PARAMOUNT INSURANCE COMPANY

LARGE GROUP

2 Level PPO PLAN

CERTIFICATE OF COVERAGE - MICHIGAN

Preferred Choices

NOTICE CONCERNING COORDINATION OF BENEFITS (COB)

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

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 ܐܢܬܘܢ ܟܐ ܗܡܙܡܝܬܘܢ ܠܫܢܐ ܐܬܘܪܝܐ، ܟܡܝܢ ܒܬܘܢ ܕܦܠܚܝܬܘܢ ܒܝܠܦܢܐ ܕܗܝܪܬܐ ܒܠܫܢܐ ܡܓܢܢܐܝܬ. ܩܪܘܢ ܥܠ ܡܢܝܢܐ 1-800-462-3589 (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

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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 Paramount 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.

Member Services
300 Madison Avenue, Suite 270
Toledo, Ohio 43604

Alternate in Person Delivery Address:
650 Beaver Creek Circle, Suite 100
Maumee, Ohio 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.

INTRODUCTION

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

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

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

SECTION ONE: ELIGIBILITY AND EFFECTIVE DATE

1. **Eligibility**. Eligibility for Plan enrollment will **not** be conditioned on past, present, or future health status, medical condition, or need for medical care, student status, pre-existing condition, genetic testing or the results of such testing or age.

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

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

(2) An employee who works on a full-time basis with a normal workweek of 30 or more hours. Eligible employee includes an employee who works on a full-time basis with a normal workweek of 17.5 to 30 hours, if an Employer so chooses and if this eligibility criterion is applied uniformly among all of the Employer's employees without regard to health-status related factors;

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

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

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

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

(1) An employee must be enrolled in a High Deductible Health Plan,

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

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

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

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

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

Coverage for a covered dependent child may be continued beyond age twenty-six (26), if the child is:

(1) incapable of self-support due to mental retardation or physical handicap; and
(2) primarily dependent upon the employee for support and maintenance.

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

Services representative at 419-887-2531 or toll-free 1-866-452-6128.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A. **New Hire Policy**. Coverage for eligible employees and those eligible dependents who enroll simultaneously with the eligible employee during the initial or subsequent yearly Election Period is effective in accordance with the New Hire Policy of the Employer's Contract with Paramount. The Waiting Period will not exceed 90 days.

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

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

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

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

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

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

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

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

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

6. **Termination of Coverage**.

A. **Employee**. Paramount will not terminate coverage for You or Your dependents due to health status, health care needs or the exercise of rights under Paramount's grievance procedures. However, Paramount will not re-enroll anyone terminated for any of the reasons listed in this section. A covered employee's coverage and that of his or her covered dependents will end (subject to Section Two, Continuation of Coverage) on the earliest of the following dates:

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

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

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

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

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

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

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

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

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

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

C. **Termination for Cause**. Your coverage may be terminated or rescinded* for cause by Paramount upon 30 calendar days' prior written notice if any of the following is true:

(1) You do not make any required premium contribution and any applicable grace periods have been exhausted.

a. Pursuant to Michigan law, a grace period of not less than ten (10) days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force.

b. The foregoing is subject to Paramount's right to terminate coverage for cause in accordance with the termination for cause provision hereof.

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

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

b. Providing untrue, incorrect, or incomplete information on behalf of Yourself or another Covered Person in the application for this Plan, which constitutes a material

misrepresentation. You will be responsible for paying charges for all Covered Services provided to You through Paramount that are related to such untrue, incorrect, or incomplete information; and

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

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

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

D. **Plan Termination**. Coverage under the Plan may be renewed each year at the option of the Employer; provided that, Paramount may terminate or non-renew the Employer's Contract for one or more of the following reasons:

(1) Failure to pay the required premiums on time;
(2) Fraud or intentional misrepresentation of a material fact by the Employer, its agent or employees in connection with such coverage;
(3) Failure to comply with any contribution and participation requirements defined by Paramount;
(4) If there is no longer a Covered Person who lives, resides, or works in the state of Michigan;
(5) If the membership of the Employer in an association (on the basis of which coverage is provided) ceases;
(6) When Paramount discontinues offering this Plan in the Large Group market, as applicable, in Michigan and:
   a. Paramount provides notice to each Employer and Covered Person provided coverage under this Plan in the Large Group Market, as applicable, of such discontinuation at least 90 calendar days prior to the date of discontinuation of such coverage;

   b. Paramount offers each Employer provided coverage in the Large Group Market, as applicable, under this Plan the option to purchase other coverage currently being offered by Paramount to an Employer or union sponsored Health Benefit Plan in such market(s); and

   c. In exercising the option to discontinue coverage of this type and in offering the option of other coverage under this provision, Paramount acts uniformly without regard to claims experience of those Employers or the health status of any Covered Persons or eligible employees or dependents; or

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

SECTION TWO: CONTINUATION OF COVERAGE

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

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

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

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

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

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

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

SECTION THREE: HOW THE PREFERRED CHOICES PLAN WORKS

1. **Surprise Billing**

Your Rights and Protections Against Surprise Medical Bills

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

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

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

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

You are protected from balance billing for:

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

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

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

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

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

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

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

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

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

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

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

- Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

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

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

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

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

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

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

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

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

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

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

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

Example (assumes the Deductible has already been met):

Out-of-Network Provider charge:	$1,000
NCA or UCR limit:	$700
Plan pays 70% of $700:	$490

You pay 30% Coinsurance:	$210
Plus balance of charge above $700	$300
Your total cost:	$510

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

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

3. **Pre-Authorization**

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

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

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

You must obtain pre-authorization by calling Paramount at 419-887-2549 or toll free 1-800-891-2549 before (preferably two weeks in advance) obtaining any of the following:

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

i. Inpatient admission to a Hospital, including Inpatient admissions for Mental Illness, substance abuse and Inpatient admissions at rehabilitation facilities; or
ii. Inpatient admission to a Skilled Nursing Facility; or
iii. Home Health services; or
iv. Organ/Bone Marrow Transplant services.
v. Autism Spectrum Disorder Services.

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

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

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

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

If You do not obtain the required pre-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 pre-authorization*** and the services are Medically Necessary, any benefit payment for a ***facility fee (including inpatient facility services under Section Three, 2,A)*** will be reduced by $500 from the Allowable Amount. The services are then subject to the applicable Deductible, Copayment and/or Coinsurance. Financial penalties for failure to obtain pre-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 the Out-of-Pocket Maximum. Also see Transplant Benefit Penalty.

Notification of Pre-Authorization Decision. Paramount will make its decision regarding coverage and notify You within two (2) business days of receiving all necessary information.

For Emergency admissions to a Hospital or Skilled Nursing Facility, You do not have to obtain pre-authorization in advance. However, You, a family member, or Your Physician must notify Paramount within 48 hours of an Emergency admission, or as soon as possible. If You have any questions, or to provide notice, call 419-887-2549 or toll-free 1-800-891-2549.

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

Remember that You must obtain pre-authorization from Paramount before You obtain the services, procedures and equipment listed above.

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

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

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

5. **Filing Claims**. For all Covered Services, a claim form or written proof of loss must be submitted to Paramount. In-Network Providers will submit the required claim forms to Paramount for You. You must show

Your Paramount identification card to the In-Network Provider. **In-Network Hospitals, Physicians and Providers have agreed to limit their charges through their contracts with the PPO Network.**

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

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

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

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

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

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

   A. **Aggregate Deductible.** The amount You and Your Dependents must pay for Covered Services including Prescription Drugs within a calendar year, before any benefits will be paid by the Plan. If You have single coverage (self only), the single Deductible is the amount You must pay. If You have family coverage (two or more covered family members), the family Deductible is the total amount any one or more covered family members must pay. The deductible amount of one family member will not exceed the individual annual cost sharing limit as set by the Department of Health and Human Services. All Covered Services except for Preventive Health Services are subject to the Deductible.

   Embedded Deductible. The amount You and Your Dependents must pay for Covered Services including Prescription Drugs within a calendar year, before any benefits will be paid by the Plan. The single Deductible is the amount each Covered Person must pay. The family Deductible is the total amount any **two** or more covered family members must pay. The deductible amount of one family member will not exceed that of the individual annual deductible maximum amount. All Covered Services except for Preventive Health Services are subject to the Deductible.

   A plan will only be used as a High Deductible Health Plan (HDHP) with a Health Savings Account (HSA) when it follows the minimum and maximum limits for a HDHP. See **Definitions** section of this certificate for more information regarding an HDHP and HSA.

   See your Schedule of Benefits for the type of Deductible and Deductible amount under your Plan.

   The expenses incurred for Covered Services from In-Network and Out-of-Network Providers including Prescription Drugs apply to the Deductible.

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

Network Providers is a percentage of the NCA or UCR charge that Paramount will pay for the services rendered.

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

C. **Out-of-Pocket Maximum**. Similar to your Deductible, you may have an Embedded or Aggregate Out-of-Pocket Maximum. Your Out-of-Pocket Maximum is stated in Your Schedule of Benefits. After that amount has been paid, there will be no additional payments required for Coinsurance or Copay/Copayment on Essential Health Benefits during the remainder of that calendar year. The Out-of-Pocket Maximum is the maximum amount of Copayments and Coinsurance including medical and prescription drug Deductibles (if any) paid by a Covered Person in a calendar year. The embedded Out-of-Pocket Maximum of one family member will not exceed that of the individual annual Out-of-Pocket Maximum amount. The aggregate Out-of-Pocket Maximum will not exceed the individual annual cost sharing limit as set by the Department of Health and Human Services. The following ***do not*** apply to the Out-of-Pocket Maximum:

- Financial penalties imposed for failure to obtain required pre-authorization for care received Out-of-Network; and
- Non-Network charges in excess of NCA or UCR.

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

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

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

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

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

SECTION FOUR: COVERED SERVICES

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

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

1. **Physician Office Visit Fees.** A Copayment and/or Coinsurance must be paid for each office or home visit with an In-Network Physician, except for Preventive Services, or Out-of-Network Physician. Please refer to the Schedule of Benefits for details.

