PARAMOUNT

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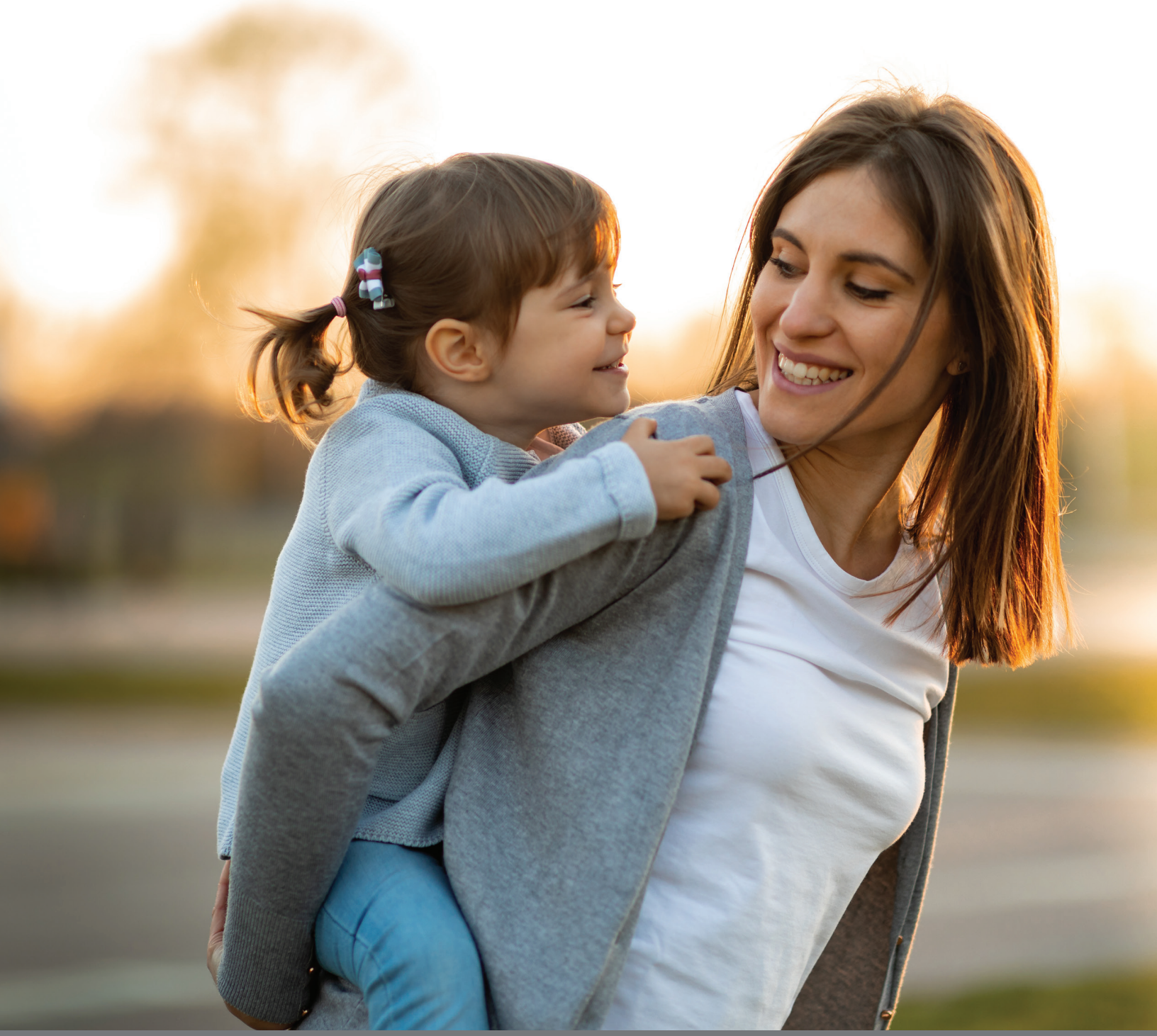
Member Guide

Frequently Asked Questions



PARAMOUNT

Get the Most Out of Your Health Insurance Benefits

Use these tips to understand your care options, maximize your benefits and save money:

- **Manage Your Plan 24/7:** MyParamount, our members-only portal, makes it easy and convenient to manage your plan. Search for in-network doctors, access your member ID card, view benefits, and more. Members may register or log in at myparamount.org.
- **Stay in Network:** Avoid higher costs by using doctors and hospitals in your plan's provider network. Log in to MyParamount to use our Find a Provider tool to find in-network providers.
- **Know What's Covered:** Review your benefits online or talk with a Paramount Member Services representative before you receive care to make sure a service is covered or find out if prior approval is needed.
- **Avoid unnecessary ER visits:** For minor injuries or illnesses, visit your primary care provider (PCP) or use an in-network convenience clinic or urgent care facility. Our free nurse line is available 6 a.m. - midnight, 7 days a week, 365 days a year. Our team of registered nurses is ready to answer your health-related questions and concerns. They can also help you decide if you should schedule an appointment with your PCP, visit an urgent care clinic, or go to the emergency room (ER).

If you do not have access to the internet or prefer to have information explained or provided in a written format, call Paramount Member Services at the number on your member ID card.

Our products are underwritten by Paramount Care, Inc or Paramount Insurance Company.

