PARAMOUNT CARE
of MICHIGAN, INC.

POINT OF SERVICE
SUBSCRIBER CERTIFICATE
AND
MEMBER HANDBOOK

IN-NETWORK PLAN
AND
OUT-OF-NETWORK PLAN

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.

Albanian: KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-800-462-3589 (TTY: 1-888-740-5670).

Arabic: ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-462-3589 (رقم هاتف الصم والبكم: 1-888-740-5670).

Bantu: ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona 1-800-462-3589 (TTY: 1-888-740-5670).

Bengali: লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১-800-462-3589 (TTY: 1-888-740-5670).

Chinese:注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-462-3589 (TTY：1-888-740-5670).

Cushite: XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-462-3589 (TTY: 1-888-740-5670).

Dutch: AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 1-800-462-3589 (TTY: 1-888-740-5670).

French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-462-3589 (ATS : 1-888-740-5670).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-462-3589 (TTY: 1-888-740-5670).

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-462-3589 (TTY: 1-888-740-5670).

Japanese:注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-462-3589 TTY:1-888-740-5670）まで、お電話にてご連絡ください。

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-462-3589 (TTY: 1-888-740-5670) 번으로 전화해 주십시오.

Nepali: ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-800-462-3589 (टिटिवाइ: 1-888-740-5670) ।

Wann du [**Deitsch (Pennsylvania German / Dutch**)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-462-3589 (TTY: 1-888-740-5670).

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-462-3589 (TTY: 1-888-740-5670).

Romanian: ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-462-3589 (TTY: 1-888-740-5670).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-462-3589 (телетайп: 1-888-740-5670).

Serbo-Croatian: OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-462-3589 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1-888-740-5670).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-462-3589 (TTY: 1-888-740-5670).

Syriac: ܙܘܗܪܐ: ܐܢ ܐܢܬ ܟܐ ܗܡܙܡܬ ܠܫܢܐ ܐܬܘܪܝܐ، ܟܐ ܡܨܝܬ ܕܦܠܚܬ ܚܠܡܬܐ ܕܗܝܪܬܐ ܒܠܫܢܐ ܡܓܢܢܐܝܬ. ܩܪܝ ܥܠ ܡܢܝܢܐ1-800-462-3589 (TTY: 1-888-740-5670)

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-462-3589 (TTY: 1-888-740-5670).

Ukrainian: УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-462-3589 (телетайп: 1-888-740-5670).

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-462-3589 (TTY: 1-888-740-5670)

Notice of Nondiscrimination and Accessibility: 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, age, disability, or sex. Paramount does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Paramount provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as:
  - ○ Qualified sign language interpreters
  - ○ Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as:
  - ○ Qualified interpreters
  - ○ Information written in other languages

If you need these services, contact Member Services at 1-800-462-3589, for TTY users, 1-888-740-5670, 8:00 a.m. to 5:00 p.m., Monday through Friday.

If you believe that Paramount has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance. You can file a grievance in person or by phone, mail, fax, or email.

Paramount Member Services
300 Madison Avenue, Suite 270
Toledo, OH 43604

Alternate in Person Delivery Address:
650 Beaver Creek, Suite 100
Maumee, OH 43537

Phone: 419-887-2525
Toll Free: 1-800-462-3589
TTY: 1-888-740-5670
Fax: 419-887-2047
Email: Paramount.MemberServices@ProMedica.org

If you need help filing a grievance, Member Services is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

In Case of Emergency

For Medical Emergency Conditions such as heart attack, stroke, poisoning, loss of consciousness, inability to breathe, uncontrolled bleeding, convulsions and other conditions in which minutes can save lives, call 911 or go directly to the nearest emergency facility.

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

List the names and numbers of the Paramount PCP for each family member.

Member Name _____
Primary Care Provider (Name) _____
(Number) _____

Member Name _____
Primary Care Provider (Name) _____
(Number) _____

Member Name _____
Primary Care Provider (Name) _____
(Number) _____

Member Name _____
Primary Care Provider (Name) _____
(Number) _____

Member Name _____
Primary Care Provider (Name) _____
(Number) _____

Police	**Fire**
Rescue	**Ambulance**
Hospital	**Poison Control**

EACH SUBSCRIBER WILL AUTOMATICALLY RECEIVE THE INFORMATION BELOW AFTER THEIR ENROLLMENT HAS BEEN PROCESSED.

- **Subscriber Certificate and Member Handbook with Summary of Benefits. These documents describe benefits, Copayment/Coinsurance, Prior Authorization procedures, limitations and exclusions**

- **Participating Physicians and Facilities Directory (available at www.paramountcareofmichigan.com)**
-

THE INFORMATION LISTED BELOW WILL BE SENT TO YOU AT YOUR REQUEST. PLEASE CALL MEMBER SERVICES AT (734) 529-7800, (TOLL FREE 1-888-241-5604, TTY 1-888-740-5670).

- **The Professional Credentials of Participating Providers**

- **The Licensing Verification Telephone Number for the Michigan Department of Consumer and Industry Services Concerning Any Complaints Filed Against a Participating Provider Within the Last Three (3) Years**

    - **Explanation of Financial Relationship Between Paramount Care of Michigan, Inc. and Participating Providers**

Or, send your request in writing to:

PARAMOUNT CARE OF MICHIGAN, INC.
214 E. ELM AVENUE, SUITE 107
MONROE, MI 48162-2678

Dear Member:

Welcome to Paramount Point of Service Plan.

This Paramount Point of Service Plan Subscriber Certificate and Member Handbook will help you understand and use your Point of Service Plan.

Under the Point of Service Plan, you must select a Paramount Care of Michigan Primary Care Provider (PCP). The Paramount PCP will help you when you need medical care.

This Point of Service Plan Subscriber Certificate and Member Handbook also explains who is covered under your plan and how the plan works. Please take a few minutes to read it.

If you have any questions or need help understanding your benefits, please ***call Member Services at (734) 529-7800, or outside the area 1-888-241-5604, Monday through Friday,*** *8:00 a.m. to 5:00 p.m.*

We look forward to serving you.

The Member Service Department

Table of Contents

THE BASICS

The Paramount Point of Service Plan

The Paramount Point of Service Plan is a plan that offers you a broad selection of Paramount providers through Paramount's Health Maintenance Organization (HMO) under In-Network Coverage. It also offers the flexibility to choose to receive Covered Services from Out-of-Network Providers. Paramount's HMO is one of the largest in this area. It provides quality managed health care coverage to thousands of members through a wide network of Paramount physicians and hospitals. Paramount providers include more than 800 physicians and the finest hospitals. These providers make up the Paramount network.

Under Paramount Point of Service Plan, you must select a Paramount Primary Care Provider (PCP) to coordinate your medical care. If you use Paramount physicians and hospitals, you will receive In-Network Coverage. You will have lower Deductibles and Copayment/Coinsurance and you will not have to file claim forms. Prior Authorization is required for certain procedures of services. It is the responsibility of the Participating Provider to obtain Prior Authorization from Paramount in advance of these procedures or services. See your Summary of Benefits for information.

This Point of Service Plan allows you to receive certain services from Out-of-Network providers. The Out-of-Network coverage has the highest Deductibles, Copayment/Coinsurance and requires the Member to call for Prior Authorization. Payments for covered services are based on Usual, Customary and Reasonable (UCR) amount determined by Paramount. You will be responsible for charges in excess of the Out-of-Network UCR. See your Summary of Benefits for Deductible and Copayment/Coinsurance information.

You will receive IN-NETWORK COVERAGE	You will receive OUT-OF-NETWORK COVERAGE
If You: • Receive care from your Paramount PCP and use Paramount Providers.	**If You:** • Use Out-of-Network Providers and/or Hospitals for Out-of-Network Covered Services.
You are responsible for: • Small Deductibles and Copayment/Coinsurance • No claim forms • No Prior Authorization	**You are responsible for:** • Calling for Prior Authorization • Paying the highest Deductibles and Copayment/Coinsurance • Paying billed charges in excess of UCR

Your Identification Card

Every Paramount Member receives a Paramount identification card with his or her name. The name of that person's Paramount Primary Care Provider (PCP) is on the card.

If your card is lost or stolen or any information is incorrect, call Member Services at (734) 529-7800 or 1-888-241-5604.

Is There a Pre-existing Condition Restriction?

Paramount does not have any restrictions on pre-existing conditions. In other words, if you were being treated for a condition before you became a Member, Paramount will provide benefits for Covered Services related to that condition on or after your effective date with Paramount as long as you follow the procedures described in the section ***How the In-Network Plan Works.***

Who to Call for Information

The Paramount Member Service Department is here to help you.

Call (734) 529-7800 or 1-888-241-5604, if you:

- Have any questions about your coverage
- Need help understanding how to use your benefits
- Need to change your Primary Care Provider
- Are changing addresses, or need to add a new family member to your plan
- Lose your Paramount identification card
- Or have any other health care coverage concerns

Members' Rights

As a Member of Paramount, you are entitled to receive certain rights from Paramount and Paramount providers. You have the right to:

- Receive information about Paramount, its services, providers and your rights and responsibilities.
- Participate with your physicians in decision making regarding your health care.
- Have a candid discussion with your physician of appropriate or Medically Necessary treatment options for your conditions regardless of cost or benefit coverage.
- Voice complaints or appeals about the health plan or care provided.
- Be treated with respect, recognition of your dignity and the need for privacy.
- Make recommendations regarding Paramount's member rights & responsibilities policies.

Members' Responsibilities

As a Member of Paramount, you have certain responsibilities that Paramount and Paramount providers can expect from you. You have the responsibility to:

- Provide, to the extent possible, information that Paramount and its participating providers need to care for you. Help your Primary Care Provider fill out current medical records by providing current prescriptions and your previous medical records.
- Engage in a healthy lifestyle, become involved in your health care and follow the plans and instructions for the care that you have agreed on with your PCP or specialists.
- Understand your health problems and participate in developing mutually agreed-upon treatment and goals to the degree possible.
- 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 1-888-241-5604
    - TTY Services for the hearing-impaired are available at 1-888-740-5670
    - You can contact the ProMedica Health System Compliance Hotline at 1-800-807-2693
    - Writing a letter to Paramount mailing address:
      Paramount Health Care
      Attn: Paramount Compliance Fraud, Waste, and Abuse
      300 Madison Avenue, Suite 270
      Toledo, Ohio 43604
    - Email Address: paramount.memberservices@promedica.org
    - Confidential fax number: 419-887-2037

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

Patient Rights and Responsibilities

- A patient or resident is responsible for following the health facility rules and regulations affecting

patient or resident care and conduct.

- A patient or resident is responsible for providing a complete and accurate medical history.
- A patient or resident is responsible for making it known whether he or she clearly comprehends a contemplated course of action and the things he or she is expected to do.
- A patient or resident is responsible for following the recommendations and advice prescribed in a course of treatment by the physician.
- A patient or resident is responsible for providing information about unexpected complications that arise in an expected course of treatment.
- A patient or resident is responsible for being considerate of the rights of other patients or residents and health facility personnel and property.
- A patient or resident is responsible for providing the health facility with accurate and timely information concerning his or her sources of payment and ability to meet financial obligations.

Medical Records

Your personal medical records are maintained by the physicians, hospitals and other health care personnel involved in providing your care. Your medical records are not maintained by Paramount. Paramount maintains only administrative records related to your benefit coverage. You have the right to review and receive a copy of your personal medical records. To do so, please contact your physician or other provider directly to make arrangements to review your records.

