PARAMOUNT INSURANCE COMPANY

CERTIFICATE OF COVERAGE - MICHIGAN

2 Level Maximum Choice

PREFERRED PROVIDER ORGANIZATION (PPO) PLAN

2 Level PPO Plan
PREFERRED CHOICES

NOTICE CONCERNING COORDINATION OF BENEFITS (COB)

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

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

English: ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-462-3589 (TTY: 711) or speak to your provider.

Spanish: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-800-462-3589 (TTY: 711) o hable con su proveedor.

Arabic:
تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 1-800-462-3589 (711) أو تحدث إلى مقدم الخدمة".

Chinese: 注意：如果您說[中文]，我們可以為您提供免費語言協助服務。也可以免費提供適當的輔助工具與服務，以無障礙格式提供資訊。請致電 1-800-462-3589（TTY：711）或與您的提供者討論。」

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-800-462-3589 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.

Vietnamese: LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin them các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-800-462-3589 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.

Korean: 주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-800-462-3589 (TTY: 711) 번으로 전화하거나 서비스 제공업체에 문의하십시오.

Pennsylvanian Dutch: Wann du Deitsch schwetzscht un hoscht Druwwel fer Englisch verschtehe, kenne mer epper beigriege fer dich helfe unni as es dich ennich eppes koschte zeelt. Mir kenne dich helfe aa wann du Druwwel hoscht fer heere odder sehne. Mir kenne Schtofft lauder mache odder iesier fer lese un sell koscht dich aa nix. Ruf 1-800-462-3589 (TTY: 711) uff odder schwetz mit dei Provider.

Russian ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-800-462-3589 (TTY: 711) или обратитесь к своему поставщику услуг.

Japanese 注：日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル（誰もが利用できるよう配慮された）な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。　1-800-462-3589（TTY: 711）までお電話ください。または、ご利用の事業者にご相談ください。

Assyrian:
ܙܘܗܪܐ: ܐܢ ܡܡܠܠܬ ܐܬܘܪܝܐ، ܒܡܓܢ ܐܝܬ ܩܐܡ ܐܝܬܐ ܩܠܬܘܢ ܡܫܡܫܢܘܬܐ ܕܥܘܕܪܢܐ ܠܫܢܢܝܐ. ܐܦ ܐܝܬ ܒܡܓܢ ܩܐܡ ܐܝܬܐ ܡܘܬܒܐ ܘܡܫܡܫܢܘܬܐ ܠܥܘܕܪܢܐ
ܠܡܛܝܐ ܥܠ ܡܦܪܫܬܐ ܕ ܡܘܕܥܢܐ ܠܡܛܠܬܐ ܝܠܗ ܒܥܘܪܢܐ ܦܫܝܛܬܐ. ܩܪܝ 1-800-462-3589 (TTY:711) ܝܢ ܡܡܠܠ ܥܡ ܡܘܪܒܢܐ ܕ ܡܫܡܫܢܘܬܐ.

French: ATTENTION: Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-800-462-3589 (TTY : 711) ou parlez à votre fournisseur.

Italian: ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l'1-800-462-3589 (tty: 711) o parla con il tuo fornitore.

Albanian: VINI RE: Nëse flisni [shqip], shërbime falas të ndihmës së gjuhës janë në dispozicion për ju. Ndihma të përshtatshme dhe shërbime shtesë për të siguruar informacion në formate të përdorshme janë gjithashtu në dispozicion falas. Telefononi 1-800-462-3589 (TTY: 711) ose bisedoni me ofruesin tuaj të shërbimit.

Bengali: মনোযোগ দিন: যদি আপনি বাংলা বলেন তাহলে আপনার জন্য বিনামূল্যে ভাষা সহায়তা পরিষেবাদি উপলব্ধ রয়েছে। অ্যাক্সেসযোগ্য ফরম্যাটে তথ্য প্রদানের জন্য উপযুক্ত সহায়ক সহযোগিতা এবং পরিষেবাদিও বিনামূল্যে উপলব্ধ রয়েছে। 1-800-462-3589 (TTY: 711) নম্বরে কল করুন অথবা আপনার প্রদানকারীর সাথে কথা বলুন।

Serbo Croation: PAŽNJA: Ako govorite srpski, na raspolaganju su Vam besplatne usluge jezičke pomoći. Besplatna su i odgovarajuća pomoć i usluge za pružanje informacija u pristupačnim formatima. Pozovite 1-800-462-3589 (TTY: 711) ili razgovarajte sa svojim pružaocem usluga.

Oromo: HUBACHIISA: Yoo Afaan Oromoo dubbattu ta’e, tajaajiloonni gargaarsa afaanii bilisaa isiniif ni argamu. Deeggarsi dabalataa fi tajaajilootni mijaa'oo ta’an odeeffannoo bifa dhaqqabamaa ta'een kennuuf gargaaranis kaffaltii malee ni argamu. Gara 1-800-462-3589 (TTY: 711) tti bilbilaa ykn dhiyeessaa keessan haasofsiisaa.

Dutch: LET OP: als je Nederlands spreekt, zijn er gratis taalhulpdiensten voor je beschikbaar. Passende hulpmiddelen en diensten om informatie in toegankelijke formaten te verstrekken, zijn ook gratis beschikbaar. Bel 1-800-462-3589 (tty: 711) of spreek met je provider.

Romanian: ATENȚIE: Dacă vorbiți [Română], aveți la dispoziție servicii de asistență lingvistică gratuite. De asemenea, sunt disponibile gratuit materiale și servicii auxiliare adecvate pentru furnizarea de informații în formate accesibile. Sunați la 1-800-462-3589 (TTY: 711) sau contactați-vă furnizorul.

Ukranian: УВАГА: Якщо ви розмовляєте українська мова, вам доступні безкоштовні мовні послуги. Відповідні допоміжні засоби та послуги для надання інформації у доступних форматах також доступні безкоштовно. Зателефонуйте за номером 1-800-462-3589 (TTY: 711) або зверніться до свого постачальник

Notice of Non-Discrimination: Discrimination is Against the Law

Paramount complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin (including limited English proficiency and primary language), sex (consistent with the scope of sex discrimination described at 45 CFR § 92.101(a)(2)), age, or disability.

Paramount Provides (free of charge and in a timely manner):

- Reasonable modifications and appropriate auxiliary aids and services for people with disabilities to communicate effectively with us, such as:
    - Qualified interpreters for individuals with disabilities.
    - Information in alternate formats (large print, audio, accessible electronic formats, other formats).
- Language assistance services for people whose primary language is not English, which may include:
    - Qualified oral interpreters.
    - Electronic and written translated documents.

If you need these services, please contact Member Services at 1-800-462-3589 (TTY 711). We are available Monday-Friday, 8:00 a.m. to 5:00 p.m. EST.

If you believe that Paramount has failed to provide these services or discriminated on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator (also called our Section 1557 Coordinator). Our Civil Rights Coordinator can help you with our grievance procedure.

Contact our **Civil Rights Coordinator** at:

- **Mail:** Paramount Civil Rights Coordinator, PO Box 928, Toledo, OH 43697
- **Phone:** 1-800-462-3589 (TTY 711)
- **E-mail:** paramount.memberservices@medmutual.com
- **Fax:** 419-887-2047

You may file a grievance in-person at 650 Beaver Creek Circle, Suite 100, Maumee, OH 43537

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights.

- **Online:** Use the Office for Civil Rights Complaint Portal at: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. For more information on filing a complaint, go to http://www.hhs.gov/ocr/office/file/index.html.
- **Mail:** U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, D.C. 20201
- **Phone:** 1-800-368-1019, 800-537-7697 (TDD)

An electronic copy of this notice is available at Paramount's website: www.paramounthealthcare.com

Table of Contents

INTRODUCTION

You have enrolled in a comprehensive program of health care benefits ("Plan") with Paramount Insurance Company ("Paramount"), a licensed insurance company.

This booklet, referred to as a Certificate of Coverage, including the accompanying Schedule of Benefits is provided to describe the Plan. This Certificate of Coverage has been issued to You as part of the Contract between Paramount and the Employer electing to sponsor this Plan. To determine Your Paramount benefits for a specific service, You should refer to both this Certificate of Coverage and Your Schedule of Benefits. **You should check both sources for information about the Plan because this Certificate of Coverage presents information about the basic Plan, while the Schedule of Benefits explains the specific program that the Employer has purchased.** Questions regarding Your Plan can also be directed to the Paramount Member Services Departments at (419) 887-2531 or toll-free at 1-866-452-6128.

The Definition Section of this booklet lists the definitions of key terms used in this Certificate of Coverage and Your Schedule of Benefits. Capitalized terms are defined at the end of the Certificate of Coverage.

SECTION ONE: ELIGIBILITY AND EFFECTIVE DATE

Eligibility. Eligibility for Plan enrollment will **not** be conditioned on past, present, or future health status, medical condition, or need for medical care. No one who is eligible to enroll or renew as a Subscriber, Dependent or Dependent with disabilities will be refused enrollment by Paramount based on student status, health status related factor, pre-existing condition, genetic testing or the results of such testing, health care needs or age.

1.

A. **Eligible Employee**. In order to be eligible under the Plan, an employee must be:

(1) Eligible to participate in the Employer's health benefits program under the written benefits eligibility policies of the Employer.

(2) An employee who works on a full-time basis with a normal workweek of 30 or more 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 without regard to health-status related factors;

(3) Actively working or retired employee, enrolled in and eligible for Medicare Part A and B, if the Employer has elected to offer Medicare-primary coverage in accordance with Medicare Secondary Payer Rules and the Employer maintains active employee benefits; and

(4) Not enrolled in any other of the Employer's health benefits plans.

Former employees of the Employer contracting with Paramount who have elected to continue group coverage in accordance with state or federal law may also be eligible. Contact the Employer's personnel or benefits office for further information about eligibility.

B. **Eligibility for Plan attached to a Health Savings Account**.

(1) An employee must be enrolled in a high deductible health plan,

(2) Not claimed as a Dependent on another Person's tax return,

(3) Not covered by any other health plan (except some limited coverages), and not eligible for Medicare.

B. **Eligible Dependent**. If the employee is eligible for family coverage, he or she also may wish to cover one or more of his or her eligible dependents. The following Persons are eligible dependents, provided that they meet any additional eligibility requirements of the Employer:

(1) The employee's legal spouse; or
(2) Any child of the employee who is married or unmarried as defined in this section until the last day of the month they turn age 26.

Child includes: any natural children, legally adopted children, children for whom the employee is the legal guardian, stepchildren who are dependent upon the employee for support, and children for whom the employee is the proposed adoptive parent and is legally obligated for total or partial support during the Waiting Period prior to the adoption becoming final. Foster children are not included. Paramount may require proof of dependency.

C. Extension of Coverage for Older Children. Coverage for a covered dependent child may be continued beyond age twenty-six (26), if the child is:

(1) incapable of self-support due to mental retardation or physical handicap; and

(2) primarily dependent upon the employee for support and maintenance.

This disability must have started before the dependent age limit was reached and must be medically certified by a Physician. You must notify Paramount of the disabled dependent's desire to continue coverage prior to or within 31 days of reaching the limiting age. You and Your Physician must complete and sign a form that will provide Paramount with information that will be used to evaluate eligibility for such disabled dependent status. You may also be required to periodically provide current proof of retardation or physical handicap and dependence, but not more often than annually after the first two years. To obtain the form required to establish disabled dependent status, please contact a Paramount Member Services representative at 419-887-2531 or toll-free 1-866-452-6128.

2. **Enrollment**. Eligible employees and eligible dependents may enroll in the Plan as follows.

(1) **Initial Election Period**. An Election Period will be held prior to the Effective Date of this Plan. An eligible employee and his or her eligible dependents may choose between this Plan and any other health care benefit plans offered by the Employer during this time and may enroll in the Plan.

B. **Subsequent Election Period.** An eligible employee and his or her eligible dependents may enroll during any subsequent annual Election Period.

C. **Marriage, Birth, Placement for Adoption, or Adoption**. An eligible employee and his or her eligible dependents may enroll within 31 calendar days of the employee's marriage or the birth, placement for adoption, or adoption of the employee's dependent child.

A newborn dependent child is automatically covered at birth for 31 calendar days for injury or sickness, including Medically Necessary care and treatment of congenital defects and birth abnormalities. The newborn child must be enrolled within the 31-calendar day period in order for coverage to continue beyond such period.

If a covered dependent child gives birth, the newborn grandchild will not be covered unless the employee adopts or assumes legal guardianship of the child.

When placed for adoption, a child is covered only for the period of time the employee is legally obligated to provide partial or full support for the child.

If an employee acquires a child by birth, placement for adoption, or adoption, the employee (if not already enrolled) and his or her spouse and child may enroll. An eligible employee must enroll or already be enrolled in order for the spouse and/or child to enroll. The eligible employee may enroll even if the child does not enroll.

D. **Special Enrollment Period** - If an eligible employee declines enrollment for themselves or their dependents (including their spouse) because of other health insurance coverage, the employee may in the future be able to enroll themselves or their dependents in this plan, provided that the employee requests enrollment within 31 days after other coverage ends because (1) there is a loss of eligibility for group health plan coverage or health insurance coverage and (2) termination of Employer contributions toward group health plan coverage. Examples of reasons for loss of eligibility include: legal separation, divorce, death of an employee, termination or reduction in hours of employment – voluntary or involuntary (with or without electing COBRA), exhaustion of COBRA, "aging out" under other parent's coverage, moving out of an HMO's service area, and meeting or exceeding lifetime limit on all benefits. Loss of eligibility for coverage does not include loss due to the individual's failure to pay premiums or termination of coverage for cause, such as fraud.

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

In addition, if the employee has a new dependent as a result of marriage, birth, adoption, or placement for adoption, the employee may be able to enroll themselves and their dependents, provided that the employee requests enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

E. **Newly Eligible**. An eligible employee and his or her eligible dependents may enroll within 31 calendar days of first becoming eligible because the employee is newly hired or in the case of a large group, newly in the class of employees to which coverage under this Plan is offered (e.g., union vs. non-union employee, employee living in a particular region, part-time employee vs. full-time employee).

F. **Legal Guardianship**. An eligible dependent may be enrolled within 31 calendar days of the date a covered employee assumes legal guardianship.

G. **Court Ordered Coverage**. If a covered or eligible employee is required by a court or administrative order to provide health care coverage for his or her child, and the child is an eligible dependent, the employee may enroll the child at any time after the order. If the employee is not already enrolled, he or she must enroll with the child.

If a covered employee fails to enroll the child, Paramount will enroll the child upon application of the child's other parent or pursuant to an order.

Covered dependents enrolled under this provision may not be terminated (while the employee remains a covered employee) unless Paramount is provided satisfactory written evidence that the court or administrative order is no longer in effect or the child is or will be enrolled under comparable health care coverage provided by another health insurer, to take effect no later than the date of termination under this Plan.

3. **Effective Date**. Coverage begins on the date specified below, so long as Paramount receives payment of applicable premiums and a completed enrollment application on behalf of each eligible Person to be enrolled in the Plan.

A. **New Hire Policy**. Coverage for eligible employees and those eligible dependents who enroll simultaneously with the eligible employee during the initial or subsequent yearly Election Period is effective in accordance with the New Hire Policy of the Employer's Contract with Paramount. For Employers with fewer than 50 employees, the affiliation period cannot exceed 90 days.

B. **Marriage, Birth Adoption, or Placement for Adoption**. If an eligible employee and/or eligible dependent(s) enrolls because of marriage, birth, adoption, or placement for adoption pursuant to Paragraph 2.C. of this section, coverage is effective as follows:

(1) In the case of marriage, on the date of a legal marriage if a completed enrollment application is received by Paramount within 31 days of the marriage date.

(2) In the case of birth, as of the date of such birth if a completed enrollment application is received by Paramount within 31 days of the birth date; or

(3) In the case of adoption or placement for adoption, the date of adoption or placement for adoption if a completed enrollment application is received by Paramount within 31 days of the date of adoption or placement for adoption.

C. **Special Enrollment Period - Loss of Other Coverage**. If an eligible employee and/or eligible dependent(s) enrolls because of loss of other coverage pursuant to Paragraph 2.D. of this section, coverage is effective on the day following the Effective Date of termination of other coverage if a completed enrollment application is received by Paramount within 31 days of the termination of other coverage.

D. **Newly Eligible**. If an eligible employee and/or eligible dependent(s) enrolls because of newly acquired eligibility pursuant to Paragraph 2.E. of this section, coverage is effective in accordance with the Employer's New Hire Policy. Please contact Your Employer's benefits

office for details.

E. **Late Enrollment.** An eligible employee or dependent who did not request enrollment for coverage during the Initial Election Period, or Special Enrollment Period, or a newly eligible dependent who failed to qualify during the Special Enrollment Period and did not enroll within 31 days of the date during which the individual was first entitled to enroll, is considered a Late Enrollee and may only apply for coverage as a Late Enrollee during the Group's Subsequent Election Period.

4. **Terms**. Once enrolled as described in this section, an eligible employee is known as a "covered employee" and an eligible dependent is known as a "covered dependent." A "Covered Person" is a defined term meaning a covered employee or covered dependent. Whenever used in this Certificate of Coverage, "You" or "Your" means a Covered Person.

5. **Pre-Existing Conditions**. Paramount Insurance Company does not have any restrictions on Pre-Existing conditions. In other words, if you were being treated for a condition before you became a Paramount member, Paramount will provide benefits for Covered Services related to that condition on or after your Effective Date with Paramount.

6. **Termination of Coverage**.

A. **Employee**. Paramount will not terminate coverage for you or your Dependents due to health status, health care needs or the exercise of rights under Paramount's internal review procedures. However, Paramount will not re-enroll anyone terminated for any of the reasons listed in this Section. You may request termination by sending a written request to Paramount 14 days in advance of the desired termination date.

A covered employee's coverage and that of his or her covered dependents will end (subject to Section Two, Continuation of Coverage) on the earliest of the following dates:

(1) The last calendar day of the month in which the covered employee terminates employment, unless the Employer's Contract with Paramount provides for a different termination date;

(2) The last calendar day of the month in which the covered employee ceases to be eligible for coverage, unless the Employer's Contract with Paramount provides for a different termination date;

(3) The last calendar day of the month preceding the first day of the next month for which any required contribution for employee coverage has not been made, unless the Employer's Contract with Paramount provides for a different termination date;

(4) The date the Plan is terminated or employee coverage is terminated;

(5) The date of the covered employee's death.

B. **Dependent**. Coverage for a covered dependent will end (subject to Section Two, Continuation of Coverage) on the earliest of the following dates:

(1) The last calendar day of the month in which the covered dependent becomes ineligible for coverage under the Plan, unless the Employer's Contract with Paramount provides for a different termination date;

(2) The date of the death of the covered dependent;

(3) The date dependent coverage terminates or the Plan terminates; or

(4) The last calendar day of the month preceding the first calendar day of the next month for which the required payment for dependent coverage has not been made, unless the Employer's Contract with Paramount provides for a different termination date; or

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

(1) Do not make any required premium contribution; or

(2) Perform any act or practice that constitutes fraud or an intentional misrepresentation of material fact under the terms of coverage, including without limitation:

a. Allowing the use of Your Paramount Identification card by any other Person or using another Covered Person's card;

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

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

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

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

D. **Plan Termination**. Coverage under the Plan may be renewed each year at the option of the Employer; provided that, Paramount may terminate or non-renew the Employer's Contract, with 30 days prior written notice for one or more of the following reasons, which will be stated in written notice:

(1) Failure to pay the required premiums on time;
(2) Fraud or intentional misrepresentation of a material fact by the Employer, its agent or employees in connection with such coverage;
(3) If there is no longer a Covered Person who lives, resides, or works in the state of Michigan;
(4) If the membership of the Employer in an Alliance (on the basis of which coverage is
(5) provided) ceases;When Paramount discontinues offering this Plan in the Small Group market, as applicable, in Michigan and:
   a. Paramount provides notice to each Employer and Covered Person provided coverage under this Plan in the Small or Large Group Market, as applicable, of such discontinuation at least 90 calendar days prior to the date of discontinuation of such coverage;
   b. Paramount offers each Employer provided coverage in the Small or Large Group Market, as applicable, under this Plan the option to purchase other coverage currently being offered by Paramount to an Employer or union sponsored Health Benefit Plan in such market(s); and
   c. In exercising the option to discontinue coverage of this type and in offering the option of other coverage under this provision, Paramount acts uniformly

without regard to claims experience of those Employers or the health status of any Covered Persons or eligible employees or dependents; or

(6) When Paramount discontinues offering coverage in the Small Group Market, in Michigan and after Paramount provides notice to the Michigan Department of Insurance and each Employer and its Covered Persons in the applicable market(s) of such discontinuation at least 180 calendar days prior to the date of discontinuation of such coverage.

