PARAMOUNT






Paramount Care of Michigan

Multi Access 3 Tier Plan Subscriber Certificate and Member Handbook

www.paramountcareofmichigan.com
Paramount offers a diverse line of products, a broad provider network, high quality and local, dependable service.

Paramount Care of Michigan, Inc.

Multi Access 3 TIER Plan

Subscriber Certificate

and Member Handbook

In-Network Plan

Preferred Provider Organization (PPO) Plan

and

Out-Of-Network Plan

PARAMOUNT CARE
OF MICHIGAN

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

In Case of Emergency

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

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

List the names and numbers of the Primary Care Providers for each family member.

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

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

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

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

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

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

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

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

- **Participating Provider Directory**

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

- **The Professional Credentials of Participating Providers**

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

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

Or, send your request in writing to:

PARAMOUNT CARE OF MICHIGAN, INC.
106 PARK PLACE
DUNDEE, MI 48131-1016

Dear Member:

Welcome to Paramount Multi Access Plan.

This Paramount Multi Access Plan Subscriber Certificate and Member Handbook will help you understand and use your Multi Access Plan.

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

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

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

We look forward to serving you.

The Member Service Department

ProMedica

Our Mission
is to improve
your health
and well-being.

Your health. Our mission.

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MEMBER HANDBOOK

SUBSCRIBER CERTIFICATE

THE BASICS

The Paramount Multi Access Plan

The Paramount Multi Access Plan is a plan that offers you a broad selection of Paramount providers through Paramount's Health Maintenance Organization (HMO) under In-Network Coverage. It also offers the flexibility to choose to receive Covered Services from a Preferred Provider Organization (PPO) network of health care professionals with lower coverage under PPO Coverage.

Paramount's HMO is one of the largest in this area. It provides quality managed health care coverage to thousands of members through a wide network of Paramount physicians and hospitals. Paramount providers include more than 800 physicians and the finest hospitals. These providers make up the Paramount network.

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

You may also see PPO Providers and receive PPO Coverage for the same Covered Services described in the Subscriber Certificate. Under PPO Coverage, you will have to pay larger Deductibles, Copayment/Coinsurance and call for prior notification. Payments for Covered Services are based on Usual, Customary and Reasonable (UCR) amount determined by the PPO Network. You will ***not*** be responsible for charges in excess of the PPO UCR. See your Summary of Benefits for Deductible and Copayment/Coinsurance information.

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

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

Your Identification Card

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

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

Who to Call for Information

The Paramount Member Service Department is here to help you.

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

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

Members' Rights

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

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

Members' Responsibilities

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

- Provide, to the extent possible, information that Paramount and its participating providers need to care for you. Help your Primary Care Provider fill out current medical records by providing current prescriptions and your previous medical records.

- Engage in a healthy lifestyle, become involved in your health care and follow the plans and instructions for the care that you have agreed on with your PCP or specialists.

- Understand your health problems and participate in developing mutually agreed-upon treatment and goals to the degree possible.

Patient Rights and Responsibilities

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

Medical Records

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

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

HOW THE IN-NETWORK PLAN WORKS

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

Start with Your Primary Care Provider

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

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

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

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

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

MEDICAL / SURGICAL	PCP STANDARD	NON-PCP STANDARD
Routine Assessments, Physicals or New Visits	**30 days**	**60 days**
Routine Follow-Up Visits Recurring problems related to chronic conditions such as hypertension, asthma, and diabetes	**14 days**	**45 days**
Symptomatic Non-urgent Visits Examples include: cold, sore throat, rash, muscle pain, and headache.	**2-4 days**	**30 days**
Urgent Medical Problems Unexpected illnesses or injuries requiring medical attention soon after they appear.	**1-2 days**	**1-2 days**
Serious Emergencies Life-threatening illness or injury, such as heart attack, stroke, poisoning, loss of consciousness, inability to breathe, uncontrolled bleeding or convulsions.	**Immediate Care**	**Immediate Care**

BEHAVIORAL HEALTH	STANDARD
Routine Assessment of Care for New Problems Non-urgent, non-emergent conditions, initial post-hospitalization visit, new behavioral or mental health problems.	**14 days**
Routine Follow-Up Visits Continued or recurring problems when member, Primary Care Physician and behavioral health care provider agree with or prefer the scheduled time.	**30 days**
Urgent Care Unexpected illnesses or behaviors requiring attention soon after they appear.	**1-2 days**
Immediate Care for Non-Life Threatening Emergency Severely limited ability to function; behavioral health care provider may either provide immediate care, or direct to the patient to call 911 or be taken to nearest emergency room.	**Immediate Care to 6 hours**
Life Threatening Emergency (Self or Others) The expectation is that the member will receive immediate care appropriate for the critical situation (e.g. calling 911).	**Immediate Care**

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

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

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

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

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

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

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

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

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

When You Need Routine OB/GYN Care

For routine obstetrical/gynecological care, a female Member may see her Paramount PCP or a Paramount participating gynecologist or nurse-midwife.

You do not need Prior Authorization from us or any other person (including a Primary Care Provider (PCP) to obtain access to obstetrical or gynecological care from a Participating Provider in our Paramount network who specializes in obstetrics or gynecology. For a list of Participating Providers who specialize in obstetrics or gynecology, contact Paramount at www.paramountcareofMichigan.com or Member Services at (734) 529-7800.

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

When You Are Referred to a Paramount Specialist

Most of your health care needs can and should be handled by your Paramount PCP.

But when you need a specialist - a cardiologist, orthopaedist or others - your Primary Care Provider will recommend a Participating Paramount Specialist. Or you may choose the Participating Specialist you wish to see from those listed in the Participating Physicians and Facilities directory (also available on the website) and make an appointment.