You may request free of charge from Paramount reasonable access to and copies of administrative records related to your benefit coverage.

HOW THE IN-NETWORK PLAN WORKS

Your Primary Care Provider is your first contact when you need medical care.

Start with Your Primary Care Provider

When you enroll with Paramount, you must select a Primary Care Provider (PCP) for yourself and each member of your family. Each family member can have a different PCP; for children you may designate a pediatrician as the PCP. If you need assistance in selecting a PCP you may contact Paramount at www.paramountcareofMichigan.com or Member Services at (734) 529-7800.

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

For doctor appointments, call your Primary Care Provider's office.

Paramount maintains specific access standards to make sure you get the care you need on a timely basis. Access refers to both telephone access and the ability to schedule appointments. If you are having difficulty scheduling an appointment or reaching a provider's office, please contact the Member Service Department. They will assist you.

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

MEDICAL/SURGICAL	PCP STANDARD	NON-PCP STANDARD
Routine Assessments, Physicals or New Visits	30 days	60 days

Routine Follow-up Visits Recurring problems related to chronic conditions such as hypertension, asthma, and diabetes.	14 days	45 days
Symptomatic Non-urgent Visits Examples include cold, sore throat, rash, muscle pain, and headache.	2-4 days	30 days
Urgent Medical Problems Unexpected illnesses or injuries requiring medical attention soon after they appear.	1-2 days	1-2 days
Serious Emergencies Life-threatening illness or injury, such as heart attack, stroke, poisoning, loss of consciousness, inability to breathe, uncontrolled bleeding or convulsions.	Immediate Care	Immediate Care
BEHAVIORAL HEALTH	**STANDARD**	
Routine Assessments or Care for New Problems Non-urgent, non-emergent conditions, initial post-hospitalization visit, new behavioral or mental health problems.	14 days	
Routine Follow-up Visits Continued or recurring problems when member, Primary Care Physician Provider and behavioral health care provider agree with or prefer the scheduled time.	30 days	
Urgent Care Unexpected illnesses or behaviors requiring attention soon after they appear.	1-2 days	
Immediate Care for Non-Life Threatening Emergency Severely limited ability to function; behavioral health care provider may either provide immediate care, or direct the patient to call 911 or be taken to nearest emergency room.	Immediate Care to 6 hours	
Life Threatening Emergency (Self or Others) The expectation is that the member will receive immediate care appropriate for the critical situation, e.g. calling 911).	Immediate Care	

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

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

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

When your doctor recommends a treatment or test, in most cases it will be covered. However, some treatments may not be covered or are covered only when authorized in advance by Paramount. Authorization is based on Medically Necessary guidelines.

Your doctor may be working with several Paramount plans; plans are often different from one company to the next. The service your doctor recommends for you may be covered under some similar plans, but not under your particular plan. If you are not sure, the best thing to do is ask Paramount Member Services. Don't be afraid to call.

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

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

If you need information about the qualifications of any participating physicians or specialists, you may call the Academy of Medicine. You also can call any of the physician's referral services listed in the Participating Physicians and Facilities directory.

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

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

What to Consider When Selecting a Physician or Hospital

If you need information about the qualifications of any participating physicians or specialists, you may call the Academy of Medicine, the Member Services Department or you may use the on-line Provider Directory available through our website at www.paramountcareofmichigan.com.

The following qualifications are important to consider in selecting a Primary Care Provider or specialist:

- Professional education – medical school/residency training,
- Current Board Certification status,
- Number of years in practice, and
- Language spoken

The following qualifications are important when selecting a hospital:

- Accreditation status with The Commission (Paramount participating hospitals are required to have The Commission accreditation),
- Hospital experience/volume in performing certain procedures, and
- Consumer satisfaction and comparable measures of quality on hospitals and outpatient surgical facilities

If you need a current directory, you may request one by calling the Member Services Department or you may use the on-line Provider Directory available through our website at www.paramountcareofmichigan.com.

When You Need Routine OB/GYN Care

You do not need Prior Authorization from Paramount or from any other person (including your PCP) in order to obtain access to obstetrical or gynecological care from a Health Care Professional in the Paramount network who specializes in obstetrics or gynecology. The Health Care Professional, however, may be required to comply with certain procedures, including obtaining Prior Authorization for certain services or following a pre-approved treatment plan. For a list of participating Health Care Professionals who specialize in obstetrics or gynecology, contact Paramount Member Services at (734) 529-7800 or toll-free 1-888-241-5604. A directory of Participating Providers is also available at: www.paramountcareofmichigan.com.

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

When You Are Referred to a Paramount Specialist

Most of your health care needs can and should be handled by your Paramount PCP. But when you need a specialist - a cardiologist, orthopedist or others - your Primary Care Provider will recommend a Participating Paramount Specialist. Or you may choose the Participating Specialist you wish to see from those listed in the *Participating Physicians and Facilities* directory (also available on the website) and make an appointment.

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

Prior Authorizations

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

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

Utilization Management

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

Utilization management decisions are not subject to incentives to restrict or deny care and services. In fact, Paramount monitors under-utilization of important preventive services, health screening services (immunizations, pap tests, etc.), medications and other services to care for chronic conditions such as asthma and diabetes. Paramount will send reminder cards to the Member and physician if a claims review suggests that important services were missed.

If you need to discuss the status of a referral, you should contact your Paramount PCP. You may also call the Member Service Department at (734) 529-7800 or toll-free 1-888-241-5604.

Initial Determinations

When prior authorization is required, Paramount will make a decision (whether adverse or not) within eleven (11) working days from obtaining all the necessary information about the admission, referral or procedure that requires approval. Paramount will advise the provider of the decision by telephone and send written confirmation to the provider and Member within three (3) working days after making the decision.

Concurrent Reviews

For concurrent reviews, which are requests to extend coverage that was previously approved for a specified length of time, Paramount will make a decision (whether adverse or not) within twenty-four (24) hours after obtaining all the necessary information. Paramount will advise the provider by telephone and send written confirmation to the provider and Member within twenty-four (24) hours of receipt of the request. The written notification will include the number of extended days or next review date, the new total number of days approved and the date services were begun.

The Member's coverage will be continued, subject to applicable copayments, until the Member has been notified of the decision.

Expedited Reviews

If the seriousness of the Member's medical condition requires an expedited review, Paramount will make the decision (whether adverse or not) as expeditiously as the medical condition requires but no later than twenty-four (24) hours after the request has been made. Paramount will notify the provider of the decision by telephone immediately. A written confirmation will be sent to the provider and the Member at the same time decision is made.

Adverse Determinations or Denials

Paramount's written notification of Adverse Determinations will include the principal reason(s) for the decision, the clinical rational or standard used to make the decision and a description of available internal appeals and/or external review processes, including information regarding how to initiate an appeal.

Obtaining Necessary Information

If a provider or Member will not release the necessary information needed to make a decision, Paramount may deny coverage.

Entering the Hospital

Your Paramount PCP or Participating Paramount Specialist will make the arrangements when you need hospital care. Paramount Participating Hospitals are listed in your *Participating Physicians and Facilities* directory or the Paramount website at www.paramountcareofmichigan.com. Show your Paramount card when you are admitted.

It is the Member's responsibility to ensure Prior Authorization is obtained through Paramount for services, except Emergency Medical Services, at nonparticipating hospitals.

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

An emergency admission to a nonparticipating hospital should be called in to Paramount within 24 hours (or as soon as reasonably possible). If and when your medical condition allows, your Paramount PCP and Paramount may arrange for you to be transferred to a Participating Hospital.

Change in Benefits

Paramount will notify you in writing if any benefits described in the Member Certificate and Handbook and Summary of Benefits change.

If a Paramount Provider Leaves the Plan

Paramount will notify affected enrollees of the termination of a contract for the provision of health care services between Paramount and a provider or facility by mail within 15 days of Paramount receiving notification of the termination. Notice will be given to members who have received health care services within the previous twelve months from the provider or if the member has selected the primary care physician within the previous twelve months. Additionally, Paramount will pay, in accordance with this handbook, all covered health care services rendered to a member between the date of the termination of the contract and five days after the notification of the termination is mailed to member's last known address.

If a Paramount Specialist Leaves the Plan

If you are being seen regularly by a Participating Paramount Specialist or a specialty group whose agreement with Paramount ends, you and your Paramount PCP will be notified by mail within 15 days of Paramount receiving notification of the termination. You may then contact a new Participating Paramount Specialist for an appointment.

Continuity of Treatment

If you are in a course of treatment when your Provider's Paramount agreement terminates, Paramount will continue to pay for Covered Services rendered by that provider until the course of treatment is completed or until Paramount arranges for the reasonable and medically appropriate transfer of the treatment to another participating provider. In most cases, coverage will be authorized for no more than 90 days. If this situation occurs, you should contact the Member Services Department.

Provider Reimbursement/Filing a Claim

You should always show your Paramount ID card to all providers. You are responsible for paying any office

visit Copayments at the time you receive services. Participating Providers must notify Paramount of the services they have rendered within 90 days from the date of service.

If you have received services from a non-participating provider and want to submit a claim for consideration, you must obtain a standard (HCFA or UB) claim form from the provider. This claim must be sent to Paramount at the address below within ***120 days from the date of service***. Be sure to include your Paramount ID number and a brief explanation of the circumstances related to the service.

Paramount Care of Michigan, Inc.
214 E. Elm Avenue, Suite 107
Monroe, Michigan 48162-2678

Paramount will send reimbursement directly to Participating Providers for Covered Services. In most cases, reimbursement for Covered Services will be sent directly to a non-participating provider, but in some individual cases (i.e., for emergency services) may be paid directly to you instead. If any claim is denied, Paramount will send you an "Explanation of Benefits" with the reason(s) for denial. If you receive a denial on a claim and need further explanation or wish to appeal the denial, you may call the Member Services Department for assistance.

Non-Covered Services

If you receive care for non-Covered Services, you are responsible for full payment to the provider of those services.

If You Receive a Bill

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

New Technology Assessment

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

Ownership and Physician Compensation

Paramount is a wholly owned subsidiary of the ProMedica Health System – one of the largest integrated delivery systems in the country. The ProMedica Health System operates acute care hospitals, ancillary facilities and primary care and specialist physician practices in northwest Ohio and southeast Michigan. ProMedica facilities and providers are participating in the Paramount network.

Paramount contracts with Participating Providers for Health Care Services on an economically competitive basis, while taking steps to ensure that Paramount Members receive quality health care. Paramount reimburses Participating Providers through "capitation" or "fee-for-service". Capitation is a fixed amount paid each month, mostly to Primary Care Providers (PCPs), to treat those Members that have selected that PCP. Fee-for-service is the payment of a specific amount for each specific service provided by the physician. The amount is determined by Paramount, based on the procedure performed, and the Paramount allowed amount for that procedure. Participating Providers agree to accept the Paramount allowed amount (from a contractual fee schedule) as payment in full. Participating Primary Care Providers

are not subject to any risk or financial incentives for hospitalization or referring their patients for specialized services.

Through the Paramount fee schedule, Paramount obtains discounts. When Copayments are charged as a percentage of eligible expenses, the amount a Member pays is determined as a percentage of the allowed amount (fee schedule) between Paramount and the Participating Provider, rather than a percentage of the provider's billed charge. Paramount's allowed amount is ordinarily lower than the Participating Provider's billed charge. Therefore, the benefit of the discount is passed on to you.