SECTION TWO: CONTINUATION OF COVERAGE

1. **Continuation of Coverage Under COBRA.** If Your coverage under the Employer's Contract with Paramount would otherwise end, You may be eligible for continuation of coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), as amended, or under other federal or state laws.

   The Employer's benefits administrator will coordinate continuation of coverage. To obtain specific details and to arrange for continuation of health care benefits, the covered employee should contact the Employer's benefits office.

2. **Continuation of Coverage During Military Service**. If You are absent from work due to U.S. military service, You may elect to continue coverage (including coverage for Your dependents) for up to a maximum 24 months from the first day of absence or, if earlier, until the day after the date You are required to apply for or return to active employment. Your contributions for the continued coverage will be the same as those paid by similarly situated active employees during the first 30 days of Your absence. Thereafter, Your contributions will be the same as those paid for COBRA continuation of coverage. Whether or not You continue coverage during military service, You may reinstate coverage under the Plan on Your return to employment provided You continue to meet the Plan eligibility requirements.

   Your reinstatement under the Plan will be without any Pre-Existing Condition Exclusion. If You dropped coverage for Your dependents under the Plan, they may re-enter the Plan with You subject to the Plan's Special Enrollment rules.

3. **Continuation of Coverage During Family and Medical Leaves of Absence**. You may be eligible for continuation coverage if You are absent from work for periods of time covered under the Family and Medical Leave Act of 1993 (FMLA). The Employer's benefits administrator will coordinate continuation of coverage. To obtain specific details and to arrange for continuation of health care benefits, You should contact Your Employer's benefits office.

4. **Other Approved Leave of Absence or Disability**. You may be eligible for continuation of coverage during an approved leave of absence of disability that causes You to be absent from work. To obtain specific details and to arrange for continuation of health care benefits, You should contact Your Employer's benefits office.

   NOTICE: If You elect COBRA continuation coverage, and the provisions of this Certificate of Coverage are changed or revised, Paramount will notify the Employer 31 calendar days before the changes become effective. It is the responsibility of the Employer to notify You. If payments continue to be made to Paramount, Paramount will assume that You have accepted the changes. If You do not consent to the changes, You may end Your coverage by notifying the Employer in writing. Any change in the premium, which resulted from a change or revision to the provisions of this Certificate of Coverage, will be made in accordance with the Employer's Contract with Paramount.

SECTION THREE: HOW THE MAXIMUM CHOICE PREFERRED CHOICES PLAN WORKS

1. Surprise Billing

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.
"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "balance billing". This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You cannot be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

In addition to the protections of the Federal No Surprises Act, the state in which you receive services may have protections that apply to your visit for emergency or non-emergency services. Your state website can be found at www.michigan.gov/difs and by searching "no surprises, balance billing or consumer protections".

Michigan law protects patients from balance billing and requires that the patient pay only their in-network cost sharing amounts for: (i) covered emergency services provided by an out-of-network provider at an in-network facility or out-of-network facility; (ii) covered nonemergency services provided by an out-of-network provider at an in-network facility if the patient does not have the ability or opportunity to choose an in-network provider; and (iii) any healthcare services provided at an in-network facility from an out-of-network provider within 72 hours of a patient receiving services from that facility's emergency room.

Certain services at an in-network hospital or ambulatory surgical center
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers cannot balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you received other services at these in-network facilities, out-of-network providers cannot balance bill you, unless you provide written consent and give up your protections.

You're never required to give up your protections from balance billing. You also are not required to get care out-of-network. You can choose a provider or facility in your plan's network.

In addition to the protections of the Federal No Surprises Act, the state in which you receive services may have protections that apply to non-emergency services at an in-network facility. Your state website can be found at www.michigan.gov/difs and by searching "no surprises, balance billing or consumer protections".

For services provided in Michigan by an out-of-network provider at an in-network health facility, the provider shall not balance bill the covered person unless: (a) the provider informs the covered person that the patient's health plan may not cover all of the health care services the out-of-network provider is scheduled to provide; (b)the provider provides to the covered person a good faith estimate of the cost of the services; (c) the provider informs the covered person that the patient may request the health care services are performed by an in-network provider; and the covered person affirmatively consents to receive the services.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network).Your health plan will pay out-of-network providers and facilities directly.

- Your health plan generally must:
  - Cover emergency services without requiring prior authorization.
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed or have unsolved issues related to air ambulance services, you may contact your state or the Centers for Medicare and Medicaid Services at 1-800-985-3059. Your state website can be found at www.michigan.gov/difs and by searching "no surprises, balance billing or consumer protections".

State	State Balance Billing Website	Surprise Billing or Department of Insurance	Department of Attorney General
MI	https://www.michigan.gov/difs/0,5269,7-303--560598--,00.html	833-ASK-DIFS (833-275-3437)	https://www.michigan.gov/documents/ag/Consumer_Complaint_Form_-_paper_642450_7.pdf

In addition, you may contact Paramount's Member Services Department at:
419-887-2525
Toll Free:1-800-462-3589
TTY: 419-887-2526
TTY Toll Free: 1-888-740-5670

Visit www.cms.gov/nosurprises for more information about your rights under federal law.

2. **Health Care Reimbursement Choices**. Paramount's Maximum Choice Preferred Choices Plan provides You with two (2) flexible choices for reimbursement any time Covered Services are required. The amount paid for the care You receive depends upon whether care is received from an "In-Network" or "Out-of-Network" Provider.

   To receive In-Network benefits, You may seek care from any Preferred Provider Organization (PPO) In- Network Provider when You require medical services. As an alternative, care may be sought

from an Out-of-Network Provider.

In-Network Option – You may seek care from any In-Network Provider. You must satisfy the Deductible under the In-Network option before any benefits will be paid and Your share of the cost for services will be lower compared to obtaining service from Out-of-Network Providers. You are also required to obtain Prior Authorization from Paramount for certain services.

To receive benefits under the In-Network Option, You must use In-Network (Paramount Preferred Options) Providers and facilities to obtain Covered Services, except Emergency Services. It is Your responsibility to ensure that Covered Services are obtained from In-Network Providers and facilities to be eligible for coverage under the In-Network Option.

Out-of-Network Option – You may seek care from Providers outside the Network. You must satisfy the Deductible under the Out-of-Network option before any benefits will be paid and Your share of the cost for services will be higher. You are also required to obtain Prior Authorization from Paramount for certain services.

Special Note on Out-of-Network Providers. For Out-of-Network Hospital Providers in Lucas County, Ohio, Paramount pays for benefits based on the lesser of the Non-Contracting Amount (NCA) that is determined payable by Paramount or the actual charge for the service. For all other Out-of-Network Hospitals, Physicians/Providers, Paramount pays for benefits based on the lesser of the Usual, Customary and Reasonable (UCR) Charge or the actual charge for the service.

If the charge billed is greater than the NCA or Usual, Customary and Reasonable (UCR) Charge, **You must pay the excess portion**. For Covered Services rendered Out-of-Network, Deductibles, Coinsurance and benefit maximums are based on the lesser of the NCA, the UCR Charge or the actual charge for the service.

Example (assumes the Deductible has already been met):

Out-of-Network Provider charge:	$1,000
NCA or UCR limit:	$700
Plan pays 70% of $700:	$490
You pay 30% Coinsurance:	$210
Plus balance of charge above $700	$300
Your total cost:	$510

In this example, only the Coinsurance of $210 would count toward the maximum out-of-pocket expense for the calendar year. When considering using Out-of-Network Providers, You should verify the limitations that may apply to the charges. If the Out-of-Network Provider has waived any portion of Your required Coinsurance payment, Your total cost would be calculated by subtracting the waived Coinsurance from the amount that You were billed by the Provider.

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

3. Prior Authorization

We will utilize our clinical coverage guidelines, such as medical policy and other internally developed clinical guidelines, and preventive care clinical coverage guidelines, to assist in making our
Medical Necessity/Medically Indicated decisions. These guidelines reflect the standards of practice and medical interventions identified as appropriate medical practice. We reserve the right to review and update these clinical coverage guidelines periodically. Your Certificate and the Employer Contract take precedence over these guidelines.

Prior Authorization is required for, but not limited to, the following list of services, procedures and equipment. A more comprehensive list can be found at www.paramounthealthcare.com/priorauth.

Even if You obtain a referral, **pre- authorization is always required before obtaining these services, procedures and equipment.** If You obtain Prior Authorization, these services, procedures and equipment will be covered at the appropriate benefit level indicated in Your Schedule of Benefits if it is Medically Necessary and/or a Covered Service. Prior Authorization is required to avoid a potential denial or reduction in payment of benefits.

Prior Authorization must be obtained by calling Paramount at 419-887-2045 or toll free 1-800-891-2045 before (preferably two weeks in advance) obtaining any of the following.

A. Services requiring Prior Authorization (not an all-inclusive listing, refer to www.paramounthealthcare.com/priorauth):

i. Inpatient admission to a Hospital, Intensive Outpatient Programs (IOP), partial hospitalizations (PHP), and Inpatient admissions at rehabilitation/residential facilities; or
ii. Inpatient admission to a Skilled Nursing Facility; or
iii. Home Health services; or
iv. Organ/Bone Marrow Transplant services.

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

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

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

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

If You do not obtain the required Prior Authorization, Paramount will conduct a Retrospective Review to determine if your care was Medically Necessary. You are responsible for all charges that are not Medically Necessary.

If You ***do not obtain Prior Authorization*** and the services are Medically Necessary, any benefit payment for a ***Facility fee and Outpatient Facility services*** will be reduced by $500 of the Allowable Amount. The services are then subject to the applicable Deductible, Copayment and/or Coinsurance. Financial penalties for failure to obtain Prior Authorization for care received In-Network will count toward Your Out-of-Pocket Maximum. Financial penalties for care received Out-of-Network will not count toward Your Out-of-Pocket Maximum.

Notification of Prior Authorization Decision. Paramount will make its decision regarding coverage and notify you within 7 calendar days after the date and time of the initial request. If additional information is requested, Paramount will notify you of the decision within 7 calendar days after the date and time of the submission of additional information. For Prior Authorization requests considered Urgent, Paramount will notify you of the decision within 72 hours after the date and time of the initial request. If additional information is requested, Paramount will notify you of the decision within 72 hours after the date and time of the submission of additional information.

For Emergency admissions to a Hospital or Skilled Nursing Facility, You do not have to obtain Prior Authorization in advance. However, You, a family member, or Your Physician must notify Paramount within 48 hours of an Emergency admission, or as soon as possible. If You have any questions, or to provide notice, call 419-887-2045 or toll-free 1-800-891-2045.

If You disagree with Paramount's determinations, You may appeal Paramount's decision by following the appeal procedure set forth in Section Eight, Questions, Problems or Grievances.

Remember that You must obtain Prior Authorization from Paramount before You obtain the services, procedures and equipment listed above.

3. **The Preferred Provider Organization (PPO) Network**. The PPO Network Directory lists all Physicians and other Providers who are part of the PPO Network. The PPO Network Directory will be updated periodically and You may access the PPO Network Directory at; www.paramounthealthcare.com]. Or by calling the Member Service Department at (419) 887-2531 or toll-free 1-866-452-6128.

   In-Network Physicians include family practitioners, internists, and pediatricians whom You may select to provide primary care. In-Network specialists include obstetrician/gynecologists, oncologists, cardiologists, orthopedists, and other designated specialists. Other In-Network Providers include psychiatrists and psychologists who provide mental Health Care Services, drug abuse and alcohol abuse treatment.

   Please note that Paramount's contracting and credentialing with In-Network Providers should not, in any case, be understood as a guarantee or a warranty of the appropriateness and/or adequacy of the medical care rendered by such Provider. In-Network Providers are independent contractors and are not employees or agents of Paramount. The selection of an In-Network Provider or any other Provider, and the decision to receive or decline to receive Health Care Services is **Your responsibility**. Health care decisions are made solely by You in consultation with Your Health Care Providers. Health Care Providers are solely responsible for patient care and related clinical decisions once You make Your health care decision.

4. **Filing Claims**. For all Covered Services, a claim form or written proof of loss must be submitted to Paramount. In-Network Providers will submit the required claim forms to Paramount for You. You must show Your Paramount identification card to the In-Network Provider. **In-Network Hospitals, Physicians and Providers have agreed to limit their charges through their contracts with the PPO Network.**

   Out-of-Network Providers may decline to submit claims to Paramount for You. In that case, it is Your responsibility to file appropriate claims in order to receive reimbursement from Paramount.

   In order for Paramount to make payments under this Plan, Paramount must receive claims for benefits within 90 calendar days after a service is received. Failure to submit a completed claim within that time will neither invalidate nor reduce any claim if it is shown that: 1) it was not reasonably possible to furnish a claim within that time; and 2) such claim was furnished as soon as reasonably possible. In no event, in the absence of legal capacity, may a claim be furnished later than ***1 year*** from the time the claim is otherwise required. After an initial claim is submitted to Paramount, Paramount may request additional medical or other information necessary to process the claim. The claimant must respond to a written request from Paramount for additional information within 6 months of the receipt of the request for additional information. Failure to respond within this timeframe may invalidate the claim.

In most cases, reimbursement for Covered Services will be sent directly to the Provider, but in some cases, Paramount may choose to send reimbursement to you. If you pay for the Covered Services you may request reimbursement from Paramount. Claim forms are available from the Employer's personnel or benefits office or by calling the Paramount Member Services Department at 419-887-2531 or toll-free at 1-866-452-6128.

Explanation of Benefits (EOB): After a claim has been filed with Paramount, You will receive an Explanation of Benefits (EOB). The EOB is a summary of the coverage for that claim. The EOB is not a bill, but a statement from Paramount to help You understand the coverage You are receiving. The EOB shows:

- Total amount charged for services/supplies received;
- The amount of the charges paid by Your coverage; and
- The amount for which You are responsible (if any).

5. **Payments under This Plan**. Your share in the cost of Covered Services may include a Deductible, Copayment, and Coinsurance as shown in the Schedule of Benefits.

A. **Deductible.** The amount You and Your Dependents must pay for Covered Services within a calendar year, before benefits will be paid by the Plan. See Your Schedule of Benefits for the Deductible amount that applies to You and Your Dependents. The single Deductible is the amount each Covered Person must pay. The family Deductible is the total amount any two or more covered family members must pay. The Deductible amount of one family member will not exceed that of the single Deductible amount. Preventive Health Services are not subject to the Deductible or any other Cost Sharing. A plan will only be used as a High Deductible Health Plan (HDHP) with a Health Savings Account (HSA) when it follows the minimum and maximum limits for a HDHP. See Definitions section of this certificate for more information regarding an HDHP and HSA.
The expenses incurred for Covered Services from In-Network and Out-of-Network Providers including Prescription Drugs apply to the Deductible.

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

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

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

Out-of-Pocket Maximum. Your Out-of-Pocket Maximum is stated in Your Schedule of Benefits. After that amount has been paid, there will be no additional Cost Sharing during the remainder of that calendar year. The Out-of-Pocket Maximum is the maximum amount of Deductible, Coinsurance and Copayments incurred by a Covered Person in a calendar year. The single Out-of-Pocket Maximum is the amount each Covered Person must pay, but the family Out-of-Pocket Maximum is the total amount any two or more covered family members must pay. The Out-of-Pocket Maximum of one family member will not exceed that of the single Out-of-Pocket Maximum amount. The following ***do not*** apply to the Out-of-Pocket Maximum:

- Financial penalties imposed for failure to obtain required Prior Authorization for care received Out-of-Network;
- Non-Network charges in excess of NCA or UCR.
- Spending for non-Covered Services.

The expenses incurred for Covered Services received from In-Network Providers apply toward satisfying the In-Network Out-of-Pocket Maximum. The expenses incurred for Covered Services received from Out-of-Network Providers apply toward satisfying the In-Network and Out-of-Network Out-of-Pocket Maximums.

6. **Medically Necessary**. Covered Services must be Medically Necessary (see the Definition Section). The fact that Your Provider prescribed the care or service does not automatically mean that the care is Medically Necessary or that it qualifies for coverage.

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

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

7. **Coverage for Emergency Services**. Usually, services obtained from Out-of-Network Providers are covered at the Out-of-Network benefit level. However, if You have an accident, unforeseen illness, or injury that requires immediate care, You may seek Emergency Services (see the Definition Section) 24 hours a day and 7 days a week at the nearest health care Facility, and You will receive the In-Network benefit level based on the lesser of the Usual, Customary and Reasonable (UCR) Charge or the actual charge for the service. Paramount must be notified within 48 hours of an Emergency admission, or as soon as possible, so Your benefits can be verified for the Provider. In-Network benefits for care received from Out-of-Network Providers are limited to Emergency Services required before You can, without medically harmful results, return to the care of In-Network Providers.

8. **Continuity of Treatment.** If your provider or facility's Paramount agreement terminates, Paramount will notify you of your right to elect continued transitional care from such provider or facility at the time of termination. You will be provided coverage under the same terms and conditions as would have applied and with respect to such services as would have been covered had such termination not occurred. Paramount will continue to pay for Covered Services rendered by that provider or facility until the earlier of: a) the 90-day period beginning on date of provider or facility termination; b) the date on which you are no longer a Continuing Care Patient with respect to such provider or facility. If this situation occurs, you should contact Paramount Member Services.

   For the purpose of this provision, Continuing Care Patient means an individual who, with respect to a provider or facility, is undergoing a course of treatment for a serious complex condition from the provider or facility; is undergoing a course of institutional or inpatient care from the provider or facility; is scheduled to undergo nonelective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery; is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or is or was determined to be terminally ill and is receiving treatment for such illness from such provider or facility.

SECTION FOUR: COVERED SERVICES

Covered Medical Services. Paramount will provide benefits for the Medically Necessary services described in this section when they are performed or ordered by a licensed Physician. The level of benefits for these services will depend on whether these services are obtained through In-Network or Out-of-Network Providers.

Plan provisions may be modified, if a Medically Necessary and less costly alternative course of treatment is available.

Ambulance Services - Ground or Air

The Benefit plan covers Emergency ground ambulance transportation by a licensed ambulance service to the nearest Hospital where Emergency Health Services can be performed.

Air ambulance transport by a licensed ambulance service is covered when you have a potentially life-threatening condition that does not permit the use of another form of transportation. Your condition must be such that the time needed to transport you by ground, or the instability of transportation by ground, poses a threat to your survival or seriously endangers your health. Transportation must be to the nearest Hospital where appropriate treatment of your condition can be performed. The list below includes examples of medical conditions in which air ambulance transport may be necessary. This list does not guarantee coverage nor is it intended to be all inclusive. Diagnosis alone does not guarantee coverage.

- Intracranial bleeding requiring neurosurgical intervention
- Cardiogenic shock Burns requiring treatment in a burn center
- Conditions requiring treatment in a hyperbaric Oxygen unit
- Multiple severe injuries
- Life-threatening trauma

Your symptoms at the time of transport must meet Paramount's established criteria for coverage. We may ask for verification by requesting the records of the attending Physician and the ambulance company.

Air ambulance transport must be to the nearest suitable Hospital. Air ambulance services are not covered for transport to a Facility that is not an acute care Hospital. Transport to a nursing Facility, a Physician's office, or your home by air ambulance is not covered.

The Benefit plan covers Medically Necessary non-Emergency ambulance transportation services when those services are recommended by the attending Physician and coordinated by us.