Welcome to the Family

Paramount believes in caring for members through each stage of life. Whether you receive health insurance through your employer, have individual coverage, or are shopping for Medicare, we have you covered. We are your local, trusted health plan.

We've created this Member Guide to help you understand how to get the most out of your health plan benefits.

Paramount members can visit MyParamount, our secure member portal, for more information. Or call Paramount Member Services at the number on your member ID card. Information about your plan benefits is also available in your Member Handbook, Evidence of Coverage, or Summary of Benefits.

The pharmacy benefits outlined in this guide apply to our members who have pharmacy coverage as part of their Paramount plan. If you have pharmacy benefits through a different carrier, please contact them directly with any questions about your pharmacy benefits.

Contents

What charges will I be responsible for paying?

Depending on your plan, you may be responsible for:

- A copay at each visit
- An annual individual and/or family deductible
- Coinsurance up to your maximum out-of-pocket amount
- Charges for non-covered services
- Charges in excess of the allowed amount if you use a doctor or facility not in our network
- Charges in excess of a coverage maximum, if applicable to your plan

For specific details about any charges, refer to your Member Handbook, Evidence of Coverage, Summary of Benefits and Coverage (SBC), or other documentation provided by your employer or broker.

How do I know if my plan covers a certain procedure, surgery, or service?

To check your covered benefits, review the Schedule of Benefits section in your Member Handbook, Evidence of Coverage, or your Summary of Benefits and Coverage (SBC). These documents may also be available when you log in to your plan's website or MyParamount member portal. Call Paramount Member Services if your specific service is not listed in the Schedule of Benefits or Exclusions.

Covered benefits usually include medically necessary hospital stays and surgeries, diagnostic tests, visits to the doctor and preventive care. Some plans include prescription drug coverage.

Medically necessary (or medical necessity) means the services, supplies or prescription drugs are needed to diagnose or treat a medical condition.

Also, Paramount must decide if this care is:

- Accepted as standard practice. It can't be experimental or investigational.
- Not just for your convenience or the provider's convenience.
- The most appropriate service, in the most appropriate facility, that can be provided to you.

When applied to your care as an inpatient, this means your medical symptoms or condition require that the services cannot be safely or adequately provided to you as an outpatient. When applied to prescription drugs, this means the prescription drug is cost-effective compared to other prescription drugs that will produce similar clinical results.

Excluded services typically are convenience or personal hygiene items, massage therapy, hypnosis, most over-the-counter drugs, vitamins or herbal remedies, experimental or investigational treatments, charges for missed appointments, or cosmetic procedures. For a full list of coverage exclusions, review your Member Handbook, which may be available on the MyParamount member portal or on your group plan's website (as applicable).

Note: The most accurate way to get specific benefit details for a particular procedure or service is to call Paramount Member Services and provide the medical coding your doctor's office will use on the claim. This includes codes for the specific service provided (the CPT codes) and the reason for the service (the diagnosis codes).

How does Paramount determine if a new medical technology or procedure is covered?

We perform an extensive evaluation of the use of new medical technologies, medications, behavioral health procedures and devices to ensure they are medically appropriate for our members. After multiple experts (both internal and external, depending on the complexity of the issue) conduct this evaluation, a decision is made whether to cover the new service for our members. Coverage for new services may be limited to specific medical conditions, age groups, gender, places of service, types of service or diagnoses. Experimental or investigational services may not be covered. A list of services requiring prior approval (also called prior authorization) can be found at paramounthealthcare.com/ParamountPriorAuthList or by calling Paramount Member Services at 800-462-3589 or 419-887-2525.

Where can I find a list of doctors, hospitals or providers in my plan's network?

- Log in to myparamount.org/provider-search to find in-network providers.
- Call our Customer Care specialists at the number on your member ID card.
- Not a member yet? Visit paramounthealthcare.com. From the Member tab, scroll down and choose Find a Provider.

What will happen if I don't use doctors or health providers in my plan's network?

Using doctors, specialists, hospitals, and other facilities (e.g., labs, urgent care clinics, radiology) in your plan's network can save you money. Using providers outside your network may cost you more.

- If you have a PPO plan and go outside the network, you will be responsible for paying a non-network deductible and coinsurance, and/or excess charges above the allowed amount we would normally pay for covered services.
- If you are a member of an HMO or EPO plan, or a health plan with a narrow or local network, you do not have out-of-network coverage except for emergency services. You will be responsible for paying 100% of out-of-network charges.

You may be subject to certain protections in emergency situations or if you are unable to choose an in-network provider. Learn about the No Surprises Act:

No Surprises Act

For members with plan years beginning on or after Jan. 1, 2022, the No Surprises Act allows members protection from balance billing (also known as surprise billing), only requiring them to pay the in-network billing amount under the following circumstances:

- Emergency care from in-network or out-of-network providers
- Non-emergency care from out-of-network providers at in-network facilities (e.g., anesthesiology, pathology, radiology)
- Air ambulance service(s) from out-of-network providers

The No Surprises Act does not apply when a member voluntarily chooses to use an out-of-network provider, receives notice, and signs a consent form to be billed for such services.

How do I get primary care services?

Primary care services, like immunizations and physical exams, are done by providers who specialize in general medicine, family practice, internal medicine, geriatrics, and pediatrics. These services are often provided in your primary care provider's office. While Paramount does not require members to have a primary care provider (PCP), establishing a relationship with a PCP can offer you consistency and efficiency in your health care.