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

Prior Authorization

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

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

Utilization Management

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

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

Initial Determinations

When prior authorization is required, Paramount will make a decision (whether adverse or not) within two (2) working days from obtaining all the necessary information about the admission, referral or procedure that requires approval. Paramount will advise the provider of the decision by telephone and send written confirmation to the provider and Member within three (3) working days after making the decision.

Concurrent Reviews

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

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

Expedited Reviews

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

Adverse Determinations or Denials

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

Obtaining Necessary Information

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

Entering the Hospital

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

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

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

Change in Benefits

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

If a Paramount Provider Leaves the Plan

If your Paramount PCP or any Participating Paramount Hospital can no longer provide medical services because their Paramount agreement expires, whenever possible, we will notify you in writing within fourteen (14) working days. We will cover all eligible services they provide between the date of termination and five (5) business days from the postmark date on the notice.

If a Paramount Specialist Leaves the Plan

If you are being seen regularly by a Participating Paramount Specialist or a specialty group whose agreement with Paramount ends, you and your Paramount PCP will be notified within fourteen (14) working days. You may then contact a new Participating Paramount Specialist for an appointment.

New Technology Assessment

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

HOW THE PPO PLAN WORKS

The PPO Plan allows you to choose to receive Covered Services from health care professionals participating in the PPO Network. You may also receive services from a PPO Primary Care Provider (PCP). See the PPO Participating Provider Directory.

PPO Pre-Notification Requirements

When you are using your Paramount PCP and Paramount Providers for covered services, **the Paramount Providers** are responsible for handling any necessary Prior Authorizations from Paramount.

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

a) Specialist physician office visits including OB/GYN visits and maternity care
b) Inpatient Hospital, Rehabilitation and Skilled Nursing Facility Admissions
c) Outpatient Hospital services
d) Hospice and Home Health Care
e) Autism Spectrum Disorder Services

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

If you do not call Paramount when required, you will have a penalty. The penalty is an additional 10% Coinsurance not to exceed $100.00 on physician's services and $500.00 on inpatient admissions.

Balance Billing

With the exception of Deductibles, Copayment/Coinsurance, pre-notification penalties and non-covered services, PPO providers may not balance bill you.

PPO Coverage

Payments for Covered Services under the PPO Plan are based on the Usual, Customary and Reasonable (UCR) schedule determined by the PPO Network and updated periodically. You will not be responsible for charges in excess of UCR.

See In-Network and PPO Covered Services and In-Network and PPO Exclusions for covered and non-covered services. See your PPO Summary of Benefits for specific Deductible, Copayment/Coinsurance and limits.

Paramount and PPO Provider Reimbursement

You should always show your Paramount ID card to all providers. You are responsible for paying any office visit fixed-dollar Copayment at the time you receive services. Participating Paramount and PPO Providers will notify Paramount of the services rendered. Paramount will send reimbursement directly to the providers for Covered Services. Paramount will send you a notice if any service is not covered. If you receive a denial notice and need further explanation or wish to appeal, you may call the Member Service Department for assistance.

Paramount contracts with providers for health care services on an economically competitive basis, while taking steps to ensure all our members receive quality health care. Through these contracts with providers, Paramount obtains discounts. This enables Paramount to offer affordable premiums.

When Coinsurance is charged as a percentage of Covered Services, the amount you pay is determined as a percentage of the payment allowance set between Paramount and the PPO Network and the participating provider rather than a percentage of the provider's billed charge. The allowed charge of Paramount and the PPO is ordinarily lower than the participating provider's billed charge. Therefore, the benefit of the discount is passed on to you.

Non-Covered Services

If you receive services that are not covered under your benefit plan, you are responsible for full payment to the provider of those services.

If You Receive a Bill

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

HOW THE OUT-OF-NETWORK PLAN WORKS

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

Out-of-Network Pre-Certification Requirements

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

a) Specialist physician office visits including OB/GYN visits and maternity care
b) Inpatient Hospital, Rehabilitation and Skilled Nursing Facility Admissions
c) Outpatient Hospital services
d) Hospice and Home Health Care
e) Autism Spectrum Disorder Services

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

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

In-Network Coverage Available with Prior Authorization

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

Balance Billing

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

Out-of-Network Coverage

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

Out-of-Network Covered Services are payable provided:

a) The service is incurred while eligible for this benefit;

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

WHAT TO DO FOR URGENT CARE OR EMERGENCY MEDICAL CONDITIONS

Urgent Care Services

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

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

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

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

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

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

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

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

Emergency Services

Emergency Services are those services which are required as the result of an **Emergency Medical Condition. Emergency Medical Condition** means a medical condition that manifests itself by such acute symptoms of severity, including severe pain, that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:

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

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

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

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

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

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

Outside the Paramount Provider Service Area: Go to the nearest emergency facility for treatment. Show your Paramount ID card. In some cases, you may be required to make payment and seek reimbursement from Paramount. Paramount will cover hospital, physician and ambulance charges from non-participating providers related to Emergency Medical Conditions under In-Network coverage. Appropriate Copayments/Coinsurance will be applicable.

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

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

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

The Paramount Provider Service Area

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

SUBSCRIBER CERTIFICATE

YOUR IN-NETWORK AND PPO PLAN

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

In-Network Plan General Limitations

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

In-Network and PPO Plan General Limitations

- Services that are not Medically Necessary are not covered under the In-Network and PPO Plan. The service you receive must be:
  1. Needed to prevent, diagnose and/or treat a specific condition.
  2. Specifically related to the condition being treated or evaluated.
  3. Provided in the most medically appropriate setting; that is, an outpatient setting must be used, rather than a hospital or inpatient facility, unless the services cannot be provided safely in an outpatient setting.