Non-Emergency Medically Necessary ambulance transportation by a licensed ambulance service between facilities is covered when the following criteria are met:

- The patient's condition must be such that any other form of transportation would not be medically recommended and
- Any of the following circumstances exists:

➢ Transfer from an acute care Facility to a patient's home or Skilled Nursing Facility; or
➢ Transfer to and from a patient's home to an acute care Facility to obtain Medically Necessary diagnostic or therapeutic services (such as MRI, CT scan, dialysis, etc.).

- Transportation to or from one acute care Facility to another acute care Facility, Skilled Nursing Facility or free-standing dialysis center in order to obtain Medically Necessary diagnostic or therapeutic services (such as MRI, CT scan, intensive care services including neonatal ICU, acute interventional cardiology, radiation therapy, etc.), provided such services are:

➢ Not available at the transferring Facility where the patient is being treated; and
➢ The patient cannot be safely transported in another way; and
➢ The patient requires continued acute Inpatient medical care.

- Ground ambulance for a deceased patient in the following circumstances:

➢ The patient was pronounced dead while in route or upon arrival at the Hospital or final destination; or
➢ The patient was pronounced dead by a legally authorized individual (Physician or medical examiner) after the ambulance call was made, but prior to pick-up.

Antineoplastic Therapy (Chemotherapy)

The Benefit plan covers federal Food and Drug Administration (FDA) approved Medically Necessary drugs used in antineoplastic therapy and the reasonable cost of administration of the drug. Benefits are provided regardless of whether the specific neoplasm for which the drug is being used as treatment is the specific neoplasm for which the drug has received approval by the federal FDA, if all of the following are true:

- The drug is ordered by or under the direction of a Physician for the treatment of a specific type of neoplasm and
- Current medical literature substantiates its efficacy and recognized oncology organizations generally accept the treatment; and
- The drug is approved by the federal FDA for use in antineoplastic therapy; and

- The drug is used as part of an antineoplastic drug regimen; and
- The Physician has obtained informed consent from the patient for the treatment regimen, which includes federal FDA approved drugs for off-label indications.

Autism Spectrum Disorders Treatment

Description

Diagnosis of Autism Spectrum Disorders includes assessments, evaluations, or tests, including the Autism Diagnostic Observation Schedule, performed by a licensed Network Physician or a licensed Network psychologist to diagnose whether an individual has one of the Autism Spectrum Disorders.

Treatment of covered Autism Spectrum Disorders involves Medically Necessary, evidence-based treatment that includes the following care prescribed or ordered for an individual diagnosed with one of the Autism Spectrum Disorders by a licensed Network Physician, licensed Network psychologist or board certified Network Behavioral Analyst:

- Behavioral health treatment (evidenced-based counseling and treatment programs, including Applied Behavioral Analysis (ABA), that are both 1) necessary to develop maintain, or restore, to the maximum extent practicable, the functioning of an individual; and 2) are provided or supervised by a board certified Behavior Analyst or a licensed psychologist so long as the services performed are commensurate with the psychologist's formal university training and supervised experience);
- Pharmacy management (Medically Necessary services related to medications prescribed by a Physician to determine the need or effectiveness of the medications);
- Psychiatric care (evidence-based direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices);
- Psychological care (evidence-based direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices);
- Therapeutic care (evidence-based services provided by a licensed or certified speech therapist, occupational therapist, physical therapist, or social worker).

Treatment for Autism Spectrum Disorder may also include Habilitative Services such as physical therapy, occupational therapy and speech therapy. The plan will not limit visits for any mandated type of treatment relating to Autism Spectrum Disorder.

Paramount may:

- Require submission of a Treatment Plan for review
- Require submission of results of the Autism Diagnostic Observation Schedule that has been used in the diagnosis of an Autism Spectrum Disorder;
- Request that an annual development evaluation be conducted and the results of that annual development evaluation be submitted to us.

Behavioral Health Services

The Benefit plan covers Medically Necessary Behavioral Health Services received in a Provider's office, a Hospital or at an Alternate Facility (depending on the service provided), including:

- Mental health, alcoholism, chemical dependency or substance use disorder evaluations and assessment.
- Diagnosis.
- Treatment planning.
- Referral services.
- Medication management.
- Individual, family and group therapeutic services (including intensive Outpatient therapy).
- Crisis intervention.
- Inpatient detoxification from abusive chemicals or substances that is limited to medical services for physical detoxification when necessary to protect your physical health and well-being.
- Residential Treatment Program.
- Partial hospitalization.
- Day Treatment

- Electroconvulsive therapy (ECT).
- Neuro/cognitive/psycho-diagnostic testing
- Personality disorders (including specific psychological testing to clarify the diagnosis of personality disorder)
- Sexual and gender identity and functional disorders.

Paramount will arrange for the services; determining the appropriate setting for the treatment, and if the treatment is Medically Necessary per Paramount medical policy and nationally recognized guidelines. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

Covered treatment settings are as follows:

- Acute Inpatient Hospitalization and Detoxification – the highest level of intensity of medical and nursing services provided within a structured environment providing 24-hour skilled nursing and medical care. Full and immediate access to ancillary medical care must be available for those programs not housed within general medical centers.
- Residential Treatment Program – a program that provides medically or clinically supervised therapies in a 24-hour setting and that is designed to treat groups of patients with a similar dependency.
- Intermediate/Day Treatment/Partial Hospitalization – an intensive, non-residential level of service where multidisciplinary medical and nursing services are required. This care is provided in a structured setting, similar in intensity to Inpatient, meeting for more than four hours (and generally less than eight hours) daily.
- Intensive Outpatient Treatment – multidisciplinary, structured services provided at a greater frequency and intensity than routine Outpatient treatment. These are generally up to four hours per day, up to five days per week. Common treatment modalities include individual, family, group and medication therapies.
- Outpatient/Ambulatory Detoxification – detoxification services delivered within a structured program having medical and nursing supervision where physiological consequences of withdrawal have non-life-threatening potential.
- Outpatient Treatment – the least intensive level of service, typically provided in an office setting from 45-50 minutes (for individuals) to 90 minutes (for group therapies) per day.
- Observation – a period of less than 24 hours during which services are provided at less than an acute level of care. It is indicated for those situations where full criteria for Inpatient hospitalization are not met because of external factors relative to information gathering or risk assessment yet the patient clearly is at risk for harm to self or others.

Treatment must be provided by a licensed Physician or other licensed behavioral health professional and received in a Facility accredited by COA, AOA or JCAHO.

NOTE: Some Covered Health Services received during the same Outpatient office visit may be subject to the Annual Deductible and Coinsurance. See other categories in this section.

Eating disorders, and feeding disorders of infancy or childhood, are covered at all levels of care described above based on Paramount medical policies.

Attention deficit hyperactivity disorders are covered for initial evaluation, and follow-up psychiatric medication management.

Personality disorders are covered only for specific psychological testing to clarify the diagnosis.

Organic brain disorders are covered for initial evaluation to clarify the diagnosis and for follow-up psychiatric medication management. Inpatient services for members with organic brain disorders, such as closed head injuries, Alzheimer's and other forms of dementia, are covered based on Paramount medical policies.

Coverage for Behavioral Health Services is limited to the most appropriate method and level of treatment that is Medically Necessary as determined by Paramount medical policy and nationally recognized guidelines.

NOTE: The Benefit plan is intended to comply with the federal Mental Health Parity and Addictions Equity Act.

Clinical Trials

Please contact us to discuss specific services if you participate in an approved clinical trial and to request authorization to ensure coverage of these services.

If you or your Provider does not obtain authorization from us, Benefits will not be paid and you may be responsible for all non-covered charges.

Description

If you are a participant in an approved clinical trial, the Benefit plan will cover routine care costs for services such as doctor visits, lab tests, X-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in an approved clinical trial or is receiving standard therapy.

An approved clinical trial includes a Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application.

Contraceptive services

All FDA Contraceptive Services for women are covered under Preventive Health Services with a prescription.

- Paramount will cover, without cost sharing, items and services that are integral to the furnishing of a recommended preventive service also applies to coverage of contraceptive services under the Health Resourced and Services Administration supported guidelines, including coverage for anesthesia for a tubal ligation procedure or pregnancy tests needed before provision of certain forms of contraceptives, such as an intrauterine device (also known as an IUD), regardless of whether the items and services are billed separately.
- If a member's physician recommends a particular service or FDA-approved, cleared, or granted product not included in a category described in the HRSA-Supported Guidelines based on a determination of medical necessity with respect to that member (including if there is only one service or product that is medically appropriate for the member, as determined by their physician), Paramount will cover that service or product without cost sharing.
- An office visit to discuss screening, education, counseling, and provisions of contraceptives (including in the immediate postpartum period) will be covered.

Refer to the Prescription Drug Benefit section of the Certificate of Coverage and the Schedule of Benefits for day supply and Mail Service coverage.

If you have questions regarding your coverage, call Member Services at (734) 529-7800 or 1-888-241-5604.

If you have concerns about Paramount's compliance with these requirements, you may contact the Department of Insurance and Financial Services at (517) 284-8800.

The HHS' Office for Civil Rights (ORC) enforces federal civil rights laws that prohibit discriminatory restrictions on access to health care. If you believe that your civil rights or health information privacy rights have been violated, you can file a complaint with OCR at https://www.hhs.gov/ocr/complaints/index.html or call toll-free at 1-800-368-1019.

Dental Anesthesia

NOTE: It is recommended that you or your Provider call us to verify coverage prior to receiving dental-related anesthesia services.

The Benefit plan covers dental-related anesthesia and associated Hospital and Facility charges provided at a Network Hospital to a Dependent or adult member when, in the opinion of the treating dentist or oral surgeon, treatment in a dental office under local anesthesia would be ineffective or compromised; and any of the following criteria apply:

- A total of six (6) or more teeth are extracted in various quadrants.
- Dental treatment needs for which local anesthesia is ineffective because of acute infection, anatomic variation, or allergy.
- Multiple extractions or multiple restorations if the patient is a child under the age of seven (i.e., through the end of the sixth year).
- Patients with a concurrent hazardous medical condition.
- Extensive oral-facial and/or dental trauma for which treatment under local anesthesia would be ineffective or compromised.

Benefits under this section are provided only for the anesthesia and related Hospital and Facility charge. Benefits are not available for any other related dental procedure (including but not limited to extractions) except as described below. Benefits are provided only if the services are provided by a Network Provider at a Network Facility.

Dental Services – Accidental Injury and Other Medical Services of the Mouth
Description

The Benefit plan covers Medically Necessary Covered Health Services provided by a Physician or dentist including:

- Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
- Excision of benign or malignant bony growths of the jaw and hard palate.
- External incision and drainage of cellulitis.
- Incision of sensory sinuses, salivary glands or ducts.
- Removal of sound natural teeth required in preparation for other medical procedures that are covered under the Benefit plan.
- Rebuilding or repair of soft tissues of the mouth or lip needed to correct anatomical functional impairment caused by congenital birth defect or accidental Injury. This includes treatment for abnormalities such as cleft lip or cleft palate, among other things.
- Treatment of fractures of facial bones.
- Medical and surgical services required to correct accidental Injuries, including Emergency care to stabilize dental structures following Injury to sound natural teeth.
- Treatment for oral and/or facial cancer.
- Treatment for conditions affecting the mouth other than the teeth.

Benefits are not available for dental and oral surgical procedures involving repair or rebuilding for cosmetic purposes, orthodontic care of the teeth, periodontal disease, or preparing the mouth for the fitting of or continued use of dentures.

NOTE: Pediatric stand-alone dental plans are available. Contact the Paramount marketing department for information.

Diabetes Services
Diabetes includes gestational diabetes, insulin-dependent diabetes and non-insulin-dependent diabetes.

The Benefit plan covers equipment, supplies and educational training for the treatment of diabetes when ordered by or under the direction of a Physician. The Benefit plan covers diabetes equipment that meets the minimum specifications for your needs. If you choose to purchase diabetes equipment that exceeds these minimum specifications, we will pay only the amount that we would have paid for equipment that meets the minimum specifications, and you will be responsible for paying any difference in cost.

The Benefit plan covers diabetes self-management training when it is provided by a diabetes Outpatient training program that is certified to receive Medicaid or Medicare reimbursement or certified by the Michigan Department of Health and Human Services. Benefits for diabetes self-management training are limited to completion of a certified diabetes education program:

- Upon the diagnosis of diabetes if the services are needed under a comprehensive plan of care to ensure therapy compliance or to provide necessary skills and knowledge.

- Upon the diagnosis of a significant change, with long-term implications, in the patient's symptoms or conditions that results in a need for changes to the patient's self-management, or a significant change in medical protocol or treatment modalities.

The Benefit plan covers shoe inserts for members with peripheral diabetic neuropathy and specialty shoes prescribed for a Person with diabetes.

NOTE: Insulin is covered when obtained from a Network Pharmacy.

Durable Medical Equipment

NOTE: It is recommended that you or your Provider call us to verify coverage prior to receiving Durable Medical Equipment that costs over $500 to rent or purchase.

The Benefit plan covers Durable Medical Equipment that meets each of the following criteria:

- Medically Necessary, as determined by Paramount medical policy and nationally recognized guidelines; and
- Ordered or provided by a Physician for Outpatient use; and
- Used for medical purposes; and
- Not consumable or disposable; and
- Of use to a Person only in the presence of a disease or physical disability.

If more than one piece of Durable Medical Equipment can meet your functional needs, Benefits are available only for the equipment that meets the minimum specifications that are Medically Necessary for your needs. If you choose to rent or purchase Durable Medical Equipment that exceeds these minimum specifications, we will pay only the amount that we would have paid for equipment that meets the minimum specifications, and you will be responsible for paying any difference in cost.

Examples of Durable Medical Equipment include:

- Equipment to assist mobility, such as a standard wheelchair.
- Benefits may be provided for power operated wheelchairs if you are capable of safely operating the controls of a power operated wheelchair, have adequate upper body stability to ride safely, and are able to transfer in and out of the wheelchair.
- A standard Hospital-type bed.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Delivery pumps for tube feedings (including tubing and connectors).
- Bi-pap and C-pap machines (including tubing, connectors and masks).
- Braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize a body part affected by an Injury, Sickness or Congenital Anomaly are considered Durable Medical Equipment and are a Covered Health Service. Dental braces are excluded from coverage.
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items are excluded from coverage).
- Burn garments.
- Insulin pumps and all related necessary supplies as described under *Diabetes Services* earlier in this section.
- Blood pressure monitor for a pregnant or postpartum Covered Person.

Benefits will never be available for some items and types of equipment. Refer to the Section titled ***Exclusions*** in this handbook***.*** Benefits under this section do not include any device, appliance, pump, machine, stimulator, or monitor that is fully implanted into the body.

Coverage of rental or purchase and repair or replacement of Durable Medical Equipment is consistent with Medicare Part B guidelines.

Emergency Department Health Services – Outpatient/Observation Stay

If you experience an Emergency Medical Condition after normal office hours, you should call 911, an ambulance or rescue squad or go to the nearest medical Facility. You do not need to obtain prior approval from your PCP or Paramount. After you are treated, you should notify your Primary Care Provider as soon as reasonably possible to coordinate your follow-up care.

Description

The Benefit plan covers Emergency Department health services that are required to stabilize or initiate treatment in an Emergency. The Emergency Department health services Benefit also covers an Outpatient observation stay regardless of the length of the observation stay for the purpose of monitoring your condition (rather than being admitted to a Hospital for an Inpatient Stay). Both Outpatient and observation stay services for Emergency Department health services are subject to the Emergency Department visit Copayment.

NOTE: Some Covered Health Services received during the same Emergency Department visit may be subject to the Annual Deductible and Coinsurance. Ancillary services such as Physician professional fees are described elsewhere in this section.

Benefits for emergent/urgent health services received in a Physician's office or in an Urgent Care Center are described later in this section.

NOTE: The Copayment is waived if admitted for an Inpatient Stay within 24 hours for the same condition.

Facility Services (Non Hospital)

Hospice Care

NOTE: It is recommended that you or your Provider call us to verify coverage prior to receiving hospice care.

Hospice care must be ordered by a Physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill. Hospice care includes physical, psychological, social and spiritual care for the terminally ill Person, and short-term grief counseling for immediate family members. The Benefit plan covers hospice care when it is received from a licensed hospice agency.

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Description

The Benefit plan covers an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits are available when Medically Necessary for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-Private Room (a room with two or more beds).

Please note that Benefits are available only if both of the following are true:

- If the initial confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a cost effective alternative to an Inpatient Hospital Stay; and
- You will receive skilled care services that are not primarily Custodial Care.

Benefits are available only when skilled care is required. Skilled care is defined as skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true:

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient; and
- It is ordered by a Physician; and
- It is not delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing or transferring from a bed to a chair; and
- It requires clinical training in order to be delivered safely and effectively; and
- It is not Custodial Care.

Our determination of available Benefits is based on whether or not skilled care is required by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A

service will not be determined to be "skilled" simply because there is not an available caregiver. These criteria to determine skilled care may differ from criteria used by other payors.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation/habilitation services or if discharge rehabilitation/habilitation goals have previously been met.

Limitations
Benefits for non-Hospital facility services are limited to 45 days per calendar year.

Genetic Testing
NOTE: It is recommended that you or your Provider call us to verify coverage prior to genetic testing.

The Benefit plan covers certain Medically Necessary Genetic Tests, including genetic testing for pregnant women.

Home Health Care
NOTE: It is recommended that you or your Provider call us to verify coverage prior to receiving home Health Care Services.

The Benefit plan covers services received from a Home Health Agency that are all of the following:

- Medically Necessary as determined by Paramount medical policy and nationally recognized guidelines; and
- Ordered by a Physician; and
- Provided by or supervised by a registered nurse in your home.

Benefits are available only when the Home Health Agency services are provided on a part-time, intermittent schedule and when skilled care is required.

Skilled care is defined as skilled nursing, skilled teaching, skilled rehabilitation/habilitation, and home infusion services when all of the following are true:

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient; and
- It is ordered by a Physician; and
- It is not delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing or transferring from a bed to a chair; and
- It requires clinical training in order to be delivered safely and effectively; and
- It is not Custodial Care.

Our determination of available Benefits is based on whether or not skilled care is required by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits for Outpatient rehabilitation/habilitation services provided in your home are described under *Rehabilitation/Habilitation Services – Outpatient Therapy* later in this section.

Home Infusion Therapy
NOTE: It is recommended that you or your Provider call us to verify coverage prior to receiving home infusion therapy services.

The Benefit plan covers home infusion therapy services that are all of the following:

- Provided to manage an incurable or chronic condition; and
- Provided to treat a condition that requires acute care if it can be managed safely at home; and
- Medically Necessary as determined by Paramount medical policy and nationally recognized guidelines; and
- Ordered by a Physician; and
- Provided by or supervised by a registered nurse on an intermittent basis in your home.

Benefits are available when provided by a home infusion therapy Provider for medical IV therapy, injectable therapy or total parenteral nutrition therapy; including nursing services, supplies, Prescription Drugs and solutions, and family education.

The Benefit plan covers nursing visits needed to:

- Administer home infusion therapy or parenteral nutrition.
- Instruct patient or caregivers on infusion administration techniques.
- Provide IV access care (catheter care).

When appropriate, Covered Person and/or caregiver will learn to administer home infusion therapy medications.

Benefits for home Health Care Services provided in conjunction with home infusion therapy are described above under *Home Health Care* earlier in this section.

Hospital - Inpatient Stay
Description

The Benefit plan covers a Medically Necessary Inpatient Stay in a Hospital for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-Private Room (a room with two or more beds).
- Long-term acute Inpatient services.

Benefits for Physician services are described under *Professional Fees for Surgical and Medical Services* later in this section.

Injections/Infusions Received in a Physician's Office
NOTE: The list of approved Specialty Pharmaceuticals is subject to change and includes drugs received in an office or ambulatory Facility or from a pharmacy. Please contact us for current information.

Description

The Benefit plan covers approved Specialty Pharmaceuticals. Specialty Pharmaceuticals are biotech drugs including high cost infused, injectable, oral and other drugs related to specialty disease categories or other categories. We determine which specific drugs are Covered Health Services and this list is subject to change. The list may include vaccines and chemotherapy drugs used in the treatment of cancer but excludes injectable insulin, which does not require authorization. Please contact us for current information and to request authorization.