To find a PCP in your plan's network, log in to myparamount.org and choose Find a Provider.

Not a Paramount member yet? Learn More.

For more information about Paramount's covered and non-covered services, network options and benefit restrictions, please review a Summary of Benefits and Coverage (SBC).

- If you are looking for an individual policy, review plans available in your area on paramounthealthcare.com (sample certificate books are also available).
- If you are part of an employer group plan, review the SBC provided as part of your Open Enrollment materials.

Additional resources and information, including our Find a Provider search tool, are available at paramounthealthcare.com.

How can I learn more about doctors, hospitals, and other providers in my plan's network?

Paramount members may log in to their MyParamount account to use the Find a Provider tool to find the following information about providers in their health plan's network. Provider types include doctors, therapists and counselors, hospitals, urgent care centers, durable medical equipment suppliers, and more.

- Name, address and phone number
- Office hours, where available
- Professional qualifications
- Specialties
- If the provider is accepting new patients
- Hospital and network affiliation
- Board certification

How do I get behavioral health, specialty, or hospital services?

To request behavioral health services, contact a behavioral health provider, including counselors and addiction specialists, in your plan's network.

Information about network specialists can be found by using Find a Provider on paramounthealthcare.com. Your primary care provider (PCP) can tell you when and where to get behavioral health, specialty, and hospital services.

To check your covered benefits, review the Schedule of Benefits section in your Member Handbook, Evidence of Coverage, or your Summary of Benefits.

How do I find a palliative or hospice care provider?

Palliative care is treatment that enhances comfort and improves the quality of a person's life during the last phase of life. We urge you to discuss this matter with your provider and family.

To find a network palliative or hospice care provider, visit paramounthealthcare.com and choose Find a Provider to search by Provider Type. If searching by specialist, choose Hospice and Palliative Care as your specialty.

What should I do if I have trouble scheduling an appointment?

We want you to be satisfied with the care you receive. If you have trouble scheduling an appointment with a medical or behavioral healthcare professional, please contact Paramount Member Services by phone or Live Chat.

How can I find care after normal office hours?

When you are ill, injured or need care, call your primary care provider (PCP) first. Your PCP can assess your symptoms and direct you to the right place for care. If your PCP's office is closed and you need prompt, non-emergency medical attention, go to a network urgent care facility or convenience clinic that can treat your condition. This may cost less than an emergency room visit. You can find a network urgent care facility by using our Find a Provider tool. Choose Urgent Care Center as the facility type.

Our free nurse line is available 6 a.m. - midnight, 7 days a week, 365 days a year, by calling Paramount Member Services at 800-462-3589 or 419-887-2525. Our team of registered nurses is ready to answer your health-related questions and concerns. They can also help you decide if you should schedule an appointment with your primary care provider (PCP), visit an urgent care clinic, or go to the emergency room (ER).

What is an emergency?

Recognizing emergency situations can be difficult for a person with no medical training. Seek emergency care if you believe not receiving immediate assistance would result in the following outcomes:

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

Everything you need, everywhere you are.

MyParamount, our secure member portal, offers quick, easy access to your health plan.

Here's how to register:

- Go to myparamount.org.
- Click on "Member Registration" at the top of the page.
- Enter your personal information from your member ID card.
- Read and accept the terms of use.
- Set up your account with a username, password, security question and additional information.
- Check your email to activate your account.
- Log in and explore.

How do I get emergency care?

During a medical emergency, go to the nearest emergency room or, if necessary, call 911. Contact your network provider within 24 hours of the emergency to arrange follow-up care, if necessary.

You should see your provider within seven days of an emergency room visit, within seven days for an inpatient stay for behavioral health services or within 30 days of an inpatient stay for other services.

If you are admitted to a hospital, our Care Management department will work with your provider to review your care. You do not need to contact Paramount for prior approval of emergency care.

Do I need prior approval for certain procedures?

Yes. Certain services and drugs require prior approval before you have the procedure or service – especially if the service or drug is considered experimental or investigational and not eligible for coverage. You're in-network provider is responsible for getting any required prior approvals. Prior approval is not a guarantee of payment – payment is based on your benefits and contract provisions. To confirm if a procedure or service needs a prior authorization, contact Paramount Member Services.

How do I get prior approval?

If your provider is in your plan's network, they will be responsible for contacting us for prior approval. If your provider is not in your plan's network, you will be responsible for getting prior approval before treatment. Contact Paramount Member Services if you need help requesting prior approval. If you are scheduled for a hospital stay, our nurses will work with your provider to gather information about your condition once you have been admitted to the hospital.

If you have questions related to inpatient admissions, denials, and appeals, including those for behavioral health services, you may call the appropriate number below. Or call Paramount Member Services at the number on your member ID card.

- Paramount Member Services - 800-462-3589 or 419-887-2525
- Utilization Management - 800-891-2520
- TTY/TDD for the Hearing and Speech Impaired - 888-740-5670; TTY: 711.

Decisions are based only on the appropriate use of care and services for you and your coverage. There isn't any direct or indirect reward or incentive for providers or any other participants in decision-making for denying or limiting coverage or service. We don't provide financial incentives for decisions that result in less use of care or services.

