PARAMOUNT






Paramount Care of Michigan

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

Subscriber Certificate and Member Handbook

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.

PARAMOUNT

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Syriac: ܙܘܗܪܐ: ܐܢ ܐܢܬܘܢ ܟܐ ܡܗܡܙܡܝܬܘܢ ܠܫܢܐ ܐܬܘܪܝܐ، ܟܐ ܡܨܝܬܘܢ ܕܩܒܠܝܬܘܢ ܚܠܡܬܐ ܕܗܝܪܬܐ ܒܠܫܢܐ ܡܓܢܢܐܝܬ. ܩܪܘܢ ܥܠ ܡܢܝܢܐ1-800-462-3589 (TTY: 1-888-740-5670)

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

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

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

Notice of Nondiscrimination and Accessibility: Discrimination is Against the Law

Paramount complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Paramount does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Paramount provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Member Services at 1-800-462-3589.

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

Member Services
1901 Indian Wood Circle, Maumee OH 43537
Phone: 419-887-2525
Toll Free: 1-800-462-3589
TTY: 1-888-740-5670
Fax: 419-887-2047
Email: Paramount.MemberServices@ProMedica.org.

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

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

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

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

In Case of Emergency

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

Your 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, Deductibles, Copayments/Coinsurance, referral procedures, limitations and exclusions**

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

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

- **The Professional Credentials of Participating Providers**

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

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

Or, send your request in writing to:

PARAMOUNT CARE OF MICHIGAN, INC.
106 PARK PLACE
DUNDEE, MI 48131-1016
(734) 529-7800
1-888-241-5604

Dear Member:

Welcome to Paramount.

This Subscriber Certificate and Member Handbook will help you understand and use your benefits most effectively.

The Primary Care Provider you chose when you joined will help you when you need medical care. ALWAYS CONTACT YOUR PRIMARY CARE PROVIDER FIRST unless there is an Emergency Medical Condition. He or she will help you coordinate all your medical care.

If you did not need to change doctors, be sure to call your Primary Care Provider's office as soon as possible to let them know you are now covered by Paramount.

If you did change doctors, it is a good idea to get to know your doctor so you can feel comfortable asking questions, especially if an Emergency Medical Condition arises. If you are a new patient with your Primary Care Provider, we encourage you to call the doctor's office for an appointment as soon as you can to discuss your medical history and to get to know each other.

This 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, feel free to ***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

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

Your health. Our mission.

Paramount Care of Michigan, Inc. is an affiliate of ProMedica a locally owned, nonprofit healthcare organization serving northwest Ohio and southeast Michigan.

TABLE OF CONTENTS

MEMBER HANDBOOK

THE BASICS

How Paramount Works

Your Primary Care Provider is your first contact when you need medical care. Your PCP will coordinate your medical care with other Participating Providers in the Paramount network. Female Members may receive OB/GYN care from a participating obstetrics/gynecology specialist without Prior Authorization from the Primary Care Provider (PCP). 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.

Your Identification Card

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

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

Is There a Pre-existing Condition Restriction?

Many health benefit plans have pre-existing condition limitations. Paramount does not have any restrictions on pre-existing conditions. In other words, if you were being treated for a condition before you became a Member, Paramount will provide benefits for Covered Services related to that condition on or after your effective date with Paramount as long as you follow the procedures described in the section ***Getting a Doctor's Care***.

What Are Deductibles, Copayments/Coinsurance and Out-of-Pocket Copayment/Coinsurance Limits?

A Deductible is the amount you must pay for Covered Services within each Contract Year before benefits will be paid by Paramount. The single Deductible is the amount each Member must pay, and the family Deductible is the total amount any two or more covered family members must pay. The deductible amount of one family member will not exceed that of the single deductible amount. Preventive Health Services are not subject to the Deductible or any other Cost Sharing. A plan will only be used as a High Deductible Health Plan (HDHP) with a Health Savings Account (HSA) when it follows the minimum and maximum limits for a HDHP. See Definitions section of this certificate for more information regarding an HDHP and HSA.

If your plan has a Deductible, it will be stated in your Summary of Benefits.

A Copayment/Coinsurance is your share of the cost for Covered Services. The Copayment/Coinsurance for any Basic Health Care Service will not exceed 50% of the reimbursement for that service. **Specific fixed-dollar Copayments are due at the time you receive services. If a cost-sharing percentage, Coinsurance, is applicable, the provider will bill you once the claim has been processed.** Copayments/Coinsurance for specific services are stated in your Summary of Benefits.

An Out-of-Pocket Copayment/Coinsurance Limit is the maximum amount of Copayments/Coinsurance you pay every Contract Year. The single Out-of-Pocket Copayment/Coinsurance Limit is the amount each Member must pay, and the family Out-of-Pocket Copayment/ Coinsurance Limit is the amount two or more family members must pay. Once the Out-of-Pocket Copayment/Coinsurance Limit is met, there will be no additional Copayments/Coinsurance on Basic Health Services during the remainder of the Contract Year. The Out-of-Pocket Copayment/Coinsurance Limit does not apply to Covered Services requiring a specific fixed-dollar Copayment, Supplemental Health Services or any penalties.