The Benefit plan covers certain injections and infusions received in a Physician's office when no other health service is received, for example allergy immunotherapy.

Mammography (Diagnostic)/Breast Cancer Services
The Benefit plan covers diagnostic mammography, breast cancer diagnostic services, breast cancer Outpatient treatment services, and breast cancer rehabilitative services provided by or under the direction of your Physician.

The Benefit plan covers routine screening mammography as described under *Preventive Health Services* later in this section.

Maternity Care and Family Planning
Description

The Benefit plan covers Pregnancy including all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications. We will pay Benefits for an Inpatient Stay of at least:

- 48 hours for the mother and newborn child following a normal vaginal delivery.
- 96 hours for the mother and newborn child following a cesarean section delivery.

NOTE: If delivery occurs outside of a Hospital, the above time periods begin on Inpatient admission to the Hospital.

If the mother agrees, the attending Provider may discharge the mother and/or the newborn child earlier than these minimum time frames.

The Benefit plan covers diagnostic, counseling, and planning services for treatment of the underlying cause of infertility. Examples of Covered Health Services are sperm count, endometrial biopsy, hysterosalpingography, and diagnostic laparoscopy.

Certain prenatal tests and screenings are covered with no member cost share (see *Preventive Health Services* later in this section).

The Benefit plan covers certain maternity classes.

Morbid Obesity Treatment – Weight Management Program
Description

Benefits are available only if participation in the weight management program is ordered by a Physician, provided by an approved Facility, determined to be Medically Necessary by us and if the Covered Person qualifies as outlined in our medical policies. Contact Member Services if you have any questions.

Non-Covered Services
Weight loss services not specifically listed under *Covered Services* are not covered. This includes, but is not limited to: food, food supplements, gastric balloons, certain weight loss surgeries, jaw wiring, liposuction, physical fitness or exercise programs.

Morbid Obesity Treatment – Surgery
Description

The Benefit plan covers Medically Necessary Covered Health Services, including room and board and other services and supplies provided in an approved Facility, for the surgical treatment of morbid obesity.

Benefits are available only if surgical treatment is ordered by a Physician and provided by a Network Physician or designated Physician in a an approved Facility, if the Covered Person qualifies under our current "Morbid Obesity Policy" and if the services are determined to be Medically Necessary by us. Contact Member Services if you have any questions.

Surgical treatment of obesity is limited to one surgery per lifetime. Unless Medically/Clinically Necessary, a second bariatric surgery is not Covered, even if the initial bariatric surgery occurred prior to Coverage under this plan.

Nutritional Counseling Services
The Benefit plan covers nutritional counseling services provided by a Network Hospital-based registered dietician. Covered Health Services must be provided under the direction of a Physician. Conditions for which nutritional counseling is a Covered Health Service include, but are not limited to:

- Weight management.
- Diabetes mellitus.
- Coronary artery disease.
- Congestive heart failure.
- Severe obstructive airway disease.
- Gout.
- Renal failure.
- Phenylketonuria.
- Hyperlipidemias.

Additional services may be covered under *Preventive Health Services* later in this section.

Benefits are available when nutritional counseling is provided during an individual session. Benefits are limited to six (6) sessions of nutritional counseling per calendar year.

Nutritional Therapy

The Benefit plan covers enteral feeding administered via tube. Formulas intended for this type of feeding as well as supplies, equipment, and accessories needed to administer this type of nutrition therapy are covered.

The Benefit plan covers parenteral nutrition administered via an IV. Nutrients, supplies, and equipment needed to administer this type of nutrition are covered.

NOTE: Except for formula specifically intended for tube feeding and nutrients necessary for IV feeding, all food, formula and nutritional supplements are not covered. This includes, but is not limited to, infant formula, protein or caloric boosting supplements, vitamins, Ensure, Osmolyte and herbal preparations or supplements, even if approved by the federal FDA.

Orthognathic Therapy
Description

The Benefit plan covers Medically Necessary orthognathic therapy involving the repositioning (but not removal) of an individual tooth, arch segment, or entire arch, if the surgery is provided along with a course of orthodontic treatment to correct bodily dysfunction. We will only cover the following orthognathic therapy services:

- Office visits for evaluation and orthognathic treatment.
- Cephalometric study and X-rays.
- Orthognathic surgery and post-operative care.
- Hospitalization.

NOTE: Orthodontic treatment is not covered.

Ostomy Supplies
The Benefit plan covers only the following ostomy supplies required as a result of a colostomy, ileostomy or urostomy:

- Pouches, face plates and belts.
- Irrigation sleeves, bags and catheters.
- Skin barriers.

Benefits are not available for gauze, filters, lubricants, tape, appliance cleaners, adhesive, adhesive removers, deodorant, pouch covers, or other items not listed above.

Outpatient Diagnostic Services
The Benefit plan covers Medically Necessary diagnostic services received on an Outpatient basis at a Hospital or Alternate Facility including but not limited to:

- Laboratory tests.
- Radiology (including X-ray and diagnostic mammography testing).
- Endoscopic procedures, such as colonoscopy and esophagogastroduodenoscopy (EGD).
- Cardiac procedures, such as Holter monitoring and cardiac catheterization.

Benefits under this category include the Facility charge, the charge for required services, supplies and equipment, and all related professional fees.

When these procedures and services are performed in a Physician's office, Benefits are described under *Physician's Office Services* later in this section.

When these procedures and services are performed on a routine, screening basis, they are covered under *Preventive Health Services* later in this section.

This category does not include Benefits for CT scans, PET scans, MRIs, MRAs or nuclear medicine, which are described immediately below.

Outpatient Advanced Diagnostic Imaging and Nuclear Medicine
The Benefit plan covers Medically Necessary CT scans, PET scans, MRIs, MRAs and nuclear medicine received on an Outpatient basis in a Physician's office or at a Hospital or Alternate Facility.

Benefits under this category include the Facility charge, the charge for required services, supplies and equipment, and all related professional fees.

Outpatient Surgery Services

The Benefit plan covers Medically Necessary surgery and related services received on an Outpatient basis at a Hospital or Alternate Facility such as an ambulatory surgical center.

Benefits under this category include only the Facility charge and the charge for required Hospital-based professional services, supplies and equipment. Benefits for the surgeon's fees related to Outpatient surgery are described under *Professional Fees for Surgical and Medical Services* below.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* below.

Outpatient Therapeutic Treatment Services

NOTE: The list of approved Specialty Pharmaceuticals is subject to change and includes drugs received in an office or ambulatory Facility or from a pharmacy. Please contact us for current information.

Description

The Benefit plan covers approved Specialty Pharmaceuticals. Specialty Pharmaceuticals are biotech drugs including high cost infused, injectable, oral and other drugs related to specialty disease categories or other categories. We determine which specific drugs are Covered Health Services and this list is subject to change. The list may include vaccines and chemotherapy drugs used in the treatment of cancer but excludes injectable insulin, which does not require authorization. Please contact us for current information and to request authorization.

The Benefit plan covers therapeutic treatments received on an Outpatient basis at a Hospital or Alternate Facility, including dialysis, intravenous chemotherapy or other intravenous infusion therapy, and radiation therapy

Benefits under this category include the Facility charge, the charge for required services, supplies and equipment, and all related professional fees. When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* below.

Pain Management

The Benefit plan covers the evaluation and treatment of chronic pain, when provided by or under the direction of your Physician. Chronic pain is unremitting and has been present for a long period of time without relief.

Physician's Office Services Illness/Injury

The Benefit plan covers services received in a Physician's office, including Primary Care Physician and specialist, regardless of whether the Physician's office is freestanding, located in a clinic or located in a Hospital, including but are not limited to:

- Radiology.
- Pathology.
- Diagnostic testing and services (including allergy testing).
- Consultations.
- Medical education services by appropriately licensed or registered healthcare professionals, including to manage chronic disease states such as diabetes or asthma, when both of the following are true:

  ➢ Education is required for a disease in which patient self-management is an important component of treatment; and
  ➢ There exists a knowledge deficit regarding the disease, which requires the intervention of a trained health professional.

NOTE: Some Covered Health Services received during the same Physician's office visit may be subject to the Annual Deductible and Coinsurance. See other categories in this section.

Network Benefits are also available for Covered Health Services received at a Non-Network Physician's office outside the state of Michigan to treat emergent or urgent conditions that require immediate medical attention to limit severity and prevent complications. Network Benefits for follow-up care are available only when provided by a Network Provider.

Refer to *Injections/Infusions Received in Physician's Office* (earlier in this section) for coverage information for injections/infusions received in the Physician's office.

When Preventive Health Services are provided in a Physician's office, Benefits are available as described under *Preventive Health Services* below.

Telemedicine Services: A service where electronic media is used to link patients with health care professionals in different locations. Telemedicine Services or telepsychiatry must be provided by a health care professional who is licensed, registered, or otherwise authorized to engage in his or her health care profession in the state where the member is located. Telemedicine Services are subject to all terms and conditions of the health insurance policy agreed upon between the policy holder and Paramount, including, but not limited to, required copayment, coinsurances, deductibles, and approved amounts.

Non Covered Services include, but are not limited to communications used for:

- Reporting normal lab or other test results
- Office appointment requests
- Billing, insurance coverage or payment questions
- Request for referrals to doctors outside the online care panel
- Benefit precertification

Prescription Drugs - Outpatient

See the Summary of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Pharmacy and Therapeutics (P&T) Working Group

The Plan has a P&T Working Group, a committee consisting of Health Care Professionals, including but not limited to local pharmacists, and Physicians. The purpose of this committee is to assist in determining clinical appropriateness of drugs; determining the tier assignments of drugs; and advising on programs to help improve care. Such programs may include, but are not limited to, drug utilization programs, Prior Authorization criteria, therapeutic conversion programs, cross-branded initiatives, drug profiling initiatives, etc.

Paramount's P&T reviews and approves Paramount's Formulary annually. However, formulary management may be delegated to the Pharmacy Benefit Manager (PBM). When formulary management is delegated, the initial formulary is approved by Paramount's P&T, but ongoing formulary changes throughout the year are reviewed and approved by the PBM's P&T committee or other clinical working group that handles the delegated function of formulary management.

Pharmacy Benefits Manager

The pharmacy benefits available to you under this Handbook are administered by Our Pharmacy Benefits Manager (PBM). The PBM is a company with which the Plan contracts to administer your pharmacy benefits. The PBM has a nationwide network of retail pharmacies and a Mail Service pharmacy.

Example services that the PBM provides include managing a network of retail pharmacies, operating a Mail Service pharmacy and prescription drug claims processing. The PBM, in consultation with the Plan, also provides services to promote and enforce the appropriate use of pharmacy benefits. These services can include reviews for possible excessive use, recognized and recommended dosage regimens, and Drug interaction screenings.

Covered Prescription Drug Benefits

A valid prescription is required to obtain all Prescription Drug benefits. Prescription Drugs, unless otherwise stated, must be Medically Necessary and not Experimental/Investigative, in order to be Covered Services. For certain Prescription Drugs, the prescribing Physician may be asked to provide additional information before the Health Plan can determine Medical Necessity. The Health Plan may establish quantity and/or limits for specific Prescription Drugs which the PBM will administer. Any such limits will be approved by the Paramount Pharmacy and Therapeutics Committee and will be based on FDA approved product dosing recommendations as well as utilization guidelines.

- FDA approved Prescription Legend Drugs.
- FDA approved Specialty Drugs
- Injectable insulin and syringes used for administration of insulin.
- Contraceptive devices, oral immunizations, and biologicals, although they are legend drugs may be payable as medical supplies based on where the service is performed or the item is obtained. If such items are over-the-counter drugs, devices or products, they are not Covered Services unless prescribed by a Physician and covered as a preventive service, as required by federal and state law.
- Off label use of FDA approved drugs. Paramount shall not limit or exclude coverage for any drug approved by the United States food and drug administration on the basis that the drug has not been approved by the United States food and drug administration for the treatment of the particular indication for which the drug has been prescribed, provided the drug has been recognized as safe and effective for treatment of that indication in one or more of the standard medical reference compendia adopted by the United States department of health and human services.
- Opioid use disorder and opioid overdose treatments: Some Participating Providers will treat opioid-use disorder with a monitored drug and therapy protocol called medication assisted treatment (MAT). To facilitate prompt treatment of opioid-use disorder, Paramount does not require Prior Authorization for a Member who has been prescribed MAT by a Participating Provider. This includes appropriate buprenorphine containing products recommended in treatment guidelines. In addition, at least one opioid reversal nasal spray will be covered when opioids have been prescribed at dosages of 50MME (morphine milligram equivalent) or higher.

Non Covered Prescription Drug Benefits

The following exclusions apply:

1. Unless otherwise specified in your summary of benefits, durable medical equipment, therapeutic devices, support garments; and other supplies or substances which may be obtained without a prescription;
2. Prescription Drugs or Refills in excess of either the quantity or days supply indicated on the prescription. For any prescription that is filled before the designated days supply on the previous fill has been exhausted, the member will be responsible for full cost of the prescription.
3. Dietary supplements and some prescription vitamins (other than prenatal vitamins or those mandated by PPACA guidelines);
4. Prescription Drugs used for cosmetic purposes such as: drugs used to decrease wrinkles, drugs to promote hair growth, and drugs to control perspiration;
5. Drugs for weight loss including diet pills and appetite suppressants;
6. Drugs that do not require a prescription for dispensing known as “Over-the-Counter” drugs unless approved by the Plan;
7. Any prescription products that are not FDA approved medications or are labeled as experimental or investigational. This includes prescription devices;
8. Prescription Drugs used to enhance athletic or sexual performance;
9. Compounded medications are not covered when a similarly equivalent product is available commercially, when the active ingredients do not require a Prescription, or there is insufficient evidence to prove the specific formulation is safe and effective. The Plan will not pay any preparation fee for compounded medications;
10. Any Prescription Drug which is determined to have been abused or otherwise misused by a Covered Person;
11. Any claim for Prescription Drug(s) submitted to the Plan or the PBM for reimbursement more than one (1) year from the date the Prescription Drug was dispensed will not be eligible for reimbursement;

12. Prescription Drugs for which the cost is recoverable under any workers' compensation or occupations disease law or any federal or state agency or any drug for which no or substantially discounted charge is made;
13. Prescription Drugs that are prescribed, dispensed or intended for use during a hospital inpatient or skilled nursing facility stay;
14. Non-Formulary Prescription Drugs unless determined to be medically necessary through the Non-formulary Exceptions process;

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15. Any drugs or devices used for treatment of male/female sexual dysfunction including but not limited to erectile dysfunction, delayed ejaculation, anorgasmia and decreased libido;

How to Obtain Prescription Drug Benefits

How you obtain your benefits depends upon whether you go to a Network or a Non-Network Pharmacy.

Network Pharmacy – Present your written Prescription Order from your Physician, and your Identification Card to the pharmacist at a Network Pharmacy. The Pharmacy will file your claim for you. You will be charged at the point of purchase for applicable Deductible and/or Copayment/Coinsurance amounts. If you do not present your Identification Card, you will have to pay the full retail price of the prescription. If you do pay the full charge, ask your pharmacist for an itemized receipt and submit it to Paramount with a written request for refund. Prior Authorizations and limitations to coverage will still apply prior to refunds.

Non-Network Pharmacy - In Emergency cases and when prescription benefits are not available In-Network, non-network pharmacies may be used. You will be charged the full retail price of the prescription at the point of purchase. Refer to your Summary of Benefits for coverage of non-network pharmacies. If you have non-Network Pharmacy coverage, ask your pharmacist for an itemized receipt and submit it to Paramount with a written request for refund. Prior Authorizations and limitations to coverage will still apply prior to refunds when non-Network Pharmacy benefits are present.

CVS Mail Order Pharmacy – Refer to your Summary of Benefits for Mail Service coverage. If you have Mail Service coverage, you will need to complete a patient profile with the appropriate pharmacy. You may mail written prescriptions from your Physician, or have your Physician fax the prescription to the Mail Service. You will need to pay the applicable Deductible, Coinsurance and/or Copayment amounts to the Mail Service when you request a prescription or refill. Not all drugs are covered through the Mail Service pharmacy. Some drugs, such as controlled substances or specialty medications, are limited by the Plan. For information about limitations and availability of coverage, you may contact Member Services at the phone number printed on the back of your card.

CVS Maintenance Choice (90-day) Pharmacy Program - The Maintenance Choice program is for prescription drugs taken continuously to manage chronic or long-term conditions, such as high blood pressure, asthma, diabetes, or high cholesterol. After two 30-day fills of a prescription medication that is on the CVS Maintenance Choice list, the prescription must be filled for a 90-day supply at either CVS Caremark mail order or a CVS retail store. Members may obtain a list of the CVS Maintenance Choice medications by calling the Member Services telephone number on the back of their Identification Card, or by reviewing the list on the internet at www.paramounthealthcare.com

Specialty Pharmacy Network

Paramount's Specialty Pharmacy Network is available to Members who use Specialty Drugs. Members may obtain a printed list of the Specialty Network Pharmacies, and covered Specialty Drugs, by calling the Member Services telephone number on the back of their Identification Card, or by reviewing an electronic copy of the lists on the internet at www.paramountheatlcare.com

Days Supply

The number of days supply of a Drug which you receive may be limited based upon the type of pharmacy and network status. The days supply limit applicable to Prescription Drug coverage is shown in the Summary of Benefits.

Payment of Benefits

The amount of benefits paid by Paramount is based upon the type of pharmacy from which you receive the Covered Services. It is also based upon which Tier we have classified the Prescription Drug or Specialty Drug, days supply, covered Additional Benefits and Programs, and Special Promotions.

The amounts for which you are responsible and the applicable number of days supply are shown in the Summary of Benefits. Your Copayment(s), Coinsurance and/or Deductible amounts will not be reduced by any discounts, rebates or other funds received by the PBM and/or the Health Plan from Drug manufacturers or similar vendors.

No payment will be made by Paramount for any Covered Service unless the negotiated rate exceeds any applicable Deductible and/or Copayment/Coinsurance for which you are responsible.

Deductible/Coinsurance/Copayment

Each Prescription Order may be subject to a Deductible and Coinsurance/Copayment. The Coinsurance/Copayment may be dependent on the Covered Drug's Formulary placement, the pharmacy network, or days supply of medication. If the Prescription Order includes more than one covered Drug, a separate Coinsurance/Copayment will apply to each covered Drug. Your Prescription Drug Coinsurance/Copayment will be the lesser of your Copayment/Coinsurance amount or the cost of the Drug. Please see the Summary of Benefits for any applicable Deductible and Coinsurance/Copayment.

Formulary

A Formulary is a list of drugs that are covered by the Plan under a member's prescription drug benefits. Members can obtain a copy of the Plan's Formulary by calling the Member Services telephone number on the back of their ID card, or by reviewing an electronic copy on the internet at www.paramounthealthcare. The Formulary list is subject to periodic review and amendment. Inclusion of a Drug or related item on the covered Prescription Drug list is not a guarantee of coverage.

Tier and Formulary Assignment Process

Your Copayment/Coinsurance amount may vary based on how the Prescription Drug, including covered Specialty Drugs, has been classified by the Plan's formulary and the type of Copayment/Coinsurance tier structure per the Summary of Benefits.

The determination of tiers and formulary assignment is made by a P&T Committee based upon clinical information, treatment options, and Drug costs relative to other Drugs used to treat the same or similar condition.

We retain the right at our discretion to determine coverage for dosage formulations in terms of covered dosage administration methods (for example, by mouth, injections, topical, or inhaled) and may cover one form of administration and exclusion or place other forms of administration in another tier.

6-Tier Copayment

Refer to the Summary of Benefits for exceptions that apply to drugs subject to Additional Benefits and Programs.