Can I get help for a chronic condition?

Yes. Paramount offers a variety of flexible programs to help members with chronic conditions, such as diabetes. These programs include digital or telephonic options. Joining a program can help you understand your condition, become more involved in your care, make healthy lifestyle changes, and improve your quality of life.

How can I get help for a complex medical condition or event?

Registered nurse case managers in our Case Management program are available to help you or your caregiver find resources and services, communicate with your healthcare team, and monitor your progress to make sure services are appropriate and effective. This voluntary program addresses the healthcare options and needs of members who have complex illnesses or life-limiting or incurable conditions, such as heart disease, chronic kidney disease, transplants, and more.

Want to talk with a registered nurse case manager? Call Paramount Member Services at 800-462-3589 or 419-887-2525, Monday through Friday from 8 a.m. to 5 p.m. ET.

How do I get care and coverage when traveling?

If you get sick or are in an accident while away from home, use our Find a Provider tool on paramounthealthcare.com, or call Paramount Member Services, for help finding a network doctor or hospital. If your condition is a medical emergency, go to the nearest emergency room or, if necessary, call 911.

If you are a member of an HMO plan or EPO plan, you only have out-of-network coverage for emergency services. You will be responsible for paying all non-emergency out-of-network charges in full.

Where can I find a claim form and how do I submit a claim?

Find claim forms at myparamount.org or paramounthealthcare.com. Or call Paramount Member Services at the number on your member ID card.

In-network providers must submit a claim for you. If you go to a doctor, hospital or provider that is not in your plan's network, ask them to submit a claim for you on a standardized claim form. If the provider will not submit the claim for you, contact Paramount Member Services for help.

If you go to a hospital or provider outside the United States, get a copy of all your medical records and an itemized bill. Submit your claim forms, bills, medical records, and proof of payment to the address on your member ID card.

Please remember, benefit coverage and limitations still apply when you are traveling. Refer to your Member Handbook, Evidence of Coverage, or Summary of Benefits for details.

Manage and Improve Your Health

Your plan may also include access to other benefits and resources designed to help you live a healthier lifestyle. This includes access to our wellness portal, which contains healthy recipes, fitness challenges, articles, trackers, health assessments and more. Contact your Human Resources manager or insurance broker for more information.

How can I ask a question or voice a complaint?

We want to make sure our members are satisfied with the care and service they receive. If you have a problem or concern, you can:

- Call Paramount Member Services at 800-462-3589 or 419-887-2525.
- Email us at Paramount.MemberServices@medmutual.com.
- Mail a letter to us at:
  Paramount
  P.O. Box 928
  Toledo, OH 43697

We will follow the complaint review procedure described in your Member Handbook.

Can I file a complaint anywhere else?

If applicable to your health plan, you may contact your state's department of insurance (DOI). You can find the contact information on your state's website, under state agencies in your phone book or by calling Paramount Member Services. If your complaint is about a denial, reduction or termination of a benefit or service, and you continue to disagree with our decision, you have the right to file a complaint with the DOI after all appeal rights have been exhausted.

In general, members of self-funded groups (other than a public employee benefit plan) should not file a complaint with the DOI. To learn how to file a complaint, contact your group official or employer, check your Member Handbook, or contact the U.S. Department of Labor Employee Benefits Security Administration (dol.gov/ebsa).

How can I file an appeal if my claims, requested services, or eligibility have been denied?

- If you are part of a self-funded group, refer to your Member Handbook for how to file an appeal.
- All other members may refer to the following appeal procedure.

As a member, you may exercise your right to appeal a denial to pay a claim or approve a service or procedure according to applicable state and federal law. There is no charge for filing an appeal.

You must file your appeal within 180 days from the date you received your original denial by calling Paramount Member Services or by providing your appeal request in writing. An appeal request must come from the patient unless they are a minor (in which case a parent or legal guardian of the patient may file the appeal), have appointed an individual as power of attorney representing the patient, or have authorized an individual to act as their representative.

To appeal a denial for services you need immediately, call Utilization Management at 800-891-2520. Urgent care appeals will be decided within 72 hours, as will appeals for care you need while you are in the hospital (or sooner if required by applicable law). Our decision about all non-urgent appeals will be made within 30 days from the date we receive your appeal request (or sooner if required by applicable law). You will receive our decision in writing. If our original decision is not overturned, you will be notified of any additional appeal rights you may have.

Could the Department of Insurance (DOI) review my case if it is denied?

Depending on the type of health plan you have and the reason that payment of a claim or approval of a service or procedure was denied, DOI review of the case might be available. **You should first file your appeal with us.** If your appeal has been reviewed and continues to be denied, you or an authorized representative (an individual authorized by you to file appeals on your behalf) will be informed of any additional appeal rights, including instructions for how and where to file your request for review by a DOI in your state, if such a review is available.

How can I get an independent, no-cost, external review of my denied claim or request for a service or procedure?

Depending on your health plan, you may qualify for an external review by an Independent Review Organization (IRO) if the service you are appealing meets certain conditions set by applicable state or federal law. You must first exhaust the internal appeal process with Paramount unless you are eligible to exercise our external review rights concurrently or immediately. You will be informed in writing of your

external review rights as part of our initial appeal decision. You will also be informed of the timeframe you have from the date you receive our initial appeal decision to request an external review. IROs will decide urgent and non-urgent cases in the timeframes established by the applicable state or federal laws and regulations. You will be informed in writing of the IRO's decision.

