverage, an adopted Child must be enrolled within 31 days from the date of adoptive placement or during an open enrollment period. Coverage will be effective from the date of the adoptive placement. Adoptive placement means the assumption and retention by Subscriber or Subscriber's spouse of a legal obligation for total or partial support of a child in anticipation of the adoption of the child. The placement terminates upon termination of the legal obligation.

3.5 New Employees. New employees or newly transferred employees will have coverage effective in accordance with the new-hire policy established by the Group so long as such person enrolls within 31 days of becoming newly eligible and the applicable prepayment is received by Health Plan in a timely manner. If the Group has fewer than 50 employees, the waiting period imposed by the Group may not exceed 90 days from date of hire.

3.6 New Spouses & Common Law Spouses. New spouses of Subscribers will have coverage effective on the date of a legal marriage so long as such person enrolls within 31 days of the marriage date and the applicable prepayment is timely received by Health Plan. Any person claiming to be the common law spouse of a Subscriber must prove to the satisfaction of Health Plan that their claimed common law marriage with the Subscriber is valid under Michigan law. Health Plan reserves the right to require at any time proof to its satisfaction of the validity of an alleged lawful marriage. Proof must include, but may not be limited to producing information requested by Health Plan that might confirm or dispute the existence of a valid common law marriage under Michigan, or, if applicable, Ohio law.

3.7 Late Enrollment & Waiver. If an eligible employee or Dependent fails to submit an enrollment application within the prescribed time period, that employee or Dependent may not enroll until the submission of a completed application and applicable premium retroactive to the eligibility effective date. If an eligible employee or

Dependent waives coverage or declines to pay for coverage from the eligibility effective date, that employee or Dependent may not enroll until the next open enrollment period or during a special enrollment period required under HIPAA.

3.8 Group Eligibility. During the term of this Agreement, Group must comply with the following eligibility requirements for Group Participation and Group Contribution. Upon request, Group must provide appropriate documentation to Health Plan so that Health Plan can determine, in its sole discretion, Group's compliance with the Eligibility Requirements for participation and contribution.

A. Group Participation. Group must have the following minimum participation of eligible actively working (as set forth in § 3.1(1)) employees enrolled with Health Plan in order to be eligible as a Group:

Groups with greater than 50 employees:

- 50 employees must have 75% participation; and
- 51 plus employees participation to be determined by Health Plan.

Groups with fewer than 50 employees (MCL 500.3709, (a)–(c)):

- 10 or fewer employees must have 100% participating;
- 11 through 25 employees must have 75% participating; and
- 26 through 50 employees must have 50% participating.

B. Group Contribution. Groups with more than 50 employees agree to contribute on behalf of the covered employees at least 50% of the total premium or 100% of the single premium applied for all employees. Groups with 2-50 employees must contribute 50% of the total premium for all employees. Provided, however, in the event that employees of Group are receiving benefits from other carriers, Group agrees to contribute on behalf of employees eligible to enroll in Health Plan

IV. EFFECTIVE DATE OF COVERAGE

4.1 Initial Open Enrollment Period. There will be an initial open enrollment period for Subscribers and their presently eligible Dependents with the dates of such period and the effective date of coverage for persons who enroll during such period as set forth on the Endorsement Page(s) of this Agreement. Completed and signed enrollment applications must be received by the Health Plan within 31 days of the effective date of Group coverage.

4.2 New Hire Policy. Newly hired employees have coverage effective after the probationary/waiting period established by Group and stated on the Endorsement Page(s) of this Agreement. If the Group has fewer than 50 employees, the affiliation period imposed by the Group may not exceed 60 days for newly hired employees and 90 days for late enrollment (MCL 500.3707, (2), (b)). In all cases, applications must be received by Health Plan within 31 days of the effective date of coverage.

The Group may change the probationary/waiting period for new hires as originally stated on the Endorsement Page(s) of this Agreement by submitting 31 days advance written request to Health Plan. Only one change per twelve-month period will be accepted.

4.3 Recall Policy. If a Member terminates coverage at the time of a layoff and thereafter returns to active employment within 6 months from the effective date of layoff, that employee will be eligible for coverage with Health Plan in accordance with Group-requested specifications, but in no case prior to the effective date of recall. If the previously enrolled employee has been laid off for longer than 6 months, that employee will be considered a new hire for purposes of this Agreement.

4.4 Periodic Open Enrollment Period. In addition to the initial open enrollment period, there will be such other open enrollment period(s) as set forth on the Rate Page of this Agreement. Except for persons who are enrolled during the initial open enrollment period or persons enrolled in accordance with Sections 3.3, 3.4, 3.5 3.6 or 3.7 of this Agreement, anyone eligible to enroll in Health Plan may do so only during a special enrollment period as required under HIPAA.

4.5 Pre-existing Conditions. Health Plan does not restrict coverage under this Agreement based upon any pre-existing conditions.

V. CHOICE OF HEALTH PLAN PHYSICIAN

5.1 **Selection of a In-Network Primary Care Physician.** Each Member must select a Paramount Primary Care Physician or have one selected on his/her behalf. This Primary Care Physician directs the Member's medical care.

5.2 **Contacting the In-Network Primary Care Physician.** In order to receive In-Network Benefits, the Member must contact his/her In-Network Primary Care Physician before seeking non-emergency medical care. Prior authorization from the In-Network Primary Care Physician is not required for treatment by In-Network Providers for the following: annual routine eye exam and treatment by participating OB/GYN specialists, allergists, dermatologists, hematologists, oncologists, ophthalmology, pediatric ophthalmology, retinology, pain management and other Participating Providers as determined by Health Plan. Members who circumvent their In-Network Primary Care Physician when seeking In-Network services, except in the case of an Emergency Medical Condition and those mentioned previously in this section, will be denied coverage on those services provided.

5.3 **Obstetrical/Gynecological Care.** A female Member may choose to see her Primary Care Physician or any participating gynecologist for treatment of obstetrical/gynecological conditions, including the annual GYN exam. If a Member chooses to see a participating gynecologist, prior authorization from the Primary Care Physician is not required.

5.4 **Changing In-Network Primary Care Physician.** A Member or his/her In-Network Primary Care Physician may decide to end his/her physician-patient relationship at any time as allowed by medical ethics and contract. If a Member wishes to change his/her In-Network Primary Care Physician, he/she shall notify Health Plan of this intent and follow the same procedure as if the Member was initially selecting a In-Network Primary Care Physician. There is no limit on the number of times that a Member may change his/her In-Network Primary Care Physician.

VI. PREMIUMS, OUT-OF-POCKET COPAYMENT LIMIT AND DEDUCTIBLE

6.1 **Amount of Premiums.** The required premium for this Agreement and the manner of payment are set forth on the Service Agreement Rate Page attached hereto. The rates will be in effect for the rate period set forth on the Rate Page. However, if the state or federal government or Group requires Health Plan to provide additional benefits, the premium may be increased in order to account for the additional/reduced costs. If there is a change in the premium at the end of the rate period set forth on the Rate Page or for any renewal period of this Agreement, Health Plan will provide Group with written notice thereof at least 30 days before the new premium goes into effect.

6.2 **Premium Payments.** All premiums are due on or before the first day of the month for which coverage is to be provided. Group must pay in accordance with the Health Plan invoice. Any additions or deletions to the invoice must be submitted in writing and credits or additional charges will be made on the next invoice. Only Members for whom the applicable premium is actually received by Health Plan are entitled to Covered Services hereunder and then only for a period for which such premium is applicable. Subscribers with effective dates falling between the first and the fifteenth of the month will be charged a premium from the beginning of the calendar month during which the coverage first became effective. Subscribers with effective dates falling between the sixteenth and the last day of the month will not be charged a premium until the first of the following month.

If payment for any Member is not made within 15 days of the due date or within 30 days of the due date for Members under COBRA continuation coverage, Health Plan will notify Group of late payment and possible termination. On the 30th day after the due date Health Plan will terminate coverage of the individual Member or all Members under this Agreement as of the date any delinquent payment was due. If coverage is terminated under the terms of this provision, the Group will be responsible for reimbursement to Health Plan for the Value of Medical Benefits Paid for services and supplies received after the effective date of termination.

If Group is twenty-five (25) days late submitting premium in two (2) out of the last six (6) months, Health Plan will require Group to pay an additional one month premium to be held in reserve. The reserve premium will be retained for the duration of the contract term and applied to the last month's coverage period upon notice of termination of this Agreement by Group. Health Plan reserves the right to charge a service fee for non-sufficient funds or declined payment transactions.

6.3 **Out-of-Pocket Copayment Limit.** Health Plan agrees to limit annual Copayments for Basic Health Services. The limits are set forth on the Endorsement Page(s). The Copayment limit does not apply, however, to Copayments for Supplemental Services. Supplemental Health Services shall include but not be limited to; inpatient

mental health, inpatient substance abuse, durable medical equipment, prosthetic devices, vision care, and prescription drugs.

6.4 Deductible. The Deductible, if applicable, is set forth on the Endorsement Page(s). All Covered Services provided by In-Network and PPO Providers, except for services subject to a specific dollar Copayment and Preventive Health Services, set forth in Attachment A, are subject to the In-Network and PPO Deductible each Contract Year, unless otherwise stated herein. All Covered Services provided by Out-of-Network Providers set forth in Attachment B, are subject to the Out-of-Network Deductible each Contract Year, unless otherwise stated herein.

6.5 Deductible Carryover. When a Member pays for Covered Services during the last three (3) months of the Contract Year, which are applied to that year's Deductible, those expenses may be carried over and applied against the Deductible for the next Contract Year.

6.6 Deductible Credit. A new Group enrolling with Health Plan that elects this option will receive credit toward Health Plan Deductible, if applicable, for expenses applied to Group's previous plan year deductible. Sufficient information, in a form acceptable to Health Plan, must be received no later than 90 days from the Group's effective date with Health Plan in order to receive credit.

VII. TERMINATION OF COVERAGE

7.1 Loss of Eligibility. If a Member ceases to meet the eligibility requirements of Article III of this Agreement, then coverage under this Agreement for the Member will terminate automatically at midnight of the last day of the month in which eligibility ceased. Group shall notify Health Plan in writing within thirty (30) days of the date that any Member ceases to meet the eligibility requirements of Article III by completing and submitting to Health Plan a "Termination Notice". Group and Member are obligated, jointly and severally, to pay Health Plan for the Value of Medical Benefits Paid for all health services and benefits received by Member or any of Member's covered Dependents after the last day of the month in which the Member's eligibility ceased.

7.2 Selection of Other Coverage. If a Subscriber elects coverage under an Alternative Health Benefits Plan or under any other plan which is offered by, through or in connection with Group as an option in lieu of coverage under this Agreement, then coverage for the Subscriber and Subscriber's Dependents terminates automatically at midnight of the last day preceding the day that the alternate coverage becomes effective. Group agrees to notify Health Plan immediately in writing in the event a Subscriber has elected other coverage.