In-Network and PPO Deductible

The Deductible is the amount the Member must satisfy each calendar year before receiving benefits for Covered Services. The Deductible applies to all In-Network and PPO Covered Services except preventive health care services and Covered Services requiring a specific fixed-dollar Copayment. The expenses incurred for Covered Services received from In-Network providers apply toward satisfying both the In-Network and PPO Deductibles. Similarly, the expenses incurred for Covered Services received from PPO providers apply toward satisfying both the PPO and the In-Network Deductibles.

In-Network AND PPO Copayment/Coinsurance

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

In-Network and PPO Copayment/Coinsurance Limit

There is an Out-of-Pocket Limit for Copayment/Coinsurance every calendar year. The annual Out-of-Pocket Limit for Copayment/Coinsurance for Basic Health Care Services will not exceed the amount indicated on the Summary of Benefits. The Out-of-Pocket Limit does ***not*** apply to Covered Services requiring a specific fixed-dollar Copayment and Supplemental Health Services such as durable medical equipment or prescription drugs.

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

Annual Dollar Limits

Your Plan may have annual dollar limits on the claims the Plan will pay each year for Essential Health Benefits. Your Plan may include other benefits not defined as Essential health Benefits, and those other benefits may have annual dollar limits. If your Plan has annual dollar limits on Essential Health Benefits they are subject to the following;

- For a plan year beginning on or after September 23, 2010, but before September 23, 2011, the limit can be no less than $750,000.
- For a plan year beginning on or after September 23, 2011, but before September 23, 2012, the limit can be no less than $1.25 million.
- For a plan year beginning on or after September 23, 2012, but before December 31, 2013, the limit can be no less than $2 million.
- For a plan year beginning on or after January 1, 2014, there is no dollar limit for Essential Health Benefits under your Plan.

Lifetime Dollar Limits

The Essential Health Benefits that may be provided by your Plan are not subject to a lifetime dollar limit. Plan benefits that are not defined as Essential Health Benefits may have a lifetime dollar limit.

Maximum Lifetime Benefit

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

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

Benefit Limits

Certain Covered Services have Benefit Limits each calendar year. Benefit Limits will be a combined limit for Covered Services rendered by Paramount and PPO providers. See the Summary of Benefits for Benefit Limits.

In-Network Coverage Available with Prior Authorization

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

IN-NETWORK AND PPO COVERED SERVICES

A Copayment or Coinsurance may be required for Covered Services when this notation (C/L) appears. The notation (C/L) also indicates that there may be day or visit limits to these services according to the Multi Access Plan. For the details, see your In-Network and/or PPO Summary of Benefits for your Deductible and Copayment/Coinsurance requirements and specific limitations on services.

The following Covered Services are listed alphabetically:

Alcohol abuse and drug addiction treatment (C/L) (See Substance Abuse Services)

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

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

Autism Spectrum Disorders (C/L) 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 for plan years beginning on or after October 15, 2012 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. Coverage available through the end of the calendar year a Child turns 18. Covered Services are subject to the same Deductible and Copayments/Coinsurance as any other physical disease or condition; visit limits will not apply. Annual benefits maximums may apply see your Summary of Benefits.

Chiropractic Services (C/L) The services of chiropractors are covered up to a benefit limit per calendar year.

Contraceptive services (C/L) Covered. All FDA Contraceptive Services for women are covered under Preventive Health Services with a prescription.

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

- First aid received within forty-eight (48) hours of an accidental injury to sound natural teeth, the jaw bones or surrounding tissues. This includes only extraction of teeth emergency treatment of teeth and repair of soft tissue.
- Medically Necessary orthognathic (jaw) surgery
- Treatment for tumors and cysts (including pathological examination) of the jaws, cheeks, lips, tongue, roof and floor of the mouth
- Medically Necessary oral surgery to repair fractures and dislocations of the upper and/or lower jawbone only
- Medical treatment for temporomandibular joint syndrome or dysfunction (TMJ)

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

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

- X-rays
- Laboratory tests
- Organ scans
- EKGs, EEGs
- Hearing tests
- Pre-admissions tests
- Mammograms and pap smears. Screening mammograms and pap smears are covered when ordered by the PCP or Participating Specialist. Coverage for breast cancer screening mammography is in accordance with MCL Section 500.3406d
- Imaging/Nuclear cardiology studies when preauthorized by PCP or Participating Specialist

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

Drug abuse/addiction treatment (C/L) (See Substance Abuse services)

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

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

Home health care (C/L) Services include:

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

Hospice services for terminally ill patients.

Hospital and other facility services

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

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

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

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

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

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

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

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

Kidney disease treatments (C/L) Covered for:

- Hemodialysis for renal disease
- Peritoneal dialysis
- Kidney transplant services (see Transplants)
- If the patient qualifies for End-Stage Renal Disease (ESRD) benefits under Medicare, we will coordinate benefits as the secondary carrier. All Paramount procedures must be followed.

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

- Prenatal and postnatal care (office visit fixed-dollar Copayment does not apply to prenatal and postnatal visits)
- Delivery, including complications of pregnancy, hospitalization and anesthesia. A minimum hospitalization of forty-eight (48) hours will be allowed for normal vaginal delivery and ninety-six (96) hours for cesarean delivery unless your physician determines otherwise. If you are discharged earlier, follow-up home health care by a participating provider will be covered for at least seventy-two (72) hours after discharge.
- Medically Necessary diagnosis and treatment of infertility

Medical equipment (Durable Medical Equipment) (C/L) Covered from Participating Providers with a Member Copayment/Coinsurance. The item must serve only a medical purpose and can withstand repeated use. Paramount covers medical equipment and supplies that are consistent with Medicare guidelines. This includes but is not limited to: oxygen, crutches, wheelchairs, hospital beds, glucometers (blood glucose montors), diabetic syringes, insulin pump and medical supplies required for the use of the pump, chem-strips, lancets, ostomy supplies, prescription medical support hose, etc. Coverage of rental or purchase and repair or replacement is consistent with Medicare guidelines. If you need clarification of coverage, you may contact a participating DME provider or call the Member Services Department.