- **Tier 1 Preferred Generic Prescription Drugs have the lowest Coinsurance or Copayment.**
- **Tier 2 Non-Preferred Generic Prescription Drugs will have a higher Coinsurance or Copayment than those in Tier 1.**

- **Tier 3 Preferred Brand Prescription Drugs will have a higher Coinsurance or Copayment than those in Tier 2.**
- **Tier 4 Non-Preferred Brand Prescription Drugs will have a higher Coinsurance or Copayment than those in Tier 3.**
- **Tier 5 Preferred Specialty Prescription Drugs will have a higher Coinsurance or Copayment than those in Tier 4.**
- **Tier 6 Non-Preferred Specialty Prescription Drugs will have the highest Coinsurance or Copayment**

DAW Status

Dispense As Written (DAW) is a designation that you may make at the pharmacy or that your prescriber may make on your prescription. DAW requires the pharmacy to dispense the exact product that was written by the prescriber and no substitutions may be made. Refer to your Summary Of Benefits for an explanation of how these drugs are covered.

Prior Authorization

Prior Authorization may be required for certain Prescription Drugs (or the prescribed quantity of a particular Drug). Prior Authorization helps promote appropriate use of medications and enforcement of guidelines for Prescription Drug benefit coverage. At the time you fill a prescription, the Network pharmacist is informed of the Prior Authorization requirement through the pharmacy's computer system. The PBM uses pre-approved edits, with criteria developed by a Pharmacy and Therapeutics Committee which is reviewed and adopted by Paramount. Prescribers or pharmacies should contact Paramount with information to determine whether Prior Authorization should be granted. We communicate the results of the decision to your Provider.

Prior Authorization is required for coverage of an opioid analgesic prescription for chronic pain. Prior Authorization is not required for coverage of an opioid analgesic prescribed for chronic pain, when the drug is prescribed under one of the following circumstances: (a) To an individual who is a hospice patient in a hospice care program; (b) To an individual who has been diagnosed with a terminal condition but is not a hospice patient in a hospice care program; (c) To an individual who has cancer or another condition associated with the individual's cancer or history of cancer.

If a Prior Authorization for a chronic medication is approved, it will be approved for a 12 month duration or until your benefit eligibility changes. Non-chronic medications, controlled substances, medications with a typical treatment duration of less than a year, or medications that require safety and efficacy monitoring may initially be given a shorter duration of approval. For some medications, quarterly medical information may be required to be submitted by your provider. Failure of the provider to respond to the request for information may result in early termination of the Prior Authorization. The providers will be notified of these requirements.

If Prior Authorization is denied, you have the right to appeal through the appeals process outlined in ***What To Do When You Have Questions, Problems or Grievances*** section of this Handbook.

For a list of the current Drugs requiring Prior Authorization, please contact the Member Services telephone number on the back of your ID card or review the medication formulary on Paramount's website. This list is subject to periodic review and amendment. Inclusion of a Drug or related item on the list is not a guarantee of coverage under your Handbook. Refer to the Covered Prescription Drug benefit section in this Handbook for information on coverage, limitations and exclusions. Your Provider or Network Pharmacist may check with Paramount to verify covered Prescription Drugs, any quantity and/or age limits, or applicable Brand or Generic Drugs recognized under the Health Plan.

Step Therapy

Step therapy is a protocol that requires a Member to use other medication(s) before a certain prescribed medication is authorized. Paramount monitors some Prescription Drugs to control utilization, to ensure that appropriate prescribing guidelines are followed, and to help Members access high

quality yet cost effective Prescription Drugs. If a Physician decides that the prescribed medication is medically necessary, the Prior Authorization process is applied.

Quantity Limits

Quantity limits are limits on the amount of a drug that may be covered for reasons of safety and/or dose optimization. Quantity limits may apply when medical literature, clinical best practice and/or the FDA has established a maximum dosage as a safe limit. Quantities that exceed these safe limits are not a covered benefit. Dose optimization is limits on the quantity of a certain dose of medication in order to promote using the recommended quantity of drug per dosages available.

Specialty Drug Program

Specialty Drugs are reviewed and designated through the Plan's P&T Committee. They will have the highest Coinsurance or Copayment and will contain Specialty and Injectable medications. Characteristics of Specialty Drugs are:

- Generally high-cost drugs prescribed for rare or complex, ongoing medical conditions.
- May be injectable, infused, oral, or inhaled drugs which typically are not stocked at traditional pharmacies due to unique storage, shipment, or dispensing requirements.
- Often they require close supervision and monitoring by a Physician or another trained healthcare professional.

Members may obtain a list of the Specialty Network Pharmacies, and covered Specialty Drugs, by calling the Member Services telephone number on the back of their Identification Card, or by reviewing the lists on the internet at www.paramouthealthcare.com.

Standard & Expedited Review Process for Prior Authorizations, Step Therapy Exceptions and Non-formulary Exceptions

A member or physician can request and gain access to clinically appropriate drugs that are not on the formulary, are subject to a Step Therapy Protocol or are subject to Prior Authorization. If your physician recommends a particular contraceptive service or FDA approved contraceptive item based on medical necessity, Paramount will defer to the determination of the physician and cover that particular service or item without cost sharing.

A standard Prior Authorization or exception request can be submitted in non-exigent circumstances and receive a decision within 72 hours of a request. For expedited requests based on Exigent Circumstances determination and notification will be provided no later than 24 hours following receipt of the request. If a medication is approved, it will be approved for a 12 month duration or until your benefit eligibility changes. Non-chronic medications, controlled substances, medications with a typical treatment duration of less than a year, or medications that require safety and efficacy monitoring may initially be given a shorter duration of approval. Medications that are approved through the Prior Authorization or exception request process will be treated as an Essential Health Benefit with member's cost share applying to the Out-of-Pocket Maximum. If the request for coverage is denied, you have the right to appeal through the appeals process outlined in Section Eight: Questions, Problems or Grievances of this Handbook. For more information or assistance, contact the Paramount Member Services Department.

Member Services Department
(419) 887-2525
Toll-Free 1-800-462-3589
TTY (419) 887-2526
TTY Toll-Free 1-888-740-5670

See Definitions section for additional information on Exigent Circumstances.

Special Promotions

From time to time we may initiate various programs to encourage the use of more cost-effective or clinically-effective Prescription Drugs including, but not limited to, Generic Drugs, Mail Service

Drugs, over the counter or preferred products. Such programs may involve reducing or waiving Copayments or Coinsurance for certain Drugs or preferred products for a limited period of time.

Preventive Health Services

The Benefit Plan covers preventive medical care when provided by a Network Provider including, but not limited to, the following as may be appropriate based on your age and/or gender:

Covered Preventive Services for Adults

- Annual routine physical exams
- Screenings such as:
  - ➢ Abdominal Aortic Aneurysm one-time screening for men of specified ages who have ever smoked
  - ➢ Alcohol Misuse screening
  - ➢ Blood Pressure screening for all adults
  - ➢ Cholesterol screening for adults of certain ages or at higher risk
  - ➢ Colorectal Cancer screening for adults over 50, including a select group of Prescription Drug Products for bowel prep (for adults ages 50 to 75)
  - ➢ Depression screening for adults
  - ➢ Type 2 Diabetes screening for adults with high blood pressure
  - ➢ HIV screening for all adults at higher risk
  - ➢ Obesity screening for all adults
  - ➢ Tobacco Use screening for all adults
  - ➢ Syphilis screening for all adults at higher risk

- Counseling such as:
  - ➢ Aspirin use for men and women of certain ages
  - ➢ Alcohol Misuse counseling
  - ➢ Diet counseling for adults at higher risk for chronic disease
  - ➢ Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk
  - ➢ Obesity counseling for all adults

- Immunization vaccines for adults--doses, recommended ages, and recommended populations vary:
  - ➢ Hepatitis A
  - ➢ Hepatitis B
  - ➢ Herpes Zoster
  - ➢ Human Papillomavirus
  - ➢ Influenza
  - ➢ Measles, Mumps, Rubella
  - ➢ Meningococcal
  - ➢ Pneumococcal
  - ➢ Tetanus, Diphtheria, Pertussis
  - ➢ Varicella
- Other services such as cessation interventions for tobacco users

Covered Preventive Services for Women, Including Pregnant Women

- Annual routine physical exams
- Annual well-woman visits
- HPV DNA testing for women 30 years and older
- Screenings such as:
  - ➢ Gestational diabetes for pregnant women
  - ➢ HIV screening
  - ➢ Interpersonal and domestic violence screening
  - ➢ Anemia screening on a routine basis for pregnant women
  - ➢ Bacteriuria urinary tract or other infection screening for pregnant women
    - ▪ Breast Cancer Mammography screenings (one screening per calendar year regardless of age).
  - ➢ Cervical Cancer screening for sexually active women
  - ➢ Chlamydia Infection screening for younger women and other women at higher risk
  - ➢ Gonorrhea screening for all women at higher risk

- ➢ Hepatitis B screening for pregnant women at their first prenatal visit
- ➢ Osteoporosis screening for women over age 60 depending on risk factors
- ➢ Rh Incompatibility screening for all pregnant women and follow-up testing for women at higher risk
- ➢ Tobacco Use screening for all women, and expanded counseling for pregnant tobacco users
- ➢ Syphilis screening for all pregnant women or other women at increased risk

- Counseling such as:
  - ➢ Sexually transmitted infection counseling
  - ➢ HIV counseling
  - ➢ Contraceptive counseling
  - ➢ Breastfeeding support and counseling
  - ➢ Interpersonal and domestic violence counseling
  - ➢ BRCA counseling about genetic testing for women at higher risk
  - ➢ Breast Cancer Chemoprevention counseling for women at higher risk
  - ➢ Use of Folic Acid supplements for women who may become pregnant

- Other services such as:
  - ➢ Tobacco Use interventions for all women
  - ➢ Breast Feeding interventions to support and promote breast feeding, including breast pumps supplied by our designated vendor
  - ➢ Select federal FDA-approved contraceptive methods

If your Employer has a Religious Employer Exemption with respect to the federal requirement to cover all Food and Drug Administration-approved contraceptive services for women, this means that your Employer will not contract, arrange, pay, or refer for contraceptive coverage. Instead, Paramount Insurance Company will notify you and provide separate payments for contraceptive services that you use, without Cost Sharing and at no other cost, for so long as you are enrolled in your group health plan. Your Employer will not administer or fund these payments. The costs for these benefits are not included in the premium paid for the healthcare coverage. If you have any questions about this notice, contact Paramount Member Services Department at (419) 887-2525 or Toll-Free 1-800-462-3589; TTY (419) 887-2526 or Toll-Free 1-888-740-5670.

Covered Preventive Services for Children

- Annual routine physical exams including well baby and well child visits
- Screenings such as:
  - ➢ Autism screening for children at 18 and 24 months
  - ➢ Cervical Dysplasia screening for sexually active females
  - ➢ Congenital Hypothyroidism screening for newborns
  - ➢ Developmental screening for children under age 3, and surveillance throughout childhood
  - ➢ Dyslipidemia screening for children at higher risk of lipid disorders
  - ➢ Hearing screening for all newborns
  - ➢ Hematocrit or Hemoglobin screening for children
  - ➢ Hemoglobinopathies or sickle cell screening for newborns
  - ➢ HIV screening for adolescents at higher risk
  - ➢ Lead screening for children at risk of exposure
  - ➢ Obesity screening
  - ➢ Phenylketonuria (PKU) screening for this genetic disorder in newborns
  - ➢ Vision screening for all children

- Assessments such as:
  - ➢ Alcohol and Drug Use assessments for adolescents
  - ➢ Behavioral assessments for children of all ages
  - ➢ Height, Weight and Body Mass Index measurements for children
  - ➢ Medical History for all children throughout development
  - ➢ Oral Health risk assessment for young children

- Counseling such as:

- ➢ Use of Fluoride Chemoprevention supplements for children without fluoride in their water source
- ➢ Use of Iron supplements for children ages 6 to 12 months at risk for anemia
- ➢ Obesity counseling
- ➢ Sexually Transmitted Infection (STI) prevention counseling for adolescents at higher risk

- Immunization vaccines for children from birth to age 18 —doses, recommended ages, and *recommended populations vary:*
  - ➢ *Diphtheria, Tetanus, Pertussis*
  - ➢ *Haemophilus influenzae type b*
  - ➢ *Hepatitis A*
  - ➢ *Hepatitis B*
  - ➢ Human Papillomavirus
  - ➢ Inactivated Poliovirus
  - ➢ Influenza
  - ➢ Measles, Mumps, Rubella
  - ➢ Meningococcal
  - ➢ Pneumococcal
  - ➢ Rotavirus
  - ➢ Varicella
- Other services such as:
  - ➢ Tuberculin testing for children at higher risk of tuberculosis
  - ➢ Gonorrhea preventive medication for the eyes of all newborns

Network Benefits are available when Preventive Health Services are provided in a Network Physician's office, at a Network Alternate Facility or at a Network Hospital.

NOTE: This Benefit Plan is intended to comply with the Affordable Care Act. The Preventive Health Services Benefit is subject to change.

Professional Fees for Surgical and Medical Services

The Benefit Plan covers professional fees for surgical procedures and other medical care received on an Outpatient or Inpatient basis in a Physician's office, Hospital (including the Emergency Department), Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility, or for Physician house calls.

Prosthetic and Orthotic/Support Devices

NOTE: It is recommended that you or your Provider call us to verify coverage prior to receiving prosthetic or orthotic/support devices.

The Benefit Plan covers surgically implanted and externally worn prosthetic devices that replace a limb or body part including but not limited to:

- Replacement hip.
- Heart pacemaker.
- Artificial limbs.
- Artificial face, eyes, ears and noses.
- Speech aid prosthetics and tracheo-esophageal voice prosthetics.
- Breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998. This includes mastectomy bras (up to 4 per calendar year) and lymphedema stockings for the arm.

The prosthetic or orthotic device must be Medically Necessary, as determined by Paramount medical policy and nationally recognized guidelines and ordered or provided by, or under the direction of a Physician. Benefits are not provided for repair, replacement or duplicate devices that result from misuse, abuse or lost or stolen devices. Benefits may be provided for repair or replacement when necessitated due to a change in your medical condition, or a change in body size due to growth, or to improve physical function.

Reconstructive Procedures

NOTE: It is recommended that you or your Provider call us to verify coverage prior to reconstructive procedures.

The Benefit Plan covers Medically Necessary services for reconstructive procedures, when a physical impairment exists and the primary purpose of the procedure is to improve or restore physiologic function. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The fact that physical appearance may change or improve as a result of a reconstructive procedure does not classify such surgery as a Cosmetic Procedure when a physical impairment exists, and the surgery restores or improves function.

Cosmetic Procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery or other procedures done to relieve such consequences or behavior as a reconstructive procedure.

Examples of procedures that may or may not be considered cosmetic include breast reduction and reconstruction (except for after cancer surgery when it is always considered a Covered health Service or for surgical treatment of male gynecomastia when considered Medically Necessary); vein stripping, ligation and sclerotherapy, upper lid blepharoplasty, panniculectomy, rhinoplasty and septorhinoplasty.

NOTE: Benefits for reconstructive procedures include breast reconstruction following a mastectomy, and reconstruction of the non-affected breast to achieve symmetry. Other services required by the Women's Health and Cancer Rights Act of 1998, including treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service. You can contact us for more information about Benefits for mastectomy-related services.

Rehabilitation/Habilitation Services – Outpatient Therapies
Physical Therapy, Occupational Therapy, Speech Therapy, Pulmonary Rehabilitation Therapy and Cardiac Rehabilitation Therapy. Please refer to your Schedule of Benefits for limitations.
Description

The Benefit Plan covers Outpatient rehabilitation/habilitation services for:

- Physical therapy.
- Occupational therapy.
- Speech therapy, including post-cochlear implant aural therapy (subject to specific restrictions and exclusions).
- Pulmonary rehabilitation therapy.
- Phase I and II cardiac rehabilitation therapy.

Rehabilitation/habilitation services must be performed by a licensed therapy Provider, under the direction of a Physician. Rehabilitation/habilitation services must be performed at a Hospital, Skilled Nursing , Alternate Facility, or through a Home Health Agency.

Benefits are not available for Inpatient or Outpatient Recreational Therapy.

Benefits are available only for rehabilitation/habilitation services that are expected to result in significant improvement in your condition within a time frame established by Paramount medical policy for your condition. Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation/habilitation services or if discharge rehabilitation/habilitation goals have previously been met.

Spinal Treatment

The Benefit Plan covers Spinal Treatment (chiropractic or osteopathic manipulation treatment) when provided by a Spinal Treatment Provider (Chiropractor or Doctor of Osteopathy, "D.O."). Benefits include the following:

- Services and supplies for analysis and adjustment of spinal subluxations(s) and spinal misalignment(s).
- Diagnosis and treatment by manipulation of the skeletal structure.
- Muscle stimulation by any means (except treatment of fractures and dislocations of the extremities).
- Rehabilitative exercise related to spinal subluxations(s) or spinal misalignment(s).

- X-rays of the spine.

Limitations

Benefits for any combination of physical therapy, occupational therapy, and Spinal Treatment received on an Outpatient basis are limited to 30 visits per calendar year.

Benefits for speech therapy received on an Outpatient basis are limited to 30 visits per calendar year.

Benefits for pulmonary rehabilitation therapy and Phase I and II cardiac rehabilitation therapy received on an Outpatient basis is limited to 30 visits per calendar year.

NOTES: If the therapies described under this category are available on both a rehabilitative and habilitative basis, there are separate limits, as stated above, for each type (e.g., 30 visits per calendar year for rehabilitative speech therapy and 30 visits per calendar year for habilitative speech therapy; and 30 combined visits per calendar year for rehabilitative physical therapy, occupational therapy and Spinal Treatment and 30 combined visits per calendar year for habilitative physical therapy, occupational therapy and Spinal Treatment (as applicable).

Outpatient rehabilitation/habilitation therapy for autism will not be included in the limits specified above.

Surgical Sterilization - Female

The Benefit Plan covers female surgical sterilization procedures and related services received in a Physician's office or on an Outpatient basis at a Hospital or Alternate Facility.

Benefits under this category include the Facility charge, the charge for required Hospital-based professional services, supplies and equipment and for the surgeon's fees.

Surgical Sterilization - Male

The Benefit Plan covers male surgical sterilization procedures and related services received in a Physician's office or on an Outpatient basis at a Hospital or Alternate Facility.

Benefits under this category include the Facility charge, the charge for required Hospital-based professional services, supplies and equipment and for the surgeon's fees.

Temporomandibular Joint Dysfunction or Syndrome
Description

The Benefit Plan covers professional fees for Medically Necessary care or services to treat temporomandibular joint dysfunction or syndrome (TMJ) resulting from a medical cause or Injury. TMJ means muscle tension and spasms related to the temporomandibular joint, facial, and cervical muscles, causing pain, loss of function and neurological dysfunction. Covered Health Services include:

- Office visits for medical evaluation and treatment.
- X-ray of the temporomandibular joint including contrast studies, but not dental X-rays.
- Myofunctional therapy.
- Surgery to the temporomandibular joint, such as condylectomy, meniscectomy, arthrotomy, and arthrocentesis.

NOTE: Bite splints, orthodontic treatment, or other dental services to treat TMJ dysfunction or syndrome are not covered.

Tobacco Cessation Program
Description

A Tobacco Cessation Program is offered to Benefit Plan members over the age of eighteen (18) that includes participation in a select credentialed counseling program and coverage for Preferred Tobacco Cessation Products.

Preferred Tobacco Cessation Products must be prescribed by a Physician and obtained from a Network retail Pharmacy, even if the product is available as an over-the-counter product. You must enroll and participate in the program to receive Preferred Tobacco Cessation Products.

Call the Member Services Department for complete details on enrolling in the counseling program, the current list of Preferred Tobacco Cessation Products and any applicable Copayments and Coinsurance.

Premium Rates for Tobacco Users

A tobacco user is someone who is age 21 or older who has regularly used tobacco (smoking or chewing) at least four or more times per week in the past six months. Religious or ceremonial uses of tobacco, for example, by American Indians and Alaskan Natives are specifically exempt.

Your Plan has different premium rates for tobacco users and non-tobacco users. If you are a tobacco user, by participating in this Tobacco Cessation Program, you can have your premium rates reduced to the non-tobacco user rate. You may decide at any time during your coverage period to participate in this program.