7.3 Nonpayment of Premium. If payment of premium for any Member is not made within 15 days of the due date or within 30 days of the due date for Members under COBRA continuation coverage, Health Plan may terminate the coverage of the individual Member or of all Members covered under this Agreement as of the date any delinquent payment was due. If coverage is terminated pursuant to this section, the Group whose coverage was terminated must reimburse Health Plan for the Value of Medical Benefits Paid for services and supplies received after the effective date of termination.

7.4 Failure to Furnish or Furnishing Incorrect or Incomplete Information. Members are required to represent in their enrollment applications (including electronic enrollment) that, to the best of their knowledge and belief, all information contained in such applications or other documents submitted to Health Plan is true, correct and complete. If a Member fails to furnish information required to be furnished by Health Plan or furnishes incorrect or misleading information that is material to Health Plan's decision to provide coverage for the Subscriber or involves fraud, then Health Plan may terminate coverage of the Member involved effective on the date such Member failed to furnish such information or the date such Member furnished incorrect or misleading information, whichever is applicable. Upon termination the Member must pay Health Plan for the cost of services received subsequent to the date of termination, based on the Value of Medical Benefits Paid, less any Copayments made or prepayments paid by the Member for the services. Health Plan may also terminate coverage of all other enrolled Members of such Member's family, effective immediately upon written notice. Health Plan shall notify Group in writing in the event Health Plan terminates coverage hereunder.

7.5 Fraud, Including Misuse of Identification Card. Any person who, with intent to defraud or knowing that he is facilitating a fraud against Health Plan, submits an application or files a claim containing a false or deceptive statement, is guilty of Insurance Fraud under Michigan or Ohio criminal law, and Health Plan may terminate the coverage of the person upon written notice to the relevant Subscriber and to Group. Health Plan may deem the termination effective as of the date of filing said application or claim.

If any Member permits the use of his/her or any other Member's Health Plan identification

card by any other person or uses another person's card or uses an invalid card, then the misused card will be retained by Health Plan, as well as Member's own identification card, and Health Plan may terminate the coverage of the Member or Members involved and may also terminate the coverage of all other enrolled Members of his/her family. Health Plan may deem the termination effective as of the day the card was first misused.

If any Member engages in fraud or deception of any kind in the use of the services or facilities of Health Plan or of Participating Providers or knowingly permits such fraud or deception by another, Health Plan may terminate the coverage to the Member or Members involved and may also terminate the coverage of all other enrolled Members of his/her family. The coverage of the Member or Members involved and the coverage of all the enrolled Members of his/her family may be terminated upon written notice to the relevant Subscriber and to Group. Health Plan may deem the termination effective as of the first day of the fraud or deception.

If Health Plan terminates a Member's coverage under this Section, the Member must pay Health Plan for the cost of services received subsequent to the date of termination, based on the Value of Medical Benefits Paid, less any Copayments made or prepayments paid by the Member for the services.

7.6 Reinstatement. If coverage of a Member is terminated under Article VII, it may be reinstated only upon written request to Health Plan. Reinstatement is within the sole discretion of Health Plan and may be subject to approval of a medical history questionnaire. The application for reinstatement must be accompanied by payment of any outstanding balance of Subscriber's account plus any current premium owed.

7.7 Refunds. If the rights of a Member hereunder are terminated pursuant to Sections 7.4 or 7.5, the premium(s) received on account of the terminated Member or Members applicable to periods after the effective date of termination, less any amounts due Health Plan or Participating Providers, will be refunded to Group within 31 days of the effective date of termination and neither Health Plan nor Health Plan Participating Providers will have any further liability or responsibility.

7.8 Continuation for Current Inpatients. In the event that a Member's coverage terminates while the Member is receiving inpatient care in a hospital, such Member's coverage will continue for the period required under HIPAA.

VIII. COORDINATION OF BENEFITS

8.1 General

- A. This coordination of benefits ("COB") provision applies to This Plan when an employee or the employee's covered Dependent has health care coverage under more than one plan. "Plan" and "This Plan" are defined below.
- B. If this COB provision applies, you should look first at the order of benefit determination rules. Those rules determine whether the benefits of This Plan are determined before or after those of another Plan. The benefits of This Plan:
 - (1) will not be reduced when, under the order of benefit determination rules, This Plan determines its benefits before another Plan; but
 - (2) may be reduced when, under the order of benefits determination rules, another Plan determines its benefits first. The above reduction is described in Section 8.4 "Effect on the Benefits of This Plan."

8.2 Definitions for Article VIII

- A. "Plan" means any of the following which provides benefits or services for, or because of, medical or dental care or treatment:
 - (1) Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.
 - (2) Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time).

- (3) "Plan" does not include school accident-type coverage, individual contracts of coverage, or some supplemental sickness and accident policies.

Each contract or other arrangement for coverage under (1) or (2) is a separate Plan. If an arrangement has two parts and COB rules apply only to one of the two, each part is a separate Plan.

- B. "This Plan" is the part of this group contract that provides benefits for health care expenses.
- C. "Primary Plan/Secondary Plan": the order of benefit determination rules set forth below state whether This Plan is a Primary Plan or Secondary Plan as to another Plan covering the person.
When This Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits.
When This Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits.
When there are more than two Plans covering the person, This Plan may be a Primary Plan as to one or more other Plans and may be a Secondary Plan as to a different Plan or Plans.
- D. "Allowable Expense" means a necessary, reasonable and customary item of expense for health care when the item of expense is covered by This Plan. However, This Plan is not required to pay for an item, service, or benefit which is not a part of This Plan's contract.
When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

8.3 Order of Benefit Determination Rules

- A. When there is a basis for a claim under This Plan and another Plan, This Plan is a Secondary Plan whose benefits are determined after those of the other Plan, unless:
- (1) The other Plan has rules coordinating its benefits with those of This Plan; and
 - (2) Both those rules and This Plan's rules, in subsection below, require that This Plan's benefits be determined before those of the other Plan.
- B. This Plan determines its order of benefits using the first of the following rules which applies:
- (1) The benefits of the Plan which covers the person as an employee, member, insured, or subscriber (that is, other than as a dependent) are determined before those of the Plan which covers the person as a dependent; except that: if the person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is
 - (a) Secondary to the Plan covering the person as a dependent and
 - (b) Primary to the Plan covering the person as other than a dependent (e.g., a retired employee).
 - (2) Benefits for a dependent child whose parents are not separated or divorced are determined as follows:
 - (a) The benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year; but
 - (b) If both parents have the same birthday, the benefits of the Plan which covered one parent longer are determined before those of

the Plan which has covered the other parent for a shorter period of time. However, if the other Plan does not have the rules described in (a) above, but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

- (3) Benefits for a dependent child whose parents are divorced or separated are determined as follows. To the extent the Plan has been notified by receiving a copy of the court decree:
 - (a) If the specific terms of the court decree state that one of the parents is responsible for health care expenses of the child, the benefits of the Plan of that parent are determined first. The Plan of the other parent is the Secondary Plan.
 - (b) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the Plans covering the child are subject to the order of benefit determination contained in subdivision 8.3 (B)(2) of this section.
 - (c) If neither subdivision (a) nor (b) applies, the order of 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 the custody of the child;
 - (iii) The Plan of the parent not having custody of the child;
 - (iv) The Plan of the spouse of the parent not having custody of the child.
- (4) The benefits of a Plan which covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before the benefits of a Plan which covers that person as a laid off or retired employee (or as that employee's dependent). If the other Plan does not have this rule and if, as a result, the Plans do not agree on the order of benefits, this paragraph should be ignored.
- (5) Continuation Coverage. If a person whose coverage is provided under a right of continuation pursuant to federal law (i.e., COBRA) or state law also is covered under another Plan, the benefits of the Plan covering the person as employee, member or subscriber (or that person's dependent) will be determined before the benefits under the continuation coverage. If the other Plan does not have this rule and if, as a result, the Plans do not agree on the order of benefits, this paragraph should be ignored.
- (6) Longer/shorter length of coverage. If none of the above rules determines the order of benefits, the benefits of the Plan which covered an employee, member or subscriber longer are determined before those of the Plan which covered that person for the shorter term.

8.4 Effect on the Benefits of this Plan

- A. This section applies when, in accordance with Section 8.3 "Order of Benefit Determination Rules," This Plan is a Secondary Plan as to one or more other Plans. In that event, the benefits of This Plan may be reduced under this section. Such other Plan or Plans are referred to as "the other Plans" in B(2) below.
- B. Reduction in This Plan's benefits. The benefits of This Plan will be reduced to the extent that the sum of:
 - (1) The benefits that would be payable for the Allowable Expense under This Plan in the absence of this COB provision; and

- (2) The benefits that would be payable for the Allowable Expenses under the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made, exceeds those Allowable Expenses.

8.5 Right to Receive and Release Needed Information

Certain facts are needed to apply these COB rules. Paramount Health Care has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. Paramount Health Care need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give Paramount Health Care any facts it needs to pay the claim. However, this Section is subject to the requirements of Section 13.11.

8.6 Facility of Payment

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

8.7 Right of Recovery

If the amount of the payments made by Paramount Health Care is more than it should have paid under this COB provision, it may recover the excess from one or more of:

- (1) The persons it has paid or for whom it has paid;
- (2) Another Plan or
- (3) The provider of service.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Whenever payments have been made by This Plan with respect to coverage under this Agreement in excess of the maximum amount of payment required under this Article VIII, This Plan may recover the excess payment from the Subscriber or from any other person, insurance company, governmental agency or any other organization which benefited from such overpayment. By executing an enrollment application, a Member agrees to do whatever is necessary to assist This Plan in completing and filing claim forms with other insurance companies, governmental agencies or organizations and in endorsing checks to Paramount Health Care.

IX. REIMBURSEMENT, NON-DUPLICATION AND SUBROGATION

9.1 Payment and Reimbursement. By executing an enrollment application and/or directly or indirectly presenting claims for payment for Covered Services, Subscribers and their Dependents agree that if sickness or injury to a Member is caused by an act or omission of a third party or the Member, Health Plan may elect to pay for the Covered Services and seek reimbursement or subrogation. If a Member or Member's legal representative settles or obtains a judgment on a claim for injuries to Member, Member agrees to reimburse Health Plan from the amounts recovered at the full Value of Medical Benefits Paid, even if the settlement or judgment is partial and does not fully compensate or make the member whole or include full payment for medical costs. Health Plan's reimbursement rights are a first priority claim against any recovery and must be paid before other claims by the Member for damages, and must be paid without any reductions for Member's attorney fees, costs or other expenses. Member agrees to make full reimbursement regardless of how the monetary recovery was designated (e.g., pain and suffering, non-economic loss, etc.), and regardless of whether the settlements or judgments obtained either by the Member or on behalf of the Member are under Member's own insurance, medical payments coverage, excess, umbrella, uninsured and/or underinsured motorist insurance, or any other source (including the party causing such sickness or injury).

9.2 Workers' Compensation/Non-Duplication. The benefits which Members are otherwise entitled to receive under Health Plan do not duplicate any benefit to which Members are entitled under Workers' Compensation laws or similar employer liability laws. All sums paid by Workers Compensation or similar employer liability laws to a Member for Covered Services are deemed to be assigned to Health Plan and subject to the procedures set forth in Sections 9.1 and 9.3.