Mental Health services (C/L) Services for biologically and non-biologically based mental illness is covered for inpatient and outpatient care subject to the same Deductible, Copayments and/or Coinsurance as any other physical disease or condition.

Morbid Obesity Surgery (C/L) Surgery or services for the purpose of weight reduction or control is covered when:

- specifically approved by Paramount as medically necessary for severely obese members with documented high-risk co-morbidities, and
- the Member qualifies under Paramount's current Morbid Obesity Surgery Policy.

Services related to this surgery will be subject to a $1,000 annual Copay which does not apply to the Member's annual out-of-pocket limit.

Office visits (C/L) Covered for:

- Your Primary Care Provider (PCP)
- Participating OB/GYNs and other Participating Specialists

- Eligible services provided during each visit, which may include:

    - Physical exams
    - Well-baby/child exams
    - Annual gynecological exams
    - Immunizations
    - Diagnostic procedures
    - Medical/surgical procedures

Oral surgery (See Dental service and oral surgery.)

Plastic surgery (See Reconstructive surgery.)

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

Preventive Health Services Eligible services have been determined by recommendations and comprehensive guidelines of governmental scientific committees and organizations. You will be notified, at least sixty (60) days in advance, if any item or service is removed from the list of eligible services. Eligible services will be updated annually to include any new recommendations or guidelines.

Preventive services include, as an example, the following:

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

- Screening and counseling for interpersonal and domestic violence
- Sterilization – tubal (preventive diagnosis)

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

Prosthetic devices/aids/support devices (C/L) The purchase, fitting, adjustment, repair and replacement of Prosthetic Devices, including breast prosthesis following reconstructive surgery, is covered with a Member Copayment or Coinsurance up to a annual benefit maximum per calendar year. Coverage of purchase, fitting, adjustment, repair and replacement of Prosthetic Devices is covered consistent with Medicare guidelines. If you need clarification of coverage, you may contact a participating Prosthetics provider or call the Member Services Department.

A Prosthetic Device is an artificial substitute that replaces all or part of a missing body part and its adjoining tissues.

Reconstructive surgery when required for: (C/L)

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

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

Skilled nursing facility in lieu of acute inpatient hospitalization when approved in advance by Paramount. (C/L)

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

Substance Abuse services (C/L) Covered for inpatient and outpatient care for the diagnosis, crisis intervention and short-term treatment of Substance Abuse services. Covered services are subject to the same Deductible, Copayments and/or Coinsurance as any other physical disease or condition.

Partial hospitalization (comprehensive outpatient treatment) and intensive outpatient programs (comprehensive and primarily education programs for Substance Abuse and some mental health conditions) are available when approved in advance by Paramount.

Therapy services (C/L) Covered for:

- Radiotherapy and radiation therapy. Chemotherapy is covered. A Food and Drug Administration (FDA) approved drug used in antineoplastic therapy and the cost of administration is covered. Coverage shall be provided regardless of whether the specific neoplasm for which the drug is being used as treatment is the

specific neoplasm for which the drug has received approval by the Federal Food and Drug Administration if all the following conditions are met:

- The drug is approved by the FDA for use in antineoplastic therapy;
- The drug is ordered by a physician for the treatment of a neoplasm;
- The drug is part of an antineoplastic drug regimen and current medical literature substantiates its efficacy and recognized oncology organizations generally accept the treatment.
- The physician has obtained informed consent from the patient for the treatment regimen that includes FDA-approved drugs for off-label indications.

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

Transplants (C/L) Covered under the In-Network Plan for certain clinical indications with prior written authorization at a Paramount approved Center of Excellence for heart, lung, kidney, liver, pancreas, heart-lung, kidney-pancreas, cornea, bowel and bone marrow transplants. Antineoplastic drugs, in accordance with Michigan Compiled Laws (MCL) 500.3406 (e), are a covered benefit. Please notify Member Services as soon as possible after you are recommended for a transplant. This will enable a Paramount Nurse Case Manager to work with you, your PCP and Specialist to coordinate your care.

Urgent care services (C/L) Covered ONLY for initial treatment of an urgent medical condition in an urgent care facility or physician office. Follow-up treatment in or outside the Paramount Service Area must be authorized in advance by the Primary Care Provider in order to be covered.

Vision care (C/L) Covered for treatment related to a medical condition of the eyes. One routine vision exam every calendar year to monitor refractory disorders of the eyes is covered, unless a separate vision program is available.

IN-NETWORK and PPO EXCLUSIONS

These services and supplies are not covered:

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

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

a. Prior approval is made by Paramount ,or
b. Such services are for Emergency Medical Conditions.

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

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

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

6. Care for disabilities related to military service to which the Member is legally entitled, and for any services received at a military, veteran or other federal health care facility.

7. Care provided to Members by relatives.

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

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

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

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

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

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

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

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

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

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

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

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

19. Experimental medical, surgical or other health procedures including experimental drugs, devices and tests as determined by Paramount. Paramount will make this determination based on the recommendation of the Medical Advisory Committee and the most recent HAYES Medical Technology Directory.

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

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

22. Prosthetic Devices that do not meet Medicare guidelines, replacement of Prosthetic Devices due to misuse and expenses for Prosthetic Devices in excess of benefit maximum.