What are my appeal rights?

For members of an Employee Retirement Income Security Act (ERISA) plan, the group administrator is required to administer the plan according to its written provisions. Members of an ERISA plan also have the right, under Section 502(a) of ERISA, to bring a civil action after a denial on appeal. Please contact your group administrator to learn if you are affected by ERISA or for more information. Any statute of limitations applicable to pursuing your claim in court will be suspended during the period of the additional voluntary appeal (if your plan includes a voluntary appeal). If you decide to proceed with a voluntary appeal (if your plan includes a voluntary appeal), you do not need to exhaust this option prior to pursuing a claim in court.

If you are an individual policyholder, your plan is not subject to ERISA, so your rights are different from those available to an ERISA plan member. Please refer to your Member Handbook for more information.

If you are a member of a health plan sponsored by a public entity (e.g., public schools, governments), your plan is also not subject to ERISA. Please refer to your Member Handbook for more information about your appeal rights.

How does Paramount improve the quality of healthcare?

We continually work to promote and improve the quality of healthcare for members through our Quality Improvement program, which supports our mission to provide clinical excellence at a reasonable cost and to improve patient outcomes. Our goals are to:

- Improve the quality of healthcare services for members and their access to those services.
- Communicate clinical information to members and providers.
- Monitor and evaluate the quality and safety of healthcare provided to members.

At times, Paramount conducts member surveys — for example, about your satisfaction with your health plan. We appreciate receiving completed responses, which help us improve our services.

How should my child's care change when he or she turns 18?

At age 18, children are considered adults when it comes to healthcare. If your child has not already done so, encourage them to transition from pediatric care to a doctor or other healthcare provider who specializes in adult care. Completing this transition helps ensure the appropriate care is provided in the appropriate setting based on your child's changing needs. Age-appropriate services include new vaccines and boosters, as well as important preventive screenings.

Once members turn 18 years of age, they should create their own MyParamount account at myparamount.org. They can use the Find a Provider tool to find an adult primary care provider (PCP). Paramount Member Services teams are also available to help.

Member Rights

What are my rights and responsibilities as a member?

As a Paramount member, you have certain rights and responsibilities. Being familiar with them will help you participate in your own healthcare, which will empower you to make the best healthcare decisions possible.

Please know we support member rights and member responsibilities, which we define as your role in working with us to achieve a high-quality, cost-effective health outcome. We encourage you to review these guidelines to be an informed healthcare consumer.

For a printed copy of the Member Rights and Responsibilities, please call Paramount Member Services at the number on your member ID card.

Information disclosure

- You have the right to receive accurate, easy-to-understand information about your health plan, providers, covered services, financial liability, health promotion, illness prevention, advance directives (e.g., living will, healthcare power of attorney), and rights and responsibilities.
- You have the right to receive information about us. As applicable to your plan, you have the right to receive information about services provided on behalf of your employer or plan sponsor as well as our staff, and staff qualifications and any contractual relationships.
- You may choose to ask another person to help you or act on your behalf if you are unable to act alone at any step in the healthcare process.
- If English is not your primary language or if you have a disability or do not understand your health plan or healthcare, we can provide help so you can make informed healthcare decisions.

Access to emergency services

- If you have severe pain, an injury or sudden illness that leads you to believe that your health is in serious jeopardy, you have the right to be screened and stabilized for an emergency medical condition in a facility that provides emergency care.
- If you are injured or experiencing severe pain or sudden illness that leads you to believe your health is in serious jeopardy, you do not need our prior approval before seeking emergency care.

When using emergency room services for emergency care, you are not required to see a network provider, and you will not be charged an out-of-network penalty for receiving services for emergency care from an out-of-network provider.

Choice of providers

- You have the right to choose providers, hospitals, pharmacies, and other facilities within our network.
- You have the right to choose a primary care provider (PCP) in our network who is accepting new patients.
- You have the right to see a specialist in our network without a referral from your PCP.

Coverage

- If you are a member of a certain group health plan or non-grandfathered individual policy, with plan years beginning on or after Jan. 1, 2014, you have the right to receive covered services without the consideration of pre-existing conditions.
- You have the right to not have your policy rescinded after it was active except in situations of fraud or intentional misrepresentation, according to federal and state laws and the terms of your policy.
- You may have the right to receive certain essential health benefits covered by your health plan without annual dollar limits.
- You have the right to get covered services and prescriptions filled within a reasonable timeframe.

- You have the right to receive coverage for an ongoing course of treatment pending the outcome of an appeal of a coverage decision that reduces or terminates benefits for that course of treatment.
- For the services provided to you within the terms of your plan, your rights include prompt and accurate payment of your claims.
- You have the right to have your coverage decisions made by individuals who have expertise in the area of medicine in which your claim falls and by individuals who are impartial.

Participation in your health plan and treatment decisions

- You have the right to talk in confidence with your healthcare provider and to participate in making decisions about your care.
- You have the right to a candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
- You have the right to decline medical treatment or participation in a program we offer and to disenroll from services we offer.
- You have the right to make recommendations about this Member Rights and Responsibilities policy statement.
- You have the right to restrict the information that your healthcare provider shares with your health plan if you self pay for services in full and notify the provider of your restriction.