Patient Safety

Paramount is working with other hospitals, physicians and health plans to educate our Members about patient safety. Here is what **you** can do to improve the safety of your medical care:

- ► Provide your doctors with a complete health history.
- ► Be an **active member** of your health care team. Take part in every decision about your health care. Speak up – ask questions.
- ► Make sure that all of your doctors know about everything that you are taking, including over the counter medications and herbal/dietary supplements.
- ► Make sure that your doctors know about any allergies and reactions to medications that you have had.
- ► Ask for test results. Don't assume that no news is good news.
- ► Advise your doctor of any changes in your health.
- ► Follow your doctor's advice and the instructions for care that you and your doctor have agreed on.
- ► Make sure that you can read the prescriptions you get from your doctor.
- ► Ask your doctor and pharmacist questions about your medications.
  - ➢ What is the medication for?
  - ➢ What are the brand and generic names of the medication?
  - ➢ What does the medication look like?
  - ➢ How should it be taken and for how long?
  - ➢ What should you do if you miss a dose?
  - ➢ How should you store the medication?
  - ➢ Does the medication have side effects? What are they? What should you do if they occur?
- ► When you pick up the medication, ask the pharmacist if this is the medication that was prescribed.
  - ➢ Make sure that you understand the instructions on the label.
  - ➢ Ask the pharmacist about the best device to measure liquid medications.
  - ➢ Read the information that is provided by the pharmacy.

It is always important that you play an active role in decisions about your health and your health care. Take responsibility – **you can make a difference!**

If you ever find yourself in the hospital, you'll likely have many health care workers taking care of you. While they make every effort to provide appropriate care, sometimes errors can happen. By taking an active role in your care and asking questions, you can help make sure the care you receive is right for you.

Should you find yourself needing hospital care, be sure to:

- ► **Do your homework.** Make sure that the hospital you're being treated in has experience in treating your condition. If you need help getting this information, ask your doctor or call Paramount Member Services Department.
- ► **See that health care workers wash their hands before caring for you.** This is one way to prevent the spread of germs at home and infections in a hospital. Studies have shown that when patients checked whether health care staff had washed their hands, the workers washed their hands more often and used more soap.
- ► **Ask about services or tests.** Make sure to ask what test or x-ray is being done to make sure you are

getting the right test. In the example of a knee surgery, be sure that the correct knee is prepped for surgery. A tip from the American Academy of Orthopedic Surgeons urges their physicians to sign their initials on the site to be operated on before surgery.

- ► **Ask about what to do when you get home.** Before leaving the hospital, be sure the doctor talks to you about any medicines you need to take. Make sure you know how often, what dose to take, and any side effects to expect from the medicine. Also ask when you can return to your regular activities. See if the doctor has advice on things you can do to help your recovery.

If you have any questions or if things just don't seem right after you come home, be sure to call your doctor right away.

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 <u>never</u> 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.

<u>When balance billing isn't allowed, you also have the following protections:</u>

- 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.g	833-ASK-DIFS (833-275-	https://www.michigan.gov/d

	ov/difs/0,526 9,7-303--560598-- ,00.html	3437)	ocuments/ag/Consumer_Co mplaint_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.

HOW THE OUT-OF-NETWORK PLAN WORKS

The Out-of-Network Plan provides benefits for certain Out-of-Network Covered Services when performed and billed by an Out-of-Network physician, provider, hospital or facility.

Out-of-Network Prior Authorization Requirements

(Prior Authorization will not result in payment of benefits that would not otherwise be payable.)

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 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.

Certain services received by a covered Member under the plan require the Member, or the attending Physician, to notify Paramount prior to receiving the service. 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.paramountinsurancecompany.com.

If you obtain Prior Authorization, these services will be covered at the appropriate benefit level indicated in your Summary of Benefits if it is Medically Necessary and/or a Covered Service.

When you are using your Paramount PCP and Paramount Providers for Covered Services, the Paramount Providers are responsible for handling any necessary Prior Authorizations from Paramount. When you use Out-of-Network providers for Out-of-Network Coverage, **you are responsible for calling Paramount prior to receiving the services below:**

A. Services requiring Prior Authorization not an all-inclusive listing, refer to www.paramounthealthcare.com/priorauth:
    a. Inpatient admission to a Hospital, Intensive Outpatient Programs (IOP), partial hospitalizations (PHP), and Inpatient admissions at rehabilitation/residential facilities;
    b. Inpatient admission to a Skilled Nursing Facility;
    c. Home Health services.

B. Procedures requiring Prior Authorization not an all-inclusive listing, refer to www.paramounthealthcare.com/priorauth:
    a. Enhanced External Counterpulsation (EECP);
    b. Prophylactic Mastectomy;
    c. Genetic, molecular diagnostic, and drug testing as identified in the above referenced list;
    d. Orthognathic and maxillofacial surgery;

e. All potentially cosmetic procedures including but not limited to eyelid surgery/lifts (blepharoplasty);
f. Cochlear implants;
g. MRI and CT Imaging;
h. New Technology (Medical & Behavioral Health Procedures, Diagnostics, Durable Medical Equipment).

C. Equipment requiring Prior Authorization not an all-inclusive listing, refer to www.paramounthealthcare.com/priorauth:
   a. Air fluidized beds;
   b. Bone stimulators and supplies;
   c. Power operated vehicles, power wheelchairs and power wheelchair accessories;
   d. Chest wall oscillation vest (ThAIRapy Vest System);
   e. Enteral nutrition;
   f. Speech generating devices;
   g. Continuous Blood Glucose Monitoring services – Long Term
   h. Cranial orthotic remolding device.

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

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 eleven (11) business calendar days of receiving all necessary 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 734-529-7800 or toll-free 1-800-241-5604.

If you disagree with Paramount's determinations, you may appeal Paramount's decision by following the grievance procedure set forth in the section titled WHAT TO DO WHEN YOU HAVE QUESTIONS, PROBLEMS OR GRIEVANCES.

IF YOU DO NOT CALL PARAMOUNT WHEN REQUIRED, PAYMENT FOR OUT-OF-NETWORK COVERED SERVICES WILL BE DENIED.

In-Network Coverage Available with Prior Authorization

In some cases, your Paramount PCP may request In-Network Coverage for services from an Out-of-Network Provider (See Prior Authorizations in the Subscriber Certificate and Member Handbook). Services from Out-of-Network Providers may be covered under In-Network Coverage only with prior written approval from Paramount's Utilization Management Department. Both the Paramount PCP's request and Paramount's response must be made prior to the services being provided. In-Network Coverage will be applicable to Out-of-Network Providers for Emergency Medical Conditions and when Paramount has prior

approved. If the requested services are available from Paramount Providers, the request for In-Network Coverage will be denied.

Balance Billing

Out-of-Network providers will bill you for Deductibles and/or Copayment/Coinsurance and the difference between the billed amount and the Usual, Customary and Reasonable (UCR) amount determined by Paramount.

OUT-OF-NETWORK COVERAGE

Payments for Out-of-Network Covered Services are based on the Usual, Customary and Reasonable (UCR) schedule determined by Paramount and updated periodically. You will be responsible for charges in excess of UCR. See Summary of Benefits for Copayment/Coinsurance and limits.

Out-of-Network Covered Services are payable provided:

a) The service is incurred while eligible for this benefit;
b) The service is included in the list of Covered Services; and
c) The service is not paid or payable under In-Network Coverage.
    1. The payment will not exceed applicable maximums shown in the Summary of Benefits.
    2. In most cases reimbursement for Covered Services will be sent directly to an Out-of-Network Provider, but in some individual cases (i.e., for emergency services) may be paid directly to you instead.

WHAT TO DO FOR URGENT CARE OR EMERGENCY MEDICAL CONDITIONS

Urgent Care Services

Urgent Care Services means covered services provided for an Urgent Medical Condition. An Urgent Medical Condition is an unforeseen condition of a kind that usually requires medical attention without delay but that does not pose a threat to the life, limb or permanent health of the injured or ill person. Urgent Medical Conditions include but are not limit to:

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

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

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

After office hours: Call the telephone number of your PCP and ask the answering service to have your doctor call you back. When the doctor or a nurse calls back, explain your condition, and the doctor or nurse will give you instructions. If you can't call your PCP, go to the nearest participating urgent care facility. Your Copayment/Coinsurance may be found in your Summary of Benefits. Paramount providers are listed in your Directory of Paramount Physicians and Facilities and at www.paramountcareofmichigan.com.

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

Follow-up care outside the Provider Service Area: In most cases only the first urgent care treatment will be covered. Follow-up services outside the Paramount Service Area will not be covered unless authorized by your Paramount PCP and Paramount in advance.

ANY TIME AN URGENT CARE PHYSICIAN RECOMMENDS ADDITIONAL CARE, such as a return visit, seeing a specialist, additional testing or X-rays, etc., call Member Services (1-888-241-5604) BEFORE you get the services. Member Services can tell you if the service will be covered, or if you need to contact your Paramount PCP.

Emergency Services

Your Plan covers Emergency Medical Conditions treated in any hospital emergency department.

Emergency Services are those services which are required as the result of an **Emergency Medical Condition**. **Emergency Medical Condition** means a medical condition that manifests itself by such acute symptoms of 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:

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

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

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

Inside the Paramount Provider Service Area: In the event of an **Emergency Medical Condition**, call 911 or go directly to the nearest medical facility. In the event you are unsure about whether a condition is an **Emergency Medical Condition**, you may contact your Paramount PCP for instructions. Medical care is available through Paramount Physicians seven (7) days a week, 24 hours a day. Appropriate Copayments/Coinsurance will apply.

You should contact your Paramount PCP or Paramount within 24 hours after the emergency has occurred (or as soon after as possible) so that follow-up care can be coordinated.

Outside the Paramount Provider Service Area: Go to the nearest emergency facility for treatment.

Show your Paramount ID card. In some cases, you may be required to make payment and seek reimbursement from Paramount. Paramount will cover hospital, physician and ambulance charges from non-participating providers related to Emergency Medical Conditions based on the greater of the median In-Network coverage rate, the Usual, Customary Rate, and the Medicare rate for those Covered Services. Appropriate Copayments/Coinsurance will be applicable.

Follow-up care within the Paramount Provider Service Area: Follow-up medical care must be arranged by your Paramount PCP.

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

If you are admitted to a hospital outside the Paramount Provider Service Area, you should call Paramount (1-888-241-5604) within 24 hours or as soon as reasonably possible. Follow-up care must be coordinated through your Paramount PCP.

The Paramount Provider Service Area

The Paramount Provider Service Area includes Monroe, Lenawee, Hillsdale, and Branch counties in Michigan.

SUBSCRIBER CERTIFICATE

YOUR IN-NETWORK PLAN

Members may receive services from In-Network Providers described in this Subscriber Certificate, subject to all the terms and provisions in this section and subject to the Deductibles, Copayments/Coinsurance and limits described in the Summary of Benefits.

In-Network Plan General Limitations

- To be covered by the Paramount In-Network Plan, the health services you receive must be from Paramount Participating Providers, except for Emergency Medical Conditions or with written Prior Authorization from Paramount.