23. Treatment in residential treatment facilities and long-term rehabilitation for Substance Abuse.

24. Testing and treatment for learning disabilities and mental retardation, behavioral modification and other training programs including but not limited to Applied Behavioral Analysis (ABA) programs, unless the Member's condition meets criteria for diagnosis and treatment of an autism spectrum disorder. Applied Behavioral Analysis (ABA) if covered, may be subject to a maximum annual benefit see your Summary of Benefits. Employment counseling, counseling for marital or relationship conflicts. Equestrian therapy.

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

26. Contact and corrective lenses and eyeglasses, unless the Group has purchased an optional vision hardware rider. Orthoptic training and radial keratotomy.

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

28. All services related to organ donations from a living donor who is not a Paramount member. Transportation costs and the cost of lodging and meals in non-medical facilities (i.e., motels, hotels, restaurants). Services related to a Paramount organ/bone marrow donor for a non-Paramount recipient.

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

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

31. Services received in a hospital emergency room for an Urgent Medical Condition without prior direction from your PCP, a participating Paramount physician or Paramount.

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

YOUR OUT-OF-NETWORK PLAN

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

OUT-OF-NETWORK GENERAL LIMITATIONS

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

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

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

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

Out-of-Network Copayment/Coinsurance Limits: There is an out-of-pocket limit for Copayment/Coinsurance every calendar year. The Out-of-Pocket Limit can be found in the Summary of Benefits. All Out-of-Network Covered Services apply to the Out-of-Network Copayment/Coinsurance Limit with the exception of

Covered Services requiring a specific fixed-dollar Copayment. After a Member has met the Out-of-Pocket Limit in a calendar year, Covered Services are payable in full for the remainder of the calendar year.

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

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

OUT-OF-NETWORK COVERED SERVICES: See the Out-of-Network Summary of Benefits for Deductible/ Copayments/Coinsurance and limits.

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

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

   A mother may request a shorter length of stay if, in consultation with her Physician or certified nurse-midwife (in collaboration with a Physician), less time is needed for recovery.
12. Treatment, services, or supplies ordered by a Physician for post-delivery care for the mother and newborn child who requested a shorter length of stay in consultation with her attending Physician or certified nurse-midwife in collaboration with a Physician. Such care must be received within seventy-two (72) hours following discharge from the Hospital. Physician ordered post-delivery care will be provided in either a medical setting or through home health care visits and includes:
   - Physician assessment;

- Parent education;
- Assistance and training in breast or bottle feeding;
- Assessment of the home support system;
- Clinical tests or services as required by the attending Physician, or certified nurse midwife; and
- Any other treatment, services, or supplies that are consistent with the post-delivery care recommended in the protocols and guidelines developed by national organizations that represent pediatric, obstetric, and nursing professionals.

Physician ordered post-delivery care for a mother and newborn child who received forth-eight (48) hours of inpatient hospital service following an uncomplicated vaginal delivery, or ninety-six (96) hours of Inpatient hospital service following an uncomplicated cesarean section, will be provided only upon recommendation by the Physician responsible for discharging such mother or newborn child.

13. Cytologic screening for the presence of cervical cancer, including Pap smears.

14. Mammography screening and exam for females at the following intervals: one mammogram from ages 35 through 39; one mammogram every 2 calendar years (or one every calendar year, if high risk factors to breast cancer are determined by a Physician) from ages 40 through 49; one mammogram every calendar year from ages 50 through 64.

15. Routine hospital nursery care and Physician charges for a newborn while the mother is an inpatient. These charges will be considered separate from the mother's. They will be subject to the Copayment/ Coinsurance shown in the Out-of-Network Summary of Benefits.

16. Autism Spectrum Disorders. Diagnosis and evidence-based treatment including Behavioral Health Treatment; Pharmacy Care (if your employer has elected to offer prescription drug coverage); Psychiatric Care; Psychological Care; and Therapeutic Care is covered for plan years beginning on or after October 15, 2012 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. Coverage available through the end of the calendar year a Child turns 18. Covered Services are subject to the same Deductible and Copayments/Coinsurance as any other physical disease or condition; visit limits will not apply. Annual benefits maximums may apply see your Summary of Benefits.

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

1. Charges paid or payable under In-Network or Preferred Provider Organization (PPO) Coverage.

2. Unnecessary early hospital admissions prior to the date of elective surgery/services. Weekend inpatient admissions for elective services.

3. Treatment, services or supplies not Medically Necessary. This does not apply to preventive or other health care services specifically covered under the Out-of-Network Coverage.

4. Service from Out-of-Network Primary Care Providers.

5. The purchase, fitting, adjustment, repair and replacement of Prosthetic Devices. (Coverage is available under In-Network and PPO Plan.)

6. Durable Medical Equipment. (Coverage is available under In-Network and PPO Plan.)

7. Dental work, treatment or x-ray including but not limited to: a) treatment on or to the teeth; b) extraction of teeth, including bony impacted wisdom teeth; c) replacement or restoration of the teeth; d) treatment of granuloma; e) treatment including splints, physical therapy, or surgery for temporomandibular joint syndrome or dysfunction; f) placement, removal or replacement of implants or the teeth or alveolar ridge; g) treatment of periodontal disease or abscess; h) root canal; i) treatment required for or as a result of, biting or chewing; or j) braces, retainers and bite plates.

8. Cosmetic or plastic surgery except: a) repair of anatomical impairment to improve or correct functional disability; b) breast reconstruction following a covered mastectomy; or c) plastic surgery after an accidental injury.

9. Routine foot care such as trimming of corns and calluses; treatment of flat feet or partial dislocations in the feet. Shoes, shoe molds and shoe inserts.

10. Prescription drugs and medicines, unless as an inpatient and prescriptions for FDA approved contraceptive methods. See Preventive Health Services. Over-the-counter drugs or medicines; vitamins, nutrients and food supplements even if prescribed or administered by a Physician.