9.3 Subrogation. As an alternative to reimbursement by Member as provided in Section 9.1 above, Health Plan, at its option, may choose to exercise its rights of subrogation to the Member's rights of recovery and remedies by joining in a Member's lawsuit, assigning its rights to Member to pursue on Health Plan's behalf, or bringing suit in the Member's name, as subrogee. Where a Member has benefits paid by Health Plan as a result of sickness or injury caused by a third party or the Member, the rights of the Member to claim or receive compensation, damages or other payment from any person, organization or insurer, including a Member's own insurer, medical payments coverage, any excess, umbrella, uninsured and/or underinsured motorist insurance, and any other source (including the party causing such sickness or injury), are transferred to Health Plan but only to the extent of the Value of Medical Benefits Paid for Covered Services provided to the Member. Health Plan's subrogation rights are a first priority claim against any recovery and must be paid before any other claims, including claims by the Member for damages, and must be paid without any reductions for Member's attorney fees, costs or other expenses, even if settlement or judgment is partial and does not fully compensate or make the Member whole.

9.4 Cooperation by Members. By executing an enrollment application and/or directly or indirectly presenting claims for payment for Covered Services, the Subscriber and his/her Dependents agree to execute and deliver all assignments or other documents as may be required and do whatever is necessary to effectuate and protect fully the rights of Health Plan or its nominee under this Article. Member may not do anything which might limit, waive or release Health Plan's reimbursement or subrogation rights.

Member agrees not to settle a claim for any sickness or injury caused by a third party or the Member without either providing for full and immediate reimbursement to Health Plan at the Value of Medical Benefits Paid from sums due from the settlement, or agreeing in writing with Health Plan before the settlement on some other payment schedule and security payment. Health Plan's right of reimbursement and subrogation under sections 9.1 and 9.3 of this article apply where Member's sickness or injury arises from any accident, trauma, product, or from the actions or inactions of any person, entity, manufacturer or the Member. Member or Member's Representative must notify Health Plan of the incident causing the sickness or injury within 30 days of the incident. Should the Member be incapacitated for 30 days or longer, the Member or Member's Representative must notify the Health Plan as soon as feasible but no later than the date on which Member or Member's Representative files a lawsuit to recover damages or 120 days prior to the expiration of the statute of limitations, whichever is sooner.

9.5 Cooperation by Employers. By executing this Agreement, the Employer agrees to assist Plan in obtaining necessary information from covered employees as may be required and do whatever is necessary to effectuate and protect fully the rights of Health Plan or its nominee under this Article.

X. GROUP CONTINUATION AND INDIVIDUAL CONVERSION COVERAGE

10.1 Group Continuation Coverage. Under certain circumstances Members who cease to meet eligibility requirements under Section III of this Agreement may be eligible for Group continuation coverage under the Group's health benefits plan. Except where COBRA, 29 U.S.C. §§ 1161-67, applies and provides to the contrary, Group continuation coverage will not be available for:

- A. Any person who is, becomes, or could be covered under Medicare as primary coverage; or
- B. Any person who is, becomes or could be covered as an employee, member or dependent by any other plan which covers health services; or
- C. Any person who does not reside in the Health Plan's Service Area; or
- D. Any person from any Group whose coverage was terminated for any reason by Health Plan.

10.2 Conditions of Group Continuation Coverage for Groups with 20 or More Employees (Consolidated Omnibus Budget Reconciliation Act). Health Plan will offer group continuation coverage to all Members entitled to such coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA), 29 U.S.C. §§ 1161-67 for the period of time COBRA requires that continuation coverage be provided for the Member. This coverage is subject to the Member's and Group's compliance with all COBRA requirements and with this Agreement. Group continuation coverage will cease upon termination of this Agreement. Unless required otherwise by COBRA, Group continuation

coverage under this section will cease upon Member (1) becoming covered under any other group plan without an exclusion relating to a pre-existing condition of such Member or (2) becoming entitled to Medicare benefits.

10.2.1 Group Continuation Coverage for Subscribers who are Reservists in the Armed Forces. Health Plan will offer continuation coverage for Subscribers who are reservists called to active duty in the Armed Forces of the United States as required by the Uniform Services Employment and Reemployment Rights Act (USERRA).

10.3 COBRA Disabled. Health Plan reserves the right to charge up to 150% of premium after the 18th month of COBRA continuation coverage if the individual was disabled under either Title II or XVI of the Social Security Act at the time of the qualifying event described in 29 U.S.C. Section 1163(2).

10.4 Termination of Group Continuation Coverage. In the event coverage under the Group's continuation coverage ceases other than for reason of nonpayment as stated in Section 6.2 and 7.3 or termination of this Agreement, Subscriber and/or eligible Dependents may convert their enrollment to individual membership without furnishing evidence of insurability. To obtain individual membership, the eligible Member must: (a) continue to reside in the Service Area, (b) submit a completed application for conversion to an individual policy within 31 days after the date of termination of the group continuation coverage, and (c) submit the payment required for the membership. The conversion option must be offered to the subscriber by the Group during the 180 days preceding the expiration of continuation of coverage. Eligibility for individual conversion is subject to the exceptions noted in Section 10.5, B.

10.5 Conversion to Individual Coverage.

A. Individual Conversion Coverage is Available in the Following Situations:

- (1) Ceasing to be Employed by Group. In the event a Subscriber ceases to be covered under this Agreement solely as a result of the termination of his/her employment with Group, the Subscriber may convert his/her enrollment to individual coverage without furnishing evidence of insurability and without regard to health status or requirements for health care services. It is the Subscriber's responsibility to apply in writing to Health Plan for individual conversion coverage within 31 days after employment with Group terminates.
- (2) Death or Divorce. In the event that the Dependent of a Subscriber who is legally capable of contracting ceases to be covered under this Agreement solely as a result of the termination of marriage to, or death of, the Subscriber, then the Dependent may convert to individual coverage without furnishing evidence of insurability and without regard to health status or requirements for health care services. It is the Dependent's responsibility to apply in writing to Health Plan for individual conversion coverage within 31 days after the termination of marriage to, or death of, Subscriber.
- (3) Dependent Child Reaching Limiting Age. In the event the Subscriber's Dependent Child ceases to be covered under this Agreement solely because the Child marries, is no longer a Dependent of Subscriber, attains the limiting age for an eligible Dependent Child or is no longer incapable of self-support, the Child may convert to individual coverage without furnishing evidence of insurability and without regard to health status or requirements for health care services. It is the Dependent's responsibility to apply in writing to Health Plan for individual conversion coverage within 31 days after the event.
- (4) Group Terminates for Non-Payment of Group Premiums. In the event this Agreement is terminated for non-payment of Group premiums, the Subscriber may convert his/her enrollment to individual coverage within 31 days of the notice of termination of Group coverage, if the Subscriber applies and pays for individual coverage. The Subscriber shall be provided coverage without furnishing evidence of insurability and without regard to health status or requirements for health care services.

- B. Notwithstanding anything in this Agreement to the contrary, conversion to individual coverage is NOT available when:
- (1) The Group Medical and Hospital Service Agreement is terminated by the Group for any reason, other than those under 10.6, A, (4); or
 - (2) Member does not reside in Service Area; or
 - (3) Member is eligible for Medicare or any other health plan coverage.

10.6 Conditions for Individual Conversion Coverage. To be considered for individual conversion coverage, the Member must submit to Health Plan a completed and signed enrollment application within 31 days from the date the Member ceases to meet the eligibility requirements of this Agreement and becomes eligible for individual conversion under Sections 10.5 or 10.6 of this Agreement or within 15 days from receipt of notice of the conversion option from Health Plan, whichever is later. Conditions for entitlement to individual coverage are as follows:

- A. All conversions to individual coverage must be in accordance with Health Plan's rules, regulations, policies and procedures governing conversion and Members who convert to individual coverage must sign and comply with the terms of Health Plan's "Individual Medical and Hospital Service Agreement". The benefits available under conversion coverage may differ from the benefits available under this Agreement.
- B. If a Member eligible for conversion elects to exercise the conversion privilege, the conversion will be retroactively effective as of the date Group coverage terminated and will be subject to the payment of any required amounts due for the 31-day election period.
- C. If a Member eligible for conversion elects not to exercise the conversion privilege, and the Member or any Member of his/her family receives health services or benefits during the 31-day election period, the Member must pay Health Plan for the Value of Medical Benefits Paid for those services, less any Copayments paid for the services.
- D. Member must remit to Health Plan the applicable payment according to the Health Plan's payment schedule as detailed in the "Individual Medical and Hospital Service Agreement."
- E. If Member becomes eligible for coverage under any other health care plan, or under Medicare, eligibility for individual coverage ceases.

XI. GRIEVANCES

11.1 Grievance – Level 1. In accordance with Michigan Public Act 251 of 2000 the total grievance process will take no longer than thirty-five (35) days. All Member problems will be resolved informally whenever possible. The Member should contact Health Plan's Member Services Department. If the initial problem is in writing, a Member Services Representative will telephone the Member to seek informal resolution within two (2) working days after receipt of the letter for urgent clinical issues and within seven (7) days for other complaints. If the first level problem or Grievance is not resolved satisfactorily on an informal basis, the Member Services Representative will inform the Member that he/she may appeal orally or in writing.

11.2 Grievance – Level 2. If the first level grievance is not resolved to the Member's satisfaction, the Member will be informed of their right to file an oral or written second level grievance with Health Plan. A written grievance should be sent to the address below.

**Paramount Care of Michigan, Inc.
Member Services Department
106 Park Place
Dundee, MI 48131-1016
734-529-7800
Toll-free 1-888-241-5604**

The Member must request an internal review *within two years* from the denial, reduction or termination of benefits. The Member will be advised that they have the right to attend an informal hearing to present the appeal in person to the Internal Grievance Committee. The member may authorize in writing that any person, including but not limited to a physician, may act on his or her behalf at any stage in the internal review.

If the service is being denied, reduced or terminated because of contract benefit limits, because the service is not covered under the contract or the case involves a membership or enrollment issue, the review will be conducted by the Internal Grievance Committee. Paramount will consult a clinical peer for this review, if it involves a clinical issue. A clinical peer is a physician or provider who has the same license as the provider who will perform the service. The clinical peer will review the medical records and determine if the service is medically necessary. The Internal Grievance Committee will base their decision on the clinical peer's determination.

Health Plan will provide a written response indicating the decision within 35 calendar days of the date Health Plan received the written request for an internal review. The 35 calendar days does not include whatever reasonable time the Member takes to prepare their response and no more than 10 additional business days if Health Plan has requested information from a health provider.

11.3 Expedited Grievance. If a Member's medical condition requires a faster review (called an expedited internal review), Health Plan must provide a response within 72 hours. An expedited internal review applies if a grievance is submitted and a physician orally or in writing verifies that the time frame for a standard internal review would seriously jeopardize the life and health of the Member or would jeopardize the Member's ability to regain maximum functioning. To request an expedited internal review, call the Health Plan at 1-888-887-5101 or fax, 1-888-740-0222.