2. **Physician Office Visit Coverage.** You are entitled to benefits for the following services at a Physician's office:

A. **Diagnosis and Treatment:** Services of Physicians and other medical personnel for diagnosis and treatment of disease, injury, or other conditions; and Urgent Care Services and Emergency Services provided 24 hours a day and 7 days a week. This includes surgical procedures performed in a Physician's office and consultations with specialists. When available in Your area, Your coverage will include online clinic visit services. Covered Services include a medical consultation using the internet via webcam, chat and voice. 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

B. **Allergy Tests and Treatment:** Allergy tests which are performed and related to a specific diagnosis. Desensitization treatments are also covered.

C. **X-Ray and Laboratory Services:** X-ray and laboratory tests and services when ordered by a Physician. This includes prescribed diagnostic X-rays, electrocardiograms, laboratory tests and diagnostic clinical isotope services. Coverage for breast cancer screening mammography in accordance with MCL 500.3406d.

D. **Physical and Occupational Therapy:** Physical and occupational therapy services, up to the maximum indicated in Your Schedule of Benefits.

E. **Speech Therapy:** Speech and speech therapy services for medical conditions up to the maximum indicated in Your Schedule of Benefits. This does not include non-medical conditions such as stuttering, lisping, articulation disorders, tongue thrust and delayed onset of speech.

F. **Radiation Therapy and Chemotherapy:** A Food and Drug Administration (FDA) approved drug used in antineoplastic therapy and the reasonable cost of its administration are covered 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 FDA if all of the following conditions are met:

1. The drug is ordered by a physician for the treatment of a specific type of neoplasm.
2. The drug is approved by the FDA for use in antineoplastic therapy.
3. The drug is used as part of an antineoplastic drug regimen.
4. Current medical literature substantiates its efficacy and recognized oncology organizations generally accept the treatment.
5. The physician obtained informed consent from the patient for the treatment regimen which includes FDA approved drugs for off-label indications.

G. **Medications Used in The Physician's Office:** Short-term medications (e.g. antibiotics, steroids, etc.), injectables, radioactive materials, dressings and casts, administered or applied by a Physician or other Provider in the Physician's office for preventive or therapeutic purposes.

H. **Second Surgical Opinion.**

I. **Spinal Manipulation Services:** Spinal manipulation services up to the annual maximum indicated in the Schedule of Benefits.

J. **Preventive Health Services:** Your Plan provides additional coverage for selected Preventive Health Services without a Copayment, Coinsurance, or Deductible when these services are delivered by an In-Network Provider. Please refer to Your Schedule of Benefits for coverage levels. Eligible services fall under four broad categories:

1. Services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of these services are screenings for:

   a. Breast cancer;
   b. Cervical cancer;
   c. Colorectal cancer;
   d. High Blood Pressure;
   e. Type 2 Diabetes Mellitus;
   f. Cholesterol;
   g. Child and Adult Obesity.

2. Immunizations for children, adolescents, and adults recommended by the Advisory Committee on

Immunization Practices of the Centers for Disease Control and Prevention;

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

4. Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including:

a. All FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity. Prescription coverage includes at least one product for each of the following contraceptive methods: Barrier (diaphragm), implanted devices (IUD), Hormonal (generic orals), and Emergency Contraception.
b. Breastfeeding support, supplies, and counseling. Benefits for breast pumps are limited to one pump per benefit period.

You may call Member Services using the number on your ID card for additional information about these services. (or view the federal government's web sites, http://www.healthcare.gov/center/regulations/prevention.html; or http://www.ahrq.gov/clinic/uspstfix.htm; http://www.cdc.gov/vaccines/recs/acip/.)

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.

Please contact us at **www.paramountinsurancecompany.com or (419) 887-2531; toll-free 1-866-452-6128**, 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.

K. **Routine Vision Exam:** An annual routine vision exam for refractory disorders of the eye.

L. **Contraceptive Services** Voluntary sterilization for men (vasectomies).

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.

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

M. **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 Schedule 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. Please see your Schedule of Benefits to determine whether your coverage includes the ProMedica OnDemand Visit benefit.

N. **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

3. **Visits to an Urgent Care Center.** If Your Physician is not available, diagnosis and treatment may be obtained from an urgent care center for the sudden occurrence of a condition that requires medical attention without delay, but that does not pose a threat to Your life, limb or permanent health.

4. **Medical Services While Hospitalized.** During any period of covered hospitalization the following are covered:

A. **Surgery** includes:

1. The performance of generally accepted operative and other invasive procedures;
2. The correction of fractures and dislocations;
3. Usual and related preoperative and post operative care: and
4. Other procedures as reasonably approved by Paramount.

The Plan will also cover medical and surgical procedures for:

1. Correction of functional defect or functional impairment which results from an acquired and/or congenital disease or injury; and
2. Reconstructive surgery to correct congenital malformations or anomalies resulting in a functional defect or functional impairment of a Covered Person; and
3. Breast reconstruction following a covered mastectomy including:
    a. Reconstruction of the breast on which the mastectomy was performed;
    b. Surgery and construction of the other breast to produce a symmetrical appearance; and
    c. Prostheses and physical complication during all stages of the mastectomy, including lyphedemas.

The Plan will not cover surgery for the purpose of improving physical appearance other than what is specifically provided for in this section (See Section Ten, Exclusions, Cosmetic or Plastic Surgery).

The benefit amount payable for surgery includes payment for related care by the surgeon before and after the operation. In other words, the one payment covers the operation and the surgeon's care before and after the operation.

Payment for surgery is also subject to the following limitation: When multiple surgical procedures are performed at the same operative session, the Plan will cover the major or first procedure at the level of reimbursement in the Schedule of Benefits, depending on whether these services are performed by In-Network or Out-of-Network Providers. The Plan will cover the lesser or subsequent surgical procedures at one-half of the payment otherwise payable.

B. **Medical Visits in a Hospital:** Medical visits by a Physician while You are a registered Inpatient in a Hospital. The medical visits are for the care of illnesses or conditions other than those related to surgery or maternity care.

C. **Complication in a Hospital:** Services of a second Physician in a Hospital when You have an Exceptional Complication during the course of surgery, maternity, or Inpatient Hospital care. An "Exceptional Complication" is a condition which is not related to the condition for which You were admitted to the Hospital, or a condition which is so unusual that it requires more than the customary surgical, maternity, or medical care.

D. **Anesthesia in a Hospital:** A Physician's administration of anesthesia in connection with surgery or maternity care. However, no payment will be made if the Physician who administers the anesthesia also performs the care, or assists the Physician who performs the care, and receives payment for that care.

E. **Consultations in a Hospital:** Consultation by a Physician who is called in by Your Physician if both the following conditions are met:

1. The consulting Physician is a specialist in Your illness or disease; and
2. The consultation takes place while You are a registered Inpatient in a Hospital.

F. **Diagnostic X-rays:** Diagnostic x-rays performed by, or on the order of, Your Physician to diagnose a condition or illness for which You showed symptoms.

G. **Radiation Services:** Radiation services performed by, or on the order of, Your Physician to diagnose a condition or illness for which You showed symptoms.

H. **Laboratory Services:** Laboratory test performed by, or on the order of, Your Physician.

5. **Services at Home:** These services include:

A. **Home Visits by a Physician:** A home visit (house call) by a Physician who provides care to You in Your home or other place of residence.

B. **Home Health Care by Home Health Agency Personnel:** Visits by home health agency personnel in Your home or other place of residence, up to a maximum indicated in the Schedule of Benefits. If home health care is recommended, Paramount must approve benefits for such care in advance. If You obtain pre-authorization, these services, procedures and equipment will be covered at the appropriate benefit level indicated in Your Schedule of Benefits. Pre-authorization is required to avoid a potential reduction or denial of benefits.

If You do not obtain the required pre-authorization, a retrospective review will be done to determine if your care was Medically Necessary. You are responsible for all charges for services that are not Medically Necessary.

Home health care includes any of the following:

1. Part-time or intermittent home nursing care by or under the supervision of a registered nurse;
2. Part-time or intermittent home health aide services which consist primarily of caring for You under the supervision of a registered nurse; and
3. Skilled treatments performed by licensed or certified home health agency personnel, including the non-prescription medical supplies and drugs used or furnished during a visit by home health agency personnel. Non-prescription medical supplies and drugs may include surgical dressings and saline solutions, but do not include prescription drugs, certain intravenous solutions, or insulin.

Each visit by a member of a home care team is counted as one home care visit. Four hours of home health aide service are counted as one home care visit.

C. **Oxygen and Oxygen Related Equipment:** These items are covered when ordered by a Physician.

6. **Medical Supplies.** These items are covered when ordered by a Physician, supplied by a Physician, supplier or pharmacy and are eligible under Medicare Part B guidelines and limits, with the exception of Outpatient prescription drugs covered by Medicare Part B.

A. **Asthmatic Supplies**: Certain asthmatic supplies may be covered under a separate program administered through a pharmacy benefit. See Limited Medical Supply Rider for details.

B. **Diabetic Equipment, Supplies and Education:** These items are covered when ordered by a Physician. The following diabetic equipment and supplies are available from Network Pharmacies, even if You are not enrolled in Paramount's Prescription Drug Program:

1. Blood glucose monitors;
2. test strips for glucose monitors, visual reading and urine testing strips, lancets, and spring powered lancet devices;
3. needles and syringes (1cc or less); and
4. medical supplies required for the use of an insulin pump

Medical supplies are small and often disposable items that are part of medical treatment for an illness or injury. The supply must be compatible with the diagnosis and generally must not be useful in the absence of illness or injury for which it is used.

7. **Durable Medical Equipment (DME).** These items are covered when ordered by a Physician, supplied by a Physician, supplier or pharmacy and eligible under Medicare Part B guidelines. However, certain diabetic and asthmatic equipment may be covered under a separate program administered through a pharmacy benefit. See Limited Medical Supply Rider for details.

Benefits will be subject to the Coinsurance amount and/or Benefit Limit indicated in the Schedule of Benefits.

Paramount will determine whether the item should be purchased or rented. At all times the maximum benefit for an item of eligible DME is the purchase price of the equipment. The purchase of a duplicate DME item will be limited to once every 24 months. Certain equipment requires pre-authorization. See Section Three.

8. **Prosthetic Devices**. These items are covered when ordered by a Physician, supplied by a Physician, supplier or pharmacy and eligible under Medicare Part B guidelines. **Benefits will be subject to the Coinsurance amount and/or Benefit Limit indicated in the Schedule of Benefits.**

Prosthetic devices are appliances which replace all or part of an absent body part, or replace all or part of the function of a permanently inoperable or malfunctioning body part. Repair and replacement of prosthetic devices is covered subject to Medicare Part B guidelines.