In-Network Deductible

A Deductible is the amount you must pay for Covered Services within each Contract Year before benefits will be paid by Paramount. The single Deductible is the amount each Member must pay, and 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. The expenses incurred for Covered Services received from In-Network providers apply toward satisfying the In-Network Deductible.

In-Network Copayment/Coinsurance

A Copayment/Coinsurance may be a fixed dollar amount or a percentage of the Paramount In-Network allowed amount that the Member is responsible for paying to the provider for Covered Services. The Copayment/Coinsurance for any particular In-Network Covered Service, **will not exceed 50 % of the reasonable charge for that service.** See the Summary of Benefits for specific Copayment/Coinsurance amounts. Specific fixed-dollar Copayments are due at the time a Member receives services. If a

Coinsurance percentage is applicable, the provider will bill the Member once the claim has been processed.

In-Network Copayment/Coinsurance Limit

An Out-of-Pocket Copayment/Coinsurance Limit is the maximum amount of Copayments/Coinsurance you pay every Contract Year. The single Out-of-Pocket Copayment/Coinsurance Limit is the amount each Member must pay, and the family Out-of-Pocket Copayment/Coinsurance Limit is the amount two or more family members must pay. Once the Out-of-Pocket Copayment/Coinsurance Limit is met, there will be no additional Copayments/Coinsurance on Essential Health Benefits during the remainder of the Contract Year. The Out-of-Pocket Copayment/Coinsurance Limit is stated in your Summary of Benefits.

The expenses incurred for Covered Services received from In-Network providers apply toward satisfying the In-Network Out-of-Pocket Limits. After a Member has met the Out-of-Pocket Limit in a Calendar Year, Covered Services are payable in full for the remainder of the calendar year.

IN-NETWORK COVERED SERVICES

A Copayment/Coinsurance may be required for Covered Services when this notation (C/L) appears. The notation (C/L) also indicates that there may be additional limits to these services according to your employer's benefits. Benefit limits may be day or visit limits each Contract Year. At the start of a new Contract Year, benefits with limitations will renew. See your Summary of Benefits for your Copayment/Coinsurance requirements and specific limitations on services.

The following Covered Services are listed alphabetically:

Acute Care at Home (C/L)
Acute Care at Home provides Members with specific qualifying conditions the option to receive certain Medically Necessary Covered Services and to recuperate in the Member’s residence. For the approved duration of the Acute Care at Home benefit (the “episode”), the Member’s care is overseen by a provider and is managed by one collaborative care team utilizing both in-person, at-home clinical encounters, and telemonitoring and remote biometric monitoring technology. Physician referral and Prior Authorization are required.

This benefit will be available for Members with one or more of the following qualifying conditions: pneumonia, chronic obstructive pulmonary disease exacerbation, congestive heart failure exacerbation, urinary tract infection, and cellulitis. The Member must meet medical criteria, including cognitive function criteria, as well as social screening criteria, to be cared for safely in the home environment.

For the following services, if delivered by and billed under the Acute Care at Home benefit, Members will be responsible only for the Inpatient Services Copays, Coinsurance, and/or Deductible listed on their Schedule of Benefits. Unless otherwise noted below, any limitations or exclusions to Covered Services as described in this Certificate apply to those Covered Services when delivered by the Acute Care at Home benefit.

- Professional services from a provider as per the Inpatient Services benefit, including both visits performed in-person and via telemedicine; excluding surgery, the administration of general anesthesia, and newborn exams.
- Ancillary services as per the Inpatient Services benefit, including prescribed medical drugs and pharmacy services, medical and surgical dressings and supplies, diagnostic services, and therapy services; excluding operating rooms and equipment and anesthesia, and therapy services and diagnostic services not Medically Necessary for management of the qualifying condition.
- General nursing services per the Inpatient Services benefits, including encounters performed in-person and via telemedicine.

- Meals, as would ordinarily be provided under the Inpatient Services benefit.
- Home health aide services as per the Home Care Services benefit.
- For the duration of the episode, rental of durable medical equipment (as defined in this Certificate), including oxygen therapy, that is Medically Necessary to treat the Member's condition in the home environment. Includes items used by individuals but which are reusable and expected to be available, such as ice bags, bedrails, canes, crutches, walkers, wheelchairs, and traction equipment; excludes any durable medical equipment unrelated to or not Medically Necessary for the delivery of services under the Acute Care at Home benefit.
- Home infusion therapy, including related nursing services, infusion durable medical equipment, and pharmaceutical services which are delivered and administered intravenously in the Member's residence during the episode. Includes but is not limited to: injections (intra-muscular, subcutaneous, continuous subcutaneous), total parenteral nutrition, enteral nutrition therapy, antibiotic therapy, pain management and chemotherapy. Excludes home infusion therapy not related to or Medically Necessary for management of the qualifying condition.
- Ambulance Services, as Medically Necessary, immediately before, during, and/or immediately after the episode.

The following services are also available under the Acute Care at Home benefit:

- Real-time patient monitoring and alerts.
- Translation and interpreter services.
- Use of a personal emergency response system (PERS), also known as a medical emergency response system.

For any Covered Service not listed above that is rendered during the episode, and for any Covered Service not delivered by and billed under the Acute Care at Home benefit, the Member will be responsible for applicable Copays, Coinsurance, and/or Deductible as listed for that Covered Service on the Schedule of Benefits.

Exclusions:

- Services provided by registered nurses and other health workers who are not acting as employees of, or under approved arrangements with, the contracted Acute Care at Home provider.
- Prescription Drug Benefits except those delivered by and billed under the Acute Care at Home benefit.
- Any services rendered prior to, or after the conclusion of, the approved duration of the episode.

Alcohol abuse and drug addiction treatment (C/L) (See Behavioral Health Services)

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

Ambulance when Medically Necessary and to the nearest medically appropriate facility. (C/L)

Autism Spectrum Disorders Treatment (C/L)
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 (Mental Illness/Substance Abuse)
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.
- 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.
- 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 Trial (C/L) 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.

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.

Chiropractic Services (C/L) chiropractic services are subject to the limitations described in the Summary of Benefits

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

- First aid received within forty-eight (48) hours of an accidental injury to sound natural teeth, the jaw bones or surrounding tissues. This includes only extraction of teeth emergency treatment of teeth and repair of soft tissue.

- Medically Necessary orthognathic (jaw) surgery

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

- Medically Necessary oral surgery to repair fractures and dislocations of the upper and/or lower jawbone only

- Medical treatment for temporomandibular joint syndrome or dysfunction (TMJ)

Diabetic Counseling and Supplies (C/L) Covered from Paramount Participating Providers.

Diagnostic services by **a Participating Provider** (C/L) Covered Services include:

- X-rays

- Laboratory tests

- Organ scans

- EKGs, EEGs

- Hearing tests

- Pre-admissions tests

- Mammograms and pap smears. Screening mammograms and pap smears are covered when ordered by the PCP or Participating Specialist. Coverage for breast cancer screening mammography is in accordance with MCL Section 500.3406d

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

Drugs and other medicines (C/L) Covered when given during a hospital stay

Drug abuse/addiction treatment (C/L) (See Behavioral Health Services)

Emergency services (C/L) Covered for facility and physician services inside or outside the Service Area for **Emergency Medical Conditions** meeting the definition in this Certificate. The facility (hospital) charge will be subject to the appropriate Copayment/Coinsurance. The emergency room Copayment (specific fixed-dollar amount) will be waived if the Member is admitted as a hospital inpatient.

Foot Care (C/L) Service from a Participating Provider is covered, including nail trimming for Members with diabetes.

Habilitative Services (C/L) Covered to help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech therapy and other services for people with disabilities. The plan will cover 30 speech therapy visits, plus a combined 30 visits for physical and occupational therapies for habilitative services.

The Commissioner has determined that habilitative services encompasses many types of services, including but not limited to applied behavioral analysis (ABA) for the treatment of autism spectrum disorder. ABA is defined by Michigan law as "the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

Home health care (C/L) Services include:

- Physician services
- Intermittent skilled nursing care
- Physical, occupational and speech therapy
- Other Medically Necessary services

Hospice services for terminally ill patients.

Hospital and other facility services

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

Outpatient services: (C/L) Covered, including surgery, observation care, and diagnostic testing. Outpatient emergency room care is covered for Emergency Medical Conditions. (See Emergency Services and Urgent Care Services.)

Outpatient Surgery: (C/L) Certain benefit plans may have a Copayment/Coinsurance if an outpatient surgical facility or hospital surgical treatment room is used. Outpatient surgical facilities or hospital surgical treatment rooms are used for surgical procedures and other procedures including but not limited to endoscopic procedures such as colonoscopy, arthroscopy, laparoscopy and pain blocks (injections).

Professional services: (C/L) Covered when related to eligible inpatient and outpatient hospital services. Covered services include:

- Surgery
- Technical surgical assistance
- Medical Care
- Newborn Care
- Obstetrical Care
- Anesthesiology
- Radiology and pathology

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

Services and supplies: Covered when Medically Necessary if you are an inpatient or outpatient.

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

Kidney disease treatments (C/L) Covered for:

- Hemodialysis for renal disease

- Peritoneal dialysis

- Kidney transplant services (see Transplants)

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

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

- Prenatal and postnatal care (office visit fixed-dollar Copayment does not apply to prenatal and postnatal visits)

- Delivery, including complications of pregnancy, hospitalization and anesthesia.
  A minimum hospitalization of forty-eight (48) hours will be allowed for normal vaginal delivery and ninety-six (96) hours for cesarean delivery unless your physician determines otherwise. If you are discharged earlier, follow-up home health care by a participating provider will be covered for at least seventy-two (72) hours after discharge.

- Medically Necessary diagnosis and treatment of infertility.

Medical equipment (Durable Medical Equipment) (C/L)
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.

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.

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 Surgery (C/L)
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.

Office visits (C/L) Covered for:

- Your Primary Care Provider (PCP)
- Participating OB/GYNs and other Participating Specialists
- Eligible services provided during each visit, which may include:
    - Physical exams
    - Well-baby/child exams
    - Annual gynecological exams
    - Immunizations
    - Diagnostic procedures
    - Medical/surgical procedures

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

ProMedica OnDemand Visit: ProMedica OnDemand allows you and your Dependents to have a live video visit via webpage or mobile device with a board-certified Provider 24 hours a day, 7 days a week, and 365 days a year. This service is ideal for conditions such as allergies, cold and flu, pinkeye, and rash. Refer to your Summary of Benefits for an explanation of how this benefit is covered. To sign up or download the mobile, device application, please visit https://www.promedica.org/Pages/medical-services/ondemand/default.aspx.

Oral surgery (See Dental service and oral surgery.)

Plastic surgery (See Reconstructive surgery.)

Physical exams as considered Medically Necessary by the physician. (C/L)

Prescription Drug Benefits

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

Pharmacy and Therapeutics (P&T) Committee

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 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 can 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 Therapeutic Committee and will be based on FDA approved product dosing recommendations as well as clinical 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.
- Certain supplies and equipment obtained by Mail Service or from a Network Pharmacy (such as those for diabetes) are covered. Contact Paramount to determine approved covered supplies. If certain supplies, equipment or appliances are not obtained by Mail Service or from a Network Pharmacy then they may be covered as Medical Supplies, Equipment and Appliances instead of under Prescription Drug benefits.
- 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;
15. Prescription Drugs obtained from Non-Network Pharmacies.
16. 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.