If Health Plan does not respond to a request for an Internal Review within 35 calendar days or within 72 hours for an expedited internal review, it is considered a denial, and the Member has the right to appeal further.

11.4 External Independent Review. If Health Plan denies an internal grievance, the Member will be informed of their right to ask the Commissioner of the Division of Insurance (DI) for an external independent review in accordance with Public Act 252 (PRIRA). Forms required to request an external review are available at the DI's website at www.cis.state.mi.us/ofis.

The address is:

**Office of Financial and Insurance Services
Division of Insurance, Health Plans division
611 West Ottawa, Third Floor
P.O. Box 30220
Lansing, Michigan 48909-7720
1-877-999-6442**

- a. A Member must request an external independent review in writing within sixty (60) calendar days of receiving notice of the denial (adverse determination) from Health Plan on a standard internal review. The request must include a completed health information release form. The member, the Member's Legal Representative, an Authorized Person, or the provider may request the review. The provider must have the member's' authorization to request a review.

If the DI accepts the request for an external independent review, the Member will receive an acknowledgement from the DI. (If the DI does not accept the request, the DI will notify the Member of the reason.) The DI will select a state-approved independent review organization (IRO) to conduct a review. The IRO will review all pertinent records available and notify the DI of its recommendation. The DI will then review the recommendation and notify the member and Paramount of the DI decision.

- b. The Member may request an expedited external review if both of the following are met:
- The adverse determination involves a medical condition in which the timeframe for completion of an expedited internal grievance would seriously jeopardize the life or health of the member or would jeopardize the member's ability to regain maximum function as substantiated by a physician either orally or in writing.
 - The Member or Member's authorized representative has filed a request for an expedited internal grievance.

The Member must request an expedited external independent review in writing within 10 calendar days of receiving an adverse determination or a denial notice on an expedited

internal review. Denials on services that have already been received do not qualify for an expedited external review. If the DI accepts the request for an expedited external independent review the Member will receive an acknowledgement from the DI. The DI will select a state-approved independent review organization (IRO) to conduct the expedited external review. The IRO will review all pertinent records available and notify the DI of its recommendation. The Member will receive a final decision from the DI within 72 hours from receipt of the request for an expedited external review.

11.5 Claims or Suits. No Member may bring an action in court against Health Plan unless and until such Grievance procedures made available by Health Plan, including appeal to the Michigan Division of Insurance, have first been exhausted.

XII. TERM AND TERMINATION OF AGREEMENT

12.1 Term. The term of this Agreement will be for the contract period set forth on the Implementation Page(s) of this Agreement. Group may not terminate this Agreement during the contract term unless Health Plan has materially breached this Agreement. The Agreement will be automatically renewed from year to year subject to premium rates determined by Health Plan unless terminated at the end of the contract term by either party giving at least 60 days prior written notice to the other. In the event a notice of a rate change is issued to the group less than 60 days prior to the end of the contract term, the contract may be terminated by either party giving prior written notice to the other at least 30 days before the end of the contract term. Health Plan may decline to renew the coverage provided under this Agreement for any reason permitted under HIPAA, including the failure of Group to meet Health Plan's Group Eligibility requirements including minimum employer contribution of premium or its group participation rules set forth in Section 3.8. Health Plan shall provide Group with notice of any change in premium rates for any renewal period in accordance with Section 6.1.

12.2 Termination of Service Agreement.

A. Upon default in making payments in accordance with Article VI, all rights to benefits hereunder shall terminate at the end of the period for which all required premiums have been made and Health Plan may deem such default as action by Group to cancel this Agreement. In such event, Health Plan shall notify Group and Subscribers of the effective date of termination. In the case of multiple year Agreements, failure to make payments will not terminate the Agreement and Group will remain liable for all outstanding payments.

B. Upon failing to provide documentation to establish Group eligibility or falling below Group participation requirements stated in Section 3.8, Health Plan shall notify Group. Group shall have sixty (60) days to provide sufficient documentation and/or bring participation up to required level. After sixty (60) days, if Group does not provide sufficient documentation and/or meet minimum participation requirement, Health Plan shall notify Group and Subscribers of the effective date of termination.

XIII. GENERAL PROVISIONS

13.1 Assignment. Neither Group nor Member may assign any benefits under this Agreement to any person, corporation or other organization. Any such assignment will be void. Health Plan may assign its rights under this Agreement to any corporation or other entity that controls or is under common control with Health Plan. Any entity that succeeds to the rights and responsibilities of Health Plan is bound by this Agreement.

13.2 Medical Records. In order to implement this Agreement, it may be necessary for Health Plan or any Participating Provider to obtain a Member's medical records and information. By executing an enrollment application and/or directly or indirectly presenting claims for payment for Covered Services, a Member gives Health Plan, its authorized agent(s) and Participating Providers permission to obtain and use those records and that information.

13.3 Identification of Members. Members must be identified as Health Plan Members by means of an identification card to be issued by Health Plan. The identification card itself confers no rights to services or other benefits under this Agreement. To be eligible for benefits, the Health Plan must have received all applicable and other payments as required under this Agreement.

13.4 Notice. Any notice required to be given to Group under this Agreement must be in writing and sent by certified mail, return receipt requested, to Group at the address appearing on the Endorsement Page(s).

Notices to Health Plan should be sent by certified mail, return receipt requested, to Health Plan's administrative offices at the address set forth on the Endorsement Page(s) hereof. Notice shall be effective when received.

13.5 Severability. If any provision of this Agreement, on its effective date or thereafter, is determined to be in conflict with Federal law, Michigan law or applicable rules and regulations of the Michigan Division of Insurance, the provision shall be fully severable and the remaining provisions shall continue in full force and effect.

13.6 Waiver. The waiver by either party of any breach of any provision of this Agreement may not be construed as a waiver of any subsequent breach of the same or any other provision. The failure to exercise any right hereunder may not operate as a waiver of such right.

13.7 Relationship Among Parties. Neither of the parties hereto, nor any of their respective employees, may be construed to be the agent or representative of the other. In addition, a Member is not the agent or representative of Health Plan, and will not be liable for any acts or omissions of Health Plan, its agents or employees or of any Participating Provider. The relationship between Health Plan and Group and between Health Plan and Participating Providers is an independent contractual relationship. Participating Providers are not agents or employees of Health Plan, nor is Health Plan, or any employee of Health Plan, an agent or employee of the Participating Providers.

13.8 Relationship between Health Plan and Participating Providers. Participating Providers are acting as independent contractors and are not employees of the Health Plan. The final responsibility for all decisions with respect to medical care rests with the Participating Providers. Health Plan is not responsible for providing Covered Services, but rather for payment of those services. No claim may be made against Health Plan or its Board Members, officers, employees, agents, successors or assigns for actions of any Participating Provider.

13.9 Governing Law. This Agreement will be governed in all respects by the laws of the State of Michigan.

13.10 Entire Agreement. This Agreement, and each Member's enrollment application, member handbook, riders, explanation of benefits, endorsements, summary/schedule of benefits, amendments, and any other attachments to this Agreement, are incorporated and made part hereof, (hereinafter referred to as "Documents") which constitute the entire agreement between the parties and, as of the effective date, supersedes all other agreements and any representations, both written and oral, by and/or between the parties. The Group Medical and Hospital Service Agreement will be the controlling document if there are disputes or inconsistencies in the Documents. No amendments to this Agreement shall be valid unless in writing and agreed to by the parties as set forth in the Agreement.

13.11 Confidentiality/Privacy/Security Health Plan is a covered entity under the Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Standards and the parties shall comply with the HIPAA requirements. Health Plan is permitted to use, obtain and disclose Member protected health information to perform Health Plan services in accordance with HIPAA and "Paramount's Notice of Privacy Practices". Pursuant to the requirements of 45 C.F.R. § 164.314 (b)(2), Group warrants and represents that it will:

A. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic protected health information that it creates, receives, maintains, or transmits on behalf of Health Plan;

B. Ensure that the adequate separation required by 45 C.F.R. § 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;

C. Ensure that any agent, including a subcontractor, to whom Group provides this information agrees to implement reasonable and appropriate security measures to protect the information; and

D. Report to Health Plan any security incident of which Group becomes aware.

13.12 Participating Providers. Health Plan does not guarantee that any one physician, hospital, or other provider will be available and/or remain under contract with Health Plan or PPO Network. Termination of any provider from Health Plan or PPO network does not constitute breach of this Agreement.

13.13 Claim Processing and Payment. Health Plan shall process claims for benefits and pay such claims using Health Plan's normal claim determination, payment and audit procedures, and applicable cost control standards in accordance with the benefits described under Attachment A and B and state and federal or ERISA regulations.

Health Plan contracts with providers for health care services on an economically competitive basis, while taking steps to ensure that Health Plan members receive quality health care. Through Health Plan contracts with providers, Health Plan obtains discounts. When Copayments are charged as a percentage of eligible expenses, the amount a Member pays is determined as a percentage of the allowed amount between Health Plan and the participating provider, rather than a percentage of the provider's billed charge. Health Plan's allowed amount is ordinarily lower than the participating provider's billed charge. If a prescription drug plan is offered through Health Plan, Health Plan will retain all pharmaceutical drug rebates. All claims submitted by or on behalf of the Member after one (1) year from date of service shall be denied.

13.14 Submission of Claims. It is Member's obligation to individually submit claims for benefits when appropriate, or to ensure that claims for benefits are submitted through the Provider and/or Hospital providing services to Member. Group is not eligible to submit claims for benefits on Member's behalf, and does not have standing to initiate a legal action against Health Plan on Member's behalf.

13.15 Benefit Period, Renewal – Health Plan will administer the application of benefit provisions such as Deductible, Copayments, Coinsurance, Out-of-Pocket Copayment Limit and any benefit limitations (day, visit or maximum dollar) according to a Contract Year or calendar year period as set forth on the Endorsement Page(s). At the start of a new Contract Year or calendar year, the Member's benefits will renew. If the benefits renew each calendar year and the Group changes benefits prior to renewal, the new benefits will be effective as of the date of the benefit change.

13.16 Indemnification. Group shall indemnify and hold Health Plan harmless against and from any and all claims, damages, losses, judgments, awards and/or expenses of any kind, including, but not limited to, reasonable attorney fees and costs incurred by Health Plan, due to Group's failure to make the premium payments required by the terms and conditions of this Agreement, Group's breach of the terms and conditions of this Agreement, or the negligence and/or intentional acts or omissions of Group, its employees or agents, in connection with this Agreement.