9. **New Technology and Medical Procedures.** The Paramount Technology Assessment Working Group (TAWG) regularly monitors the medical literature concerning new technology and medical procedures for which coverage is not currently provided for under the Plan. The working group evaluates data on safety

and efficacy of new technology, new applications of existing technology and medical procedures from a variety of sources. These include medical journals, recommendations of medical specialty societies, local medical experts, and government agencies. After considerable study and discussion of information from these sources, the Physicians on the TAWG develop recommendations regarding coverage of the new technology and medical procedures under review. You and Your Physician may request the working group to review particular new technology or medical procedures.

10. **Cancer Clinical Trial**. Routine patient care for Covered Persons enrolled in an Eligible Cancer Clinical Trial is covered. Routine patient care means all Health Care Services consistent with the coverage under this Plan for the treatment of cancer, including the type and frequency of any diagnostic modality, that is typically covered for a cancer patient who is not enrolled in a cancer clinical trial, and that is not necessitated solely because of the trial.

11. **Autism Spectrum Disorder Treatment:** 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 when Prior Authorized. 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. Outpatient rehabilitation/habilitation therapy for autism will not be included in limits specified elsewhere in this certificate for Physical Therapy, Occupational Therapy, and Speech Therapy services.

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.

Covered Services are subject to the same Deductible and Copayments/Coinsurance as any other physical disease or condition.

SECTION FIVE: HOSPITAL CARE

The level of benefits for these services will depend on whether these services are obtained through In-Network or Out-of-Network Providers. ***Covered Services must be Medically Necessary (see the Definition Section).***

When You receive Inpatient Hospital Services (except for Emergency Services) You must obtain pre-authorization before the benefits will be made available. If You obtain pre-authorization, these services, procedures and equipment will be covered at the appropriate benefit level indicated in Your Schedule of Benefits. Pre-authorization is required to avoid a potential reduction or denial in payment of benefits.

If You do not obtain the required pre-authorization, a retrospective review will be done to determine if your care was Medically Necessary. You are responsible for all charges for services that are not Medically Necessary.

If You ***do not obtain pre-authorization*** and the services are Medically Necessary, any benefit payment for a ***facility fee (including inpatient facility services under Section Three, 2,A)*** will be reduced by $500 from the Allowable Amount. The services are then subject to the applicable Deductible, Copayment and/or Coinsurance. Financial penalties for failure to obtain pre-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.

1. **Acute Care General Hospital:** The Plan will pay for Covered Services at the most common charge for semi-private accommodations in an acute care general Hospital. An acute care general Hospital is a licensed institution primarily engaged in providing: Inpatient diagnostic and treatment services for surgical and medical patients; treatment and care of injured and sick persons by or under the supervision of Physicians; and 24 hour nursing service by or under the supervision of registered nurses.

3. **Inpatient Care in a Hospital:** The Plan will pay for services customarily furnished by an acute care general Hospital when You are a registered Inpatient in such Hospital. Your share of the cost will vary depending on whether care is obtained from an In-Network or Out-of-Network Hospital.

4. **Hospital Services:** The Plan will pay for services customarily furnished in an acute care general Hospital such as room and board, nursing care, medical social work, pharmacy services and supplies, diagnostic laboratory tests, operating room charges, and labor and delivery room charges.

   As a general rule, services are not covered Hospital services unless the following conditions are met: The service is provided by an employee of the Hospital, the Hospital bills for the service, and Hospital retains the payment collected for the service.

4. **Visits to the Emergency Room:** An emergency room Coinsurance must be paid as indicated in the Schedule of Benefits for each visit to a Hospital emergency room. Your Plan covers Emergency Services for an Emergency Medical Condition treated in any hospital emergency department. If You are admitted to the Hospital from the emergency room, the emergency room Copayment will be waived. If You have an Emergency Medical Condition, dial 911 for assistance or go to the nearest hospital emergency room. Your Plan will not require prior authorization or impose any other administrative requirements or benefit limitations that are more restrictive if you receive Emergency Services from an Out-of-Network Provider. However, an Out-of-Network Provider of Emergency Services may send you a bill for any charges remaining after your Plan has paid (this is call "balance billing").

   Except where your Plan provides a better benefit, your Plan will apply the same Copayments and Coinsurance for Out-of-Network Emergency Services as it generally requires for In-Network Emergency Services. A Deductible may be imposed for Out-of-Network Emergency Services, only as part of the Deductible that generally applies to Out-of-Network benefits. Similarly, any Out-of-Pocket Maximum that generally applies to Out-of-Network benefits will apply to Out-of-Network Emergency Services.

   Your Plan will calculate the amount to be paid for Out-of-Network Emergency Services in three different ways and pay the greatest of the three amount: 1) the amount your Plan pays to In-Network Providers for the Emergency Services furnished (this calculation is not required if your Plan does not have negotiated per service amounts with In-Network Providers for the services furnished); 2) the amount that would be paid using the same method your Plan generally uses to determine payment for Out-of-Network services (such as the usual, customary and reasonable charges), but substituting In-Network Copayments and Coinsurance amounts; and 3) the amount that would be paid under Medicare for the services provided. All three of these amounts are calculated before application of any In-Network Copayments or Coinsurance.

5. **Outpatient Care in a Hospital:** The Plan will pay for the Covered Services provided to You in the Outpatient department of a Hospital if equivalent services would also be covered on an Inpatient basis.

   The Plan will also pay the facility's charges for Covered Services provided in a health center, diagnostic center, or treatment center which is licensed under appropriate state law. These facilities are sometimes called birthing centers, ambulatory surgical centers or hemodialysis centers. However, regardless of the name of the facility, payments will be made only if the facility possesses all licenses, permits, certifications and approvals required by applicable state, local, and federal law. Your share of the cost will vary depending on whether care is obtained from an In-Network or Out-of-Network Provider.

6. **Care in a Skilled Nursing Facility or Rehabilitation Facility:** Covered Services include care in a Skilled Nursing Facility or rehabilitation facility subject to the maximum benefit indicated in the Schedule of Benefits. Your share of the cost will vary depending on whether care is obtained from an In-Network or Out-of-Network Facility.

7. **Receiving Care from Hospital-Based Providers:** Hospitals employ many physicians and other providers, such as emergency room physicians, radiologists, pathologists and anesthesiologists, who only serve patients in the hospital. The Paramount Network has contracts with a vast majority of hospital-based physicians. These contracts mean the services will be paid under In-Network benefits and protects the Covered Person from being balanced billed. Protection against balance billing means the Covered Person will not receive a bill for the difference between the provider's charge and the fee that the In-Network pays for that service. However, there are cases where the Paramount Network has been unable to secure a contract with a hospital-based physician or provider. Please note that services from Out-of-Network hospital-based providers even though rendered in an In-Network hospital will be paid under Out-of-Network benefits. Additionally, Out-of-Network providers may not accept the UCR payment as payment in full and you may be responsible for additional charges.

8. **Ambulance Service:** Covered Services include the use of a licensed motor vehicle or air ambulance which charges a fee for its service if:

A. Because of an accident or sudden Emergency Medical Condition, it is necessary to transport You in an ambulance to the closest Hospital that is medically equipped to provide treatment for Your condition;

B. It is necessary to transport You from a Hospital where You are an Inpatient to another Hospital because;

1. The first Hospital lacks the equipment or expertise necessary to care for You properly and You are admitted as an Inpatient to the other Hospital; or
2. You are taken to another Hospital to receive a test or service which is not available at the Hospital where You have been admitted, and You return after the test or service is completed; or
3. The first Hospital is not an In-Network Hospital, and You are taken to an In-Network Hospital after Your condition has stabilized. "Stabilize" means, to provide such medical treatment of an Emergency Medical Condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

C. You are transported directly from a Hospital where You were an Inpatient to a Skilled Nursing Facility where You are then admitted as a patient.

SECTION SIX: MENTAL HEALTH / SUBSTANCE ABUSE

Mental Health Services include treatment for Biologically and Non-Biologically Based Mental Illness.

Biologically and Non-Biologically Based Mental Illness. Inpatient and outpatient services and emergency care for the treatment of Biologically and Non-Biologically Based Mental Illnesses and substance abuse disorders are covered subject to the same terms, Deductible, Copayments and/or Coinsurance as any other medical/surgical benefit within the same classification or sub classification. This includes intermediate levels of care such as residential treatment, partial hospitalization and intensive Outpatient services. Refer to Section Four: Covered Services and Section Five: Hospital Care. The level of benefits for these services will depend on whether these services are obtained through In-Network or Out-of-Network Providers, and will be provided in accordance with MCL 500.3406b.

1. **Levels of Treatment**

A. **Outpatient Services:** The Outpatient benefit are listed in Your Schedule of Benefits. Outpatient services include the following:

- Diagnostic evaluation,
- Individual psychotherapy;
- Group psychotherapy; and
- Convulsive therapy.

B. **Inpatient Services:** The Inpatient benefit are listed in Your Schedule of Benefits.

1. **Hospitalization Services:** Services provided while You are confined in a Hospital on a 24 hour a day basis to treat Mental Illness, substance abuse, including room and board, Physician services, nursing care, pharmacy services, diagnostic tests, and the following:

- Diagnostic evaluation;
- Individual psychotherapy;
- Group psychotherapy; and
- Convulsive therapy.

2. **Pre-authorization:** You, or someone doing so on Your behalf, must call Paramount at (419) 887-2549 or toll-free at 1-800-891-2549 to obtain pre-authorization for Inpatient Hospital Services (except for Emergency Services). If You obtain pre-authorization, these

services, procedures and equipment will be covered at the appropriate benefit level indicated in Your Schedule of Benefits. Pre-authorization is required to avoid a potential reduction or denial in payment of benefits.

If You do not obtain the required pre-authorization , a retrospective review will be done to determine if your care was Medically Necessary. You are responsible for all charges for services that are not Medically Necessary.

If You ***do not obtain pre-authorization*** and the services are Medically Necessary, any benefit payment for a ***facility fee (including inpatient facility services under Section Three, 2,A)*** will be reduced by $500 from the Allowable Amount. The services are then subject to the applicable Deductible, Copayment and/or Coinsurance. Financial penalties for failure to obtain pre-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.

Call Paramount at (419) 887-2549 or toll free 1-800-891-2549 for pre-authorization.