Privacy and confidentiality

- You have the right to exercise all federal and state privileges that protect your personal and medical information and records. You can also exercise your privacy rights under the Health Information Portability and Accountability Act (HIPAA) without fear of retaliation or condition of payment.
- You have the right to privacy and confidentiality in the usage of your personal and medical information and records.

Respect and nondiscrimination

- You have the right to fair, considerate, courteous, respectful, and nondiscriminatory care from your healthcare providers, our employees and plan representatives. You have the right to be treated with respect and recognition of your dignity and your right to privacy.
- You have the right to ask for help if you think you are treated unfairly or your rights are not respected.
- You are not required to waive rights to get benefits from your health plan.

Request to place restrictions on use/ disclosure of protected health information

- You have the right to request that your information receive special treatment, meaning that you can request additional restrictions on your information when used for treatment, payment, or other day-to-day operations. Note: Paramount is not required to agree to the restriction.
- You have the right to access or receive a copy of your protected health information (PHI) maintained by us in a designated record set. For access to your entire medical record, you must contact the doctor or facility that provided the service.
- You have the right to request an amendment to your personal and medical information. We cannot amend information we did not create. We will refer you to the service provider if you request an amendment to your diagnosis or treatment information.
- You have a right to an accounting of certain disclosures of your information made by us and our business associates over the last six years.
- You have the right to complain if you believe your rights have been violated, including the right to complain to the Secretary of the U.S. Department of Health and Human Services.
- You have the right to receive a Notice of Privacy Practices describing our legal duties and privacy practices with respect to your PHI.

- You have the right to request that we communicate with you in confidence about your information at a location different from the address associated with your policy.

Complaints and appeals

- You have the right to voice complaints or appeals about us, the care provided or any quality issue.
- You have a right to communicate complaints to us and receive instructions on how to use the complaint process that includes our standards of timeliness for responding to and resolving complaints and quality issues.
- You have the right to request and receive, at no charge, copies of the information and documentation we considered or relied on to make a coverage decision.
- You have the right to file an appeal of a denial or reduction of a benefit or a claim because you were informed it was not medically necessary, was experimental or investigational, was not a benefit of your health plan, or involved a pre-existing condition.
- You have the right to file an appeal if you were denied coverage because of ineligibility or your policy was rescinded after you became an active member.
- You have the right to get a fair, objective and timely review and resolution of an appeal; to be informed how the appeal will be managed according to federal and state laws; and informed of any relevant time limits related to filing your appeal.
- If you are covered by a fully insured plan, you have the right to request a review of a denied service or benefit by your state's department of insurance (DOI). A review by your state's DOI may be available if we deny, reduce, or discontinue coverage for a service you were told is not covered, not medically necessary, or is experimental or investigational.
- Once you have exhausted your internal appeals, you may have the right to an external review by an Independent Review Organization (IRO). This right may exist if we deny, reduce, or discontinue coverage for a service on the basis of medical necessity, appropriateness of care, healthcare setting, level of care, effectiveness of a covered benefit, or an experimental or investigational determination. This right depends on the type of health plan you have. Contact us or your health plan administrator to find out if this right and the process for pursuing this right applies to your health plan.

Member Responsibilities

- When speaking with us or your provider, supply all the information needed to provide care.
- When speaking with us or your provider, understand your health problems and participate in developing a mutually agreed-upon treatment plan and goals that work for you and your doctor or health provider, to the degree possible.
- When speaking with us or your provider, follow the agreed-upon plan and instructions for care.
- Choose a primary care provider (PCP) who is accepting new patients and can coordinate medical services if required or advised by your plan.
- Take responsibility for improving or maintaining your healthy lifestyle habits including exercising, not smoking, controlling stress, eating a healthy diet, drinking alcohol only in moderation and following safety guidelines.
- Learn how to voice a complaint and file an appeal.
- Learn about your coverage options, limitations, and exclusions by reviewing the resources available to you.
- Know the rules about use of network providers, coverage, and prior approval according to your plan.
- Know how to get information from your health plan's website, customer service and/or your health plan administrator.

- Meet your financial obligations to the providers who treat you.
- Report to us suspected wrongdoing and fraud.
- Be a responsible consumer of healthcare resources available to you.

What does Paramount do to protect my right to privacy?

We have strict policies and procedures to protect your personal information, including health information, stored on our computer systems and files. You can view our Notice of Privacy Practices on our website, paramounthealthcare.com, where you can find more information on the collection, use and disclosure of members' protected health information (PHI), as well as how to access, amend or request a restriction to the use or disclosure of your PHI by Paramount.

Visit paramounthealthcare.com and review the Notice of Privacy Practices link or call Paramount Member Services at 800-462-3589 or 419-887-2525.

How do I change my personal contact information?

You can change your contact information (e.g., address, phone number, email, primary care provider) by contacting Paramount Member Services at the number on your member ID card. If you have coverage through a group health plan, it may be necessary for you to contact your plan sponsor to make the necessary updates.

How can I update family members on my plan?

If you have coverage through your employer, work with your employer to add or remove dependents. If you have individual or family coverage through a broker, work with your broker to add or remove dependents. If you have individual coverage that you bought directly from Paramount without a broker, or need assistance, please contact Paramount Member Services.