CVS Mail Order Pharmacy – Refer to your Schedule 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.paramount insurancecompany.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 the lists on the internet at www.paramountinsurancecompany.com.

Days Supply

The number of days supply of a Drug which you receive can be limited based upon the type of pharmacy and network status. The days supply limit applicable to Prescription Drug coverage is shown in the Schedule 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 Schedule 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 Schedule 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.paramountinsurancecompany.com. 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 varies 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 Schedule 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 Schedule 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 request 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 Schedule Of Benefits for an explanation of how these drugs are covered.

Prior Authorization

Prior Authorization will be required for certain Prescription Drugs (or for the prescribed quantity of a particular Drug). Prior Authorization helps promote appropriate use of dangerous drugs 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 (P&T) 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. Refer to Prescription Drug Benefits in Section IV of the member handbook, for the Prior Authorization process. Prior Authorization is not required for coverage of an opioid analgesic prescribed for the treatment of 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 section titled WHAT TO DO WHEN YOU HAVE QUESTIONS, PROBLEMS OR GRIEVANCES.

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 sections 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.paramountinsurancecompany.com.

Oral Chemotherapy
This plan shall not provide coverage or impose cost sharing for a prescribed, orally administered cancer medication on a less favorable basis than the coverage it provides or cost sharing it imposes for intravenously administered or injected cancer medications.

Standard & Expedited Exceptions Process
A member or physician can request and gain access to clinically appropriate drugs, and Preventive Health Services items or services that are not otherwise covered by the Plan as described. However, 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 exception request can be submitted in non-exigent circumstances and receive a decision within 3 business days of a request. For expedited exception 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 and will be treated as an Essential Health Benefit with member's cost share applying to the Out-of-Pocket Maximum. If the request is denied, members may appeal to an accredited Independent Review Organization (IRO). The member and physician will be notified of the IRO's decision no later than 24 hours following receipt of request for expedited exception request and 3 business days following receipt of a standard request. For more information, or to request coverage of a non-formulary drug or appeal a denial, contact the Member Services Department.

Preventive Health Services Eligible services have been determined by recommendations and comprehensive guidelines of governmental scientific committees and organizations. With respect to women's health, additional preventive care and screenings supported by the Health Resources and Services Administration will be covered. You will be notified, at least sixty (60) days in advance, if any item or service is removed from the list of eligible services. Eligible services will be updated annually to include any new recommendations or guidelines.

Preventive services include, as an example, the following:

- Well-baby care from birth and newborn screenings.
- Periodic health evaluations, health screenings (obesity, type 2 diabetes, osteoporosis, gestational diabetes and HPV) and physical examinations for children and adults including well women visits
- Routine adult and pediatric immunizations,
- Breast and pelvic exams and Pap smears for women,
- Breast cancer screening (mammography)
- Routine eye examinations
- Routine hearing examinations
- Genetic risk assessment and BRCA mutation screening for breast and ovarian cancer susceptibility.
- Colorectal cancer screening (fecal occult blood testing, sigmoidoscopy, or colonoscopy).
- Abdominal aortic aneurysm (AAA) testing
- Aspirin therapy counseling for the prevention of cardiovascular disease.
- Blood pressure screening.
- Routine screenings during pregnancy (screening for asymptomatic bacteriuria, hepatitis B virus, PH(D) incompatibility.
- Screening and counseling for sexual transmitted infections (Chlamydia, gonorrhea, syphilis).
- Human immunodeficiency virus (HIV) screening and counseling
- Depression screening, substance abuse/chemical dependency screening.
- Nutritional counseling including diabetes self-management and diet behavioral counseling.
- Tobacco cessation counseling
- Contraceptive methods and counseling – injections, tablets under the skin, IUD
- Breast feeding support, supplies and counseling
- Screening and counseling for interpersonal and domestic violence
- Sterilization – tubal (preventive diagnosis)

Please contact us at www.parmountcareofMichigan.com or (734) 529-7800 if you have any questions or need to determine whether a service is eligible for coverage as a preventive service. For a comprehensive list of recommended preventive services please visit www.healthcare.gov/center/regulations/prevention.html.

Prosthetic devices/aids/support devices (C/L) A Prosthetic Device is an artificial substitute that

replaces all or part of a missing body part and its adjoining tissues. Paramount covers the purchase, fitting, adjustment, repair and replacement of prosthetic devices consistent with Medicare Part B guidelines.

Reconstructive surgery when required for: (C/L)

- Repair of anatomical impairment to improve or correct functional disability within 2 years of accident or injury or up to age 18 if a congenital anatomical functional impairment.
- Breast reconstruction following a covered mastectomy; surgery and reconstruction of the other breast to produce a symmetrical appearance; prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas. In accordance with the Women's Health and Cancer Rights Act of 1998, these benefits are subject to the same Copayment/Coinsurance requirements as other covered services.
- Plastic surgery following an accidental injury. That results in a significant defect or deformity within 2 years of the accident.
- A malignant or non-malignant neoplasm within 2 years following initial surgery for neoplasm.

Reconstructive surgery is performed on abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease. It is generally performed to improve function, but may also be done to approximate normal appearance.

Skilled nursing facility in lieu of acute inpatient hospitalization. (C/L)

Sleep Studies in American Sleep Disorder Association (ASDA) accredited plan facilities for certain clinical indications of obstructive sleep apnea, narcolepsy and seizure disorder when approved in advance by Paramount. (C/L)

Surgical Sterilization (C/L) Covered for male surgical sterilization procedures and related services received in a Physician's office or on an Outpatient basis at a Hospital or alternate facility.

Therapy services (C/L) Covered for:

- Radiotherapy, radiation therapy and chemotherapy is covered.
- A Food and Drug Administration (FDA) approved drug used in antineoplastic therapy and the cost of administration is covered. Coverage shall be 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 Food and Drug Administration if ***all*** the following conditions are met:
  - The drug is approved by the FDA for use in antineoplastic therapy;
  - The drug is ordered by a physician for the treatment of a neoplasm;
  - The drug is part of an antineoplastic drug regimen and current medical literature substantiates its efficacy and recognized oncology organizations generally accept the treatment.
  - The physician has obtained informed consent from the patient for the treatment regimen that includes FDA-approved drugs for off-label indications.

- Outpatient physical/occupational therapy. See Summary of Benefits for limitations.

- Outpatient speech therapy. See Summary of Benefits for limitations.

- Cardiac and pulmonary rehabilitation. See Summary of Benefits for limitations.

- Inpatient Rehabilitation

Tobacco Cessation Program (C/L) 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.

Transplants (C/L) Covered under the In-Network Plan 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. Antineoplastic drugs, in accordance with Michigan Compiled Laws (MCL) 500.3406 (e), are a covered benefit. 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 services (C/L) Covered ONLY for initial treatment of an urgent medical condition in an urgent care facility or physician office. Follow-up treatment in or outside the Paramount Service Area must be authorized in advance by the Primary Care Provider in order to be covered.

Vision care (C/L) Covered for treatment related to a medical condition of the eyes.

Pediatric Vision

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.

Vision Services for Members Age 19 and Over

Covered Services:

One routine vision exam every calendar year to monitor refractory disorders of the eyes is covered, unless a separate vision program is available.

Non-Covered Services

- Eyeglasses, eyeglass frames, all types of contact lenses or corrective lenses;
- Eye exercises, visual training, orthoptics, sensory integration therapy;
- Radial keratotomy, laser surgeries and other refractive keratoplasties;
- Refractions;
- All other vision care services unless the group has purchased an optional vision hardware rider.

IN-NETWORK EXCLUSIONS

These services and supplies are not covered:

1. Services by providers chosen only for convenience (for example, if your doctor suggests using nonparticipating X-ray or lab work providers because their offices are nearby).

2. Any service received from any other nonparticipating Paramount physician, hospital, person, institution or organization unless:

    a. Prior approval is made by Paramount ,or

    b. Such services are for Emergency Medical Conditions.

3. Services received before coverage began or after coverage ended. However, if coverage ends while the Member is a patient in a hospital for a service covered by Paramount, charges related to that hospital stay will be covered according to the plan until the Member is discharged if the Member has no other coverage. If the Member has new coverage, Paramount will cover up to midnight of the termination date.

4. Any court-ordered testing, treatment or hospitalization that is not otherwise a Covered Service.

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

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

7. Care provided to Members by relatives.

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

9. All charges for completion of reports, transfer of medical records, or missed appointments.

10. Assisted reproductive technology including, but not limited to artificial insemination, in vitro fertilization, embryo transplant services, GIFT, ZIFT, ovarian tissue transplant, infertility drugs, and reversal of voluntary sterilization. Surrogate and/or gestational parenting and pregnancy related services when the intended parents or another party have paid for the surrogate mother's medical expenses.

11. Abortion, unless medically necessary to save the life of the mother.

12. Transportation services in non-emergency medical situations and to hospitals beyond the nearest medically appropriate facility.

13. Cosmetic Surgery to reshape normal structures of the body in order to improve the patient's appearance and self-esteem. Cosmetic surgery includes, but is not limited to:

- Breast augmentation. Breast reduction, except when medically necessary
- Face lifts, tummy tucks, liposuction, panniculectomy, blepharoplasty (eyelid lift), unless medically necessary
- Skin tags, torn pierced ear lobes
- Sclerotherapy for spider angiomas for cosmetic purposes
- Laser treatment including candela, V-beam and photodynamic therapy for rosacea, port wine stains and other skin disorders
- Scar revision and correction
- Removal of pigmentation, tattoo removal
- Chemical face peels and dermabrasion
- Staged procedures and surgeries when performed in preparation of a non-covered reconstructive surgery

14. Custodial care, respite care, domicilliary care; personal comfort items such as television, telephone, private rooms (except as Medically Necessary) in a hospital or Skilled Nursing facility; care provided by family members; housekeeping services and meal services as a part of Home Health Care; private duty nursing (unless group has purchased an optional rider); bathing and grooming.

15. General dental care services including but not limited to: treatment on or to the teeth, bridges, crowns; extraction of teeth including wisdom teeth; treatment of granuloma; placement , restoration or re-placement of teeth or implants of the teeth and alveolar ridge including preparatory oral and maxillofacial surgery (bone grafts); treatment of periodontal disease and abscesses; root canals; treatment required for an injury as a result of chewing or biting; bite plates, retainers, snore guards, splints, orthodontic braces or any other device which is fitted to the mouth. Upper and lower jawbone surgery except as required for direct treatment of acute traumatic injury or cancer, or as necessary to safeguard a Member's health due to a non-dental physiological impairment.

16. Foot orthotics including shoe molds and inserts, trimming and/or scraping of calluses, corns and nails for all conditions including fungal conditions, unless the Member's condition meets Medicare Part B criteria. Extra Corporeal Shock Wave Therapy (ESWT)

17. Non-surgical weight loss programs and dietary supplements for the treatment of weight loss.

18. Growth hormones and steroids except when medically necessary for growth and development.

19. Experimental medical, surgical or other health procedures including experimental drugs as determined by Paramount. Paramount will make this determination based on the recommendation of the Medical Advisory Committee and the most recent HAYES Medical Technology Directory. Pharmaceuticals and devices which have not received FDA approval are considered experimental. Experimental organ transplants.

20. Prescription drugs, except those provided on an inpatient basis, and prescriptions for FDA approved contraceptive methods. See Preventive Health Services.