How the premium rate reduction works

If you are a tobacco user paying the tobacco user rate and enroll in this program, your premium rate will be adjusted to the non-tobacco user rate. If you are a tobacco user and you do not participate in this program, your premium rate will remain at the tobacco-user premium rate.

To have the tobacco-user rate adjusted you will be required to submit a signed attestation to Paramount certifying your enrollment in the Tobacco Cessation Program. You can obtain a copy of the attestation form by contacting Paramount or visiting our website.

Transplantation Services

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

Urgent Care Center Services

The Benefit plan covers services received at an Urgent Care Center. When services to treat urgent health care needs are provided in a Physician's office, Benefits are available as described under *Physician's Office Services* earlier in this section.

NOTE: Some Covered Health Services received during the same urgent care center visit may be subject to the Annual Deductible and Coinsurance. Ancillary services such as Physician professional fees are described elsewhere in this section.

Vision Benefits Information

A. Diagnostic Services

Diagnostic Services are available for **all Covered Persons when care is obtained from Participating Providers in the Paramount Network.** Only Emergency care and treatment is covered when obtained from Non-Network Providers, unless otherwise noted.

The Benefit Plan covers.

- ➢ Eye exam, includes dilation, if professionally indicated – limited to 1 per calendar year
- ➢ Eye exams can be new or established patient exams, and new and established routine ophthalmologic exams with refraction.

B. Pediatric Vision Benefit

Covered Services discussed below are covered in full for any Member or dependent to the end of the month they turn age 19.

- **One Exam with Dilation as Necessary including contact lenses fit/follow-up**
- **One pair of frames including plastic lenses (single, bifocal, trifocal, lenticular) or one set of contact lenses**

*** Full version details can be found in the Summary of Benefits.**

SECTION FIVE: EXCLUSIONS

We Do Not Pay Benefits for Exclusions
We will not pay Benefits for any of the services, treatments, items or supplies described in this section, even if either of the following is true:
It is recommended or prescribed by a Physician; or
It is the only available treatment for your condition.
The services, treatments, items or supplies listed in this section are not Covered Health Services, except as may be specifically provided for in ***Covered Services*** Section.

Benefit Limitations
When Benefits are limited within any of the Covered Health Service categories described in Covered Services Section, those limits are stated in the corresponding Covered Health Service category. Limits may also apply to some Covered Health Services that fall under more than one Covered Health Service category. Please review all limits carefully, as we will not pay Benefits for any of the services, treatments, items or supplies that exceed these Benefit limits.

Please note that in listing services or examples, when we say "this includes," it is not our intent to limit the description to that specific list. When we do intend to limit a list of services or examples, we state specifically that the list "is limited to."

A. Alternative Testing and Treatment
1. Acupressure and acupuncture.
2. Aromatherapy.
3. Hypnotism.
4. Massage therapy.
5. Rolfing.
6. Herbal or vitamin therapies
7. Hair testing and analysis.
8. Saliva testing and analysis.
9. Environmental testing and analysis.
10. Body fat testing and analysis, unless qualifies under our Morbid Obesity Treatment Benefit.
11. Clinical ecology and environmental medicine. “Clinical ecology” and “environmental medicine” are defined here as medical practice that is based on the belief that exposure to low levels of numerous common substances in the environment can be responsible for a variety of symptoms affecting numerous body systems.
12. Other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM), a component of the National Institutes of Health.

B. Behavioral Health
1. Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
2. Behavioral Health Services as treatment for neurological disorders and other disorders with a known physical basis when such conditions are solely medical in nature.
3. Treatment for conduct and impulse control disorders, and paraphilias.
4. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements, unless authorized by the Behavioral Health Designee.
5. Services provided outside of an Inpatient, intermediate or Outpatient setting.
6. Behavioral Health Services for the following:
   - ➢ Sleep disorders.
   - ➢ Delirium, dementia, and amnesic and other cognitive disorders (except as provided under *Behavioral Health Services* in ***Covered Services*** Section).
   - ➢ Therapy for pervasive developmental disorders, except for treatment of certain Autism Spectrum Disorders.
   - ➢ Psychotherapy for feeding, tic, and elimination disorders (except as provided under *Behavioral Health Services* in ***Covered Services*** Section).
   - ➢ Marital counseling.
   - ➢ Transitional living centers, wrap-around care services, halfway or three-quarter-way houses, non-licensed programs, therapeutic boarding schools or milieu therapies.
   - ➢ Sex therapy.
   - ➢ Psychotherapy for Attention Deficit Disorder and disruptive behavior disorders (except as provided under *Behavioral Health Services* in ***Covered Services*** Section).

- ➢ Mental disorders due to a general medical condition.

7. Services or supplies for the diagnosis or treatment of Mental Illness, alcoholism or substance use disorders that, in the reasonable judgment of the Behavioral Health Designee, are any of the following:
   - ➢ Not consistent with prevailing national standards of clinical practice for the treatment of such conditions.
   - ➢ Not consistent with prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome.
   - ➢ Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective.
   - ➢ Not consistent with the Behavioral Health Designee's level of care guidelines or best practices as modified from time to time.

NOTE: The Behavioral Health Designee may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information regarding whether a service or supply meets any of these criteria.

C. Dental and Related Oral/Mouth Conditions

1. Dental care and all associated expenses except as specifically described in Covered Services Section under the heading *Dental Services – Accidental Injury and Other Medical Services of the Mouth*.
2. Preventive care, diagnosis, treatment of or related to the teeth or gums. Examples include all of the following:
   - ➢ Extraction, restoration and replacement of teeth, except as described in Covered Services Section under the heading *Dental Services – Accidental Injury and Other Medical Services of the Mouth*.
   - ➢ Medical or surgical treatments of dental conditions except as described in Covered Services Section under the heading *Dental Services – Accidental Injury and Other Medical Services of the Mouth*.
   - ➢ Services to improve dental clinical outcomes.
3. Tooth implants and related services, bone grafts and other implant-related procedures and related services, even when required as a result of an Injury.
4. Orthodontic services, including braces.
5. Dental X-rays, all hospitalization charges, Facility charges, and anesthesia charges related to dental care. The only exceptions to this are for any of the following:
   - ➢ Transplant preparation.
   - ➢ Initiation of immunosuppressives.
   - ➢ The direct treatment of acute traumatic Injury, cancer or cleft palate.
   - ➢ Dental-related anesthesia and associated Hospital Facility charges provided as described under the category, *Dental Anesthesia* in ***Covered Services*** Section.
6. Supplies and appliances and all associated expenses (including occlusal splints, dental prosthetics and dental orthotics). Mouth rehabilitation. Bridges. Partial plates. Dentures.
7. Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a Congenital Anomaly.
8. Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), when the services are provided as part of a treatment for documented dental conditions.

E. Experimental, Investigational or Unproven Services

Experimental, Investigational and Unproven Services are excluded. The fact that an Experimental, Investigational, or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.

NOTE: This Exclusion does not apply to antineoplastic drugs for which Benefits are available as described in *Antineoplastic Therapy (Chemotherapy)* in ***Covered Services*** Section. These terms are defined in Terms and Definitions.

F. Medical Supplies, Appliances and Equipment

1. Devices used specifically as safety items and/or to affect performance in sports-related activities.
2. Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:
   - ➢ Elastic, surgical and compression stockings (for example TEDs and JOBST stockings).
   - ➢ Ace bandages.
   - ➢ Disposable dressings used for wound care.

- ➢ Syringes, except as Benefits are provided in *Diabetes Services* in ***Covered Services*** Section.

NOTE: This Exclusion does not apply for diabetes supplies for which Benefits are provided in *Diabetes Services* in ***Covered Services*** Section or supplies necessary for proper functioning or application of covered DME.

3. Shoe orthotics, except for shoe inserts for peripheral neuropathy, or those determined to be habilitative.
4. Shoes, except for specialty shoes prescribed for a Person with diabetes, or those determined to be habilitative.
5. Cranial helmets.

G. Nutrition

1. Megavitamin and nutrition based therapy.
2. All food, formula and nutritional supplements are not covered. This includes, but is not limited to, infant formula, donor breast milk, protein or caloric boosting supplements, vitamins, Ensure, Osmolyte and herbal preparations or supplements, even if approved by the federal FDA, except for formula specifically intended for tube feeding and nutrients necessary for IV feeding as provided in *Nutritional Therapy* in ***Covered Services*** Section.

H. Personal Services, Comfort or Convenience

1. Custodial care, domiciliary care or basic care, including room and board, provided in a residential, institutional or other setting that is, for the purpose of meeting your personal needs, and that could be provided by Persons without professional skills or training.
2. Personal comfort and convenience items, including but not limited to, telephone and television services during an Inpatient Stay, and home or vehicle modifications or appliances.
3. Lodging and/or meals necessary while receiving healthcare services.
4. Services of personal care attendants.
5. Beauty/barber services.
6. Guest services.
7. Supplies, equipment and similar incidental services and supplies for personal comfort, or for the convenience of either the Covered Person or his or her Physician.

I. Physical Appearance

1. Cosmetic Procedures. See the definition in Terms and Definitions. Examples include:
   - ➢ Pharmacological regimens, nutritional procedures or treatments.
   - ➢ Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
   - ➢ Skin abrasion procedures and other dermatological treatment that is cosmetic in nature.
   - ➢ Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.
   - ➢ Treatment for skin wrinkles or any treatment to improve the appearance of the skin.
   - ➢ Treatment for spider veins.
   - ➢ Hair removal by any means.
   - ➢ Plastic surgery.
   - ➢ Collagen implants
   - ➢ Diastasis recti repair.
2. Removal or replacement of an existing breast implant if it was initially performed as a Cosmetic Procedure, unless due to Medically Necessary complications.
   NOTE: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See the category, *Reconstructive Procedures* in ***Covered Services*** Section.
3. Treatment of benign gynecomastia (abnormal breast enlargement in males), unless Medically Necessary per Paramount medical policy.
4. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation.
5. Any hair replacement product or process, including wigs, regardless of the reason for the hair loss.

J. Providers

1. Services performed by a Provider who is a family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the Provider may perform on himself or herself.

2. Services performed by a Provider with your same legal residence.
3. Services provided at a free-standing or Hospital-based diagnostic Facility without an order written by a Physician or other Provider. Services that are self-directed to a free-standing or Hospital-based diagnostic Facility. Services ordered by a Physician or other Provider who is an employee or representative of a free-standing or Hospital-based diagnostic Facility, when that Physician or other Provider:
   - ➢ Has not been actively involved in your medical care prior to ordering the service, or
   - ➢ Is not actively involved in your medical care after the service is received.

   NOTE: This Exclusion does not apply to mammography screening.
4. Foreign language and sign language interpreters.
5. Telephone consultations that do not meet the criteria as described in Telemedicine Services in ***Covered Services*** Section.
6. Academic services including tuition for or services that are school-based for children or adolescents provided under the Individuals With Educational Disabilities Act (IDEA).

K. Reproduction

1. All services and supplies relating to Elective Abortions
2. Health services and associated expenses for Assisted Reproductive Technology (ART) including but not limited to: artificial insemination, in vitro fertilization, gamete intrafallopian transfer (GIFT) procedures, zygote intrafallopian transfer (ZIFT) procedures or any other treatment or procedure designed to create a Pregnancy, and any related prescription medication treatment. Embryo transport. Donor ovum and semen and related costs including collection and preparation.
3. The reversal of surgical sterilization.
4. Cryo-preservation and other forms of preservation of reproductive materials.
5. Long-term storage of reproductive materials such as sperm, eggs, embryos, ovarian tissue and testicular tissue.

L. Services Provided under Another Plan

1. Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. This includes, but is not limited to, coverage required by workers' compensation or similar legislation. This applies whether or not you choose to file a claim.

NOTE: This Exclusion does not apply to no-fault automobile insurance.

If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness or Mental Illness that would have been covered under workers' compensation or similar legislation had that coverage been elected.

2. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.
3. Health services while on active military duty.

M. Spinal Treatment

1. Any Spinal Treatment service not related to the spine.
2. Any service not included in the scope of services defined in the Michigan Public Health Code, Chapter 333, Part 164.
3. Laboratory services.
4. Consultations.
5. Rehabilitative exercise not related to spinal subluxations or spinal misalignments.
6. Nutritional advice or supplements, drugs, medical equipment, or supplies dispensed by or prescribed by a Spinal Treatment Provider.
7. Inpatient hospitalization.
8. Treatment of fractures and dislocations of the extremities.

N. Transplants

1. Health services for organ and tissue transplants, except those described in ***Covered Services*** Section.
2. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another Person. (Donor costs for removal are payable for a transplant through the organ recipient's Benefits under the Policy).
3. Health services for transplants involving mechanical or animal organs.
4. Transplant services that are not performed at a Designated Facility. **NOTE:** This Exclusion does not apply to cornea transplants.
5. Any solid organ transplant that is performed as a treatment for cancer.

6. Any multiple organ transplant not listed as a Covered Health Service under the heading *Transplantation Services* in *Covered Services* Section.

O. Travel

1. Health services provided in a foreign country, unless required as Emergency Health Services.
2. Travel, lodging, room and board or transportation expenses, even though prescribed by a Physician or necessitated due to where treatment is received.

P. Vision and Hearing

1. Purchase and fitting of eye glasses, or refractive contact lenses for Dependent Children after the end of the calendar year in which they turn age nineteen (19).
2. Purchase and fitting of hearing aids.
3. Eye exercise therapy or visual therapy.
4. Surgery that is intended to allow you to see better without glasses or other vision correction including radial keratotomy, laser, and other refractive eye surgery.
5. Special lens designs or coatings other than those described in ***Covered Services*** Section under *Vision Benefits*.
6. Replacement of lost/stolen eyewear; non-prescription (Plano) lenses; two pairs of eyeglasses in lieu of bifocals; services not performed by licensed personnel; or insurance of contact lenses.
7. Any other vision treatment or services except for treatment of medical conditions and diseases of the eye as provided under each applicable Covered Health Service category in ***Covered Services*** Section.

Q. All Other Exclusions

1. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in Terms and Definitions.
2. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments when:
   - ➢ Required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage or adoption.
   - ➢ Related to judicial or administrative proceedings or orders.
   - ➢ Conducted for purposes of medical research.
   - ➢ Required to obtain or maintain a license of any type.
3. Illegal Occupation or Criminal Activity. The insurer is not liable for any loss to which a contributing cause was the insured's commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal occupation or other Willfull Criminal Activity.
4. Health services received after the date your coverage under the Policy ends, including health services for medical conditions arising before the date your coverage under the Policy ends.
5. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Policy.
6. Services and supplies, which are provided while member is in the custody of any law enforcement authorities or while incarcerated in a Facility such as a youth home or charges involving a member's medical condition, which arise out of the commission of a felony by such a member, if convicted, unless resulting from an underlying medical condition or act of domestic violence.
7. In the event that a Provider waives Copayments, Coinsurance amounts and/or the Annual Deductible for a particular health service, no Benefits are provided for the health service for which the Copayments, Coinsurance and/or Annual Deductible are waived.
8. Charges in excess of Eligible Expenses or in excess of any specified limitation.
9. Surgical treatment of morbid obesity that is not provided at a Designated Facility.
10. Weight loss programs whether or not they are under medical supervision, unless the Covered Person qualifies under our current "Morbid Obesity Policy."
11. Ambulance services that are provided by an Emergency responder that does not provide transportation except when an Emergency Medical Condition can be remedied without transportation.
12. Services provided by fire departments, rescue squads, or other Emergency transport Providers that are supported by a government or where fees are in the form of a voluntary donation.
13. Ambulance transport (ground or air) that is not to the closest Hospital equipped to treat the condition, including transport to a preferred Hospital or for the convenience of being closer to your home or someone to provide continuing care to you.
14. Services and supplies for home births.
15. Freestanding birthing centers.
16. Private duty nursing.

17. Respite care, except as allowed under Paramount medical policy as part of hospice services.
18. Rest cures.
19. Work hardening (individualized treatment programs designed to return a Person to work or to prepare a Person for specific work).
20. Autopsy.
21. Long term (more than 30 days) storage. Examples include cryo-preservation of tissue, blood and blood products.
22. Psychosurgery.
23. Medical and surgical treatment of excessive sweating (hyperhidrosis), except for Medically Necessary Covered Health Services as allowed under Paramount medical policy.
24. Medical and surgical treatment for snoring or daytime sleepiness, except when provided as a part of treatment for documented obstructive sleep apnea.
25. Oral appliances for snoring.
26. Audio therapy.
27. All devices and computers, including electronic access/connectivity, to assist in communication, speech and Telemedicine Services, for example special TV used for closed caption and reading machines, except for speech aid prosthetics and tracheo-esophageal voice prosthetics.
28. Gym memberships. Aquatic exercise programs or classes. Personal trainers. Exercise equipment, including pools even if prescribed by a Physician.
29. Inpatient or Outpatient Recreational Therapy.
30. Covered Health Services for which Benefits would otherwise be available under the Policy that are related to a specific condition, when a Covered Person has refused to comply with or has terminated the scheduled service or treatment against the advice of a Physician or the Behavioral Health Designee.
31. Penile implants for the treatment of impotence having a psychological origin.
32. Legal/court fees, copy/fax fees, late fees, shipping charges, long distance telephone charges, and fees for copying X-rays.
33. Charges for missed appointments.
34. Power operated wheel chairs if you:
    - ➢ Can walk, or
    - ➢ Can use a manual wheelchair, or
    - ➢ Only need it for leisure activities, or
    - ➢ Would not need it for use in your home.
35. Benefits are not payable for any of the following:
    Medical equipment and supplies that do not meet Medicare Part B guidelines, (except for diabetic and ostomy supplies), exercise equipment, air conditioners, wigs, and test kits (except for diabetic supplies).
36. Services for the treatment of an overbite or underbite. Maxillary and mandibulary osteotomies, unless Medically Necessary.
37. Mouth orthotics, mouth splints, mouth prosthetics and mouth appliances.
38. Medical and surgical services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), unless Medically Necessary.
39. Biofeedback training, unless for treatment of medical diagnoses when Medically Necessary, as determined according to Paramount medical policies.
40. Skin titration (Rinkle Method), cytotoxicity testing (Bryan's Test), MAST testing, urine auto-injections, bronchial or oral allergen sensitization and provocative and neutralization testing for allergies.
41. Cognitive rehabilitative/habilitative therapy (neurological training or retraining); craniosacral therapy; rehabilitation/habilitation services obtained from non-Health professionals, including massage therapists; relational, educational and sleep therapy and any related diagnostic testing; and visual training and sensory integration therapy.
42. Items or services furnished, ordered, or prescribed by any Provider that involves Fraud.
43. Health services and supplies that are not Medically Necessary – see the definition in Terms and Definitions.

SECTION SIX: COORDINATION OF BENEFITS

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

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

Paramount pays for health care only when you follow our rules and procedures. If our rules conflict with those of another plan, it may be impossible to receive benefits from both plans, and you will be forced to choose which plan to use.

Plans That Do Not Coordinate
Paramount will pay benefits without regard to benefits paid by the following kinds of coverage:

- Individual (not group) policies or contracts, except where Paramount may have subrogation rights against your rights to recover under certain individual policies.
- Hospital indemnity benefits or other fixed indemnity coverage;
- Accident only coverage or disability income insurance;
- Specified disease or specified accident coverage
- School accident-type coverage;
- Benefits provided in long term care insurance policies for non-medical services;
- Medicare supplement policies; or
- A state plan under Medicaid, or other governmental plan when, by law, its benefits are in excess of those of any private insurance plan or other non-governmental plan.

How Paramount Pays as Your Primary Plan
When we are primary, we will pay the full benefit allowed by your contract as if you had no other coverage.

How Paramount Pays as Your Secondary Plan

- Our payments will be based on the balance left after the primary plan has paid. We will pay no more than that balance. In no event will we pay more than we would have paid had we been primary.

- We will pay only for health care expenses that are covered by Paramount.

- We will pay only if you have followed all of our procedural requirements, including care obtained from or arranged by your Primary Care Provider, Participating Specialists, Prior Authorization, etc.