C. **Partial Hospitalization Services:** The same services covered under hospitalization services described above in this section (except room and board). However, partial hospitalization services are provided only for a duration of six to eight hours a day and do not require an overnight stay in the Hospital.

D. **Intensive Outpatient Program (IOP) Services:** The same services covered under hospitalization services described above in this section (except room and board, nursing and pharmacy). However, intensive Outpatient program (IOP) services are structured ambulatory behavioral health services with a duration of two to four hours per day, at least three days per week.

2. **Determination of Appropriate Levels of Treatment:** In determining the appropriate levels of treatment, Paramount considers:

A. The intensity and scope of care necessary to meet the standard of Medical Necessity through an appropriate treatment plan that supports problem-focused treatment; and

B. The least restrictive environment that will provide appropriate care for You and Your family and offers the opportunity for independent functioning.

SECTION SEVEN: HOSPICE CARE

Coverage for the following services is available when a Covered Person is diagnosed by their Physician as being terminally ill with a prognosis of six months or less to live. Your share of the cost for hospice care will depend on whether the care is obtained from an In-Network or Out-of-Network Provider.

1. **Hospices.** In order to receive coverage, You must obtain care from a Medicare certified hospice with all licenses, certifications, permits, and approvals required by applicable state and local law.

2. **Hospice Care Covered.** Covered Services include hospice care authorized by Your Physician during the period when hospice has admitted You to its program. Covered Services include the following services provided by the hospice:

A. Inpatient palliative care, excluding room and board, in a free standing hospice, hospice unit within a Hospital or Skilled Nursing Facility, or regular Hospital bed; and

B. Home care services provided by the hospice either directly or under arrangements with other licensed Providers.

SECTION EIGHT: TRANSPLANT BENEFITS

Benefit levels for transplants will depend on where Your care is obtained. Transplant services obtained at a Center of Excellence will be paid at the In-Network benefit level. Transplant services not obtained at a Center of Excellence will be subject to a significant penalty outlined in paragraph 5 below. A facility is a “Center of Excellence” when it appears on Paramount’s list of centers for the specific transplant being performed. Pre-authorization for transplant

services is required or a penalty will apply (see paragraph 4 below). Paramount will cover transplant services as follows:

1. **Transplant Procedures covered.** The Plan will pay for Covered Services for heart, lung, kidney, heart-lung, liver, pancreas, kidney-pancreas, bowel, bone marrow and cornea transplants. Benefits will not be provided for any organ or tissue transplant procedures not specifically covered under the Plan, or for any transplants that do not meet the established criteria.

2. **General Description of Transplant Covered Services.** Covered Services include any Hospital, medical-surgical, and other service related to the transplant, including blood and blood plasma.

   The Plan will pay for Covered Services for organ transplants, subject to Deductibles, Coinsurance, benefit maximums or other limits after pre-authorization is obtained. In order to be pre-authorized, the organ transplant must be Medically Necessary, medically appropriate, and not experimental or investigational for the medical condition for which the transplant is recommended. These determinations must be made by a Plan-approved external Independent Review Organization specializing in transplant services.

3. **Specified Covered Services.**

   A. **Hospital Care:** All Inpatient and Outpatient care.

   B. **Organ Procurement:** The tissue typing, surgical procedure, storage expense, and transportation costs directly related to the donation of an organ or other human tissue used in Your pre-authorized transplant procedure will be covered as follows:

      1. If the donor is covered under another health care benefit plan which includes coverage for donations used in the covered transplant procedure, then the donor's plan will be primary and this Plan will be secondary; and

      2. If the donor is not covered by any health care benefit plan or is covered by a health care benefit plan which excludes from coverage donation benefits, this Plan will be primary.

   C. **Operative Care and Post-Operative Care:** Benefits paid will vary depending on whether You obtain care through a Center of Excellence or other Provider. Pre-authorization is required (see paragraph 4 below).

      Covered Services related to transplant surgery will be paid if the expense is incurred during the 5 calendar days prior to surgery and the 365 calendar days thereafter.

      The following operative and post-operative care are Covered Services:

      - Hospital room, board, and general nursing in semi-private rooms and/or special care units;
      - Medically Necessary Hospital ancillaries while You are an Inpatient;
      - Physician's services for surgery, surgical assistance, administration of anesthetics, and Inpatient medical care;
      - Acquisition, preparation, transportation and storage of a human heart, lung, kidney, heart-lung, liver, pancreas, kidney-pancreas, bowel, bone marrow or cornea;
      - Diagnostic X-rays and other radiology services; laboratory and pathology services; and EKGs, EEGs and radioisotope tests.

      With prior approval by Paramount, benefits will be paid for other services (such as home health care and certain therapy services) when such services are directly related to a covered transplant and are ordered by Your Physician.

4. **Pre-authorization Required.** You, or someone doing so on Your behalf, must call Paramount at (419) 887-2549 or toll-free at 1-800-891-2549 to obtain pre-authorization for Inpatient Transplant Services (except for Emergency Services). If You obtain pre-authorization, these services, procedures and equipment will be covered at the appropriate benefit level indicated in Your Schedule of Benefits. Pre-authorization is required to avoid a potential reduction or denial in payment of benefits.

If You do not obtain the required pre-authorization, a retrospective review will be done to determine if your care was Medically Necessary. You are responsible for all charges for services that are not Medically Necessary.

If You ***do not obtain pre-authorization*** and the services are Medically Necessary, any benefit payment for a ***facility fee (including inpatient facility services under Section Three, 2,A)*** will be reduced by $500 from the Allowable Amount. The services are then subject to the applicable Deductible, Copayment and/or Coinsurance. Financial penalties for failure to obtain pre-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.

5. **Transplant Benefit Penalty.** Transplant services received at a non-Center of Excellence (Out-of-Network facility) will be subject to a reduction of benefit payment for all services of 50% of the Allowable Amount. The penalty does not count toward any out-of-pocket maximum. The transplant will be eligible for benefit payment only if it is a Medically Necessary Covered Service.

6. **Limitation.** In accordance with and to the extent permitted by applicable law, reimbursement to You under this Plan will be secondary to any and all governmental or institutional sources of funding that will offset the cost of Covered Services. No benefits are provided for an artificial organ.

SECTION NINE: MOTHER AND NEWBORN CARE

The level of benefits for maternity and newborn care will depend on whether care is obtained through In-Network or Out-of-Network Providers. Paramount will cover such services as follows:

1. **Covered Services.** Covered Services include the full range of obstetrical services at a Physician's office, including prenatal visits and postnatal visits and all other services set forth in Section Four, Covered Services, with respect to pregnancy.

   During any period of covered hospitalization, Covered Services include obstetrical services for the termination of a pregnancy by delivery of a baby, or miscarriage, and the initial examination of a covered newborn child performed by a Physician other than the delivery Physician. Payment for maternity care includes payment for all the Medically Necessary care related to the pregnancy.

2. **Hospital Services.** Coverage for Inpatient care for a covered mother and her newborn pursuant to Section Five, Paragraph 2, Inpatient Care in a Hospital, shall extend for 48 hours following normal vaginal delivery or 96 hours following a cesarean delivery or until a Physician or nurse-midwife in collaboration with a Physician determines that an earlier discharge is warranted after conferring with the mother or person responsible for the mother or newborn (e.g. parent, guardian or other person with authority to make medical decision for the mother or newborn). You are not required to stay in the Hospital for the above specified period of time, and if Medically Necessary, longer stays will be covered by Paramount. Pre-authorization is required for Inpatient delivery services. See Section Five: Hospital Care.

3. **Follow-up Care.** The following Physician-directed services provided after discharge from Inpatient care are covered as follow-up care:

   A. Physical assessment of the mother and newborn;
   B. Parent education, assistance, and training in breast and bottle feeding;
   C. Assessment of the home support system;
   D. Performance of any Medically Necessary clinical tests; and
   E. Performance of any other services that are consistent with the follow-up care recommended in the protocols and guidelines developed by national organizations that represent pediatric, obstetric, and nursing professionals.

   If the mother or newborn is discharged prior to the expiration of the applicable number of Inpatient hours specified in paragraph 2 of this section, all follow-up care provided within 72 hours after discharge is covered. If the mother or newborn receive at least the number of Inpatient hours specified in paragraph 2 of this section, all such care determined to be Medically Necessary by the Physician or nurse-midwife in collaboration with a Physician responsible for discharge is covered. Follow-up care may be provided in a Physician's office or during a home health visit if the Health Care Professional conducting the home visit is knowledgeable and experienced in maternity and newborn care.

SECTION TEN: EXCLUSIONS

To help manage health care premiums, Paramount excludes from coverage certain services that are considered to be insufficiently effective, experimental, inappropriate or outside the practical scope of coverage. However, certain sections of this Certificate of Coverage may waive an exclusion or limitation or may list additional exclusions or limitations. Please be certain to check the specific provisions of this Certificate of Coverage. Services not listed as Covered Services are considered not covered. The exclusions and limitations listed below will not, under any circumstances, be covered by this Plan.

Benefits for the following will not be provided.

1. **Admission to a Hospital Before You Became Covered Under this Plan:** Services provided at a Hospital or Skilled Nursing Facility as a registered Inpatient before the Effective Date of this Plan.

2. **Asthmatic Equipment and Supplies.** The following Asthmatic equipment and supplies are not covered under this Plan:

   - Peak expiratory flow rate meter (hand-held)
   - Spacers for metered dose inhaler
   - Masks and tubing for nebulizers
   - Limited ostomy supplies
   - Diaphragms

   The above may be covered under a under a separate program administered through a pharmacy benefit. See Limited Medical Supply Rider for details.

3. **Bariatric Treatment/Surgery.** Medical services or supplies (such as weight loss or weight maintenance programs), dietary counseling programs and surgical procedures to treat morbid obesity are not covered.

4. **Cancer Clinical Trial Services.** A health care service, item or drug that is:

   a. The subject of a cancer clinical trial;
   b. A health care service, item, or drug provided solely to satisfy data collection and analysis needs for the cancer clinical trial that is not used in the direct clinical management of the patient;
   c. An investigational or experimental drug or device that has not been approved for market by the United States food and drug administration;
   d. Transportation, lodging, food, or other expenses for the patient, or a family member or companion of the patient, that are associated with the travel to or from a facility providing the cancer clinical trial;
   e. An item or drug provided by the cancer clinical trial sponsors free of charge for any patient;
   f. A service, item, or drug that is eligible for reimbursement by a person other than the insurer, including the sponsor of the cancer clinical trial.