ATTACHMENT A: In-Network and PPO Schedule of Benefits

ATTACHMENT B: Out-of-Network Schedule of Benefits

**ATTACHMENT A
PARAMOUNT CARE OF MICHIGAN, INC.
SCHEDULE OF IN-NETWORK AND PPO BENEFITS AND COVERAGE**

IN-NETWORK AND PPO BENEFITS

COVERED SERVICES ARE SPECIFICALLY LISTED IN PARTS I, II AND III, BELOW. ALL OTHER SERVICES AND/OR SUPPLIES ARE NOT COVERED SERVICES. UNLESS SPECIFICALLY PROVIDED OTHERWISE, SERVICES MUST BE PRESCRIBED, PROVIDED BY OR AUTHORIZED BY A HEALTH PLAN IN-NETWORK PHYSICIAN OR PPO PHYSICIAN IN ORDER TO BE COVERED SERVICES UNDER IN-NETWORK OR PPO BENEFITS. HEALTH PLAN WILL NOT PAY FOR ANY SERVICES THAT ARE NOT COVERED SERVICES. PAYMENT FOR SERVICES THAT ARE NOT COVERED SERVICES IS THE RESPONSIBILITY OF THE MEMBER. **CERTAIN SERVICES ARE SUBJECT TO DEDUCTIBLE AND COPAYMENTS BY MEMBERS AND MAY BE SUBJECT TO MONETARY LIMITS AS SO NOTED ON THE ENDORSEMENT PAGE (S).**

I. IN-NETWORK AND PPO PLAN

Members may receive services from In-Network and PPO Providers described in Attachment A, subject to all the terms and provisions in this section and subject to the Deductibles, Copayments and limits described in the Endorsement Page(s).

A. In-Network Plan General Limitations

- To be covered by the Paramount In-Network Plan, the health services must be from Paramount Participating Providers, except for Emergency Medical Conditions or with prior written approval from Paramount.
- The Paramount PCP must authorize referrals to Participating Paramount Specialists except for routine OB/GYN care, Allergists, Dermatologists, Hematology/Oncology and vision care services.

B. In-Network and PPO Plan General Limitations

Services that are not medically necessary are not covered under the In-Network and PPO Plan.

The service must be:

1. Needed to prevent, diagnose and/or treat a specific condition, except when indicated otherwise.
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.

C. In-Network and PPO Deductible

The Deductible is the amount the Member must satisfy each Contract Year before receiving benefits for Covered Services. All Covered Services provided by In-Network and PPO Providers except for services subject to a specific dollar Copayment and Preventive Health Services, set forth in Attachment A are subject to the In-Network and PPO Deductible each Contract Year, unless otherwise stated herein. Expenses incurred for Covered Services during the Contract Year from In-Network and PPO Providers count toward satisfying the In-Network and PPO Deductible. The expenses incurred for Covered Services during the Contract Year from Out-of-Network Providers will apply to the Out-of-Network Deductible only.

D. In-Network and PPO Copayments

A Copayment may be a specific dollar amount or a percentage of the Paramount In-Network or PPO allowed amount that the Member is responsible for paying to the provider for Covered Services. The Copayment for any particular In-Network or PPO Covered Service, will not exceed 50 % of the allowed charge for that service. See the Endorsement Page(s) for specific Copay amounts. Specific dollar Copayments are due at the time a Member receives services. If a cost-sharing percentage is applicable, the provider will bill the

Member once the claim has been processed.

E. In-Network and PPO Out-of-Pocket Copayment Limit

There is an Out-of-Pocket Copayment Limit every Contract Year. The annual Out-of-Pocket Copayment Limit for Basic Health Care Services will not exceed the amount indicated on the Endorsement Page(s). Copayment for Supplemental Health Services and any penalties do not count toward the Out-of-Pocket Copayment Limit.

Expenses incurred for Covered Services during the Contract Year from In-Network and PPO Providers count toward satisfying the In-Network and PPO Out-of-Pocket Copayment Limit. The expenses incurred for Covered Services during the Contract Year from Out-of-Network Providers will count toward the Out-of-Network Out-of-Pocket Copayment Limit only. After a Member has met the Out-of-Pocket Limit in a Contract Year, Covered Services are payable in full for the remainder of the Contract Year.

F. Maximum Lifetime Benefit: There is no Maximum Lifetime Benefit for In-Network Covered Services from Paramount Providers.

The PPO Plan will pay for Covered Services from PPO providers up to the PPO Maximum Lifetime Benefit shown in the Endorsement Page(s). This applies individually to the Subscriber and each Member. When reimbursement in such amount has been paid for the Subscriber or Member, all coverage for that person under the PPO Plan will terminate.

G. Substance Abuse Maximum Lifetime Benefit: There is no Substance Abuse Maximum Lifetime Benefit for In-Network Covered Services from Paramount Providers. The PPO Plan will pay for substance abuse Covered Services from PPO providers up to the PPO Substance Abuse Maximum Lifetime Benefit shown in the Endorsement Page(s). This applies individually to the Subscriber and each Member. When reimbursement in such amount has been paid for the Subscriber or Member, all substance abuse coverage for that person under the PPO Plan will terminate.

H. Benefit Limits: Certain Covered Services have Benefit Limits each calendar year. Benefit Limits will be a combined limit for Covered Services rendered by Paramount and PPO providers. See the Endorsement Page(s) for Benefit Limits.

I. In-Network Coverage Available with Prior Approval

In some cases, the Paramount PCP may request In-Network Coverage for services from a PPO Provider. Services from PPO Providers may be covered under In-Network Coverage only with prior written approval from Paramount's Utilization Management Department. Both the Paramount PCP's request and Paramount's response must be made prior to the services being provided. In-Network Coverage will be applicable to PPO Providers for Emergency Medical Conditions and when Paramount has prior approved. If the requested services are available from Paramount Providers, the request for In-Network Coverage will be denied.

J. PPO Pre-Notification Requirements

When Members use their Paramount PCP and Paramount Providers for covered services, the Paramount Providers are responsible for handling any necessary authorizations from Paramount.

When Members use a PPO PCP or other PPO providers for PPO Coverage, Members are responsible for calling Paramount prior to receiving the services below:

- Specialist physician office visits including OB/GYN visits and maternity care
- Inpatient Hospital, Rehabilitation and Skilled Nursing Facility Admissions
- Outpatient Hospital services
- Hospice and Home Health Care

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

If the Member does not call Paramount when required, the Member will have a penalty. The penalty is an additional 10% Copayment not to exceed \$100.00 on physician's services and \$500.00 on inpatient admissions.

II. PROFESSIONAL MEDICAL SERVICES AND SUPPLIES

A. Medical Services

- 1) Physician office visits. See Endorsement Page(s) for copay amount.
- 2) Provision of, or Primary Care Physician referral for, Emergency care on a 24-hour per day, 7-day per week basis.
- 3) Diagnostic/Therapeutic
 - a) Diagnostic and treatment services as performed, requested or directed by a Primary Care Physician or participating gynecologist, including, but not limited to, consultation and treatment by Specialist Physicians, routine eye examinations limited to one per Member every 12 months, surgical procedures, laboratory, x-ray services, injections, application of casts and dressings, radiotherapy and administration of anesthesia. Certain diagnostic procedures require prior authorization from the Health Plan. A listing of the diagnostic procedures that require prior authorization from Health Plan is available upon request, but subject to change at Health Plan's sole discretion.
 - b) Obstetrical/gynecological care may be provided or referred by a participating gynecologist without the prior authorization of the Member's Primary Care Physician. Care rendered by Participating vision care, allergists, dermatologists, pediatric pulmonologists, hematologists, oncologists, ophthalmology, pediatric ophthalmology, retinology, pain management providers and other Participating Providers as determined by Health Plan do not require a referral from the Member's Primary Care Physician.
 - c) Prescribed x-ray and laboratory tests, services and materials, e.g., diagnostic x-rays, mammograms, x-ray therapy chemotherapy, fluoroscopy, electrocardiograms, electroencephalograms, and therapeutic radiology services.
 - d) Physician office visits for allergy testing. See Endorsement Page(s) for copay amount.
- 4) Preventive Health Services
Preventive Health Services include the following:
 - a) Well-baby and well-child care including hearing screenings,
 - b) Childhood immunizations,
 - c) Annual physical examinations,

- d) Cytologic screenings (Pap smears),
- e) Mammography screenings,
- f) Immunizations for influenza, tetanus, pneumonia and HPV,
- g) Pre-natal care,
- h) Prostate screening (PSA), and
- i) Colorectal screening.

5) Other Professional Services

- a) Voluntary sterilization and Contraceptive methods are covered when optional rider is purchased. See Endorsement Page(s). Contraceptive Services are limited to the following: Depo-Provera injections, IUD, diaphragms and Norplant.
- b) Routine vision and hearing screening in the Primary Care Physician's office. A routine eye exam every 12 months by a Specialist Physician is covered without a referral from Primary Care Physician. Hearing examination by Participating Provider when ordered by a Health Plan Physician. A separate vision insurance plan will be primary. Health Plan will be primary to a discount plan.
- c) Primary Care Physicians and other Providers may provide counseling and literature on issues including, but not limited to, diet, alcohol and drug abuse, exercise, smoking and family planning.
- d) Health Plan will reimburse for one smoking cessation class at a participating Health Plan facility.

6) Maternal, Newborns and Infertility

- a) Full hospital and medical services including prenatal and postpartum care, including use of delivery room and nursery, general medical services, operations and special procedures, Caesarean sections, administration of anesthesia and injectables, and x-ray and laboratory services. All office visits for pre- and post-natal care are covered in full with no Co-payment.
- b) Services related to the diagnosis and treatment of infertility. See Endorsement Page(s) for applicable Copayments and Section V-B, 16 of Attachment A, regarding exclusions of all services related to in vitro fertilization, embryo transplant services, reversal of voluntary sterilization and outpatient self-administered prescription drugs.
- c) Care of a newborn Child of Subscriber.

B. Oral Surgical Services

1) Covered Oral Surgical Procedures

General dental services are not covered. Certain limited oral surgical procedures are covered when referred by the Primary Care Physician, rendered by a participating oral surgeon and approved in advance by Health Plan. Inpatient services require specific Health Plan approval as detailed in Section II. Only the following oral surgical procedures are eligible for coverage:

- a) Initial first aid treatment received within 48 hours of an accidental injury to sound natural teeth, the jaw bones, or surrounding tissues. This includes only extraction of teeth and repair of soft tissue. Replacement and restoration of teeth are not covered.
- b) Medically Necessary orthognathic surgery.
- c) Treatment for tumors and cysts (including pathological examination) of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
- d) Medically Necessary oral surgery to repair fractures and dislocations.
- e) Medical treatment for temporomandibular joint syndrome (TMJ).

2) Primacy of Dental Plan

Notwithstanding Article VIII of the Agreement, a dental plan will be primary when available in addition to this coverage.

C. Reconstructive Surgery

Covered when required, as determined by Health Plan, for:

- a) a malignant or non-malignant neoplasm within 2 years following initial surgery for neoplasm;
- b) repair of anatomical impairment to improve or correct a physiological functional disability within 2 years of accident or injury or up to age 18 if a congenital anatomical functional impairment;
- c) breast reconstruction following a covered mastectomy in accordance with the Women's Health and Cancer Rights Act of 1998; and
- d) plastic surgery following an accidental injury within 2 years of the accident;

D. Medical Equipment and Supplies

1) Durable Medical Equipment.