About Your Prescription Coverage

The pharmacy benefits outlined in this section apply to Paramount members who have pharmacy coverage as part of their Paramount plan. If you have pharmacy benefits through a different carrier, please contact them directly for information about your pharmacy benefits.

What procedures should I follow to fill prescription drugs?

1. Set up an account on Caremark.com using the information on your Paramount member ID card. This will allow access to numerous resources that can assist you with understanding your pharmacy benefits. Download the CVS Health mobile app for additional resources to help manage and track your prescriptions.
2. Visit Caremark.com or use the CVS Health app to find a pharmacy in your network.
3. If you choose to use a retail pharmacy store, present your member ID card to your pharmacist to ensure your benefits are used.
4. Use drugs on your plan's formulary. The formulary contains a wide selection of brand-name and generic medications that could help lower your costs. To see if a prescribed drug is covered by your plan, log in to your Caremark.com account or CVS Health app to use the Check Drug Cost and Coverage tool. In addition to coverage information, you can also gather information about what your cost share will be for your prescription. Some medications may have limitations or other requirements that must be met prior to coverage being provided. Find more information under "Are there any limitations on the medications my doctor might order?" in this same document.
5. Find information about our available formularies and any associated restrictions or limitations at https://www.paramounthealthcare.com/members/member-tools/prescription-benefits. Call Paramount Member Services at 419-887-2525 for assistance locating the formulary that applies to your plan. Consult with your doctor to make sure you are using the most cost-effective medicine for your condition. When possible, use a generic or preferred brand if a generic is not available. Find other ways to lower costs under "Are there ways to lower my drug costs?" in this same document.
6. Pay your copay or coinsurance, as applicable.
7. If you take a long-term medication, it is often most cost-effective to use home delivery or a pharmacy that fills 90-day prescriptions. Some plans require this. Have your provider write a prescription for up to a 90-day supply with three refills, when appropriate. Learn more under "How do I use home delivery for my maintenance medications?" in this same document.

What if I have questions about my prescription drug coverage?

If you have questions about your prescription drug coverage, call Paramount Member Services. You may also access network, coverage, and pricing information at Caremark.com or by using the CVS Health app.

Are there ways to lower my drug costs?

Your copay may be less if you chose to use Caremark's home delivery pharmacy.

Depending on your benefit, there may also be a level of copay or coinsurance specific to generic, preferred brand, non-preferred brand and/or specialty prescription drugs. Always discuss using generics first with your healthcare provider.

Generic drugs approved by the Food and Drug Administration (FDA) are just as safe and strong as the corresponding brand-name drugs. Members will typically have a lower cost share for generic drugs as well as preferred brand drugs when compared to non-preferred brand drugs.

If you are an existing member, you can check medication coverage and pricing information for home delivery and retail pharmacies by logging in to your Caremark.com account or CVS Health app and using the Check Drug Cost and Coverage tool. You'll see prices for the brand-name medication, the generic medication, and therapeutic alternatives. If a price is not listed, it means the drug isn't covered. If you'd like to save money on your prescription costs, look for the "best value" option on your list. You can also compare home delivery pharmacy pricing to retail pharmacy store pricing.

How do I use home delivery for my maintenance medications?

Depending on your plan, you may have lower copays for 90-day supplies of medications using home delivery or certain retail pharmacy locations for your maintenance medications (those you take for two months or more). Check your Member Handbook, Evidence of Coverage, or Summary of Benefits for details. Some members are required to fill extended-day supplies for maintenance medications using Caremark's Mail Order Pharmacy, CVS/ Pharmacy, Costco, or Kroger. This benefit is referred to as the Maintenance Choice program. Even if you are not required, you may save money on your maintenance medications if you choose to use Caremark's Home Delivery Pharmacy.

Please refer to "Are there ways to lower my drug costs?" in this same document to find out how to find pricing information for retail and home delivery. To start using home delivery, ask your healthcare provider to write a prescription for up to the maximum days' supply allowed by your plan, usually a 90-day supply, plus refills for up to one year. Your healthcare provider can e-prescribe or fax your prescription directly to CVS Caremark; or you can mail your prescription with a completed home delivery form. For more information or to initiate a transfer of your existing prescriptions, log in to Caremark.com or the CVS Health app.

When ordering through home delivery, your medication should be delivered in about eight days (10-14 days if it's a new prescription). Please have a sufficient supply of your medicine on hand when you place your order. Once your prescription has been sent by your healthcare provider, call the Rx Information number on your member ID card to reach CVS/Caremark to confirm your prescription was received and to provide additional payment and allergy information. CVS/Caremark cannot process your prescription without this information. Check your order status and order additional refills for existing and unexpired prescriptions at Caremark.com.

Are specialty drugs covered by my plan?

In most cases, specialty drugs will be covered by your plan. For best price and service, your plan requires you to use one of our contracted specialty pharmacies to fill these prescriptions: CVS Caremark Specialty Pharmacy or ProMedica Specialty Pharmacy.

When filling specialty medications, only the amount you actually pay out of pocket will accumulate toward your annual deductible and/or maximum out-of-pocket amount. For example, if your medication costs $500 and you use a manufacturer's coupon to pay $450 of the cost, only $50 applies toward your deductible and/or your out-of-pocket limits.