11. Testing and treatment for learning disabilities and mental retardation, employment counseling, vocational rehabilitation, counseling for marital or relationship conflicts, social skills classes, behavioral modification and other training programs including but not limited to Applied Behavioral Analysis (ABA) programs, unless the Member's condition meets criteria for diagnosis and treatment of an autism spectrum disorder. Applied Behavioral Analysis (ABA) if covered, may be subject to a maximum annual benefit see your Summary of Benefits. Equestrian therapy.

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

13. Surgery, services or supplies rendered for treatment of obesity or for weight reduction. This includes any surgical procedures or reversal. (Coverage is available under In-Network and PPO Plan.)

14. Treatment of craniomandibular and temporomandibular joint disorders by use of orthodontic appliances and treatment; crowns; bridges; or dentures. This does not apply to the extent the disorder is trauma related.

15. Treatment, services or supplies that are required only for insurance, travel, employment, school, camp, or similar purposes.

16. Convenience or personal comfort items such as telephone, radio, television, or barber services.

17. Care which Paramount determines is custodial. Custodial care is care: a) which is furnished mainly to assist a person in the activities of daily living; and b) for which professional skills or training is not required. Such care includes--among other things--help in eating; getting out of bed; bathing; dressing; toileting; and supervision in taking medications.

18. Eye exams for the correction of vision; the providing or fitting of eye glasses, contact lenses, or hearing aids; audiology (hearing) exams or refractive surgery (radial keratotomy).

19. Organ transplant services. (Organ transplant services at Paramount approved centers with Paramount authorization are covered under In-Network Coverage.)

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

21. Non-Emergency transportation services

22. Penile implants, erectile devices.

23. Cardiac Rehabilitation, Phase III.

24. Manual manipulation of the spine.

25. Growth hormones or steroids. (Coverage is available under In-Network and PPO Plan.)

26. Emergency services including transportation to a Hospital by a professional licensed ambulance service and care rendered at an Urgent Care Facility. (These services are payable under In-Network Coverage.)

27. Sex transformation; sterilization reversals; or surgery or treatment related to sexual dysfunction. Infertility treatment by artificial means for the purpose of causing a pregnancy, such as drugs; medicines; artificial insemination; in vitro fertilization; embryo transplants, surrogate and/or gestational parenting and pregnancy related services when the intended parents or another party have paid for the surrogate mother's medical expenses and elective abortions.

28. Dietician counseling services.

29. Male sterilization (vasectomies).

30. Private duty nursing.

31. Outpatient physical, occupational, speech therapies. (Coverage is available under In-Network and PPO Plan.)

32. Breast reduction surgery. (Coverage is available under In-Network and PPO Plan.)

33. Services for which pre-certification is required but was not obtained by the Member.

Filing Claims for Out-of-Network Coverage

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

WHO IS ELIGIBLE?

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

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

Spouse The legal spouse of the Subscriber.

Dependent children This Plan will cover your married or unmarried child as defined in the "Who is Eligible?" section of this Plan until your child reaches age 26.

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

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

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

Not eligible: Grandchildren and parents.

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

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

Adopted children

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

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

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

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

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

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

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

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

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

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

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

Group Probationary or Waiting Period New employees of employers with more than fifty (50) employees will have coverage effective after the probationary or waiting period established by the employer. For employers with less than fifty (50) employees, the probationary or waiting period will not be more than ninety (90) days. See your benefits office for details.

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

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

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

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

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

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

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

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

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

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

Nondiscrimination No one who is eligible to enroll as a Subscriber, Dependent or Dependent with Disabilities will be refused enrollment by Paramount based on health status, health care needs or age. Paramount will not terminate coverage for you or your Dependents due to health status, health care needs or the exercise of rights under Paramount's internal procedures. However, Paramount will not re-enroll anyone terminated for any of the reasons listed in the Termination of Coverage section.

Renewal of Coverage

If all the conditions of eligibility are met, the coverage will be renewed at the end of the term specified in the Group Medical and Hospital Service Agreement. Renewal of coverage is not based on the Member's health condition and is not subject to any genetic testing or the results of such testing.

Paramount will renew coverage at the option of the Group. Paramount will not renew Group coverage only under the following conditions:

- Non-payment of premiums
- Fraud
- The Group falls below minimum contribution or participation rules.

Termination of Member Coverage

A Member's coverage under Paramount may end for any of the following reasons:

- You fail to pay, or have paid for you, the required prepayments.
- You no longer meet the eligibility requirements.
- You no longer reside in the Michigan Service Area (except for court-ordered dependents).
- You have performed an act or practice that constitutes fraud or material misrepresentation of material fact under the terms of the coverage.

The termination may not be based, either directly or indirectly, on any health status-related factor concerning the Member.

Rescission of Coverage

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

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

Benefits After Cancellation of Coverage

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

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

Certificate of Creditable Coverage

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

Confidentiality

Paramount maintains your documented personal health information, whether obtained in writing, electronically or verbally, in the strictest confidence. Every Paramount employee is required to maintain Paramount's confidentiality policy as a condition of employment and signs an annual certification on confidentiality procedures. Except when required by law, Paramount will not release any identifiable personal health information to a third party (including your employer) without first giving you the opportunity to approve or deny the request through written authorization.

Any individual, provider, vendor or organization performing services on Paramount's behalf is also required to maintain confidentiality.

See Paramount's Notice of Privacy Practices for more information.

Insurance Fraud

Insurance fraud significantly increases the cost of health care. Paramount encourages you to let us know if you have any questions or concerns about Paramount providers and/or the services you receive. Please contact the Paramount Member Service Department for confidential handling at 734-529-7800, or toll-free at 1-888-241-5604. TTY services for the hearing-impaired are available at 1-800-740-5670. You may also contact the ProMedica Health System Compliance Hotline for confidential investigation. That hotline number is 1-800-807-2693.
Any person who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud under Michigan law and is subject to immediate termination of benefits.