Medically Necessary durable medical equipment and supplies approved by Medicare Part B and subject to Medicare Part B criteria and limitations on quantity. See exceptions under c) below. Durable medical equipment and supplies must be ordered by a Health Plan Physician from a participating provider. Certain items require prior authorization from the Health Plan.

- a) See Endorsement Page(s) for applicable limits and Copayments. (See additional reference under "Home Health Services", page A-10).
- b) Electrical versus manual equipment is at the discretion of Health Plan. The option to

purchase or rent is at the discretion of Health Plan. Repair and replacement of equipment will be covered at the discretion of Health Plan.

- c) Specifically Excluded: Any items not approved by Medicare Part B, except for diabetic supplies such as syringes with needles, refill kit for implantable infusion pump, external drug infusion and supplies, blood glucose monitors, test strips, lancing devices and lancets; and asthma supplies such as peak expiratory flow rate meters (hand-held) and spacers for metered-dose inhalers. Any exceptions are at the sole discretion of Health Plan.

2) Prosthetic Devices

Prosthetic Devices as determined to be Medically Necessary, and when ordered or approved by a Health Plan Physician and such devices meet the criteria for coverage under the rules of eligibility for Medicare. Repair of and/or replacement devices if such devices meet the criteria for coverage under the rules of eligibility for Medicare. See the Endorsement Page(s) for applicable limits and Copayments. A Prosthetic Device is an artificial substitute that replaces all or part of a missing body part and its adjoining tissues.

3) Penile Implants and Erectile Devices

Penile implants and erectile devices are not covered unless the Group has purchased an optional rider. See Endorsement Page(s).

E. Health Education Newsletter

In order to facilitate a preventive approach to medical care, Health Plan has provided for a newsletter to be distributed to Subscribers by direct mail on a periodic basis. Information will be included which updates Health Plan's procedures. Items of general health interest, nutritional education, reminders of existing procedures for obtaining services and referrals will be included.

III. HOSPITAL SERVICES

A. Medical/Surgical

The following acute inpatient services are provided at hospitals and skilled nursing facilities under contract with Health Plan when, except in the case of Emergency admissions, they are ordered by a Health Plan Physician and Health Plan gives prior written authorization. Benefits will be provided for care rendered in a non-participating institution only with prior written authorization by Health Plan, except in the case of certain Emergencies as specified in Section III.E.(3) of Attachment A. Services related to a hospital admission where the patient discharges himself Against Medical Advice (AMA), or when the facility requires a disciplinary discharge, will be subject to an additional Copayment not to exceed 50%. For the application of additional Copayments for Hospital Services, see the Endorsement Page(s) of this Agreement. Benefits include:

- 1) Room and board for semi-private accommodations. Private accommodations and special diets will be covered if Medically

Necessary as determined by Health Plan's Medical Director in consultation with the Member's Health Plan Physician.

- 2) Diagnostic and interventional radiology services, clinical laboratory and other diagnostic tests, anesthesia, oxygen services, radiation and respiratory therapy, encephalography, cardiography, nuclear medicine and chemotherapy.
- 3) FDA approved drugs, medications and biologicals.
- 4) Use of operating room, intensive and coronary care units, recovery room and special treatment rooms. Use of outpatient hospital surgical treatment rooms or outpatient surgical facilities may be subject to a Copayment. See the Endorsement Page(s).
- 5) Physical, speech, occupational and respiratory therapies.
- 6) Administration of blood and blood products. The cost of these products is not covered when a volunteer replacement program is available.
- 7) Pre-and post-hospital planning and referral to community and social welfare resources.
- 8) Heart, lung, heart/lung, liver, pancreas, pancreas/kidney, bone marrow and bowel transplants are covered if, and only if:
 - a) specific clinical indications are present; and
 - b) the procedure is not considered to be an Experimental Service for the diagnosis and circumstances present; and
 - c) approval is obtained from Health Plan in advance of transplant, and confirmed in writing; and
 - d) services are rendered in an institution specifically approved by Health Plan.

Payments related to the search for a bone marrow donor are limited to \$20,000 per Member per lifetime.

- 9) Surgery for the purpose of weight reduction or control when specifically approved by Paramount as medically necessary for severely obese Members with documented high-risk comorbidities, and the Member qualifies under Paramount's Morbid Obesity Surgery Policy. Services related to this surgery will be subject to a \$1,000 Copay which does not apply to the Member's annual out-of-pocket limit.

B. Physical Rehabilitation.

1) Inpatient

Short-term INPATIENT rehabilitation services due to injury, trauma or surgery will be provided when prescribed by a Health Plan Physician and authorized in advance by Health Plan. See Endorsement Page(s) for applicable limits and Copayments.

2) Outpatient

Physical, occupational and speech therapy on an outpatient basis will be covered. See Endorsement Page(s) for applicable limits and Copayments.

Outpatient services must be prescribed by a Health Plan Physician and rendered by Participating Providers.

C. Kidney Disease and Dialysis

- 1) All Medically Necessary services for hemodialysis for renal disease and for kidney transplants, subject to all federal and state requirements regarding end-stage renal disease including equipment, training, and medical supplies required for home dialysis, and directly related reasonable medical and hospital expenses of a donor or prospective donor who is a Member of Health Plan.
- 2) Should the Member qualify for Medicare benefits for end-stage renal disease, Health Plan will coordinate benefits as noted in Article VIII of this Agreement. Services are covered only upon referral by a Primary Care Physician at facilities in the Service Area under contract with Health Plan.

D. Mental Illness/Substance Abuse

- 1) Mental Illness

Inpatient and outpatient treatment of Biologically and Non-Biologically Based Mental Illness is covered subject to the same terms, Deductible, Copayments and/or Coinsurance as any other physical disease or condition. See the Endorsement Page for further details.

- 2) Substance Abuse (Drug and Alcohol Abuse/Addiction)

The following substance abuse services are covered, subject to the same terms, Deductible, Copayments and/or Coinsurance as any other physical disease or condition. See the Endorsement Page for further details.

- a) Inpatient services at a Participating Hospital on order of a Health Plan Physician and approved by Health Plan or its Designated Representative for the direct care and treatment of the acute phase of a substance abuse condition.
- b) Partial hospitalization (comprehensive outpatient treatment arranged through case management process). Services must be approved in advance by Health Plan or its Designated Representative.
- c) Intensive outpatient programs (comprehensive and primarily educational programs for substance abuse conditions). Services must be approved in advance by Health Plan.
- d) Outpatient services of a Participating Provider for the direct care and treatment of the acute phase or rehabilitation for substance abuse conditions. Benefits are paid for individual, group or family therapy, evaluation and consultations and must be approved in advance by Health Plan or its Designated Representative.

E. Emergency and Urgent Care Services

1) Emergency Services are those services that are needed to evaluate or stabilize an Emergency Medical Condition. Examples of an Emergency Medical Condition include, but are not limited to, symptoms of heart attack, stroke, poisoning, labor, loss of consciousness or respiration, hemorrhaging, and convulsions. During retrospective claim review, the determination as to whether or not an Emergency Medical Condition existed will rest with Health Plan.

2) Emergency Services Within the Plan Service Area

a) Medical Care and Notification. In case of an Emergency Medical Condition, Members are to proceed directly to the nearest medical facility. In the event a Member is unsure about whether a condition is an Emergency Medical Condition, the Member may contact his/her Primary Care Physician for instructions. Medical care is available through Health Plan Physicians 7 days a week, 24 hours a day. The determination of whether or not an Emergency Medical Condition exists rests with Health Plan.

b) Payment for Non-Participating Providers. Payment for Emergency Services of Non-Participating Providers shall be limited to expenses for such care required before the Member can, without serious threat to life or health, utilize the services of Participating Providers. Coverage for Emergency Services provided to a Member by a Non-Participating Provider will also be provided if a prudent layperson with an average knowledge of health and medicine would have reasonably believed that, under the circumstances, the time required to travel to a Participating Hospital's emergency room could result in one or more of the adverse health consequences described in Section 2.8 of this Agreement.

c) Follow-Up Care. All follow-up care must be authorized in advance by the Primary Care Physician.

3) Out-of-Area Emergency Services

a) Medical Care and Notification. If the Member is outside the Service Area and suffers an injury or illness which requires Emergency Services, benefits will be provided.

If the Member is unable to contact Health Plan due to shock or unconsciousness, and immediate Emergency treatment is necessary, all Professional and Hospital Services will be covered. However, the Member must, at the earliest time reasonably possible, contact Primary Care Physician to receive authorization for follow-up care.

b) Follow-Up care. Continuing or follow-up treatment for accidental injury or an Emergency Medical Condition must be approved in advance by Health Plan and is limited to care

required before the Member can, without medically harmful or injurious consequences, return to the Service Area. Benefits for continuing or follow-up treatment are otherwise provided only in the Service Area, subject to all provisions of this Agreement. Failure to contact Health Plan will result in denial of payment of all claims for services.

- c) Limitation. Out-of-area benefits and services are limited to situations in which care is required immediately and unexpectedly; elective or specialized care required as a result of circumstances which could reasonably have been foreseen prior to departure from the Service Area is not covered. For example, normal term childbirth outside the Service Area is not covered. However, complications of pregnancy or unexpected delivery are covered outside the Service Area.

4) Transportation Services

In cases of an Emergency Medical Condition, or when authorized by the Primary Care Physician and Health Plan, transportation services to the nearest medically appropriate facility are covered. Certified air ambulance will be covered if Medically Necessary. See Endorsement Page(s) for applicable Copayments.

5) Urgent Care Services

Urgent Care Services are those services provided for an Urgent Medical Condition. An Urgent Medical Condition is an unexpected illness or injury requiring medical attention soon after it appears that is not permanently disabling or life-threatening. Services received at a participating urgent care facility or physician's office for an Urgent Medical Condition are covered. The determination of whether or not an Urgent Medical Condition exists rests with Health Plan. Other than specifically set forth herein, services received for an Urgent Medical Condition are not covered.

6) Emergency Room and Urgent Care Facility Copayments

Hospital Emergency room and urgent care facility visits are subject to a Copayment for each incident. See Endorsement Page(s) for applicable Copayments.

IV. OTHER FACILITY SERVICES

A. Skilled Nursing Facility Services

- 1) Coverage. Medically Necessary services rendered in a skilled nursing facility under contract with Health Plan are covered when prescribed by a Health Plan Physician and authorized, in advance, by Health Plan.
- 2) Limits. See Endorsement Page(s) for applicable Copayments and/or limits.

B. Home Health Services

Home Health Services are covered upon the order of a Health Plan Physician and approved in advance by Health Plan. All Home Health Service benefits are coordinated through the case management process. Examples of Medically Necessary services which may be arranged through case management include: physician services, skilled nursing care, physical, occupation and other related therapies, supplies and equipment as determined by Health Plan. See Endorsement Page(s) for applicable Copayments and/or limits. Convalescent and custodial services are not covered. Coverage for personal comfort and convenience items and services, such as meals and housekeeping, are not covered.