   This exclusion does not apply to routine patient care of a Covered Person in an Eligible Cancer Clinical Trial.

5. **Cardiac Rehab:** Services provided as part of Cardiac Rehabilitation, Phase III and Phase IV.

6. **Care Provided by a Family Member:** Care provided by an individual who normally resides in Your household or is a member of Your immediate family or the family of Your spouse. Immediate family is defined as parents, siblings, spouses, children, grandparents, aunts, uncles, nieces, and nephews.

7. **Care Rendered in Certain Non-Hospital Institutions:** Care or supplies in convalescent homes or similar institutions, facilities providing primarily custodial or rest care or domiciles, care or supplies in health resorts, spas, sanitariums, tuberculosis Hospitals, or infirmaries at schools, colleges or camps.

8. **Charges in Excess of Annual or Lifetime Maximums:** Any service, supply or treatment in excess of the annual or lifetime maximums shown in the Schedule of Benefits.

9. **Charges in Excess of NCA or UCR:** Charges for Out-of-Network services that are in excess of the Non-Contracting Amount (NCA) or in excess of Usual, Customary and Reasonable (UCR) charges.

10. **Complementary Treatments:** Acupuncture, Acupressure, Hypnotherapy, Massotherapy, Aroma Therapy, Chelation therapy, Rolfing, Biofeedback training, neurofeedback training and related diagnostic tests and other forms of alternative treatments including but not limited to non-prescription drugs or medicines, vitamins, nutrients and food supplements are not Covered Services. This limitation applies even if the service or item is prescribed by or administered by a Physician.

11. **Convenience Items:** Items that are primarily for Your convenience and personal comfort. These are items that are not directly related to the provision of Covered Services. Such items include, but are not limited to, telephone, television, barber or beauty service, guest service, private rooms (except as Medically Necessary) in a Hospital or Skilled Nursing Facility, housekeeping services and meal services as part of Home Health care, travel, transportation, or living expenses, rest cures, recreational or diversional therapy.

12. **Cosmetic or Plastic Surgery:** This limitation applies to any procedures, services, equipment, or supplies provided in connection with cosmetic or plastic surgery which is intended primarily to improve appearance or to treat a mental or emotional condition through a change in body form. In addition, the Plan will not cover procedures, services, equipment or supplies for any disease or condition resulting from a cosmetic or plastic surgery excluded under this Section. This limitation does not apply to the repair of anatomical impairment to improve or correct functional disability, breast reconstruction following a covered mastectomy or plastic surgery after an accidental injury.

13. **Custodial or Convalescent Care:** Services for Hospital care, nursing home or Skilled Nursing Facility care, home care, respite care or any other setting which is determined to be custodial. Custodial care means (1) non-health related services, such as assistance in activities of daily living, or (2) health-related services which do not seek to cure or which are provided during periods when the medical condition of the patient is not changing, or (3) services which do not require continued administration by trained medical personnel. Custodial care includes, but is not limited to, help in eating, getting out of bed, bathing, dressing, toileting and supervision in taking medications.

14. **Dental Care:** Dental work, treatment, supplies or x-rays including but not limited to, treatment of cavities and extractions; bridges, crowns, root canals; replacement or restoration of the teeth; care of gums or bones supporting the teeth; treatment of periodontal abscess; removal of impacted teeth; orthodontia (including braces, retainers and bite plates); false teeth; treatment of temporomandibular joint syndrome (TMJ) and orthognathic surgery; or any other dental service.

    This exclusion does not apply to the following procedures performed by a dentist or oral surgeon and when benefits are not available under a separate dental plan. These procedures are:
    a. initial first aid treatment received within 72 hours of an accidental Injury to sound natural teeth, the jaw bones, or surrounding issues, to the extent of extraction of teeth and repair of soft tissue;
    b. treatment for tumors and cysts (including pathological examination) of the jaws, cheeks, lips, tongue, roof and floor of the mouth; or
    c. repair of fractures and dislocations.

15. **Designated Blood Donation.** If You choose to designate another person to be a blood donor so that You may receive the designated blood at a future time, the Plan will not cover storage of such donated blood or any extra charges associated with designated blood donation.

16. **Donor Searches:** Searches for organ and tissue transplants, including compatibility testing of potential donors who are not immediate, blood related family members (parent, child, sibling).

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

18. **Enteral Nutrition.** All services and supplies associated with enteral nutrition. However, the Plan will cover these services and supplies if You have a disease or malfunction of the structures that normally

permit food to reach the gastrointestinal tract. In this case, coverage will be provided when it is required to maintain Your weight and/or prevent clinical deterioration.

19. **Equipment.** Items not eligible under Medicare Part B guidelines including but not limited to: hypoallergenic pillows, central or unit air conditioners, humidifiers, dehumidifiers, air purifiers, water purifiers, mattresses, waterbeds, commodes, exercise equipment, common first aid supplies, adhesive removers, cleansers, underpads or ice bags. Charges relating to the purchase or rental of household fixtures, including but not limited to, escalators, elevators, handrails, ramps, stair glides, adjustments to a vehicle and swimming pools are also not covered.

20. **Experimental and Investigational Procedures, Treatments, Drugs or Medicines:** Treatments, procedures, drugs or medicines that are determined to be experimental or investigational. This means that one or more of the following is true:
    a. the device, drug or medicine cannot be lawfully marketed without approval of the U. S. Food and Drug Administration and approval for marketing has not been given at the time the device, drug or medicine is furnished.
    b. reliable evidence shows that the treatment, procedure, device, drug or medicine is the subject of ongoing phase, I, II, or III clinical trials or is under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis.
    c. reliable evidence shows that the consensus of opinion among experts regarding the treatment, procedure, device, drug or medicine is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis. Reliable evidence means only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same treatment, procedure, device, drug or medicine; or the written informed consent used by the treating facility or by another facility studying substantially the same treatment, procedure, device, drug or medicine.
    d. A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational or for research purposes.

21. **First Aid Supplies.** Common first aid supplies.

22. **Foot Orthotic Devices:** Heel cups, arch supports, lifts, wedges, shoe inserts, corrective shoes, foot orthotics used solely for sports and devices not eligible under Medicare Part B guidelines.

23. **Fraudulent or Misrepresented Claims:** Services related to fraudulent or misrepresented claims.

24. **Free Care.** Care furnished without charge or care that would normally be furnished without charge. This exclusion also applies if the care would have been furnished without charge if You were not covered under this Plan or under any other health care benefit plan or other insurance.

25. **Genetic Testing:** Genetic testing services other than fetal screenings. Services for potential illnesses that may result from genetic predisposition or family history are not covered in the absence of signs or symptoms.

26. **Government Expense and Programs:** Services where care is provided at the Government's expense. This includes charges for Covered Services that are payable under Medicare or any other federal, state or local government program. The Plan will not cover treatment of disabilities from diseases contracted or injuries sustained as a result of military service or war, declared or undeclared, or any act of war. This exclusion does not apply if You are legally obligated to pay for such treatment or service in the absence of insurance or where the law prohibits it.

27. **Growth Hormone Therapy.** All services, drugs, and procedures associated with growth hormone therapy.

28. **Hair Loss Treatment.** Services and supplies for the treatment of hair loss.

29. **Hearing Care.** Hearing examinations, hearing aid evaluations, hearing aids and other hearing care services and supplies except Covered Services required for newborn hearing screening and the diagnosis and

treatment of diseases of, or injury to, the ears. (If the Employer has purchased an optional hearing aid rider, additional benefits may be available. See the Schedule of Benefits.)

30. **Home Monitoring Equipment:** Charges for services and supplies used for home monitoring, including but not limited to blood pressure equipment, hydrospray jet injectors, bed wetting alarms, home pregnancy, ovulation, HIV and any other home testing kits.

31. **Infertility Services.** Any procedure intended to induce pregnancy, such as artificial insemination, in vitro fertilization, infertility drugs, embryo or ovum transplant or transfer services, gamete intrafallopian transfer (GIFT) procedures, zygote intrafallopian transfer (ZIFT) procedures, experimental and investigational infertility services, donor ovum, and semen related costs, including collection and preparation, storage of eggs and sperm, cryogenics, sperm banking, surrogate parenting, reversal of voluntary sterilization and any related procedures, and associated counseling. (If the Employer purchased an optional rider, additional benefits may be available. See the Schedule of Benefits.)

32. **Illegal Occupation Or Criminal Activity.** Health Plan is not liable for any loss to which a contributing cause was the insured's commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal occupation or other Willful Criminal Activity. See Definitions Section of this certificate for more information regarding Willful Criminal Activity.

33. **Insulin.** Insulin, insulin injections, or other insulin therapy. (If the Employer has purchased a prescription drug rider, additional benefits may be available. See the Schedule of Benefits.)

34. **Mandated or Court Ordered Care.** Any medical, psychological, alcohol and drug abuse, or psychiatric care which is solely the result of court order or otherwise mandated by a third party (such as an Employer or licensing board).

35. **Marriage-related Services:** Marriage relationship counseling and charges relating to premarital laboratory work required by any state or local law.

36. **Medical Reports.** Special medical reports not directly related to treatment; appearances at hearings and court proceedings.

37. **Mental Illness * / Substance Abuse Services*.** Covered Services do not include the following treatments for mental illness, substance abuse:

    a. Special or remedial education, including testing and services for learning and behavioral disabilities, social skills classes, behavioral modification and other training programs including but not limited to Applied Behavioral Analysis (ABA) programs, unless the insured person's condition meets criteria for treatment of an Autism Spectrum Disorder. Applied Behavioral Analysis (ABA) if covered, may be subject to a maximum annual benefit see your Summary of Benefits. This limitation applies whether or not associated with manifest Mental Illness or other disturbances.
    b. Services which are extended beyond the period necessary for the evaluation and diagnosis of developmental disability, or pervasive developmental disorders, including but not limited to hyperkinetic syndrome, developmental disability, Rett's, Asperger's Disorder, Childhood Disintegrative Disorder, Atypical Autism or Pervasive Developmental Disorder Not Otherwise Specified;
       ;
    c. Structured sexual therapy programs;
    d. Services for narcotic maintenance therapy in which an agonist, antagonist, or agonist/antagonist drug is used for chronic administration, as well as detoxification services related to such chronic drug maintenance use;
    e. Testing for ability, aptitude, intelligence or interest;
    f. Vocational and recreational activities or coma stimulation therapy;
    g. Treatment in a specialized facility or program for a patient who has not been or would not be responsive to therapeutic management or who has not been or is not motivated;
    h. Inpatient treatment for codependency or environmental changes;
    i. Services or care provided or billed by a school, halfway house, custodial care center, or outward bound programs, even if psychotherapy is included;
    j. Cognitive rehabilitation therapy;
    k. Family counseling or marriage counseling;

l. Social skills classes;
m. Treatment for sleep disorders; or
n. Positron Emission Tomography (PET scans) for Mental Illness.