The Out-of-Pocket Copayment/Coinsurance Limit is stated in your Summary of Benefits.

Who to Call for Information

The Paramount Member Services Department is here to help you.

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

- Have any questions about your coverage
- Have questions about the providers who participate with Paramount
- Have questions about how to obtain health care services
- 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.
- To voice complaints or appeals about Paramount or the 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.

GETTING A DOCTOR'S CARE

Start with Your Primary Care Provider

Your PCP is the doctor you chose to handle your medical care through your Paramount plan. Paramount requires the designation of a Primary Care Provider (PCP) for each Member. You have the right to designate any PCP who participates in the Paramount network as a PCP and who is available to accept you or your family members. PCPs are family practitioners, internists and pediatricians participating in the Paramount network. For children, you may designate a pediatrician as the PCP. Each family member can have a different PCP. For information on how to select a PCP, and a list of the Participating PCPs, contact Paramount Member Services at (734) 529-7800 or toll-free 1-888-241-5604. A directory of Participating Providers is also available at: www.paramountcareofmichigan.com.

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 Services Department for assistance.

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.

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

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

What to Consider When Selecting a Physician or Hospital

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

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

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

The following qualifications are important when selecting a hospital:

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

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

When You Need OB/GYN Care

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

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

When You Are Referred to a Specialist

Most of your health care needs can and should be handled by your Primary Care Provider. But when you need a specialist, a cardiologist, orthopedist or others, your Primary Care Provider will recommend a Participating 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 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 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 Primary Care Provider. If your Primary Care Provider and the specialist agree that your condition requires the coordination of a specialist, your PCP will contact Paramount. Together, you, your Primary Care Provider, your specialist and Paramount will agree on a treatment plan. Once this is approved, the specialist will be authorized to act as your Primary Care Provider in coordinating your medical care.

Utilization Management

Participating 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 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 PCP or Paramount**. After you are treated, you should notify your Primary Care Provider as soon as reasonably possible to coordinate your follow-up care.

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

If you need to discuss the status of a referral, you should contact your Primary Care Provider. You may also call the Member Services 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 Primary Care Provider or Participating 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 web site 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 any services, except Emergency Medical Services, at nonparticipating hospitals.

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

An emergency admission to a nonparticipating hospital should be called in to Paramount within 24 hours (or as soon as reasonably possible). If and when your medical condition allows, your Primary Care Provider 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 Subscriber Certificate and Member Handbook and Summary of Benefits change.

If a Provider Leaves the Plan

If your Primary Care Provider or any Participating 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 Specialist Leaves the Plan

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

Continuity of Treatment

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

Provider Reimbursement/Filing a Claim

You should always show your Paramount ID card to all providers. You are responsible for paying any office visit Copayments at the time you receive services. Participating Providers must notify Paramount of the services they have rendered within 90 days from the date of service.

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

Paramount Care of Michigan, Inc.
106 Park Place
Dundee, Michigan 48131-1016

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

Non-Covered Services

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

If You Receive a Bill

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

New Technology Assessment

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

Ownership and Physician Compensation

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

Paramount contracts with Participating Providers for health care services on an economically competitive basis, while taking steps to ensure that Paramount Members receive quality health care. Paramount reimburses Participating Providers through "capitation" or "fee-for-service". Capitation is a fixed amount paid each month, mostly to Primary Care Providers (PCPs), to treat those Members that have selected that PCP. Fee-for-service is the payment of a specific amount for each specific service provided by the physician. The amount is determined by Paramount, based on the procedure performed, and the Paramount allowed amount for that procedure. Participating Providers agree to accept the Paramount allowed amount (from a contractual fee schedule) as payment in full. Participating Primary Care Providers are not subject to any risk or financial incentives for hospitalization or referring their patients for specialized services.

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

Paramount also offers optional Prescription Drug coverage to employer groups. If your employer has elected to offer Prescription Drug coverage, it is administered by a pharmacy benefit manager (PBM) on behalf of Paramount. Part of this PBM service is to obtain discounts at pharmacies that contract with the PBM. If your drug Copayment is a percentage, the amount you pay is determined as a percentage of the discounted cost, rather than a percentage of the retail cost. Therefore, the benefit of the discount is passed on to you. If the drug costs less than your Copayment, you will pay the lesser of your Copayment or the discounted cost of the drug plus the pharmacist's dispensing fee. Under the Paramount agreement with the PBM, there are also certain administrative costs and rebates. Neither the

administrative costs nor the rebates are included in your drug benefit. Paramount pays the administrative costs and retains the rebates to help offset administrative expenses. Not all benefit plans include coverage for Outpatient Prescription Drugs. Refer to your summary of Benefits. Contact the Member Services Department if you have questions.