21. Medical equipment and supplies that do not meet Medicare guidelines, disposable medical supplies (except for diabetic and ostomy supplies), exercise equipment, air conditioners, test kits (except for diabetic supplies), penile implants and erectile devices (unless the group has purchased an optional rider), and hearing aids (unless the group has purchased an optional rider).

22. Prosthetic Devices that do not meet Medicare guidelines, replacement of Prosthetic Devices due to misuse.

23. Testing and treatment for learning disabilities and mental retardation, behavioral modification and other training programs including but not limited to Applied Behavioral Analysis (ABA) programs, unless the Member's condition meets criteria for diagnosis and treatment of an autism spectrum disorder. Summary of Benefits. Employment counseling, counseling for marital or relationship conflicts. Equestrian therapy.

24. Examinations, reports and immunizations for the purpose of obtaining or maintaining employment, insurance, governmental licensure, employer requested annual physical exams or for pre-marital purposes.

25. Contact and corrective lenses and eyeglasses for Members age 19 and over, unless the Group has purchased an optional vision hardware rider. Orthoptic training and radial keratotomy refractive surgery (e.g., LASIK).

26. Physical, occupational and speech therapy, beyond limits described in the Summary of Benefits; non-medical services such as vocational rehabilitation, employment counseling and psychological counseling, training and educational therapy for learning disabilities.

    All services related to organ donations from a living donor who is not a Paramount Member unless no other coverage exists.

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

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

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

30. Surgery for the treatment of morbid obesity that does not meet the criteria in Paramount's Morbid Obesity Surgery medical policy and/or was not prior authorized by Paramount. Morbid Obesity Surgery, and related services, that are not performed by Participating Providers authorized by Paramount to perform Morbid Obesity Surgery.

31. Sleep studies for sexual dysfunction.

YOUR OUT-OF-NETWORK PLAN

Members may receive services from Out-of-Network Providers described in this Subscriber Certificate, subject to all the terms and provisions in this section and subject to the Deductibles, Copayments/Coinsurance and limits described in the Summary of Benefits.

OUT-OF-NETWORK GENERAL LIMITATIONS

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

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

Out-of-Network Deductible: The Out-of-Network Deductible is the amount the Member must satisfy each calendar year before receiving benefits for Covered Services. The Out-of-Network Deductible applies to all Out-of-Network Covered Services with the exception of Covered Services requiring a specific fixed-dollar Copayment. Costs incurred in paying for Covered Services during the calendar year from Out-of-Network providers count toward satisfying the Out-of-Network Deductible. Any amount by which an Out-of-Network provider's billed charges exceeds the Usual, Customary and Reasonable (UCR) amount will ***not*** be counted toward satisfying the Out-of-Network Deductible.

Out-of-Network Copayment/Coinsurance: An Out-of-Network Copayment/Coinsurance may be a fixed dollar amount or a percentage of the UCR amount that the Member is responsible for paying to the Out-of-Network Provider for Covered Services. See the Summary of Benefits for specific Copayment/Coinsurance amounts.

Out-of-Network Copayment/Coinsurance Limits: There is an out-of-pocket limit for Copayment/Coinsurance every calendar year. The Out-of-Pocket Limit can be found in the Summary of Benefits. All Out-of-Network Covered Services apply to the Out-of-Network Copayment/Coinsurance Limit. After a Member has met the Out-of-Pocket Limit in a calendar year, Covered Services are payable in full for the remainder of the calendar year.

Benefit Limits: Benefit Limits will be a combined limit for Covered Services rendered by In-Network and Out-of-Network providers in a calendar year. See the Summary of Benefits for limits.

OUT-OF-NETWORK COVERED SERVICES:

See the Out-of-Network Summary of Benefits for Deductible/Copayments/Coinsurance and limits.

1. Inpatient hospital care including intensive care, nursing care and necessary services and supplies in non-private rooms.
2. Inpatient care in an Extended Care or Skilled Nursing Facility.
3. Inpatient and outpatient Out-of-Network Specialist Physicians' services including office visits, hospital consultations, surgery, delivery and anesthesia.
4. Radiation treatment and chemotherapy.
5. Diagnostic procedures including x-rays, laboratory exams, CT scans and Magnetic Resonance Imaging (MRI).
6. Hospice care for the terminally ill.
7. Outpatient surgery in a hospital or outpatient surgical facility.
8. Skilled home health care, except:
    a) treatment of mental illness and drug- or alcohol-related disorders;
    b) meals (other than special meals provided through dietary counseling);

c) personal comfort items; or
d) housekeeping services.

Skilled home health care services are limited to 4 hours of treatment within any 24-hour period. They must be provided in place of inpatient hospital service and according to a prescribed treatment plan.

10. Preadmission testing prior to a scheduled inpatient hospital admission.
11. Treatment, services or supplies in connection with childbirth for:
    a) Forty-eight (48) hours of inpatient hospital service following an uncomplicated vaginal delivery; and
    b) Ninety-six (96) hours of inpatient hospital service following an uncomplicated cesarean section.

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

    Physician ordered post-delivery care for a mother and newborn child who received forth-eight (48) hours of inpatient hospital service following an uncomplicated vaginal delivery, or ninety-six (96) hours of Inpatient hospital service following an uncomplicated cesarean section, will be provided only upon recommendation by the Physician responsible for discharging such mother or newborn child.
13. Routine hospital nursery care and Physician charges for a newborn while the mother is an inpatient. These charges will be considered separate from the mother's. They will be subject to the Copayment/Coinsurance shown in the Out-of-Network Summary of Benefits.
14. Service from Out-of-Network Primary Care Provider.
15. Durable Medical Equipment

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

1. Charges paid or payable under In-Network Coverage.
2. Unnecessary early hospital admissions prior to the date of elective surgery/services. Weekend inpatient admissions for elective services.
3. Treatment, services or supplies not Medically Necessary. This does not apply to other health care services specifically covered under the Out-of-Network Coverage.
4. The purchase, fitting, adjustment, repair and replacement of Prosthetic Devices. (Coverage is available under In-Network Coverage.)
5. Dental work, treatment or x-ray including but not limited to: a) treatment on or to the teeth; b) extraction of teeth, including bony impacted wisdom teeth; c) replacement or restoration of the teeth; d) treatment of granuloma; e) treatment including splints, physical therapy, or surgery for temporomandibular joint syndrome or dysfunction; f) placement, removal or replacement of implants or the teeth or alveolar ridge; g) treatment of periodontal disease or abscess; h) root canal; i) treatment required for or as a result of, biting or chewing; or j) braces, retainers and bite

plates.

6. Cosmetic or plastic surgery except: a) repair of anatomical impairment to improve or correct functional disability; b) breast reconstruction following a covered mastectomy; or c) plastic surgery after an accidental injury.
7. Routine foot care such as trimming of corns and calluses; treatment of flat feet or partial dislocations in the feet. Shoes, shoe molds and shoe inserts.
8. Prescription drugs and medicines, unless as an inpatient. Over-the-counter drugs or medicines; vitamins, nutrients and food supplements even if prescribed or administered by a Physician.
9. Testing and treatment for learning disabilities and mental retardation, employment counseling, vocational rehabilitation, counseling for marital or relationship conflicts, social skills classes, behavioral modification and other training programs including but not limited to Applied Behavioral Analysis (ABA) programs, unless the Member's condition meets criteria for diagnosis and treatment of an autism spectrum disorder. Equestrian therapy.
10. Non-surgical weight loss programs and dietary supplements for the treatment of weight loss.
11. Surgery, services or supplies rendered for treatment of obesity or for weight reduction. This includes any surgical procedures or reversal. (Coverage is available under In-Network Coverage.)
12. Treatment of craniomandibular and temporomandibular joint disorders by use of orthodontic appliances and treatment; crowns; bridges; or dentures. This does not apply to the extent the disorder is trauma related.
13. Treatment, services or supplies that are required only for insurance, travel, employment, school, camp, or similar purposes.
14. Convenience or personal comfort items such as telephone, radio, television, or barber services.
15. Care which Paramount determines is custodial. Custodial care is care: a) which is furnished mainly to assist a person in the activities of daily living; and b) for which professional skills or training is not required. Such care includes--among other things--help in eating; getting out of bed; bathing; dressing; toileting; and supervision in taking medications.
16. Eye exams for the correction of vision; the providing or fitting of eye glasses, contact lenses, or hearing aids; audiology (hearing) exams or refractive surgery (radial keratotomy).
17. Organ transplant services. (Organ transplant services at Paramount approved centers with Paramount authorization are covered under In-Network Coverage.)
18. Alternative Medicine/Therapy including but not limited to: non-prescription drugs or medicines, vitamins, nutrients, food supplements, biofeedback training, neurofeedback training, hypnosis, acupuncture, acupressure, massage therapy, aromatherapy, chelation therapy, rolfing and related diagnostic tests.
19. Non-Emergency transportation services
20. Penile implants, erectile devices.
21. Cardiac Rehabilitation, Phase III.
22. Manual manipulation of the spine.
23. Growth hormones or steroids. (Coverage is available under In-Network Coverage.)
24. Emergency services including transportation to a Hospital by a professional licensed ambulance service and care rendered at an Urgent Care Facility. (These services are payable under In-Network Coverage.)
25. Sterilization reversals; or surgery or treatment related to sexual dysfunction. Infertility treatment by artificial means for the purpose of causing a pregnancy, such as drugs; medicines; artificial insemination; in vitro fertilization; embryo transplants, surrogate and/or gestational parenting and pregnancy related services when the intended parents or another party have paid for the surrogate mother's medical expenses and elective abortions.
26. Dietician counseling services.
27. Male sterilization (vasectomies).
28. Private duty nursing.
29. Outpatient physical, occupational, speech therapies. (Coverage is available under In-Network Coverage.)
30. Breast reduction surgery. (Coverage is available under In-Network Coverage.)
31. Services for which Prior Authorization is required but was not obtained by the Member.

32. Respiratory therapy rendered by a certified respiratory therapist.
33. Cytologic screening for the presence of cervical cancer, including Pap smears.
34. Mammography screening and exam for females at the following intervals: one mammogram from ages 35 through 39; one mammogram every 2 calendar years (or one every calendar year, if high risk factors to breast cancer are determined by a Physician) from ages 40 through 49; one mammogram every calendar year from ages 50 through 64.
35. Autism Spectrum Disorders. Diagnosis and evidence-based treatment including Behavioral Health Treatment; Pharmacy Care (if your employer has elected to offer prescription drug coverage); Psychiatric Care; Psychological Care; and Therapeutic Care is covered with written Prior Authorization from Paramount. Care must be prescribed or ordered for an individual diagnosed with one of the autism spectrum disorders by a licensed physician or a licensed psychologist who determines the care to be medically necessary.

Filing Claims for Out-of-Network Coverage

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

WHO IS ELIGIBLE?

The following persons are eligible for coverage. The Subscriber (employee) must reside in the Paramount Michigan Service Area and the Subscriber (employee) must list them on the enrollment application.

Subscriber The employee who meets eligibility requirements established by the Group and in accordance with the Group Medical and Hospital Service Agreement.

Spouse The legal spouse of the Subscriber.

Dependent children This Plan will cover your married or unmarried child as defined in the “Who is Eligible?” section of this Plan through the end of the month in which your child turns age 26.