*** Note** – Biologically and Non-Biologically Based Mental Illness and Substance Abuse is covered the same as any medical/surgical benefit within the same classification or sub classification.

38. **Natural Disaster or Uncontrolled Event:** Benefit coverage may be limited due to the extent that a natural disaster, war, riot, civil uprising or any other Emergency or similar event not within the control of Paramount, results in the inability to provide Health Care Services in accordance with the Plan. Paramount will make a good faith effort to continue operations, taking into account the severity of the event.

39. **Not Medically Necessary Services:** Services and supplies which are not Medically Necessary. The exclusion of coverage in such cases is solely a benefit determination and not a medical treatment determination or recommendation. You or Your Provider may elect to proceed with the Planned treatment, at Your expense, and appeal the denial of claim for such services in accordance with the Plan's appeal procedure.

40. **Nutrition Counseling:** Nutrition counseling and related services, except when provided as part of diabetes education.

41. **Organ Donation Services:** Organ transplant services related to donation of an organ by a Covered Person; artificial organs and services related to the implantation thereof, and other related services, except as specified in Section Eight, Transplant Benefits.

42. **Orthopedic Devices:** Orthopedic devices not eligible under Medicare Part B guidelines.

43. **Paternity Testing:** Testing to establish paternity is not covered.

44. **Penile Implants:** Penile implants for the treatment of impotence of a psychological origin.

45. **Prescription Drugs and Non-Prescription Drugs:** Outpatient Prescription Drugs whether self-administered or administered by a Provider, with the exception of infused chemotherapy and short-term medications (e.g., antibiotics, steroids, etc.). Benefits are not available for vitamins, nutrients, infant formula and food supplements even if prescribed by a Physician. However, benefits for such Prescription Drugs may be available if the Employer's Contract with Paramount provides coverage under a separate Prescription Drug Program. Refer to the Schedule of Benefits and Section Fifteen, Prescription Drug Programs, if applicable.

46. **Private Duty Nursing:** Private duty nursing services.

47. **Private Room:** If You occupy a private room, You will have to pay the difference between the Hospital's charges for a private room and the Hospital's most common charge for semi-private accommodations, unless it was Medically Necessary for You to have a private room or if the Hospital only provides private rooms.

48. **Reports:** Services relating to telephone consultations, care plan oversight in the absence of the patient, missed appointments, completion of claim forms, copies of medical records or special medical reports not directly related to treatment; appearances at hearings and court proceedings.

49. **Required Examinations:** Examinations specifically for the purpose of obtaining or maintaining employment, obtaining insurance and/or professional or other licenses; examinations precedent to engaging in athletic or recreational activities or attending camp, school or other program, unless obtained in the context of the periodic examination described in Section Four, paragraph 2.J, Preventive Health Services and services for other than therapeutic purposes such as custody evaluations, adoption, research and judicial proceedings.

50. **Reversal of Sterilization:** Any procedures or related care to reverse previous voluntary sterilization.

51. **Routine Foot Care:** Any services, supplies, or devices used to improve comfort or appearance including but not limited to trimming and/or scraping of calluses, bunions (except capsular and bone surgery), toenails, subluxations, fallen arches, weak feet, chronic foot strain, or sympathetic complaints of the feet.

52. **Self-Inflicted Injuries:** Charges for the diagnosis, care, or treatment of any condition arising from self-inflicted injuries or attempted suicide, if the result of Willful Criminal Activity at the level of a misdemeanor or felony.

53. **Services After Termination of Coverage:** Services after Your coverage under this Plan ends.

54. **Services Normally Considered Non-Covered:** Services and supplies which are normally considered non-covered when another health care benefit plan has the primary Coordination of Benefits obligation, and/or services for which no charge would be made if the individual had no health care benefit.

55. **Services Not Recommended by a Physician.** Services not recommended and approved by a Physician. Also excluded are services not completed in accordance with the attending Physician's orders.

56. **Services Not Specified as Covered:** Any services not specifically described as covered in this Certificate of Coverage.

57. **Services Not Within Providers Scope:** Services and supplies that are not performed or provided within the scope of the Provider's license.

58. **Sex-related Disorders:** Gender reassignment surgery performed solely for the purpose of improving or altering appearance or self-esteem, or to treat complaints related to one's appearance are considered cosmetic in nature and not Medically Necessary. Services related to gender dysphoria and gender transition are covered when Medically Necessary. Evidence based and nondiscriminatory criteria will be used to determine Medical Necessity.

59. **Skilled Nursing Facility:** Stays for the treatment of psychiatric conditions and senile deterioration, or facility services during a temporary leave of absence from the facility.

60. **Stand-by Charges:** Physician stand-by charges.

61. **Surrogate and/or Gestational Pregnancy:** Surrogate and/or gestational pregnancy and any related procedures.

62. **Therapy Services**: Group speech therapy, group physical therapy or recreational therapy which includes but is not limited to sleep, dance, arts, crafts, aquatic, gambling, horseback riding (equestrian therapy) and nature therapy.

63. **Topical Anesthetics:** Topical anesthetics are not covered.

64. **Transplant Services:** The transportation and/or lodging costs of the transplant recipient or individuals traveling with him or her are not covered. Transplants using artificial organs or non-human donors, or any transplant which is not specifically listed in Section Eight, Transplant Benefits are not covered.

65. **Travel Related Immunizations and Services:** Immunizations for the purpose of fulfilling requirements for international travel. Charges for confinement, treatment, services or supplies received outside the United States, unless required for an emergency medical Condition.

66. **Vision Care:** Orthoptic training, eyeglasses, contact lenses, contact lens evaluation and fittings, sunglasses of any type, and surgery including but not limited to: eye surgery to correct refractory errors, LASIK surgery, Keratomileusis, excimer laser, photo refractory keratectomy (interwave technology), radial keratotomy, and other vision care services and supplies, except Covered Services required for the diagnosis and treatment of diseases of, or injury to, the eyes. (If the Employer has purchased an optional Vision Hardware Rebate Rider, additional benefits may be available. See the Schedule of Benefits.)

67. **Work-Related Injuries:** Care for treatment of a work or occupational related injury or illness. This includes charges for injury or illness arising out of or in the course of past or current work for pay, profit, or gain, unless workers' compensation or benefits under similar law are not required or available.

68. **X-Rays:** Diagnostic x-rays performed in connection with a research project are not covered.

SECTION ELEVEN: COORDINATION OF BENEFITS

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

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

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

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

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

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

How Paramount Pays as Your Secondary Plan

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

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

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

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

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

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

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

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

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

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

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

Coordination Disputes

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

SECTION TWELVE: MEDICARE AND YOUR COVERAGE

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

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

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

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

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

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

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

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

SECTION THIRTEEN: QUESTIONS, PROBLEMS OR GRIEVANCES

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

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

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

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

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

   An **"adverse benefit determination"** eligible for internal grievance includes a denial, reduction, or termination of, or a failure to provide or make a payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make a payment that is based on:

   - A determination of an individual's eligibility for coverage;
   - A determination that a benefit is not a covered benefit;
   - The imposition of a 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 or an ongoing course of treatment.

For grievances, you should follow the steps outlined below:

Internal Grievance – Level 1

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

Internal Grievance – Level 2

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

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

You will receive an acknowledgement from Paramount within five (5) working days from receipt of your request. You will also be advised that you have the right to attend an informal hearing to present your appeal in person to the Internal Grievance Committee. The member may authorize in writing that any person, including but not limited to a physician, may act on his or her behalf at any stage in the grievance review. You may request free of charge from Paramount reasonable access to and copies of all pertinent documents, records and other information regarding your appeal.

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

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

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

Rights on Grievance

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

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

3. **Additional Appeals**. If Paramount denies your internal grievance, Paramount will provide you with written or electronic notification of the determination. The notification will tell you the specific reason(s) for the Adverse Determination, the specific plan provisions on which the benefit determination is based, that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information, relevant to your claim for benefits and a statement of your right to request a review by the Director of the Department of Insurance and Financial Services, and 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. Send your Request for External Review to:

DIFS – Office of General Counsel
Appeals Section
P.O. Box 30220

Lansing, Michigan 48909-7720
1-877-999-6442
Fax: 517-284-8838
Email: difs-HealthAppeal@michigan.gov

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

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

If DIFS accepts the request for an external independent review, you will receive an acknowledgement from DIFS. (If DIFS does not accept the request, DIFS will notify you of the reason.) DIFS will 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 Members Authorized Representative, the information must be provided within thirty (30) days after receiving notification.

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

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

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

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

SECTION FOURTEEN: REIMBURSEMENT/SUBROGATION

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

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

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

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

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

SECTION FIFTEEN: PRESCRIPTION DRUG PROGRAMS

1. **Prescription Drug Benefits**. You may be enrolled in one or more of the following programs – Retail Pharmacy Program, Mail Order Pharmacy Program, Limited Medical Supplies, Specialty Drugs, Infertility Drugs, and Sexual Dysfunction Drugs. Refer to your Schedule of Benefits for more details.

2. **Pharmacy Benefits Management**. Paramount uses a pharmacy benefits manager (PBM) to manage the benefits under the Prescription Drug Program. If you have Prescription Drug coverage as part of your Plan, the PBM is indicated on your Paramount identification card. The PBM has a national network of participating pharmacies referred to as Network Pharmacies. Your Drug Copay will be lower if you use a Network Pharmacy. See #9, "How to Obtain Prescription Drug Benefits".