Are there any limitations on medications my doctor might order?

Some medications may have quantity limits, require prior approval, or have other requirements that must be met before your prescription will be covered. For some formularies, certain medications, referred to as non-formulary drugs, may be excluded from coverage. To see if a prescribed drug prescribed is covered by your plan or has restrictions, log in to your Caremark.com account or CVS Health app and use the Check Drug Cost and Coverage tool.

A coverage review is a process to determine whether prescriptions that are covered only when medically necessary meet the criteria for coverage. To request a coverage review, ask your healthcare provider to complete an electronic prior authorization request through their electronic health record (EHR) system.

For assistance or alternative submission options, have your healthcare provider visit the Paramount provider website.

Check your Member Handbook, Evidence of Coverage, or Summary of Benefits for details on drug classes that are excluded from your prescription drug benefits. These are typically products that are not approved by the FDA as prescription drugs or products used for weight loss, erectile dysfunction, or cosmetic improvements.

What if my provider prescribes a non-formulary medication?

Talk with your doctor or healthcare provider to see if your plan's formulary includes a medication to treat your condition. In most cases, your provider will find one that meets your needs.

In the rare instance that none of the covered medications is appropriate for you and a non-formulary medication is required, you may request an exception to cover the non-formulary medication by asking for a coverage review. Ask your healthcare provider to complete a prior authorization request through their electronic health record (EHR) system. For assistance or alternative submission options, have your healthcare provider visit the Paramount provider website.

If an exception is made based on medical necessity, you will only pay your plan's applicable cost share (e.g., generic, non-preferred brand, specialty) for the non-formulary medication. If your provider does not request a coverage review and you fill a prescription for a non-formulary medication, you will pay the full cost.

How can I file an appeal if my prescription drug is not on the formulary or was denied?

You may submit a written standard appeal by mail or fax:

Paramount Health Care

Attention: Appeals Department
P.O. Box 928 Toledo, OH 43697-0928
Fax: 888-740-0222

You may request an expedited/fast appeal by phone:

800-462-3589; TTY: 711

How do I file a claim from an out-of-network pharmacy?

If you are unable to use an in-network pharmacy or your pharmacy is unable to electronically file your claim with CVS Caremark, you may submit a claim within 12 months of purchasing your medication.

Please refer to your Member Handbook, Evidence of Coverage, or Summary of Benefits to make sure your plan covers non-network pharmacies. You are not guaranteed coverage if your medication has restrictions or is non-formulary, even if you have out-of-network pharmacy benefits.

To submit a claim electronically, log in to Caremark.com or contact Paramount Member Services for assistance.

Common Health Plan Terminology

Allowed amount: The highest amount your plan will cover (pay) for a service.

Coinsurance: The set percentage you must pay during each benefit period after you have paid your deductible. This payment is for covered services only. You may still have to pay a copay.

Copayment (Copay): The amount you pay to a health provider at the time you receive services. You may have to pay a copay for each covered visit to your doctor, depending on your plan. Not all plans have a copay.

Covered charges: Charges for covered services that your health plan paid. There may be a limit on covered charges if you receive services from providers who are not included in your plan's provider network.

Deductible: The amount you pay for your healthcare services before your health plan pays. Deductibles are based on your plan's benefit period.

HMO (Health Maintenance Organization): Under an HMO plan, you might have to choose a primary care provider (PCP) who will be your main healthcare provider and will refer you to other HMO specialists when needed. If you use providers who are not in your plan's network, you will be responsible for all charges (except for emergencies).

Medical necessity: Services, supplies, or prescription drugs that are needed to diagnose or treat a medical condition are considered medically necessary. Also, an insurer must decide if this care is:

- You have the right to voice complaints or appeals about us, the care provided or any quality issue.
- Accepted as standard practice (it can't be experimental or investigational)
- Not just for your or the provider's convenience
- The most appropriate service, provided in the most appropriate facility, that can be provided to you

PPO (Preferred Provider Organization): With this type of plan, you'll pay the lowest out-of-pocket cost when you use contracted providers in the plan's network. If you choose to use out-of-network providers, you'll pay more.

Preventive services vs. medical services: Preventive services are those you get before you have any related condition or problem. They are important to maintain your health. Medical services are related to diagnosing, monitoring, and treating existing health conditions.

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

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

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

Arabic:

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

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

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

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

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

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

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

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

Assyrian:

ܟܬܒܐ ܟܬܝܦ ܟܝܢ ܦܩ ܚܟܝ ܒܟ ܐܦ .ܟܝܢ ܠܥܬܢ ܟܝܢܚ ܟܬܒܥܐ ܥܡܒ ܟܝܢ ܦܩ ܒܟ ܚܟܝ ,ܟܝܢܒܒ ܒܚܝܚܦ ܝܟ :ܟܝܡ
ܚܟ ܒܚܝܚܦ ܐܟ (TTY:711) 1-800-462-3589 ܡܢ .ܟܒܥܡ ܟܝܢܟ ܥܡ ܟܒܠܚ ܟܝܬ ܘ ܟܒܚܦ ܩܒ ܟܝ ܠܟܝܡ ܟܝܢ
.ܥܬܒܚܦ ܘ ܟܝܬ ܦܚ

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

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

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

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

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

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

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

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

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