If a Subscriber or Subscriber’s spouse has been court-ordered to maintain health care coverage on their dependent Child, the Child shall be eligible to enroll in this plan. Coverage for service rendered outside the Service Area by non-participating providers will be limited to Emergency Medical Conditions unless Prior Authorized by Paramount.

Dependents with disabilities If covered children ages twenty-six (26) or older meet the requirements of Dependents with disabilities because of physical handicap or mental retardation (they are unable to earn their own living and rely primarily on the subscriber for support), coverage may continue past age twenty-six (26). Proof of disability must be provided to Paramount within thirty-one (31) days of the Dependent's twenty-sixth birthday or within thirty-one (31) days of new Paramount eligibility and may be requested annually.

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

Not eligible: Grandchildren and parents.

Paramount, through its **Dependent Child Coverage Program**, provides coverage for emergency, urgent and follow-up care as well as care provided by student health centers while your Dependent student is away at school outside of the Paramount Service Area. If your Dependent student needs medical care away from home that is not available from the student health center and it is not an emergency or urgent condition, before seeking services you or your Dependent student should contact our Utilization Management Department to obtain Prior Authorization. In the event of an Emergency Medical Condition, call 911, an ambulance or rescue squad or go directly to the nearest medical facility.

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

Newborn children A newborn child of a Subscriber (or the Subscriber's spouse) who has a family contract (same rate for three or more family members) will be covered for the first thirty-one (31) days following birth. To be covered beyond the 31-day period, a completed enrollment application must be received within the first thirty-one (31) days. This provision does not apply if the Subscriber has a single contract, two-party contract or a contract in which the rate is based on the number of covered Members. In that situation, a completed enrollment application and required prepayment must be received within the first thirty-one (31) days. If the application is not received, the newborn child will not be eligible for any benefits.

The only other time you may enroll a child is during the Group's open enrollment period, or a special enrollment period.

Adopted children
Coverage for newly adopted children will be effective from the date of adoptive placement. Adoptive placement means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of the adoption of the child. The child's placement with a person terminates upon termination of the legal obligation. The adopted child must be enrolled within thirty-one (31) days from the event.

The only other time you may enroll adopted children or stepchildren is during the Group's open enrollment period, or a special enrollment period.

Marriage
When a completed enrollment application or change form is received by Paramount within thirty-one (31) days from the date of marriage, coverage of new spouses becomes effective on the date of marriage.

The only other time you may enroll your spouse is during The Group's open enrollment period, or a special enrollment period.

Divorce
You must notify Paramount that you are removing your ex-spouse and any other ineligible Dependents from the plan at the time the annulment, dissolution or divorce decree is final. Coverage will end at the end of the month in which the decree is final.

Any ineligible Dependents may be eligible for continuation coverage under the Group's health benefits plan or individual conversion coverage. See your benefits officer for details.

Death of a Subscriber
Dependents of a deceased Subscriber may be eligible for continuation coverage under the employer group's health benefits plan or individual conversion coverage. See your benefits officer for details.

Adding and Removing Members
When you need to change the number of Members covered under your plan, it is your responsibility to notify your employer and Paramount within thirty-one (31) days of the event. For example, new marriage, new birth, divorce or death. YOU MUST COMPLETE AN ENROLLMENT APPLICATION OR CHANGE FORM WHEN YOU NEED TO ADD A MEMBER TO OR REMOVE A MEMBER FROM YOUR PLAN. Contact your benefits office.

Choosing a Primary Care Provider When you enroll in Paramount, you select a Primary Care Provider (PCP) for yourself and each member of your family from the list of plan Primary Care Providers. You may choose or change your PCP based on availability of the physician. To change your PCP, you must call the Member Service Department.

Effective Date of Coverage Eligible Members will be covered under this Certificate on the Effective Date of coverage agreed upon between the Group and Paramount after all the requirements below have been met:

1. The names of the Subscriber and all eligible Dependents have been received in writing by Paramount, and
2. The required prepayment has been received by Paramount for all listed Subscribers and Dependents.

Group Probationary or Waiting Period
New employees and late enrollees will have coverage effective after the Probationary or Waiting Period established by the employer. The Probationary or Waiting Period will not be more than ninety (90) days. See your benefits officer for details.

Group Annual Open Enrollment Period
If you do not enroll eligible Dependents for coverage during the first Group enrollment period or within thirty-one (31) days of eligibility, you must wait until the Group's next annual open enrollment period to add them. See your benefits office for your group’s open enrollment period.

Enrollment
Enrollment is accomplished by submitting a completed enrollment application to the Group, receipt of the application by Paramount and appropriate monthly payment and reporting by the Group to Paramount.

Member Identification Cards
Each enrolled Member will receive a Member Identification Card. Member Identification Cards are the sole property of Paramount. They may not be used after termination of coverage. Loss or theft of a Member Identification Card must be reported to Paramount’s Member Service Department immediately.

Special Enrollment Period
If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request 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 you 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 you or your dependent's Medicaid or CHIP coverage ends.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Coverage under the special enrollment period will be effective on the day following the date other coverage ends or the date of the event. See your benefits office for details.

Payment for Coverage
Unless otherwise provided in the Group Medical and Hospital Service Agreement, the Group, or the Subscriber, will pay the amount specified in the Group Service Agreement to Paramount on behalf of each Subscriber and his or her eligible Dependents on or before the first day of the month of coverage. If payment is not made within a grace period of 30 days from the due date, Paramount will terminate coverage as of the due date.

Change of Address
The Subscriber must notify Paramount's Member Service Department of any change of address for himself or any eligible Dependent. A change of address outside the Paramount Michigan Service Area (except for court-ordered dependent children) will result in automatic termination of this coverage.

Transfer of Benefits
This Subscriber Certificate is not transferable, and no person other than a Member is entitled to services described here. If any Member aids, attempts to aid, or permits any person to obtain services described here, Paramount may, in addition to exercising any of its rights under the law, cancel this Certificate.

Nondiscrimination
No one who is eligible to enroll as a Subscriber, Dependent or Dependent with Disabilities will be refused enrollment by Paramount based on health status, health care needs or age. 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 procedures. However, Paramount will not re-enroll anyone terminated for any of the reasons listed in the Termination of Coverage section.

Renewal of Coverage
If all the conditions of eligibility are met, the coverage will be renewed at the end of the term specified in the Group Medical and Hospital Service Agreement. Renewal of coverage is not based on any Member's health condition. Paramount will not limit coverage or adjust premiums based on genetic information, will not request or require genetic testing, and will not use any collected or acquired genetic information from an individual for underwriting purposes.

Termination and Non-renewal of Member Coverage
Paramount will renew coverage at the option of the Group. Paramount will not renew Group coverage only under the following conditions;

- Non-payment of premiums
- Fraud

A Member's coverage under Paramount may end, or Paramount may decline to renew a Member's coverage, for any of the following reasons:

- You fail to pay, or have paid for you, the required prepayments.
- Paramount exits the market.
- You no longer meet the eligibility requirements.

- You no longer reside in the Michigan Service Area (except for court-ordered dependents).
- You have performed an act or practice that constitutes fraud or material misrepresentation of material fact under the terms of the coverage.

The termination or non-renewal of coverage may not be based, either directly or indirectly, on any health status-related factor concerning the Member. Paramount will provide written notice thirty (30) days in advance of termination and the notice will include the reason for termination.

Rescission of Coverage
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.

Benefits After Cancellation of Coverage
If a Member is an Inpatient on the date coverage ends, the benefits of this coverage will continue for only that Member until the earliest of:

- The effective date of any new coverage.
- The date of discharge.
- The attending physician certifies that inpatient care is no longer medically indicated.
- The maximum in benefits have been reached.
- The effective date of any other coverage.

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

Privacy and Confidentiality
Paramount takes the security of your information very seriously and has established safeguards and procedures to prevent unauthorized access to and use and disclosure of Member information. Paramount reserves the right to share your information as allowed by law. Federal law permits Paramount to use and disclose Protected Health Information for treatment, payment and health care operations activities. Paramount will not use or disclose Protected Health Information for any other purpose without your written authorization. See Paramount's Notice of Privacy Practices for more information.

Insurance Fraud
Insurance fraud significantly increases the cost of health care. Paramount encourages you to let us know if you have any questions or concerns about Paramount providers and/or the services you receive. Please contact the Paramount Member Service Department for confidential handling at 734-529-7800, or toll-free at 1-888-241-5604. TTY services for the hearing-impaired are available at 1-800-740-5670. You may also contact the ProMedica Health System Compliance Hotline for confidential investigation. That hotline number is 1-800-807-2693.

Any person who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer,

submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud under Michigan law and is subject to immediate termination of benefits.

WHAT HAPPENS WITH YOUR PLAN

When You Have Other Coverage - How Coordination of Benefits Works

"Coordination of benefits" is the procedure used to pay health care expenses when a person is covered by more than one 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.
- 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 a 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, or Participating Specialists, Prior Authorizations,

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.

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.

1. **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 you believe that we have not paid a claim properly under coordination of benefits, you should first attempt to resolve the problem by contacting us. Please refer to section titled WHAT TO DO WHEN YOU HAVE QUESTIONS, PROBLEMS OR GRIEVANCES, of this Subscriber Certificate for the appeal/grievance procedures.

When You Are Eligible for Medicare
If any enrolled Member is entitled to Medicare benefits, federal law will control whether Paramount or Medicare is primary. Contact your employer for current guidelines.

When You Qualify for Worker's Compensation
If you or your Dependents receive health care services due to an injury which may be covered by Worker's Compensation, you must notify Paramount as soon as possible.

If you filed a claim for Worker's Compensation, Paramount will withhold payment to your providers until the case is settled. If Paramount has made any payment to your provider and services are covered by Worker's Compensation, the Workers Compensation carrier is expected to reimburse Paramount for the amounts paid. Please refer to the Group Medical and Hospital Service Agreement filed with your employer for further details.

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

Paramount's reimbursement and subrogation rights are equal to the value of medical benefits paid for Covered Services provided to the Member. Paramount subrogation rights are a first priority claim against any recovery and must be paid before any other claims, including claims by the Member for damages. This means the Member must reimburse Paramount in full, in an amount not to exceed the Members total recovery, even when the Member's settlement or judgment is for less than the Member's total damages and must be paid without any reductions for attorney's fees, costs or other expenses incurred by Member.

When You Leave Your Job
Members who no longer meet eligibility requirements under section titled WHO IS ELIGIBLE of this handbook may be eligible for continuation coverage under the employer group's health benefits plan or for individual conversion coverage. See your benefits office for more information.

How You May Continue Group Coverage
To get continuation coverage when you are no longer eligible for the Group plan, you must be entitled to such coverage under federal law, you must live in the Paramount Service Area, and you must pay the required monthly prepayment (the share your former employer used to pay) to the group plan, your former employer. How long you are allowed to continue your coverage depends on the circumstances and the conditions provided in your employer group's plan. See your benefits office for details.

The following are conditions under which you may continue Paramount coverage under your current plan. See your benefits office for further information.

1. If any of the following events occur and your employer group has ***more than 20*** employees, you or your Dependents may be able to continue your coverage under the federal Consolidated Omnibus Budget Reconciliation Act (COBRA):

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

   Unless federal law requires otherwise, group continuation coverage will terminate under any of the following circumstances.

   - The Member becomes entitled to Medicare benefits
   - The Member becomes covered under another group plan without an extension relating to a pre-existing condition of the Member
   - The termination of the group agreement with the employer. See your benefits officer for more information.
   - The end of a child's status as a dependent under the plan.