3. **Drug Formulary.** A Drug Formulary is a listing of Prescription Drugs established by Paramount's Pharmacy & Therapeutics Working Group (P & T). A Drug Formulary may be managed as "modified open", "open", or "closed" based upon the benefit design selected by the Employer. An open Drug Formulary provides benefits for all covered Prescription Drugs. A modified open Drug Formulary provides benefits For all covered Prescription Drugs with the exception of select excluded medications. A closed formulary only covers medications that are added to the formulary by the Pharmacy and Therapeutics Committee. Your specific Drug Formulary is indicated on your Schedule of Benefits.

   If it is Medically Necessary for you to take a Prescription Drug that is not on the formulary, your doctor must first have it approved through Paramount. Refer to the Standard and Expedited Review for Prior Authorizations, Step Therapy Exceptions, and Non-formulary Exceptions for details of the process.

   Questions regarding your specific Drug Formulary may be answered by calling the Paramount Member Services Department. Information on the Prescription Drug Program is also available on the Paramount website at: www.paramountinsurancecompany.com

4. **Generic Drugs**. To get the greatest savings on Prescription Drugs, it's important to request a Generic Drug, when available, instead of a Brand Name Drug. Your Prescription Drug Program may have Generic Mandate or Generic Substitution. Refer to your Prescription Drug formulary and your Schedule of Benefits to determine if certain brand name drugs are covered.

   • Generic Mandate means when an identical generic is available for a prescribed brand drug, only the generic drug will be covered on the formulary. The brand name drug will no longer be considered a covered formulary drug when the generic becomes available. If the physician believes the brand name drug is medically necessary they may submit a non-formulary exception request on your behalf. If

Paramount approves the request for the brand name medication you will pay the copay/coinsurance associated with the highest cost brand tier on your benefit. If the request is denied by Paramount and you still wish to receive the brand name medication, you will be required to pay the entire retail cost of the medication.

• Generic Substitution means generic drugs, when available, will be dispensed in place of a brand name drug. Your benefit tier structure determines the cost of the brand name drugs.

1. Single, 2-tier and 3-tier Copay/coinsurance - If the Physician has specified “Dispense as Written” (“DAW”), the Member will pay the Copayment required for a Brand Name Drug. If the Member requests a Brand Name Drug and the Physician has not specified "DAW", the Member will pay the amount by which the Brand Name Drug price exceeds the Generic Drug price, plus the highest Drug Copay within the Copayment arrangement.

2. 4-tier Copay/coinsurance - If the Physician has specified "Dispense as Written" ("DAW"), or the Member requests a Brand Name Drug for which a Generic Drug is available, the Member will pay the Multi Source Drug Copayment. A Multi Source Drug is a drug that has a generic, over-the-counter or isomeric brand drug equivalent. An isomeric brand drug is a drug with a molecular structure similar to an existing drug already on the market (e.g. enantiomer having a mirror image relationship to a drug already on the market.). Examples include Clarinex (desloratadine) is an isomeric brand drug of Claritin (loratadine) and Xopenex (levalbuterol) is an isomeric brand drug of Proventil (albuterol).

3. Specialty Drug - If the Physician has specified “Dispense as Written” (“DAW”), the Member will pay the Specialty Drug Copay/Coinsurance. If the Member requests a Brand Name Drug and the Physician has not specified "DAW", the Member will pay the amount by which the Brand Name Drug price exceeds the Generic Drug price, plus the Specialty Drug Copay/Coinsurance.

Preferred drugs are a list of commonly prescribed brand name drugs selected by Paramount based on clinical and cost-effectiveness. You can save money by asking your doctor to prescribe preferred drugs.

Your drug formulary may have two generic tiers. Refer to your summary of benefits to determine the tier structure that applies to you. Generic drugs are split into two tiers based on clinical efficacy, safety, and cost-effectiveness. Value Generics will have a lower copayment than Generic Drugs.

5. **Drug Deductible, Drug Copays and Coinsurance**. The Prescription Drug Program requires that you meet a Deductible and pay Coinsurance. The expenses incurred for Covered Services from In-Network, and Out-of-Network Providers including Prescription Drugs apply to a Deductible. With the exception of certain preventive medications all drug benefits are subject to the Deductible. The Deductible for your Plan is stated on Your Schedule of Benefits.

The coinsurance is a percentage of the Prescription Drug cost for which you are responsible. The Coinsurance for Your Plan is stated on Your Schedule of Benefits.

The amount You pay for Drug Deductibles and Drug Coinsurance under any benefit of a Prescription Drug Program does not count toward Your Preferred Choices Deductible but does count toward the Out-of-Pocket Maximum.

Your Drug Copays will not be reduced by any discounts or rebates received by Paramount or PBM. Any payments made by third parties such as manufacturer assistance programs and coupons do not count toward member cost share accumulations for deductibles and out of pocket maximums.

6. **Smoking Cessation Drugs -** Prescription Drugs and over-the-counter medications for smoking cessation are mandated as preventive services under federal law (PPACA). The level of benefits will depend on whether care is obtained through In-Network or Out-of-Network Providers. If You use an Out-of-Network Provider, You may be responsible for additional charges up to and including the balance of the amount billed as outlined in SECTION THREE: HOW THE PREFERRED CHOICES PLAN WORKS. For a comprehensive list of preventive services, please visit www.hhs.gov/healthcare/prevention/index.html.

7. **Contraceptive/Birth Control Drugs -** All FDA Contraceptive Services for women are covered under

Preventive Health Services as mandated under federal law (PPACA). The level of benefits will depend on whether care is obtained through In-Network or Out-of-Network Providers. If You use an Out-of-Network Provider, You may be responsible for additional charges up to and including the balance of the amount billed as outlined in SECTION THREE: HOW THE PREFERRED CHOICES PLAN WORKS. Contraceptive (birth control) services, devices and supplies, including but not limited to, voluntary sterilization (including tubal ligations and vasectomies), implantable contraceptive drugs, IUDs, or diaphragms are not covered.

8. **Days Supply, Quantity Limits, Step Therapy, and Prior Authorization**.

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.

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 should contact Paramount with information to determine whether Prior Authorization should be granted. We communicate the results of the decision to your Provider. Refer to the Standard and Expedited Review for Prior Authorizations, Step Therapy Exceptions, and Non-formulary Exceptions for details of the process.

Prior Authorization is required for coverage of an opioid analgesic prescription for chronic pain. Prior Authorization is not required for coverage of an opioid analgesic prescribed for 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.

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, a Step Therapy exception request can be submitted. Refer to the Standard and Expedited Review for Prior Authorizations, Step Therapy Exceptions, and Non-formulary Exceptions for details of the process.

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.

9. **How to Obtain Prescription Drug Benefits**. If you have the Retail Pharmacy Program, show your Paramount identification card to the pharmacist when purchasing Prescription Drugs and certain over-the- counter medications approved by Paramount. If you use a Network Pharmacy, you will be responsible for your Drug Copay and the pharmacist will submit your claim electronically to the PBM.

If you use a Non-Network Pharmacy, you will have to pay the full price of the Prescription Drug to the Non-Network Pharmacy. You will have to submit your itemized receipt to Paramount for reimbursement. Paramount or the PBM will reimburse you **50% of the benefit available, less the applicable Drug Deductible and Copay**. You must send an original, itemized pharmacy receipt to

Paramount within ninety (90) days to receive reimbursement. Refer to Section Three, #4, Filing Claims for additional information.

10. **Mail Order Pharmacy Program.** If you have the Mail-Order Pharmacy Program, it is stated on your Schedule of Benefits. A convenient network mail order service is beneficial for those who take medications regularly for chronic conditions. If your Physician prescribes this type of medication, you may want to use the Mail Order Pharmacy Program. Certain medications are required to be obtained through a mail order pharmacy. Your medication will be mailed directly to your home.

11. **CVS Maintenance Choice (90-day) Pharmacy Program** – Refer to your Schedule Benefits to determine if your plan is enrolled in the Maintenance Choice 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.paramountinsurancecompany.com.

12. **Additional Coverage Options. A**dditional coverage options, are stated on Your Schedule of Benefits.

A. **Value-Added Preventive Drug List. -** A list of Prescription Drugs, as determined by the Paramount Pharmacy & Therapeutics Working Group (P & T), that are taken for chronic conditions and used for preventive purposes. Paramount reserves the right to periodically modify the Prescription Drugs on this list. Prescription Drugs on the Preventive Drug List are not subject to the Drug Deductible, but some drugs may be subject to a Drug Copay or Coinsurance as stated in Your Schedule of Benefits.

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B. **Limited Medical Supplies -** Diabetic, asthma and other supplies as determined by Paramount's P& T subject to Copay or Coinsurance when covered under Your benefit are stated in the Schedule of Benefits. The supplies covered under the Limited Medical Supplies benefit include:

- Needles and syringes (1cc or less)
- Tubing for insulin pumps
- Blood glucose monitor, test strips and control solutions
- Lancing devices, lancets
- Peak expiratory flow rate meter (hand-held)
- Spacers for metered dose inhaler
- Masks and tubing for nebulizers
- Limited ostomy supplies
- Diaphragms

C. **Specialty Drugs -** Specialty Drugs are complex Prescription Drugs, as determined by Paramount's P & T, used to treat chronic conditions. These drugs are self-administered as injectable/infused or oral drugs and often require special handling and monitoring**.** When covered under your benefits, Specialty Drugs are subject to a Specialty Drug Copay or Coinsurance, as stated in the Schedule of Benefits. The Prescription Drugs under the Specialty Drug option are subject to prior authorization.

D. **Infertility Drugs -** Prescription Drugs for the treatment of infertility when covered under your benefits are subject to the Deductible, Infertility Copay or Coinsurance, Infertility Drug Limit stated in the Schedule of Benefits.

E. **Sexual Dysfunction Drugs -** Prescription Drugs for the treatment of sexual dysfunction when covered under Your benefits are subject to Deductible, Drug Copay or Coinsurance, applicable quantity limits stated in the Schedule of Benefits.

F. **Orally Administered Cancer Medication** - Oral chemotherapy medications will be covered when medically necessary and when the medical literature, guidelines, and expert consensus support use for the condition being treated.

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

Certain supplies and equipment obtained by Mail Service or from a Network Pharmacy (such as those for diabetes) are covered under Prescription Drug Benefits. Refer to your Schedule of Benefits and formulary list or contact Paramount to determine approved covered supplies. Other supplies, equipment or appliances may be covered as Medical Supplies, Equipment and Appliances instead of under Prescription Drug benefits.