C. Hospice Services

Inpatient and outpatient hospice services, including care provided by a Michigan or Ohio-licensed hospice, for treatment directed at controlling pain, relieving other symptoms and such other supportive services as are regularly provided by the hospice in support of terminally ill patients. Covered Services must be upon the order of a Health Plan Physician and approved in advance by Health Plan. See Endorsement Page(s) for applicable Copayments and/or limits.

V. RESTRICTIONS AND EXCLUSIONS

A. In-Network Restrictions on Choice of Providers. The following are excluded from coverage:

- 1) Services rendered by In-Network Specialist Physicians not listed in I(A)(3)(b) in a non-Emergency situation without Member first consulting, and obtaining a written Health Plan authorization through, his/her Primary Care Physician.
- 2) Services obtained from Out-of-Network Providers in a non-Emergency situation without prior referral from a Health Plan Physician and written authorization from Health Plan.
- 3) Services of chiropractors, unless Group has purchased an optional chiropractic rider.
- 4) Any services or supplies furnished by a non-eligible institution, which is defined as other than a hospital, outpatient surgical facility or skilled nursing facility, i.e., custodial, domiciliary, residential treatment facility, convalescent and intermediate or day care.
- 5) Any court-ordered testing, treatment or hospitalization unless determined to be Medically Necessary by Health Plan and rendered by a participating In-Network or PPO provider.
- 6) Care rendered to self or to a Member by a relative.
- 7) Non-Emergency Services from hospital emergency facilities and providers unless prior direction is received from the Primary Care Physician and/or Health Plan.

B) Excluded In-Network and PPO Benefits. Unless specifically referenced as Covered Services, services and/or supplies are not Covered Services and, therefore, are excluded from coverage. The following services and benefits are among those services excluded from coverage:

- 1) Services rendered before coverage began or after coverage ended.
- 2) Benefits in skilled nursing facilities except as specifically provided in Section IV-A of Attachment A.
- 3) Examinations, reports and immunizations for the purpose of obtaining or maintaining employment, insurance, governmental licensure, employer-requested annual physical exams/treatment, court-ordered or forensic evaluations, or for premarital or paternity purposes.

- 4) Cosmetic or plastic procedures including surgery except as Medically Necessary and provided in Section I-C. Cosmetic or plastic procedures including surgery are those procedures that improve physical appearance or treat a mental or emotional condition through a change in body form, but do not correct or materially improve a physiological function.
- 5) Dental care, except for Medically Necessary oral surgery incidental to fracture, dislocations and tumors or as otherwise provided in Section II-B of Attachment A. Exclusions include, but are not limited to:
 - Treatment on or to the teeth
 - Extraction of teeth, including bony impacted wisdom teeth
 - Treatment of dental abscess or granuloma
 - Dental treatment for temporomandibular joint syndrome or dysfunction
 - Placement, removal or replacement of implants of the teeth and alveolar ridge including preparatory oral and maxillofacial surgery (bone grafts)
 - Treatment of periodontal disease and abscess
 - Root canal
 - Treatment required for, or as a result of, biting or chewing
 - Braces, retainers, bite plates, snore guards or any appliance or device which is fitted to the mouth
- 6) Treatment for mental retardation and mental deficiency. Psychological counseling, training and educational therapy for learning disabilities and developmental disorders/delay. Social skills classes, Behavioral modification and other training programs including but not limited to Applied Behavioral Analysis (ABA) programs. Long-term rehabilitation and residential treatment.
- 7) Non-surgical weight loss treatments, weight reduction programs and surgical services except as provided under III, A, 9 of Attachment A. Dietary or nutritional supplements for gaining or maintaining weight are excluded, except for charges for nonmilk or nonsoy formula required to treat diagnosed diseases and disorders of amino acid or organic acid metabolism, protein sensitivity resulting severe chronic diarrhea, and severe malabsorption syndrome resulting in malnutrition, provided the formula is prescribed by a Participating Physician, and the Physician furnishes supporting documentation to Health Plan. 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.
- 8) Refractive eye surgery including radial keratotomy and LASIK. Orthoptic (vision) training.
- 9) Custodial or domiciliary care; personal comfort items such as television, telephone, private rooms (except as Medically Necessary) in a hospital or skilled nursing facility; housekeeping services and meal services as a part of Home Health Care.
- 10) Experimental medical, surgical, or other health procedures including experimental drugs as determined by Health Plan.

Health Plan will make this determination based on the recommendation of the Medical Advisory Committee and the most recent HAYES Medical Technology Directory. In addition, pharmaceuticals and devices which have not received FDA approval are considered experimental.

- 11) Care for conditions which state or local law requires to be treated in a public facility or for which a Member has no legal obligation to pay.
- 12) Care for military service connected disabilities to which the Member is legally entitled, and for any services received at a military, veteran or other federal health care facility.
- 13) Transportation services other than as set forth in Section III-E-4 of Attachment A.
- 14) Medical equipment, appliances and supplies for home use not approved by Medicare Part B.
- 15) Trimming of corns, calluses and nails except for diabetic conditions approved in advance by Paramount.
- 16) Assisted reproductive technology including but not limited to artificial insemination, in vitro fertilization (IVF), embryo transplant services (GIFT, ZIFT), reversal of voluntary sterilization, ovarian tissue transplant and related services and outpatient self-administered infertility prescription drugs. Infertility injections or medications normally self-administered by the Member will not be covered in the Physician office.
- 17) Abortions and any related procedures, unless Medically Necessary.
- 18) Oral contraceptives.
- 19) Transsexual surgery and related services.
- 20) Physical therapy and occupational therapy, except as provided under Section II-B of Attachment A; non-medical services such as vocational rehabilitation, employment counseling and psychological counseling, equestrian therapy, training and educational therapy for learning disabilities and developmental delay.
- 21) Speech therapy except as provided in Section III-B-2 of Attachment A.
- 22) Prescription drugs except those provided on an inpatient basis in Section III-A-3 of Attachment A.
- 23) Experimental organ transplants (See Article II, "Definitions" of Agreement and Section III-A-8 of Attachment A).
- 24) Private duty nursing, unless Group has purchased optional rider.
- 25) Contact and corrective lenses and eyeglasses, unless Group has purchased optional rider.
- 26) Growth hormones or steroids except when medically necessary for growth and development.

- 27) Cranial electrotherapy units.
- 28) Counseling for marital or relationship conflicts, employment counseling and vocational rehabilitation counseling services.
- 29) Sclerotherapy for spider angiomas.
- 30) Breast augmentation surgery. Breast reduction surgery except when medically necessary.
- 31) Hearing aids, unless Group has purchased optional rider.
- 32) Penile implants and erectile devices, unless Group has purchased optional rider.
- 33) Services rendered primarily for the convenience of a Member in the absence of a specific clinical requirement.
- 34) Charges for completion of forms and reports other than for the patient's medical record.
- 35) All services related to organ donations from a living donor who is not a Health Plan Member, unless no other coverage is available. Travel, lodging or meals for a donor who is not a Health Plan Member. And all services related to a Health Plan Member who is donating to a recipient who is not a Health Plan Member.
- 36) Surrogate pregnancy, including gestational pregnancy, and any related procedures.
- 37) Upper and lower jawbone surgery except as required for direct treatment of acute traumatic injury or cancer, or as necessary to safeguard a Member's health due to a non-dental physiological impairment. Surgery for the treatment of the temporomandibular joint which is dental in nature.
- 38) Staged procedures or surgeries when performed in preparation of a non-covered reconstructive surgery.
- 39) Alternative medicine/therapy including but not limited to: related laboratory testing, non-prescription drugs or medicines, vitamins, nutrients, food supplements, biofeedback training, neurofeedback training, hypnosis, acupuncture, acupressure, massage therapy, aromatherapy, Chelation therapy, rolfing and related diagnostic tests.
- 40) Laser treatment including Candela, V-beam and photodynamic therapy for rosacea, port wine stains and other skin disorders.
- 41) Extra Corporeal Shock Wave Therapy (ESWT) for conditions of the feet, elbows and shoulders.
- 42) Removal of skin tags.

ATTACHMENT B
PARAMOUNT CARE OF MICHIGAN, INC.
SCHEDULE OF OUT-OF-NETWORK BENEFITS AND COVERAGE

I. OUT-OF-NETWORK BENEFITS

Members may receive services from Out-of-Network Providers described in this Attachment B, subject to all the terms and provisions in this section and subject to the Deductibles, Copayments and limits described in the Endorsement Page(s).

Payments for Out-of-Network Covered Services are based on the Usual, Customary and Reasonable (UCR) schedule determined by Paramount and updated periodically. The Member will be responsible for charges in excess of UCR. See the Endorsement Page(s) for Copayments and limits.

Out-of-Network Covered Services are payable provided:

1. The service is incurred while eligible for this benefit;
2. The service is included in the list of Covered Services; and
3. The service is not paid or payable under In-Network or PPO Coverage.
4. The payment will not exceed the Maximum Lifetime Benefit and any other applicable maximums shown in the Endorsement Page(s).

A. Out-of-Network General Limitations

Out-of-Network Coverage is not available for services incurred in connection with the following, unless specifically stated otherwise in the Out-of-Network Covered Services.

1. Charges in excess of Usual, Reasonable and Customary.
2. Care for conditions for which the Member has or had a right to payment under any workers' compensation or similar law.
3. Care for disabilities related to military service to which the Member is legally entitled, and for any services received at a military, veteran or other federal health care facility.
4. Care provided to Members by relatives.
5. Care for conditions that state or local laws require to be treated in a public facility or for which the Member is not legally required to pay.
6. Treatments, procedures, drugs or medicines which Paramount determines are experimental or investigational.
8. Court-ordered testing and treatment.

B. Out-of-Network Deductible.

The Out-of-Network Deductible is the amount the Member must satisfy each Contract Year before receiving benefits for Covered Services. The Out-of-Network Deductible applies to all Out-of-Network Covered Services. Expenses incurred for Covered Services during the Contract Year from Out-of-Network Providers count toward satisfying the Out-of-Network Deductible only. The expenses incurred for Covered Services from In-Network and PPO Providers will apply to the In-Network and PPO Deductible. Any amount by which an Out-of-Network Provider's billed charges exceeds the Usual, Customary and Reasonable (UCR) amount will *not* be counted toward satisfying the Out-of-Network Deductible.

C. Out-of-Network Copayments.

An Out-of-Network Copayment may be a specific dollar amount or a percentage of the UCR amount that the Member is responsible for paying to the Out-of-Network Provider for Covered Services. See the Endorsement Page(s) for specific Copayment amounts.

D. Out-of-Network Copayment Limits.

There is an Out-of-Pocket Copayment Limit every Contract Year. The Out-of-Pocket Limit can be found in the Endorsement Page(s). Copayments on all Out-of-Network Covered Services apply to the Out-of-

Network Copayment Limit. The expenses incurred for Covered Services during the Contract Year from an Out-of-Network Provider will count toward the Out-of-Network Out-of-Pocket Copayment Limit only. Expenses incurred for Covered Services during the Contract Year from In-Network and PPO Providers count toward satisfying the In-Network and PPO Out-of-Pocket Copayment Limit. After a Member has met the Out-of-Pocket Copayment Limit in a Contract Year, Covered Services are payable in full for the remainder of the Contract Year.