2. If you as a covered Subscriber (employee) are called to active duty in the Armed Forces of the United States including the Michigan National Guard and Michigan Air National Guard you or your Dependents may be able to continue your coverage under the federal Uniformed Services Employment and Reemployment Rights Act (USERRA):

   ➢ The covered Subscriber and Dependents may continue coverage for up to 24 months
   ➢ Covered Dependents may continue coverage for up to 36 months if any of the following events occurs during that 24 month period:

      a. The death of the reservist
      b. The divorce or separation of a reservist from the reservist's spouse
      c. A covered Dependent child's eligibility under this coverage ends

   ➢ Continuation coverage will end on the date any of the following occurs:

      a. The subscriber or Dependent becomes covered by another group plan without any pre-existing condition restriction.
      b. The maximum period of months expires.
      c. The Subscriber or Dependent does not make the required payment
      d. The group contract with Paramount is terminated.

If Paramount Ends Operations
In the event Paramount would end operations, members' benefits would be covered until the Group Medical and Hospital Service Agreement expired. All prepayments must be made in accordance with the terms of the agreement.

WHAT TO DO WHEN YOU HAVE 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 734-529-7800 or use our toll-free number 1-888-241-5604. You can contact us by e-mail at: member.services@promedica.org

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.paramountcareofmichigan.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.

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.

Filing a Grievance

Under Michigan Compiled Laws (MCL), 500.2213, 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 preexisting 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 of an ongoing course of treatment.

For grievances, you should follow the steps outlined below:

Internal Grievance – Level 1

If you have a grievance, call or write the Member Services Department. A Member Services representative will try to resolve the grievance within two (2) working days for urgent clinical issues, 15 calendar days for pre-service grievance or 30 calendar days for a post-service grievance. You will be advised of the disposition of your grievance by telephone call or in writing. If the first level grievance 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 Care of Michigan, Inc.
Member Services Department
214 E. Elm Avenue, Suite 107
Monroe, MI 48162-2678
(734) 529-7800
Toll-free 1-888-241-5604

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 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 request free of charge, reasonable access to, and copies of , all documents, records, and other information relevant to your claim for benefits;
- will receive no reduction or termination of an ongoing course of treatment without advance notice from Paramount or an opportunity for advance review;
- 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 a grievance representative of Paramount who is neither the individual who made the adverse benefit determination that is the subject of the grievance, nor his or her subordinate;
- will receive a review from the grievance 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 that date;
- 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 grievance process and may initiate an external review if Paramount has failed to strictly adhere to all the requirements of the internal grievance process, will receive no reduction or termination of an ongoing course of treatment without advance notice from Paramount or an opportunity for advance review.

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
Healthcare Appeals Section
Office of General Counsel
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.

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.

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:

- The Adverse Determination involves a medical condition in which the timeframe for completion of an expedited internal grievance would seriously jeopardize the life or health of the member or would jeopardize the member's ability to regain maximum function as substantiated by a physician either orally or in writing.
- The member or member's Authorized Representative has filed a request for an expedited internal grievance.

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.

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.

TERMS AND DEFINITIONS

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.

PROBATIONARY OR WAITING PERIOD is the period between the date the individual files a substantially complete application for coverage and the first day of coverage.

APPLIED BEHAVIOR ANALYSIS – means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

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.

AUTISM DIAGNOSTIC OBSERVATION SCHEDULE – means the protocol available through Western psychological services for diagnosing and assessing Autism Spectrum Disorders or any other standardized diagnostic measure for Autism Spectrum disorders that is approved by the Director of the Department of Insurance and Financial Services, if the Director determines that the diagnostic measure is recognized by the health care industry and is an evidence-based diagnostic tool.

AUTISM TREATMENT PLAN – means a written, comprehensive, and individualized intervention plan that incorporates specific treatment goals and objectives and that is developed by a board certified or licensed Network provider who has the appropriate credentials and who is operating within his or her scope of practice, when the treatment of an Autism Spectrum Disorder is first prescribed or ordered by a licensed Physician or licensed psychologist.

BASIC HEALTH CARE SERVICES include physician's services, inpatient hospital services, outpatient medical services, emergency health services, diagnostic laboratory services, diagnostic and therapeutic radiology services, and preventative health services including family planning, infertility services, periodic physical examinations, prenatal obstetrical care and well-child care as defined in MCL 500.3501.

BEHAVIORAL HEALTH TREATMENT means evidence-based counseling and treatment programs, including Applied Behavior Analysis, that meet both of the following requirements: (i) are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual (ii) 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.

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

COINSURANCE is your share of the cost of some Covered Services as a percentage of the amount allowed. For example, you may be responsible for 20% of the total allowed amount for Covered Services.

CONTRACT YEAR is a calendar year or term for which the employer group has an agreement with Paramount to provide Covered Services to eligible Subscribers and their Dependents.

COPAYMENT is your share of the cost of some Covered Services. It is a specific fixed-dollar amount, such as $5.00 or $10.00. Copayment which are for a specific fixed-dollar amount are due and payable at the time services are provided.

COVERED SERVICES means the comprehensive health care services and terms and conditions for their delivery described in this document.

CREDITABLE COVERAGE is the period of prior health plan coverage of an individual enrollee which may entitle the enrollee to reduce the effective time period of a pre-existing condition exclusion that may be present in future coverage sought by the individual. Upon termination of your coverage with Paramount, you are entitled to receive a Certificate of Creditable Coverage which provides information regarding prior coverage with Paramount. Creditable coverage does not include coverage solely for dental, vision or prescription drug benefits.

DEDUCTIBLE is the amount the Member must satisfy each calendar year before receiving benefits for Covered Services.

DEPENDENT means any member of a Subscriber's family who meets all the applicable eligibility requirements, has been enrolled in the plan and for whom the payment required by the employer's group agreement has been received by Paramount.

EFFECTIVE DATE is the date your coverage begins.

ELECTIVE ABORTION is 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.

EMERGENCY MEDICAL CONDITION means a medical condition that manifests itself by such acute symptoms of 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 woman, the health of the woman or the unborn Child, in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

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

ESSENTIAL HEALTH BENFITS 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. Your plan may contain some or all of these types of benefits prior to 2014 when they become mandatory. If your plan contains any of these benefits, there are certain requirements that may apply to those benefits.

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.

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

EXPERIMENTAL is any treatment, procedure, facility, equipment, drug, device or supply which is not recognized as accepted medical practice or which did not have required governmental approval when you received it. (See New Technology Assessment on page 18.) This includes treatments and procedures which:

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

Antineoplastic drugs in accordance with MCL Section 21054b are Covered Benefits.

This determination is based on the recommendation of the Medical Advisory Committee, the most recent *HAYES Medical Technology Directory*® and on current evidenced-based medical/scientific publications.

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.

GROUP means the legal entity that has contracted with Paramount Care of Michigan, Inc. on behalf of its employees or members for the benefits described in this Certificate.

GROUP MEDICAL AND HOSPITAL SERVICE AGREEMENT means the executed agreement between Paramount Care of Michigan, Inc. and a Group to which this Certificate is attached and incorporated.

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

INDEPENDENT REVIEW ORGANIZATION - means a person that conducts independent external reviews of adverse determinations.

IN-NETWORK COVERED SERVICES are authorized services in the list of services covered and applies when: 1) the Member sees the Paramount PCP for treatment and obtains referrals, and 2) the Member receives Covered Services from Paramount Providers. In-Network Covered Service may be subject to a Deductible, Copayment/Coinsurance or other limitations.

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

IN-NETWORK COVERAGE applies when the Member receives Covered Services from Paramount Participating Providers.

MEDICAL NECESSITY means the service you receive must be:

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

MEMBER means any Subscriber or Dependent as defined in Who Is Eligible.

MICHIGAN SERVICE AREA means Monroe and Lenawee counties in Michigan.

OUT-OF-NETWORK COVERED SERVICE are authorized services in the list of services covered and applies when the Member receives Out-of-Network Covered Services from Out-of-Network Providers. Out-of-Network Covered Service are subject to a Deductible, Copayment/Coinsurance or other limitations.

OUT-OF-NETWORK PROVIDER means a physician, hospital or other health professional or facility that does not have a contract with Paramount In-Network to provide Covered Services to Members.

OUT-OF-POCKET LIMIT: Means the maximum amount of expenses a Member may incur each calendar year as shown in the Summary of Benefits.

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

PARAMOUNT PROVIDER SERVICE AREA means Monroe and Lenawee counties in Michigan.

PARTICIPATING PARAMOUNT HOSPITAL means any hospital with which Paramount has contracted or established arrangements for inpatient/outpatient hospital services and/or emergency services.

PARTICIPATING PARAMOUNT PROVIDER means a physician, hospital or other health professional or facility that has a contract with Paramount to provide Covered Services to Members.

PARTICIPATING PARAMOUNT SPECIALIST means a physician who provides Covered Services to

members within the range of his or her medical specialty and has chosen to be designated as a specialist physician by Paramount.

Pharmacy Care means medications prescribed by a licensed physician and related services performed by a licensed pharmacist and any health-related services considered medically necessary to determine the need or effectiveness of the medications.

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

PRIMARY CARE PROVIDER means a physician or other provider who specializes in family practice, internal medicine or pediatrics and is designated by Paramount as a Primary Care Provider.

PRIOR AUTHORIZATION is required for certain procedures or services. It is the responsibility of the Participating Provider to obtain Prior Authorization from Paramount in advance of these procedures or services. It is the responsibility of the member to ensure Prior Authorization is in place for any non-emergency services provided by a non-Participating Provider.

PROMEDICA ONDEMAND VISIT is a live video consultation with a board-certified Provider scheduled by you or your Dependents via the webpage or downloadable mobile device application located at https://www.promedica.org/Pages/medical-services/ondemand/default.aspx.

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.

PSYCHIATRIC CARE means evidence-based direct or consultative services provided by a psychiatrist licensed in the State in which the psychiatrist practices.

PSYCHOLOGICAL CARE means evidence-based direct or consultative services provided by a psychologist licensed in the State in which the psychologist practices.

SUBSCRIBER means a person who meets all applicable eligibility requirements, is employed by an employer who has a contract in effect with Paramount and enrolls with an employer as the subscriber.

SUPPLEMENTAL HEALTH CARE SERVICES means any service that is not a Basic Health Care Service as defined in this Subscriber Certificate and Member Handbook.

TELEMEDICINE SERVICES means 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.

THERAPEUTIC CARE means evidence-based services provided by a licensed or certified speech therapist, occupational therapist, physical therapist, or social worker.

URGENT CARE SERVICES means Covered Services provided for an Urgent Medical Condition and may include such health care services for an Urgent Medical Condition provided out of the Paramount Provider Service Area.

URGENT MEDICAL CONDITION is an unforeseen condition of a kind that usually requires medical

attention without delay but that does not pose a threat to the life, limb or permanent health of the inured or ill person.

USUAL, CUSTOMARY AND REASONABLE (UCR) means a schedule of reimbursement as determined by Paramount and updated periodically.

PARAMOUNT CARE
OF MICHIGAN, INC.

214 E. Elm Avenue, Suite 107
Monroe, MI 48162-2678

(734) 529-7800
1-888-241-5604
TTY: Toll-Free: 1-888-740-5670
www.paramountcareofmichigan.com

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