14. **Drug Exclusions.**

The following exclusions apply:

- Unless otherwise specified in your Schedule of Benefits, durable medical equipment, therapeutic devices, support garments; and other supplies or substances which may be obtained without a prescription;
- 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.
- Dietary supplements and some prescription vitamins (other than prenatal vitamins or those mandated by PPACA guidelines);
- Prescription Drugs used for cosmetic purposes such as: drugs used to decrease wrinkles, drugs to promote hair growth, and drugs to control perspiration;
- Drugs for weight loss including diet pills and appetite suppressants;
- Drugs that do not require a prescription for dispensing known as “Over-the-Counter” drugs unless approved by the Plan;
- Any prescription products that are not FDA approved medications or are labeled as experimental or investigational. This includes prescription devices;
- Prescription Drugs used to enhance athletic or sexual performance;
- 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;
- Any Prescription Drug which is determined to have been abused or otherwise misused by a Covered Person;
- 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;
- 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;
- Prescription Drugs that are prescribed, dispensed or intended for use during a hospital inpatient or skilled nursing facility stay;
- Non-Formulary Prescription Drugs, unless determined to be medically necessary through the Non-

formulary Exceptions process;

- 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;
- Growth hormones for growth and development unless medically necessary and covered according to your Schedule of Benefits;
- Fertility drugs unless otherwise stated in your Schedule of Benefits.

15. **Standard and Expedited Review for Prior Authorizations, Step Therapy Exceptions, and Non-formulary Exceptions.** A Covered Person or physician can request and gain access to clinically appropriate drugs, and Preventive Health Services items or services that are not on the formulary, are subject to a Step Therapy Protocol, or are subject to Prior Authorization. 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 Prior Authorization or exception request can be submitted in non-exigent circumstances and receive a decision within 72 hours of receipt of a request. For expedited requests based on Exigent Circumstances determination and notification will be provided no later than 24 hours following receipt of the request. If a medication is approved, it will be approved for a 12 month duration or until your benefit eligibility changes. Non-chronic medications, controlled substances, medications with a typical treatment duration of less than a year, or medications that require safety and efficacy monitoring may initially be given a shorter duration of approval. For medications that are approved through the Prior Authorization or exception request process, the insured's cost share will apply to the Out-of-Pocket Maximum. If the request for coverage is denied, insured has the right to appeal through the appeals process outlined in Section Thirteen: INTERNAL CLAIMS AND APPEALS PROCESS AND EXTERNAL REVIEW of this Handbook.). The insured and physician will be notified of the IRO's decision no later than 24 hours following receipt of request for expedited exception request and 72 hours following receipt of a standard request. For more information or assistance, or to request coverage of a non-formulary drug or appeal a denial, contact the Paramount Member Services Department.

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

See DEFINITIONS for additional information on Exigent Circumstances.

SECTION SIXTEEN: MISCELLANEOUS PROVISIONS

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

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

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

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

5. **Domestic Violence**. Paramount shall not rate, cancel coverage on, refuse to provide coverage for, or refuse to issue or renew a health insurance policy solely because an insured or applicant for insurance is or has been a victim of domestic violence. Domestic violence means inflicting bodily injury on, causing serious emotional injury or psychological trauma to, or placing in fear of imminent physical harm by threat or force a person who is a spouse or former spouse of, has or has had a dating relationship with, resides or has resided with, or has a child in common with the person committing the violence.

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

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

8. **Right To Develop Guidelines**. Paramount reserves the right to develop or adopt criteria which set forth in more detail the instances and procedures when Paramount will make payments of benefits under the Plan. Examples of the use of the criteria are: to determine whether care was Medically Necessary, whether Emergency Services in the Outpatient department of a Hospital were Medically Necessary, or whether certain services are skilled care. These criteria will be interpretive and illustrative only and will not be contrary to any term or provision of the Plan. If You have a question about the criteria which applies to a particular benefit, You may contact Paramount for further information.

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

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

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

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

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

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

15. **Facility of Payment:** If an Insured Person dies while benefits under the Group Plan remain unpaid, the Company may, at its option, make direct payment to the Provider on whose charges the claim is based; or to the surviving spouse of the Insured Person; or if none, to his or her surviving child or children (including

legally adopted child or children) share and share alike; or if none, to the executors or administrators of the Insured Person's estate.

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

17. **Incontestability:** In the absence of fraud, any statement made by the Insured Person in applying for insurance under the Group Plan will be considered a representation and not a warranty. After the Group Plan has been in force for 3 years, its validity cannot be contested except for nonpayment of premiums or fraudulent misstatement. After an Insured Person's insurance has been in force for 3 years during his or her lifetime, its validity cannot be contested due to misstatement other than a fraudulent misstatement. Only statements that are in writing and signed by the Insured Person can be used in a contest.

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

DEFINITIONS

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

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

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

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.

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

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

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

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

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

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

Copay/Copayment - The fixed dollar amount You must pay each time You receive certain Covered Services. See Your Schedule of Benefits for a list of those services that require Copayments.

Covered Person - An eligible employee and/or his or her eligible dependents who elect coverage, become covered, and remain covered under this Plan, continuing to meet the Plan's eligibility requirements.

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

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

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

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

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

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

(a) A purpose of the trial is to test whether the intervention potentially improves the trial participant's health outcomes.

(b) The treatment provided as part of the trial is given with the intention of improving the trial participant's health outcomes.

(c) The trial has a therapeutic intent and is not designed exclusively to test toxicity or disease pathophysiology.

(d) The trial does one of the following:

- (i) Tests how to administer a health care service, item, or drug for the treatment of cancer;
- (ii) Tests responses to a health care service, item, or drug for the treatment of cancer;
- (iii) Compares the effectiveness of a health care service, item, or drug for the treatment of cancer with that of otherHealth Care Services, items, or drugs for the treatment of cancer;
- (iv) Studies new uses of a health care service, item, or drug for the treatment of cancer.

(e) The trial is approved by one of the following entities:

- (i) The national institutes of health or one of its cooperative groups or centers under the United States department of health and human services;
- (ii) The United States food and drug administration;
- (iii) The United States department of defense;
- (iv) The United States department of veterans' affairs.

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

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

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

Essential Health Benefits – is defined under federal law (PPACA) as including benefits in at least the following categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and Habilitative Services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. Your plan may contain some or all of these types of benefits. If your plan contains any of these benefits, there are certain requirements that may apply to those benefits.

Experimental, Investigational or Unproven Medications or Therapies -.
Treatments, procedures, drugs or medicines that are determined to be experimental or investigational. This means that one or more of the following is true:

a. the device, drug or medicine cannot be lawfully marketed without approval of the U. S. Food and Drug Administration and approval for marketing has not been given at the time the device, drug or medicine is furnished.
b. reliable evidence shows that the treatment, procedure, device, drug or medicine is the subject of ongoing phase, I, II, or III clinical trials or is under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis.
c. reliable evidence shows that the consensus of opinion among experts regarding the treatment, procedure, device, drug or medicine is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis. Reliable evidence means only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same treatment, procedure, device, drug or medicine; or the written informed consent used by the treating facility or by another facility studying substantially the same treatment, procedure, device, drug or medicine.
d. A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational or for research purposes.

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

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

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

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

Health 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.

Health Savings Account (HSA) - a tax-exempt trust or custodial account you set up with a qualified HSA trustee to pay or reimburse certain medical expenses you incur. You must be an eligible individual to qualify for an HSA. To be an eligible individual and qualify for an HSA, you must meet the following requirements.

- You must be covered under a High Deductible Health Plan (HDHP)
- You have no other health coverage except as permitted and explained in IRS Publication 969.
- You are not enrolled in Medicare.
- You cannot be claimed as a dependent on someone else's tax return.

High Deductible Health Plan (HDHP) -An HDHP has:

- A higher annual deductible than typical health plans, and
- A maximum limit on the sum of the annual deductible and out-of-pocket medical expenses that you must pay for covered expenses. Out-of-pocket expenses include copayments and other amounts, but do not include premiums.

A HDHP provides Preventive Health Services not subject to a deductible.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Multi Source Brand Drug – A Multi source Brand Drug includes:

- A Brand Drug that has a generic, over-the-counter or isomeric brand drug equivalent;
- A Brand Drug with An isomeric brand drug is a drug with a molecular structure similar to an existing drug already on the market (e.g. enantiomer having a mirror image relationship to a drug already on the market.). Examples include Clarinex (desloratadine) is an isomeric brand drug of Claritin (loratadine) and Xopenex (levalbuterol) is an isomeric brand drug of Proventil (albuterol).
- A Brand Drug representing a metabolite of an existing marketed drug; or
- A Brand Drug with an existing or substantially similar Brand or Generic Drug marketed by utilizing an oral, transdermal, inhaled, transscleral, etc. proprietary drug delivery system. Examples include OROS, Zydis, EnSolv, EnCirc, EnVel, CDT, or AdvaTab.

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

Non-Biologically Based Mental Illness - Non-biologically Based Mental Illness means mental illnesses that are defined in the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* and are not Biologically Based Mental Illnesses.

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

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

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

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

Out-of-Pocket Maximum - After that amount has been paid, there will be no additional payments required for Coinsurance or Copay/Copayment on Essential Health Benefits during the remainder of that calendar year.

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

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

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

Pre-existing Condition - Any physical or mental condition, regardless of the cause, for which You have received medical advice, diagnosis or care, or have had treatment recommended within the 6-month period preceding Your Effective Date.

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

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

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

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

ProMedica OnDemand Visit – 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.

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

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

Single Source Brand Drug - A Brand Name Drug that is marketed under a registered trade name or trademark and is available from only one manufacturer. These drugs are generally patent protected for a period of time.

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

Telemedicine Services 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.

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

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

Utilization Review - means a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, Health Care Services, procedures, or settings. Techniques may include ambulatory review, prospective review, second opinion, certification, Concurrent Review, case management, discharge planning, or retrospective review.

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

Waiting Period - A period of time not to exceed 90 days that must pass before an employee or dependent's coverage is effective under the terms of an Employer or union sponsored Health Benefit Plan. If an employee or dependent enrolls under an enrollment period similar to one described in Section One, Paragraph 2.C., Marriage, Birth, Placement for Adoption, or Adoption or 2.D, Special Enrollment Period, any period before such enrollment is not a Waiting Period.

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

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