- In determining the amount to be paid on a claim if Paramount is a secondary plan, Paramount will calculate the benefits it would have paid on the claim in the absence of other health care coverage and apply the calculated amount to any allowable expense under the health plan that is unpaid under the primary plan. Paramount will then reduce its payment by the calculated amount so that, when combined with the amount paid under the primary plan, the total benefits paid or provided under all plans for the claim do not exceed 100% of the allowable expense for the claim.

  "Allowable Expenses" means a healthcare expense, including Coinsurance or Copayments and without reduction for any applicable Deductible that is covered in full or in part by any of the plans covering the Covered Person. The amount of a reduction may be excluded from allowable expenses if a Covered Person's benefits are reduced under a primary plan for either of the following reasons:
  - Because the Covered Person does not comply with the plan provisions concerning second surgical opinions or precertification of admissions or services.
  - Because the Covered Person has a lower benefit because the Covered Person did not use a preferred Provider.

Determining Which Plan Is Primary
To decide which plan is primary, we have to consider both the coordination provisions of the other plan and which member of your family is involved in a claim. The primary plan will be determined by the first of the following factors which applies:

1. **Employee** The plan which covers you as an employee (neither laid off nor retired) is always primary.

2. **Nondependent/Dependent**. If the plan covers the Covered Person other than as a dependent, it is the primary plan; and the plan covering the Covered Person as a dependent is the secondary plan.

3. **Children** (parents divorced, separated or not living together) If the court decree makes one parent responsible for health care expenses, that parent's plan is primary. If the court decree gives joint custody and does not mention health care, we follow the birthday rule. (See point 4 below.)

4. If there is no court order or judgment allocating responsibility for the child's health care coverage, the order of benefits for the child are as follows:
   I) The plan covering the custodial parent.
   II) The plan covering the custodial parent's spouse.
   III) The plan covering the non-custodial parent.
   IV) The plan covering the non-custodial parent's spouse.

5. **Children (parents married or living together) and the birthday rule**
   When your children's health care expenses are involved, we follow the "birthday rule". The plan of the parent with the first birthday is always primary for the children. For example, if your birthday is in January and your spouse's birthday is in March, your plan will be primary for all of your children. If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.

   If your spouse's plan is issued in another state and has some other coordination rule which differs from the coordination of benefits rules in Michigan, the out of state plan will be primary.

6. **Other situations** For all other situations not described above, the order of benefits will be determined in accordance with the Michigan Compiled Laws Section 550.253 and any regulation issued there under.

Coordination Disputes

If the You believe that Paramount has not paid a claim properly, under the coordination of benefits, You should first attempt to resolve the problem by contacting Paramount at (419) 887-2525 or refer to Section Eight: Questions, Problems or Grievances.

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

SECTION SEVEN: MEDICARE AND YOUR COVERAGE

You may have coverage under the Plan and under Medicare. Medicare means the benefits offered under Title XVIII of the Social Security Act, and includes all of the benefits provided by Parts A and B of Medicare. Federal law controls whether Paramount or Medicare is primary. Contact your Employer for current guidelines. Or for more information, please visit: https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Overview.htm. In general, when You have coverage under both the Plan and Medicare, the Plan will pay primary benefits for:

1. An active employee who is age 65 and over (only if the Employer has 20 or more employees);

2. An active employee's spouse age 65 or over;

3. An active employee under age 65 entitled to Medicare because of disability (only if the Employer has 100 or more employees);

4. An active employee's covered dependent(s) under age 65 entitled to Medicare because of disability (only if the Employer has 100 or more employees); or

5. Up to 30 months after Your treatment for end stage renal disease begins.

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

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

SECTION EIGHT: QUESTIONS, PROBLEMS OR GRIEVANCES

Paramount's Member Service Department welcomes your questions from 8:00 A.M. to 5:00 P.M., Monday through Friday. The Member Service staff can be reached by calling 419-887-2531 or use our toll-free number 1-866-452-6128. You can contact us by e-mail at: member.services@medmutual.com. Written and oral communications will be given in an appropriate language upon request.

If you call the Member Service Department after hours, you may leave a message and you will receive a return call on the next working day. You may also email us through the Paramount website at www.paramounthealthcare.com.

The Member Service Department's goal is to help you with any questions about procedures, benefits, payment for services, enrollment, etc. We encourage you to call us with any questions. Paramount provides a TTY number for members who are hearing impaired. Paramount will also provide translation services for members who do not speak English. If a member needs foreign language translation services, he/she should call the Member Service Department. If you have any suggestions for improving our service or if you wish to recommend changes in procedures or benefits please write us or call us.

1.How to Handle a Problem. If you have a problem or you are dissatisfied with any aspect of Paramount service, call or write the Member Services Department. (If you have a problem with one of Paramount's Providers, we encourage you to first discuss the issue with the Provider.) A Member Services Representative will attempt to resolve the problem informally. If we are not able to resolve the problem to your satisfaction, you may file a grievance.

2. Filing a Grievance Under Michigan Public Act 252 of 2000, a “grievance” means a complaint by the member concerning any of the following:
a) The availability, delivery, or quality of Health Care Services, including a complaint regarding an Adverse Determination (denial) made by Utilization Review,
b) Benefits or claims payment, handling, or reimbursement for Health Care Services,
c) Matters concerning the contractual relationship between a member and Paramount.

An **“adverse benefit determination”** eligible for internal grievance includes a denial, reduction, or termination of, or a failure to provide or make a payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make a payment that is based on:
• A determination of an individual’s eligibility for coverage;
• A determination that a benefit is not a covered benefit;
• The imposition of a pre-existing condition exclusion, source-of-injury exclusion, network exclusion, or other limitation on otherwise Covered Benefits;
• A determination that a benefit is experimental, investigational, or not Medically Necessary or appropriate; or
• Any rescission of coverage, whether or not there is an adverse effect on any particular benefit at that time.

As a member of Paramount, you have the right to file a grievance concerning adverse benefit determinations. You must file a grievance ***within 180 days*** of receiving notification of the adverse benefit determination. Paramount will conduct a review and will issue a written decision within:

Post Service Claims: 60 calendar days from receipt of the grievance
Pre-Service Claims: 30 calendar days from receipt of the grievance
Urgent Care Claims: 72 hours from receipt of the grievance

If Paramount's decision is provided orally, written confirmation will be provided no later than 2 business days after the oral determination. Paramount will notify you of a benefit determination, whether adverse or not, with respect to an urgent care claim as soon as possible, but not later than 72 hours from receipt of the grievance, unless you fail to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under your Benefit Plan. In addition, concurrent internal grievance and external review is allowed for claims involving urgent care or an ongoing course of treatment.

For grievances, you should follow the steps outlined below:

Internal Grievance – Level 1

If you have a problem, call or write the Member Services Department. A Member Services representative will try to resolve the problem or grievance within two (2) working days for urgent clinical issues, 15 calendar days for a pre-service grievance or 30 calendar days for a post-service grievance. You will be advised of the disposition of your problem by telephone call or in writing. If the first level problem is not resolved to your satisfaction, you may appeal to Paramount orally or in writing.

Internal Grievance – Level 2

If the first level problem is not resolved to your satisfaction, you will be informed of your right to file an oral or written second level grievance with Paramount. A written grievance should be sent to the address below.

Paramount Insurance Company
Attention: Complaint/Appeals Department
300 Madison Ave, Suite 270
Toledo, Ohio 43604

You will receive an acknowledgement from Paramount within five (5) working days from receipt of your request. You will also be advised that you have the right to attend an informal hearing to present your 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 grievance review. You may request free of charge from Paramount reasonable access to and copies of all pertinent documents, records and other information regarding your appeal.

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 your medical records and determine if the service is Medically Necessary. The Internal Grievance Committee will base their decision on the clinical peer's determination.

If your medical condition requires a faster review (called an expedited grievance), Paramount must provide you with a response ***within seventy-two (72) hours***. An expedited grievance applies if a grievance is submitted and a Physician orally or in writing verifies that the time frame for a standard grievance would seriously jeopardize the life and health of the member or would jeopardize the member's ability to regain maximum functioning. In addition, concurrent expedited grievance and external review is allowed for claims involving urgent care or an ongoing course of treatment. If a member meets the urgent care or ongoing treatment requirement, the Member will be considered to have exhausted Paramount's internal grievance process. If you wish to request an expedited grievance, you may call the Paramount office at 1-888-887-5101 or fax, 1-888-740-0222.

In addition, Paramount may waive its internal grievance process and the requirement for a Covered Person to exhaust the process before filing a request for an external review, or an expedited external review.

Rights on Grievance

In connection with your right to file a grievance on an Adverse Determination, you:

• may submit written comments, documents, records, and other information relating to the claim for benefits;
•may appear in person or by phone to present comments, documents, records, and other information relating to the claim for benefits;
• may request free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits;
• will receive a review of the determination that takes into account all comments, documents, records, and other information that you submit relating to the claim, without regard to whether this information was submitted or considered in the initial benefit determination;
• will receive a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appeal representative of Paramount who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor his or her subordinate;
• will receive a review from the appeal representative of Paramount in consultation with a Health Care Professional who has appropriate training and experience in the field of medicine involved in the medical judgment of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not Medically Necessary or appropriate;
• will receive a review in a manner designed to avoid conflicts of interest by ensuring the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual will not be made based upon the likelihood that the individual will support the denial of benefits;
• will receive, free of charge, any new or additional evidence or rationale considered, relied upon, or generated by Paramount sufficiently in advance of the date on which the notice of benefit determination on review is required to be provided to allow you a reasonable opportunity to respond prior to that date;
• will receive no reduction or termination of an ongoing course of treatment without advance notice from Paramount or an opportunity for advance review;
• will be provided, upon request, with the identification of the Health Care Professional whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and
• will be deemed to have exhausted the internal appeals process and may initiate an external review if Paramount has failed to strictly adhere to all the requirements of the internal appeals process, regardless of whether Paramount asserts that it substantially complied with all requirements or that any error it committed was de minimis.

3. Additional Appeals. If Paramount denies your internal grievance, Paramount will provide you with written or electronic notification of the determination. The notification will tell you the specific reason(s) for the Adverse Determination, the specific plan provisions on which the benefit determination is based, that you are entitled to receive, upon request and free of charge, reasonable access to , and copies of, all documents, records, and other information, relevant to your claim for benefits and a statement of your right to request within 10 days after a determination, a review by the Director of the Department of Insurance and Financial Services, an external review and/or bring an action under section 502(a) of ERISA. If the Director of the Department of Insurance and Financial Services requires additional information from the Member, the Member, or the Members Authorized Representative must provide the information within thirty (30) days.

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

Forms required to request an external review will be made available to you by Paramount and are available at the Department of Insurance and Financial Services website at https://difs.state.mi.us/Complaints/ExternalReview.aspx.

Department of Insurance and Financial Services
Consumer Services
P.O. Box 30220
Lansing, Michigan 48909-7720
1-877-999-6442

Paramount complies with the expanded scope of external review guidelines as outlined under the federal No Surprises Act.

A. Instructions for Requesting an External Independent Review
Not later than ***127 days*** after the date you receive a notice of an Adverse Determination or Final Adverse Determination, you or your Authorized Representative may file a request for an external review with DIFS. If you request an external review, you will be required to authorize the release of any medical records that may be required to be reviewed for the purpose of reaching a decision on the external review.

If DIFS accepts the request for an external independent review, you will receive an acknowledgement from DIFS. (If DIFS does not accept the request, DIFS will notify you of the reason.) DIFS will either independently perform the review or DIFS will select a state-approved Independent Review Organization (IRO) to conduct a review. The IRO will review all pertinent records available and notify DIFS of its recommendation. DIFS will then review the recommendation and notify the member and Paramount of the DIFS decision. If DIFS requests additional information from the Member, or the Member's Authorized Representative, the information must be provided within thirty (30) days after receiving notification.

B. Expedited External Reviews
You or your Authorized Representative may make a request for an expedited external independent review with DIFS ***within 10 days*** after receiving an Adverse Determination if both of the following are met:

1.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.

2. The member or member's Authorized Representative has filed a request for an Expedited Internal Grievance.

Denials on services that have already been received do not qualify for an expedited external review. If DIFS accepts the request for an expedited external independent review you will receive an acknowledgement from DIFS. DIFS will either independently perform the expedited external review or DIFS 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 DIFS of its recommendation. You will receive a final decision from DIFS within 72 hours from receipt of your request for an expedited external review.

4. Limitation on Legal Actions. You may not bring action in court against Paramount until you have exhausted all the applicable procedures described above. In no event may you bring an action in court against Paramount more than three (3) years after the occurrence upon which the legal action is based. If the occurrence that is the basis for the legal action concerns a denial of a claim, the occurrence will be the date of service if the service was in fact received.

SECTION NINE: REIMBURSEMENT/SUBROGATION

1. **Reimbursement and Subrogation**. Where a Covered Person has benefits paid by Paramount for the treatment of sickness or injury caused by a third party or the Covered Person, these are conditional payments that must be reimbursed by the Covered Person if the Covered Person receives compensation, damages or other payment as a result of the sickness or injury from any person, organization or insurer, including the Covered Person's own insurer, medical payments coverage, excess umbrella, uninsured and/or underinsured motorist insurance, or any other source (including the party causing sickness or injury). As an alternative to reimbursement by the Covered Person, Paramount may subrogate to the Covered Person's rights of recovery and remedies by joining in Covered Person's lawsuit, assigning its rights to Covered Person to pursue on Paramount's behalf, or bringing suit in Covered Person's name as subrogee. Paramount has reimbursement and subrogation rights equal to the value of medical benefits paid for Covered Services provided to the Covered Person. Paramount subrogation rights are a first party claim against any recovery and must be paid before any other claims, including claims by the Covered Person for damages. This means the Covered Person must reimburse Paramount in full, in an amount not to exceed the total recovery, even when the Covered Person's settlement or judgment is for less than the Covered Person's total damages and must be paid without any reductions in attorney's fees, costs or other expenses incurred by Covered Person.

2. **Workers' Compensation/Non-Duplication**. The benefits which You are entitled to receive under Paramount's insured plans do not duplicate any benefit to which You are entitled under Workers' Compensation laws or similar Employer liability laws. All sums paid for services provided to any Covered Person pursuant to Workers' Compensation are deemed to be assigned to Paramount.

3. **Cooperation by Covered Persons**. By executing an enrollment application, You and Your covered dependents agree to execute and deliver all assignments or other documents as may be required and do whatever is necessary to effectuate and protect fully the rights of Paramount or its nominee under this Section. You may not do anything which might limit, waive or release Paramount's reimbursement or subrogation rights.

4. **Cooperation by Employer**. By executing the Group Policy, the Employer agrees to assist Paramount in obtaining the necessary information from covered employees as may be required and to do whatever is necessary to effectuate and protect fully the rights of Paramount or its nominee under this Section.

SECTION TEN:
MISCELLANEOUS PROVISIONS

1. **No Assignment**. You may not assign any benefits or monies under this Plan to any Person, corporation, organization, or other entity. Any such assignment will be void and have no effect. Assignment means the transfer to another Person, corporation, organization, or other entity of a right to the benefits provided under this Plan. The Plan will not prevent a Provider from receiving payment for eligible charges for Covered Services rendered under a valid assignment. Paramount will determine whether an assignment of benefits to a Provider is a valid assignment.

2. **Notice**. Any notice which the Employer or Paramount gives to You will be in writing and mailed to You at the address as it appears on the records. If You have to give the Employer or Paramount any notice, it should be in writing and mailed to the address set forth in the Introduction section of this Certificate of Coverage.

3. **Medical Records**. Paramount is a covered entity under HIPAA and is permitted to use, obtain and Disclose Protected Health Information to perform Paramount operations in accordance with Paramount's Notice of Privacy Practices. Paramount may obtain Your medical records and information relating to Your care from Physicians, Hospitals, Skilled Nursing Facilities, pharmacies, or other treating Providers in order to pay claims or carry out other health care operations as explained in Paramount's Notice of Privacy Practices. Paramount will not use or Disclose Your Protected Health Information other than for the purposes allowed by HIPAA without Your authorization.

4. **Genetic Testing**. Paramount will not seek or use genetic screening or test results for the purpose of determining group health care plan rates or eligibility for enrollment.

5. **Recovery of Overpayments**. On occasion, a payment may be made to or for You when You are not covered, for a service which is not covered, or which is more than is appropriate for that service. When this happens, Paramount will explain the problem, and You must return to Paramount within 60 calendar days the amount of the mistaken payment, or provide Paramount with written notice stating the reasons why You may be entitled to such payment. In accordance with and to the extent permitted by applicable law, Paramount may reduce future payments to You in order to recover any mistaken payment. Overpayments and mistaken payments made to Providers will be recovered directly from them.

6. **Confidentiality**. Medical records, which Paramount receives from Providers, are confidential. Paramount will use Your individually identifiable personal health information only in performance of treatment, payment or health care operations in accordance with Paramount's Notice of Privacy Practices. See Paramount's Notice of Privacy Practices for further details.

7. **Right To Develop Guidelines**. Paramount reserves the right to develop or adopt criteria which set forth in more detail the instances and procedures when Paramount will make payments of benefits under the Plan. Examples of the use of the criteria are: to determine whether care was Medically Necessary, whether Emergency Services in the Outpatient department of a Hospital

were Medically Necessary, or whether certain services are skilled care. These criteria will be interpretive and illustrative only and will not be contrary to any term or provision of the Plan. If You have a question about the criteria which applies to a particular benefit, You may contact Paramount for further information.

8. **Review**. If a claim for benefits is denied, a review of the denial may be obtained through the appeal procedure described in Section Eight, Questions, Problems or Grievances.

9. **Limitation on Benefits of This Plan**. No Person or entity other than the Employer, Paramount, and Covered Persons hereunder is or shall be entitled to bring any action to enforce any provision of the Plan against the Employer, Paramount, or Covered Persons hereunder, and the covenants, undertakings and agreements set forth in the Employer's Contract with Paramount and this Certificate of Coverage shall be solely for the benefit of, and shall be enforceable only by the Employer, Paramount, and the Covered Persons covered under this Plan.

10. **Action at Law**. No action at law or in equity may be brought to recover under this Plan prior to the expiration of 60 calendar days after a claim for benefits has been filed as required by this Certificate of Coverage. Also, no such action may be brought after 3 years from the expiration of the time within which a claim for benefits is required by this Certificate of Coverage.

11. **Certification**. Upon request, Paramount will issue certification of Creditable Coverage under this Plan to You. A Paramount Member Services Representative (419-887-2525 or toll-free 1-800-462-3589) can assist You if You need to obtain certification of Creditable Coverage under this Plan.

12. **Applicable Law**. The Plan, the rights and responsibilities of Paramount and Covered Persons under the Plan, and any claims or disputes relating thereto, shall be governed by and construed and administered in accordance with the laws of the State of Michigan and any applicable federal law.

13. **Qualified Medical Child Support Orders**. Paramount will comply with all valid medical child support orders (QMCSOs) that meet the requirements of the Employee Retirement Income Security Act of 1974, as amended.

14. **Facility of Payment:** If an Insured Person dies while benefits under the Group Plan remain unpaid, the Company may, at its option, make direct payment to the Provider on whose charges the claim is based; or to the surviving spouse of the Insured Person; or if none, to his or her surviving child or children (including legally adopted child or children) share and share alike; or if none, to the executors or administrators of the Insured Person's estate.

15. **Time Effective:** The effective time for any dates used is 12:01 A.M. at the address of the Insured Person.

16. **Incontestability:** In the absence of fraud, any statement made by the Insured Person in applying for insurance under the Group Plan will be considered a representation and not a warranty. Only statements that are in writing and signed by the Insured Person can be used in a contest.

17. **Misstatement of Age:** If the age of any Person insured under the Group Plan has been misstated: 1) premiums shall be adjusted to correspond to his or her true age; and 2) if benefits are affected by a change in age, benefits will be corrected accordingly (in which case the premium adjustment will take the correction into account).