WHAT HAPPENS WITH YOUR PLAN

When You Have Other Coverage - How Coordination of Benefits Works

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

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

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

Plans That Do Not Coordinate

Paramount will pay benefits without regard to benefits paid by the following kinds of coverage:

- Individual (not group) policies or contracts, except where Paramount may have subrogation rights against your rights to recover under certain individual policies.
- Medicaid
- Group hospital indemnity plans which pay less than $100 per day
- School accident coverage
- Some supplemental sickness and accident policies

How Paramount Pays as Your Primary Plan

When we are primary, we will pay the full benefit allowed by your contract as if you had no other coverage.

How Paramount Pays as a Secondary Plan

- Our payments will be based on the balance left after the primary plan has paid. We will pay no more than that balance. In no event will we pay more than we would have paid had we been primary.
- We will pay only for health care expenses that are covered by Paramount.
- We will pay only if you have followed all of our procedural requirements, including care obtained from or arranged by your Primary Care Provider, or Participating Specialists, Prior Authorizations, etc.
- We will pay no more than the "allowable expenses" for the health care involved. If our allowable expense is lower than the primary plan's, we will use our allowable expense. That may be less than the actual bill.

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. **Children** (parents divorced or separated) 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.)

If neither of those rules applies, the order will be determined in accordance with the Michigan Compiled Laws Section 550.253 and any regulations issued there under.

3. **Children (parents not divorced or separated) 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.

However, if your spouse's plan is issued in another state and has some other coordination rule (for example, a "gender rule" which says the father's plan is always primary), we will follow the rules of that plan.

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

Coordination Disputes

If you believe that we have not paid a claim properly under coordination of benefits, you should first attempt to resolve the problem by contacting us. Please refer to Section 6, of this Subscriber Certificate for the appeal/ grievance procedures.

When You Are Eligible for Medicare

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

When You Qualify for Worker's Compensation

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

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

When Someone Else Is Liable (Subrogation and Reimbursement)

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

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

When You Leave Your Job

Members who no longer meet eligibility requirements under Section 4 of this handbook may be eligible for continuation coverage under the employer group's health benefits plan or for individual conversion coverage. See your benefits office for more information.

How You May Continue Group Coverage

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

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

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

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

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

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

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

- The covered Subscriber and Dependents may continue coverage for up to 24 months
- Covered Dependents may continue coverage for up to 36 months if any of the following events occurs during that 24 month period:
  a. The death of the reservist
  b. The divorce or separation of a reservist from the reservist’s spouse
  c. A covered Dependent child’s eligibility under this coverage ends

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

How to Convert to Individual Coverage (When Group Coverage Is No Longer Available)

If your group coverage or continuation coverage ends other than for nonpayment or fraud, you and/or your eligible Dependents can convert to individual membership without providing evidence of insurability. You may call Paramount's Member Service Department and they will send you a summary of the available conversion benefits and a payment schedule. A Member who meets the definition of a Federally Eligible Individual will have the option to convert to an individual membership.

1. To obtain individual membership, you must meet all of the following conditions:

- You must continue to live in the Michigan Service Area.
- You must have been continuously covered under the group agreement for at least three (3) months prior to the termination of group coverage.
- You must submit a complete application for conversion to an individual policy within thirty-one (31) days after the date your coverage ends.
- You must submit any prepayment required. Details of the current prepayment rates will be sent to you at your request for conversion information.

2. Conversion to individual membership is not available when:

- The Group agreement has been terminated by the group or Paramount for any reason and has been replaced by other group coverage.
- A Member is covered under Medicare.
- A Member is covered by or eligible for any other pre-paid or expense-incurred policy, health plan or health insurance.

- Termination of a Member's group coverage occurred because of nonpayment of required premiums or because of fraud.

3. If you are under group continuation coverage, the conversion option must be offered to you by your former employer during the 180 days before the expiration of continuation (COBRA) coverage.

Please be aware that an individual plan may not offer all the same benefits as your group coverage plan.

Conditions of Individual Conversion

- Conversion to individual coverage will be available to Members who live in the Paramount Michigan Service Area, are not eligible for Medicare benefits or any other policy of insurance or health care plan providing comparable benefits, and have lost eligibility due to termination of employment conditions or Dependent eligibility requirements.

- If a Member chooses to apply for conversion, the conversion will be effective retroactively from the date group or continuation coverage ended.

- If a Member chooses not to apply for conversion and receives health services or benefits during the 31-day decision period, that Member must pay for those services.

- The Member is responsible for the required payment according to the plan's prepayment schedule as detailed in the individual plan document ("Individual Medical and Hospital Service Agreement").

If Paramount Ends Operations

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

WHAT TO DO WHEN YOU HAVE QUESTIONS, PROBLEMS OR GRIEVANCES

Paramount's Member Service Department welcomes your questions from 8:00 A.M. to 5:00 P.M., Monday through Friday. The Member Service staff can be reached by calling 734-241-5604 or use our toll-free number 1-888-241-5604. You can contact us by e-mail at: member.services@promedica.org

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

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

How to Handle a Problem

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

Filing a Grievance

Under Michigan 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 the 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:	35 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

Paramount will notify you of a benefit determination, whether adverse or not, with respect to an urgent care claim as soon as possible, but not later than 72 hours from receipt of the grievance, unless you fail to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under your benefit plan. In addition, concurrent internal grievance and external review is allowed for claims involving urgent care of an ongoing course of treatment.

For grievances, you should follow the steps outlined below:

Internal Grievance – Level 1

If you have a 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 and seven (7) calendar days for other problems. 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 Care of Michigan, Inc.
Member Services Department
106 Park Place
Dundee, MI 48131-1016
(734) 529-7800
Toll-free 1-888-241-5604

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

of charge from Paramount reasonable access to and copies of all pertinent documents, records and other information regarding your appeal.