E. Out-of-Network Maximum Lifetime Benefit.

Out-of-Network Coverage will pay for Covered Services from Out-of-Network providers up to the Out-of-Network Maximum Lifetime Benefit shown in the Endorsement Page(s). This applies individually to the Subscriber and each Member. When reimbursement in such amount has been paid for the Subscriber or Member, all coverage for that person under the Out-of-Network Coverage will terminate. The expenses incurred for Covered Services from In-Network and PPO providers will *not* apply to the Out-of-Network Maximum Lifetime Benefit. The expenses incurred for Covered Services from Out-of-Network providers will *not* apply to the PPO Maximum Lifetime Benefit. See the Endorsement Page(s) for the Out-of-Network Maximum Lifetime Benefit.

F. Substance Abuse Maximum Lifetime Benefit.

The Out-of-Network Plan will pay for substance abuse Covered Services from Out-of-Network providers up to the Out-of-Network Substance Abuse Maximum Lifetime Benefit shown in the Endorsement Page(s). Expenses incurred for substance abuse Covered Services by an Out-of-Network provider will also apply to the PPO Substance Abuse Maximum Lifetime Benefit. This applies individually to the Subscriber and each Member. When reimbursement in such amount has been paid for the Subscriber or Member, all substance abuse coverage for that person under the PPO Plan will terminate.

G. Out-of-Network Pre-Certification Requirements

When a Member uses Out-of-Network Providers for Out-of-Network Coverage, **the Member is responsible for calling Paramount prior to receiving the services below:**

- Specialist physician office visits including OB/GYN visits and maternity care
- Inpatient Hospital, Rehabilitation and Skilled Nursing Facility Admissions
- Outpatient Hospital services
- Hospice and Home Health Care

The Member must call the Paramount Utilization Review Department toll-free at 1-800-891-2549 for pre-certification.

IF THE MEMBER DOES NOT CALL PARAMOUNT WHEN REQUIRED, PAYMENT FOR OUT-OF-NETWORK COVERED SERVICES WILL BE DENIED.

H. Benefit Limits.

Benefit Limits will be a combined limit for Covered Services rendered by In-Network and Preferred Provider Organization (PPO) providers and Out-of-Network providers in a calendar year. See the Endorsement Page(s) for limits.

II. OUT-OF-NETWORK COVERED SERVICES

The following services are covered. See the Endorsement Page(s) for Out-of-Network Copayment and limits.

1. Inpatient hospital care including intensive care, nursing care and necessary services and supplies in non-private rooms.
2. Inpatient care in an Extended Care or Skilled Nursing Facility.
3. Inpatient and outpatient Out-of-Network Specialist Physicians' services including office visits, hospital consultations, surgery, delivery and anesthesia.
4. Respiratory therapy rendered by a certified respiratory therapist.
5. Radiation treatment and chemotherapy.

6. Diagnostic procedures including x-rays, laboratory exams, CT scans and Magnetic Resonance Imaging (MRI).
7. Hospice care for the terminally ill.
8. Outpatient surgery in a hospital or outpatient surgical facility. Skilled home health care, except:
 - a) treatment of mental illness and drug- or alcohol-related disorders;
 - b) meals (other than special meals provided through dietary counseling);
 - c) personal comfort items; or
 - d) housekeeping services.

Skilled home health care services are limited to 4 hours of treatment within any 24-hour period and must be provided in place of inpatient hospital service and according to a prescribed treatment plan.
10. Preadmission testing prior to a scheduled inpatient hospital admission.
11. Treatment, services or supplies in connection with childbirth for:
 - a) Forty-eight (48) hours of inpatient hospital service following an uncomplicated vaginal delivery; and
 - b) Ninety-six (96) hours of inpatient hospital service following an uncomplicated cesarean section.

A mother may request a shorter length of stay if, in consultation with her Physician or certified nurse-midwife (in collaboration with a Physician), less time is needed for recovery.
12. Treatment, services, or supplies ordered by a Physician for post-delivery care for the mother and newborn child who requested a shorter length of stay in consultation with her attending Physician or certified nurse-midwife in collaboration with a Physician. Such care must be received within seventy-two (72) hours following discharge from the Hospital. Physician ordered post-delivery care will be provided in either a medical setting or through home health care visits and includes:
 - Physician assessment;
 - Parent education;
 - Assistance and training in breast or bottle feeding;
 - Assessment of the home support system;
 - Clinical tests or services as required by the attending Physician, or certified nurse midwife; and
 - Any other treatment, services, or supplies that are consistent with the post-delivery care recommended in the protocols and guidelines developed by national organizations that represent pediatric, obstetric, and nursing professionals.

Physician ordered post-delivery care for a mother and newborn child who received forth-eight (48) hours of inpatient hospital service following an uncomplicated vaginal delivery, or ninety-six (96) hours of Inpatient hospital service following an uncomplicated cesarean section, will be provided only upon recommendation by the Physician responsible for discharging such mother or newborn child.
13. Cytologic screening for the presence of cervical cancer, including Pap smears.
14. Mammography screening and exam for females at the following intervals: one mammogram from ages 35 through 39; one mammogram every 2 calendar years (or one every calendar year, if high risk factors to breast cancer are determined by a Physician) from ages 40 through 49; one mammogram every calendar year from ages 50 through 64.
15. Routine hospital nursery care and Physician charges for a newborn while the mother is an inpatient. These charges will be considered separate from the mother's. They will be subject to the copayment shown in the Out-of-Network Endorsement Page(s).
16. Charges for treatment, services, or supplies in connection with alcohol or drug abuse received in a Physician's office, a Hospital, a community mental health facility or an alcoholism or drug treatment facility from or under the clinical supervision of a Physician who is a medical doctor or psychologist. The Hospital or alcohol treatment facility must be approved by The Joint Commission or certified by the state Department of Health.
17. Charges for treatment, services, or supplies received during a Hospital Confinement or on an outpatient basis in connection with mental illness. The Hospital, community mental health facility or other providers must meet the requirements under applicable state law.

III. OUT-OF-NETWORK EXCLUSIONS: The following services are not covered.

1. Charges paid or payable under In-Network or Preferred Provider Organization (PPO) Coverage.
2. Unnecessary early hospital admissions prior to the date of elective surgery/services. Weekend inpatient admissions for elective services.

3. Treatment, services or supplies not Medically Necessary. This does not apply to preventive or other health care services specifically covered under the Out-of-Network Coverage.
4. Service from Out-of-Network Primary Care Physicians. Primary Care Physician means a family practitioner, internist, pediatrician or community health center.
5. The purchase, fitting, adjustment, repair and replacement of Prosthetic Devices. (Coverage is available under In-Network and PPO Plan.)
6. Durable Medical Equipment. (Coverage is available under In-Network and PPO Plan.)
7. Dental work, treatment or x-ray including but not limited to: a) treatment on or to the teeth; b) extraction of teeth, including bony impacted wisdom teeth; c) replacement or restoration of the teeth; d) treatment of granuloma; e) treatment including splints, physical therapy, or surgery for temporomandibular joint syndrome or dysfunction; f) placement, removal or replacement of implants or the teeth or alveolar ridge; g) treatment of periodontal disease or abscess; h) root canal; i) treatment required for or as a result of, biting or chewing; or j) braces, retainers and bite plates.
8. Cosmetic or plastic surgery except: a) repair of anatomical impairment to improve or correct functional disability; b) breast reconstruction following a covered mastectomy; or c) plastic surgery after an accidental injury.
9. Routine foot care such as trimming of corns and calluses; treatment of flat feet or partial dislocations in the feet. Shoes, shoe molds and shoe inserts.
10. Prescription drugs and medicines, unless as an inpatient. Over-the-counter drugs or medicines; vitamins, nutrients and food supplements even if prescribed or administered by a Physician.
11. Special education; counseling; therapy; or care for learning deficiencies or behavioral problems.
12. Non-surgical weight loss programs and dietary supplements for the treatment of weight loss.
13. Surgery, services or supplies rendered for treatment of obesity or for weight reduction. This includes any surgical procedures or reversal. (Coverage is available under In-Network and PPO Plan.)
14. Treatment of craniomandibular and temporomandibular joint disorders by use of orthodontic appliances and treatment; crowns; bridges; or dentures. This does not apply to the extent the disorder is trauma related.
15. Treatment, services or supplies that are required only for insurance, travel, employment, school, camp, or similar purposes.
16. Convenience or personal comfort items such as telephone, radio, television, or barber services.
17. Care which Paramount determines is custodial. Custodial care is care: a) which is furnished mainly to assist a person in the activities of daily living; and b) for which professional skills or training is not required. Such care includes--among other things--help in eating; getting out of bed; bathing; dressing; toileting; and supervision in taking medications.
18. Eye exams for the correction of vision; the providing or fitting of eye glasses, contact lenses, or hearing aids; audiology (hearing) exams or refractive surgery (radial keratotomy).
19. Organ transplant services. (Organ transplant services at Paramount approved centers with Paramount authorization are covered under In-Network Coverage.)
20. Acupuncture; biofeedback; hypnotherapy.
21. Non-Emergency transportation services
22. Penile implants, erectile devices.
23. Cardiac Rehabilitation, Phase III.
24. Manual manipulation of the spine.
25. Growth hormones or steroids. (Coverage is available under In-Network and PPO Plan.)
26. Emergency Services including transportation to a Hospital by a professional licensed ambulance service and care rendered at an urgent care facility. (These services are payable under In-Network Coverage.)
27. Sex transformation; sterilization reversals; or surgery or treatment related to sexual dysfunction. Infertility treatment by artificial means for the purpose of causing a pregnancy, such as drugs; medicines; artificial insemination; in vitro fertilization; embryo transplants, surrogate and/or gestational parenting and pregnancy related services when the intended parents or another party have paid for the surrogate mother's medical expenses and elective abortions.
28. Dietician counseling services.
27. Contraception services, tubal ligations and vasectomies.
28. Private duty nursing.
29. Outpatient physical, occupational, speech therapies. (Coverage is available under In-Network and PPO Plan.)
30. Breast reduction surgery. (Coverage is available under In-Network and PPO Plan.)
31. Services for which pre-certification is required but was not obtained by the Member.
32. Treatment for mental retardation and mental deficiency. Psychological counseling, training and

educational therapy for learning disabilities and developmental disorders/delay. Social skills classes, Behavioral modification and other training programs including but not limited to Applied Behavioral Analysis (ABA) programs. Long-term rehabilitation and residential treatment.

IV. Filing Claims for Out-of-Network Coverage

The Member must send a completed, itemized written claim for Out-of-Network Coverage to Paramount within 90 days after the service is rendered. Failure to furnish a claim within that time will neither invalidate or reduce any claim if it is shown that; 1) it was not reasonably possible to furnish a written claim within that time; and 2) such claim was furnished as soon as reasonably possible. In no event, in the absence of legal capacity, may a claim be furnished later than one year from the time a claim is otherwise required.