18. **Fraud, Waste and Abuse:** Please notify Paramount if you suspect healthcare fraud, waste or abuse against the company by using the following resources:

    - Contact Paramount's Member Services Department for a confidential discussion at 734-529-7800 or toll free at 1-888-231-5604
    - TTY services for the hearing-impaired are available at 1-888-740-5670 or 419-887-2526
    - You can contact the Paramount's Compliance Hotline at 1-800-807-2693
    - Writing a letter to Paramount Mailing address:
      Attn: Paramount Compliance Fraud, Waste, and Abuse
      300 Madison Ave, Suite 270

Toledo, Ohio 43604
- Email Address: paramount.memberservices@medmutual.com
- Confidential fax number: (419) 887-2037

For more information, please visit Paramount's website at https://www.paramounthealthcare.com/fraud-waste-and-abuse/

TERMS AND DEFINITIONS

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

Adverse Determination - means a determination by a Health Carrier or its designee Utilization Review Organization that an admission, availability of care, continued stay, or other health care service that is a covered benefit has been reviewed and, based on the information provided, does not meet the Health Carrier's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, and the requested service or payment for the service is therefore denied, reduced, or terminated. Failure to respond in a timely manner to a request for a determination is an Adverse Determination.

Affiliation Period – means a period of time required by a small employer carrier that must expire before health coverage becomes effective.

Allowable Amount – The maximum amount that Paramount determines is reasonable for the Covered Services received.

Ambulatory Review - means Utilization Review of Health Care Services performed or provided in an Outpatient setting.

Authorized Representative - means any of the following:
(i) A Person to whom a Covered Person has given express written consent to represent the Covered Person in an external review.
(ii) A Person authorized by law to provide substituted consent for a Covered Person.
(iii) If the Covered Person is unable to provide consent, a family member of the Covered Person or the Covered Person's treating Health Care Professional.

Brand Name Drug - A Prescription Drug that is dispensed under a proprietary name and classified as a brand by a national drug-pricing source.

Case Management - means a coordinated set of activities conducted for individual patient management of serious, complicated, protracted, or other health conditions.

Certificate of Coverage - This document, which includes the Schedule of Benefits.

Certification - means a determination by a Health Carrier or its designee Utilization Review Organization that an admission, availability of care, continued stay, or other health care service has been reviewed and, based on the information provided, satisfies the Health Carrier's requirements for medical necessity, appropriateness, health care setting, level of care, and effectiveness.

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

Clinical Review - means the written screening procedures, decision abstracts, clinical protocols, and practice guidelines used by a Health Carrier to determine the necessity and appropriateness of Health Care Services.

Coinsurance – The fixed percentage of charges that You must pay toward the cost of certain Covered Services. See Your Schedule of Benefits to determine whether a service requires a Coinsurance payment and the amount for that service. Coinsurance on benefits received from In-Network Providers is

a percentage of the contract charge negotiated between the PPO Network and the Provider. This means that You receive the benefit of any discount. Coinsurance on benefits received from Out-of-Network Providers is a percentage of the NCA or UCR charge that Paramount will pay for the services rendered.

Concurrent Review - means Utilization Review conducted during a patient's Hospital stay or course of treatment.

Continuing Care Patient - An individual who, with respect to a provider or facility, is undergoing a course of treatment for a serious complex condition from the provider or facility; is undergoing a course of institutional or inpatient care from the provider or facility; is scheduled to undergo nonelective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery; is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or is or was determined to be terminally ill and is receiving treatment for such illness from such provider or facility.

Contract (Entire Contract) - The agreement between the Employer and Paramount consists of this policy, including the applicable riders and endorsements; the application for coverage; the identification card; and the attached papers, if any. No change in this policy is valid until approved by an executive officer of Paramount and unless the approval is endorsed on this policy or attached to this policy. An insurance producer does not have the authority to change this policy or to waive any of its provisions.

Copay/Copayment - The fixed dollar amount You must pay each time You receive certain Covered Services. See Your Schedule of Benefits for a list of those services that require Copayments. Copayments for specific dollar amounts are due and payable at the time services are provided.

Cost Sharing is any expenditure required by or on behalf of a Member with respect to Essential Health Benefits; the term includes Deductibles, Coinsurance, Copayments, or similar charges, but excludes premiums, balance billing amount for non-network Providers, spending for non-Covered Services and for cost-sharing for services obtained out-of-network.

Covered Benefits or Benefits - means those Health Care Services to which a Covered Person is entitled under the terms of a Health Benefit Plan.

Covered Person - means a policyholder, subscriber, member, enrollee, or other individual participating in a Health Benefit Plan.

Covered Services - The Health Care Services and items described in this Certificate of Coverage and updated in the Schedule of Benefits, for which Paramount provides benefits to You.

Creditable Coverage - Coverage under one or more of the following: an Employer or union sponsored Health Benefit Plan, a health insurer, a health maintenance organization, Medicare, Medicaid, a medical and dental plan for members (and certain former members) of the uniformed services, a medical program of the Indian Health Service or a tribal organization, a state health benefits risk pool, the Federal Employees Health Benefits Program, a public health plan, State Children's Health Insurance Programs, coverage provided by a foreign country or a health plan through the Peace Corps.

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

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

Department - means the department of insurance and financial services.

Director - means the director of the department.

Discharge Planning - means the formal process for determining, before discharge from a Facility, the coordination and management of the care that a patient receives following discharge from the Facility.

Disclose - means to release, transfer, or otherwise divulge Protected Health Information to any Person other than the individual who is the subject of the Protected Health Information.

Effective Date - The first day You are covered under the Plan or the first day after the last day of the Employer's Waiting Period.

Election Period - The annual period of time during which an eligible employee and/or his or her dependents may select or turn down coverage under an Employer-sponsored health care benefit plan. An eligible employee and/or his or her eligible dependents may also change from one Employer sponsored health care benefit plan to another at this time.

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

Elective Abortion – The intentional use of an instrument, drug, or other substance or device to terminate a woman's pregnancy for a purpose other than to increase the probability of a live birth, to preserve the life or health of the child after live birth, or to remove a fetus that has died as a result of natural causes, accidental trauma, or a criminal assault on the pregnant woman. Elective Abortion does not include any of the following: (i) Use or prescription of a drug or device intended as a contraceptive. (ii) The intentional use of an instrument, drug, or other substance or device by a Physician to terminate a woman's pregnancy if the woman's physical condition, in the Physician's reasonable medical judgment, necessitates the termination of the woman's pregnancy to avert her death. (iii) Treatment upon a pregnant woman who is experiencing a miscarriage or has been diagnosed with an ectopic pregnancy.

Eligible Cancer Clinical Trial means a cancer clinical trial that meets all of the following criteria:

(a) A purpose of the trial is to test whether the intervention potentially improves the trial participant's health outcomes.
(b) The treatment provided as part of the trial is given with the intention of improving the trial participant's health outcomes.
(c) The trial has a therapeutic intent and is not designed exclusively to test toxicity or disease pathophysiology.
(d) The trial does one of the following:
    (i) Tests how to administer a health care service, item, or drug for the treatment of cancer;
    (ii) Tests responses to a health care service, item, or drug for the treatment of cancer;
    (iii) Compares the effectiveness of a health care service, item, or drug for the treatment of cancer with that of other Health Care Services, items, or drugs for the treatment of cancer;
    (iv) Studies new uses of a health care service, item, or drug for the treatment of cancer.
(e) The trial is approved by one of the following entities:
    (i) The national institutes of health or one of its cooperative groups or centers under the United States department of health and human services;
    (ii) The United States food and drug administration;
    (iii) The United States department of defense;
    (iv) The United States department of veterans' affairs.

Eligible Employee – means an employee who works on a full-time basis with a normal workweek of 30 or more 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.

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

Emergency Services - A medical screening examination, as required by federal law, that is within the capability of the Emergency department of a Hospital, including ancillary services routinely available to the Emergency department, to evaluate an Emergency Medical Condition; such further medical examination and treatment that are required by federal law to stabilize an Emergency Medical Condition

and are within the capabilities of the staff and facilities available at the Hospital, including any trauma and burn center of the Hospital.

Employer - The Employer that elected to sponsor this Plan for its eligible employees/members and their eligible dependents.

Essential Health Benefits - is defined under federal law (PPACA) as including benefits in at least the following categories: ambulatory patient services; Emergency Services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and Habilitative Services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Evidence-Based Standard - means the conscientious, explicit, and judicious use of the current best evidence based on the overall systematic review of the research in making decisions about the care of individual patients.

Exigent Circumstances (Expedited Exception Request) exist when a member is suffering from a health condition that may seriously jeopardize the enrollee's life, health, or ability to regain maximum function or when a member is undergoing a current course of treatment using a non-formulary drug.

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

Expedited Internal Grievance - means an expedited grievance under section 2213(1)(l) of the insurance code of 1956, 1956 PA 218, MCL 500.2213, or section 404(4) of the nonprofit health care corporation reform act, 1980 PA 350, MCL 550.1404.

Facility or Health Facility - means:
(i) A Facility or agency or a part of a Facility or agency that is licensed or authorized under parts 201 to 217 of the public health code, 1978 PA 368, MCL 333.20101 to 333.21799e.
(ii) A psychiatric Hospital, psychiatric unit, partial hospitalization psychiatric program, or center for persons with disabilities operated by the department of health and human services or certified or licensed under the mental health code, 1974 PA 258, MCL 330.1001 to 330.2106.
(iii) A Facility providing Outpatient physical therapy services, including speech pathology services.
(iv) A kidney disease treatment center, including a freestanding hemodialysis unit.
(v) An ambulatory health care Facility.
(vi) A tertiary health care service Facility.
(vii) A substance use disorder services program licensed under part 62 of the public health code, 1978 PA 368, MCL 333.6230 to 333.6251.
(viii) An Outpatient psychiatric clinic.
(ix) A home health agency.

Federally Eligible Individual - Any individual:

(1) Who has at least 18 months of Creditable Coverage; however, if Your coverage otherwise eligible to be counted as Creditable Coverage was followed by a Significant Break in Coverage, such coverage will not be counted in determining Creditable Coverage. For the purposes of this definition only, a "Significant Break in Coverage" means a continuous period of 63 calendar days or more without Creditable Coverage;

(2) Whose most recent prior Creditable Coverage was under or in connection with a group health plan, governmental plan, or church plan;

(3) Who is not eligible for coverage under any other group Health Benefit Plan, Medicare, or Medicaid;

(4) Who does not have any other health insurance coverage;

(5) Whose most recent coverage was not terminated for nonpayment of premiums or fraud; and

(6) Who has elected and exhausted any applicable COBRA continuation coverage or continuation coverage under any similar state program.

Final Adverse Determination - means an Adverse Determination involving a covered benefit that has been upheld by a Health Carrier, or its designee Utilization Review Organization, at the completion of the Health Carrier's internal grievance process procedures as set forth in section 2213 of the insurance code of 1956, 1956 PA 218, MCL 500.2213, or sections 404 or 407 of the nonprofit health care corporation reform act, 1980 PA 350, MCL 550.1404 and MCL 550.1407.

Generic Drug - Any Prescription Drug that is dispensed under a non-proprietary name and classified as a generic by a national drug-pricing source.

Habilitative Services cover Health Care Services and devices that help a Person keep, learn, or improve skills and functioning for daily living.

Health Benefit Plan - means a policy, contract, certificate, or agreement offered or issued by a Health Carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of covered Health Care Services.

Health Care Professional - means an individual licensed, certified, registered, or otherwise authorized to engage in a health profession under parts 161 to 183 of the public health code, 1978 PA 368, MCL 333.16101 to 333.18315.

Health Care Provider or Provider - means a Health Care Professional or a Health Facility.

Health Care Services - means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

Health Carrier - means a Person that is subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the Director, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of Health Care Services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit health care corporation, a nonprofit dental care corporation operating under 1963 PA 125, MCL 550.351 to 550.373, or any other Person providing a plan of health insurance, health benefits, or health services. Health Carrier does not include a state department or agency administering a plan of medical assistance under the social welfare act, 1939 PA 280, MCL 400.1 to 400.119b.

Health Information - means information or data, whether oral or recorded in any form or medium, and personal facts or information about events or relationships that relates to 1 or more of the following:
(i) The past, present, or future physical, mental, or behavioral health or condition of an individual or a member of the individual's family.
(ii) The provision of Health Care Services to an individual.
(iii) Payment for the provision of Health Care Services to an individual.

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

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

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

Independent Review Organization - means a Person that conducts independent external reviews of Adverse Determinations.

In-Network - A group of Providers who participate in the Preferred Provider Organization (PPO) Network to provide Covered Services, as set forth in this Certificate of Coverage.

In-Network Physician/Provider - Any Physician, Hospital, or other health services Provider who has a contract with the PPO Network to provide Covered Services to Covered Persons.

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

Mail Order Pharmacy - A Mail Order Pharmacy that is contracted with Paramount or PBM to provide mail order Prescription Drug benefits for Covered Persons.

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

Medical or Scientific Evidence - means evidence found in any of the following sources:
(i) Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff.
(ii) Peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia, and other medical literature that meet the criteria of the National Institutes of Health's United States National Library of Medicine for indexing in the former Index Medicus or its current online version, MEDLINE, and Elsevier B. V. for indexing in EMBASE.
(iii) Medical journals recognized by the secretary of the United States Department of Health and Human Services under 42 USC 1395x(t)(2)(B)(ii)(I).
(iv) The following standard reference compendia:
(A) The American Hospital Formulary Service drug information.
(B) Drug facts and comparisons.
(C) The American Dental Association's accepted dental therapeutics.
(D) The United States Pharmacopoeia drug information.
(v) Findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including the following:
(A) The Agency for Healthcare Research and Quality.
(B) The National Institutes of Health.
(C) The National Cancer Institute.
(D) The National Academy of Sciences.
(E) The Centers for Medicare and Medicaid Services.
(F) The United States Food and Drug Administration.
(G) Any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of Health Care Services.
(vi) Any other Medical or Scientific Evidence that is comparable to the sources listed in subparagraphs (i) to (v).

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

(1) It is provided by a Physician, Hospital, or other Provider under the Plan and is consistent with the diagnosis or treatment of the patient's sickness or injury. Certain routine and preventive Health Care Services and supplies will be considered needed and appropriately provided for medical care only if they are included in the list of Covered Services and supplies;

(2) The prevailing opinion within the appropriate specialty of the United States medical profession is that it is safe and effective for its intended use, and that its omission would adversely affect the patient's medical condition;

(3) It is furnished by a Provider with appropriate training, experience, staff and facilities for the administering of the particular service or supply;

(4) It must be the appropriate supply or level of service which can be safely provided to the patient; and with regard to a Person who is an Inpatient, it must mean the patient's illness or injury requires that the service or supply cannot be safely provided to that Person on an Outpatient basis;

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

(6) It must not be scholastic, vocational training, educational or developmental in nature, or experimental or investigational; and

(7) It must not be provided primarily for the purpose of medical or other research.

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

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

The fact that a patient's Physician has ordered a particular treatment or supply does not make it Medically Necessary under terms of the Plan.

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

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

Network Pharmacy - A retail pharmacy that is contracted with Paramount or PBM to provide Prescription Drug benefits for Covered Persons.

Non-Contracting Amount (NCA) – The maximum amount determined as payable and allowed by Paramount for a Covered Service provided by an Out-of-Network Hospital Provider in Lucas County.

Non-Preferred Brand Drug – A Prescription Drug that is denoted as "Non-Preferred" by Paramount as determined by Paramount's P&T.

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

Out-of-Network Physician/Provider - Any Physician, Hospital or health services Provider who does not have a contract with the Preferred Provider Organization (PPO) Network to provide Covered Services to Covered Persons.

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

- Financial penalties imposed for failure to obtain required Prior Authorization;
- Non-Network charges in excess of NCA or UCR.

The single Out-of-Pocket Maximum is the amount each Covered Person must pay, but the family Out-of-Pocket Maximum is the total amount any two or more covered family members must pay.

The expenses incurred for Covered Services received from In-Network Providers apply toward satisfying the In-Network Out-of-Pocket Maximum. The expenses incurred for Covered Services received from Out-of-Network Providers apply only toward satisfying the Out-of-Network Out-of-Pocket Maximum.

Person - means an individual or a corporation, partnership, association, joint venture, joint stock company, trust, unincorporated organization, or similar entity, or any combination of these.

Pharmacy and Therapeutics Working Group (P & T) - A Paramount committee comprised of Physicians and pharmacists that reviews medications for safety, efficacy and value. This committee continually monitors and updates the Paramount Formulary and Maintenance List and makes periodic revisions to plan guidelines regarding coverage for specific drugs and/or therapeutic categories.

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

Plan - The Paramount plan of health benefits described in this Certificate of Coverage and the Schedule of Benefits.

Preferred Brand Drug - A Prescription Drug that is approved for coverage as a “Preferred Brand Drug” by Paramount as determined by Paramount’s P & T.

Prescription or Prescription Drug - A drug which has been approved by the U.S. Food and Drug Administration (FDA) and which may, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. For the purpose of coverage under this Rider, this definition shall include insulin.

Prescription Order or Refill - An authorization for a Prescription Drug issued by a Physician who is duly licensed to make such an authorization in the ordinary course of his or her professional practice.

Preventive Services – Means evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (Task Force); immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (Advisory Committee); with respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and with respect to women, evidence-informed preventive care and screening provided for in comprehensive guidelines supported by HRSA (not otherwise addressed by the recommendation of the Task Force). For a complete list of recommendations and guidelines visit https://www.healthcare.gov/coverage/preventive-care-benefits/.

Prospective Review - means Utilization Review conducted before an admission or a course of treatment.

Protected Health Information - means Health Information that identifies an individual who is the subject of the information or with respect to which there is a reasonable basis to believe that the information could be used to identify an individual.

Provider - A Person or organization responsible for furnishing Health Care Services, including a: Hospital, Skilled Nursing Facility, Physician, Doctor of Podiatry (D.P.M.), Licensed Psychologist, Certified Nurse Midwife acting within the scope of her or her license, under the direction and supervision of a licensed Physician; Licensed Physician Therapist (L.P.T.); Licensed Occupational Therapist (L.O.T.); Licensed Speech Therapist (L.S.T.); Licensed Optometrist; Certified Mechanotherapist acting within the scope of his or her license, and performing services ordered by a Physician; Professional Clinical Counselor; Professional Counselor; or Independent Social Worker.

Retrospective Review - means a review of medical necessity conducted after services have been provided to a patient, but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjudication for payment.

Schedule of Benefits – The insert included with this Certificate of Coverage that provides information on the limits and maximums of the Plan and Deductible, Copayment, and Coinsurance amounts that You must pay and explains the specific program the Employer has purchased.

Second Opinion - means an opportunity or requirement to obtain a clinical evaluation by a Provider other than the one originally making a recommendation for a proposed health service to assess the clinical necessity and appropriateness of the initial proposed health service.

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

Telemedicine Services - The use of an electronic media to link patients with health care professionals in different locations. To be considered telemedicine or telepsychiatry, the health care professional must be able to examine the patient via a real-time, interactive audio or video, or both, telecommunications system and the patient must be able to interact with the off-site health care professional at the time the services are provided.

Usual, Customary and Reasonable (UCR) Charges – Charges for Hospitals, except for those located in Lucas County, medical services and/or supplies that do not exceed the amount charged by most Providers of like and/or similar services and supplies in the locality where the services and/or supplies are received.

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

Utilization Review - means a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, Health Care Services, procedures, or settings. Techniques may include Ambulatory Review, Prospective Review, Second Opinion, Certification, Concurrent Review, Case Management, Discharge Planning, or Retrospective Review.

Utilization Review Organization - means a Person that conducts Utilization Review, other than a Health Carrier performing a review for its own health plans.

Waiting Period - A period of time that must pass before an employee or dependent's coverage is effective under the terms of an Employer or union sponsored Health Benefit Plan. If an employee or dependent enrolls under an enrollment period similar to one described in Section One, Paragraph 2.C., Marriage, Birth, Placement for Adoption, or Adoption or 2.D, Special Enrollment -Loss of Other Coverage, any period before such enrollment is not a Waiting Period.

Willful Criminal Activity – includes but is not limited to, (i) Operating a vehicle while intoxicated in violation of section 625 of the Michigan vehicle code, 1949 PA 300, MCL 257.625, or similar law in a jurisdiction outside of this state; (ii) Operating a methamphetamine laboratory. It does not include a civil infraction or other activity that does not rise to the level of a misdemeanor or felony.

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