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

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

Rights on Grievance

In connection with your right to file a grievance on an adverse determination, you:

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

receive no reduction or termination of an ongoing course of treatment without advance notice from Paramount or an opportunity for advance review.

If Your Grievance is Denied

If your grievance is denied, 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 Superintendent of Insurance, an external review and/or bring an action under section 502(a) of ERISA. 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.

Additional Appeals

If Paramount denies your internal grievance (issues a final adverse determination), you will be informed of your right to ask DIFS for an external independent review. 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 www.michigan.gov/difs.

The address is:

Department of Insurance and Financial Services
Healthcare Appeals Section
Office of General Counsel
P.O.Box 30220
Lansing, Michigan 48909-7720
1-877-999-6442

Instructions for Requesting an External Independent Review

Not later than *60 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.

Expedited External Reviews

You or your authorized representative may make a request for an expedited external independent review with DIFS ***within 10 days*** after receiving an adverse determination if both of the following are met:

- The adverse determination involves a medical condition in which the timeframe for completion of an

expedited internal grievance would seriously jeopardize the life or health of the member or would jeopardize the member's ability to regain maximum function as substantiated by a physician either orally or in writing.

- The member or member's authorized representative has filed a request for an expedited internal grievance.

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

Limitation on Legal Actions

No action at law or in equity shall be brought to recover on this plan prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this plan. No such action shall be brought after the expiration of 3 years after the time written proof of loss is required to be furnished. We encourage you to exhaust all the applicable procedures described above prior to bringing an action in court.

TERMS AND DEFINITIONS

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

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

BEHAVIORAL HEALTH TREATMENT means evidence-based counseling and treatment programs, including Applied Behavior Analysis, that meet both of the following requirements: (i) are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual (ii) are provided or supervised by a board certified behavior analyst or a licensed psychologist so long as the services performed are commensurate with the psychologist's formal university training and supervised experience.

BENEFIT LIMIT: For certain services, Paramount will pay Covered Services limited to the amount listed in the Summary of Benefits for a Member in a calendar year. This applies individually to each Member. When benefits in such amount have been paid, or are payable, to the Member, all coverage for the service under this Multi Access Plan will terminate for the rest of the calendar year. In-Network, PPO and Out-of-Network benefits will be combined in order to calculate a Member's Benefit Limit.

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

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

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

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

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

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

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

EFFECTIVE DATE is the date your coverage begins.

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

1. Placing the health of the individual or, with respect to a pregnant woman, the health of the woman or the unborn Child, in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

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

ESSENTIAL HEALTH BENFITS is defined under federal law (PPACA) as including benefits in at least the following categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services; including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. Your plan may contain some or all of these types of benefits prior to 2014 when they become mandatory. If your plan contains any of these benefits, there are certain requirements that may apply to those benefits.

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

- Are still in the investigative or research state
- Have not been adopted for general clinical use
- Have not been approved or accepted by the appropriate review body
- Are not generally accepted by the local medical community as safe, appropriate and effective treatment Antineoplastic drugs in accordance with MCL Section 500.3406e are covered benefits.

FEDERALLY ELIGIBLE INDIVIDUAL is an individual who meets the qualifications listed below:

1. The individual has at least 18 months of creditable coverage without a significant break (63 days) as of the date on which the individual seeks coverage.
2. The individual's most recent prior creditable coverage was under a group health plan, government plan, or church plan (or health insurance coverage offered in connection with any of these plans).
3. The individual is not eligible for coverage under any of the following:
   (I) A group health plan.
   (II) Part A or Part B of Title XVIII (Medicare) of the Social Security Act.
   (III) A state plan under Title XIX (Medicaid) of the Social Security Act (or any successor program).
4. The individual does not have other health insurance coverage.
5. The individual's most recent coverage was not terminated because of nonpayment of premiums or fraud.
6. If the individual has been offered the option of continuation under a COBRA continuation provision or a similar State program, the individual has both elected and exhausted the continuation coverage.

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

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

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

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

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

MAXIMUM LIFETIME BENEFIT: Paramount will pay benefits limited to the Maximum Lifetime Benefit shown in the Summary of Benefits. This applies individually to the Subscriber and each Member.

MEDICAL NECESSITY means the service you receive must be:

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

MEMBER means any Subscriber or Dependent as defined in Section 4/Who Is Eligible.

MICHIGAN SERVICE AREA means Monroe and Lenawee counties in Michigan.

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

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

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

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

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

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

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

PARTICIPATING PARAMOUNT SPECIALIST means a physician who provides Covered Services to members within the range of his or her medical specialty and has chosen to be designated as a specialist physician by Paramount.

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

PREFERRED PROVIDER ORGANIZATION (PPO) HOSPITAL AND PROVIDER means a hospital, primary care or specialist physician or other health care professional or facility that has a contract with the Multi Access Plan PPO Network to provide Covered Services to Members.

PREFERRED PROVIDER ORGANIZATION (PPO) COVERED SERVICES are authorized services in the list of services covered and applies when the Member receives Covered Services from PPO Participating Providers. PPO Covered Service are subject to a Deductible, Copayment/ Coinsurance or other limitations.

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

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

PRIOR AUTHORIZATION is required for certain procedures or services. It is the responsibility of the Participating Provider to obtain Prior Authorization from Paramount in advance of these procedures or services.

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

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

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

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

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

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

URGENT MEDICAL CONDITION is an unforeseen condition of a kind that usually requires medical attention without delay but that does not pose a threat to the life, limb or permanent health of the inured or ill person.

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

PARAMOUNT CARE
OF MICHIGAN, INC.

106 Park Place
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