Patient Safety

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

- Provide your doctors with a complete health history.
- Be an **active member** of your health care team. Take part in every decision about your health care. Speak up – ask questions.
- Make sure that all of your doctors know about everything that you are taking, including over the counter medications and herbal/dietary supplements.
- Make sure that your doctors know about any allergies and reactions to medications that you have had.
- Ask for test results. Don't assume that no news is good news.
- Advise your doctor of any changes in your health.
- Follow your doctor's advice and the instructions for care that you and your doctor have agreed on.
- Make sure that you can read the prescriptions you get from your doctor.

- Ask your doctor and pharmacist questions about your medications.
    - What is the medication for?
    - What are the brand and generic names of the medication?
    - What does the medication look like?
    - How should it be taken and for how long?
    - What should you do if you miss a dose?
    - How should you store the medication?
    - Does the medication have side effects? What are they? What should you do if they occur?

- When you pick up the medication, ask the pharmacist if this is the medication that was prescribed.
    - Make sure that you understand the instructions on the label.
    - Ask the pharmacist about the bet device to measure liquid medications.
    - Read the information that is provided by the pharmacy.

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

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

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

- **Do your homework.** Make sure that the hospital you're being treated in has experience in treating your condition. If you need help getting this information, ask your doctor or call Paramount Member Services Department.

- **See that health care workers wash their hands before caring for you.** This is one way to prevent the spread of germs at home and infections in a hospital. Studies have shows that when patients checked whether health care staff had washed their hands, the workers washed their hands more often and used more soap.

- **Ask about services or tests.** Make sure to ask what test or x-ray is being done to make sure you are getting the right test. In the example of a knee surgery, be sure that the correct knee is prepped for surgery. A tip from the American Academy of Orthopaedic Surgeons urges their physicians to sign their initials on the site to be operated on before surgery.

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

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

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 limited to:

- Colds and cough, sore throat, flu
- Earache
- Persistent high fever
- Minor cuts where bleeding is controlled
- Sprains
- Sunburn or minor burns
- 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: Call your Primary Care Provider'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 is stated 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 is stated 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: 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 Copayment/Coinsurance depending on where you receive treatment. Your Copayment/Coinsurance is stated 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 Primary Care Provider 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 Primary Care Provider.

Emergency Services

Your plan covers Emergency Services for an Emergency Medical Condition treated in any hospital emergency department.

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

1. 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;
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.

The determination as to whether or not an **Emergency Medical Condition** exists in accordance with the definition stated in this section rests with Paramount or its Designated Representative. Examples of **Emergency Medical Condition** Include: heart attack, stroke, poisoning, loss of consciousness, inability to breathe, uncontrolled bleeding and convulsions. Paramount may determine that other similarly acute conditions are also **Emergency Medical Conditions. Inside the 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 Primary Care Provider for instructions. Medical care is available through Paramount Physicians seven (7) days a week, 24 hours a day. Appropriate Copayment/Coinsurance will apply.

Afterward you should contact your Primary Care Provider so that follow-up care can be coordinated.

Outside the Provider Service Area: Call 911 or 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 subject to applicable Copayment/Coinsurance.

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

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

The Paramount Provider Service Area

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

SUBSCRIBER CERTIFICATE

YOUR PLAN

Members may receive services described in this Subscriber Certificate, subject to all the terms and provisions and subject to the Deductible, Copayments/Coinsurance and limits stated in the Summary of Benefits.

General Limitations

To be covered by Paramount, the health services you receive must meet Medical Necessity criteria and be from Paramount Participating Providers, except for Emergency Medical Conditions or with written Prior Authorization from Paramount.

Leaving the Hospital "Against Medical Advice"

If you discharge yourself from any hospital or facility *"against medical advice"* (AMA), there will be an additional Copayment on all charges related to that admission. Also, if a hospital or facility requires your discharge ("a *disciplinary discharge"*) for any reason, you will be responsible for an additional Copayment on all charges related to that admission. The total of your Copayments/Coinsurance (if any) and the penalty will be up to but will not exceed 50% of the total reimbursement for Covered Services on admissions.

Covered Services

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

The following Covered Services are listed alphabetically:

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

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

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

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 when Prior Authorized. Care must be prescribed or ordered for an individual diagnosed with one of the autism spectrum disorders by a licensed physician or a licensed psychologist who determines the care to be medically necessary. Outpatient rehabilitation/habilitation therapy for autism will not be included in limits specified elsewhere in this handbook for Physical Therapy, Occupational Therapy, and Speech Therapy services.

Paramount may:

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

Coverage is 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.

Behavioral Health Services

All Inpatient Stays, Residential Treatment Programs for substance use disorders, intermediate care (such as day treatment and partial hospitalization) and certain outpatient services (such as intensive outpatient therapy (IOP), ECT, extended psychotherapy (more than 50 minutes), and neuro/cognitive/psycho-diagnostic testing) require Prior Authorization.

Description

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

- Mental health, alcoholism, chemical dependency or substance use disorder evaluations and assessment.
- Diagnosis.
- Treatment planning.
- Referral services.
- Medication management.
- Individual, family and group therapeutic services (including intensive outpatient therapy).
- Crisis intervention.
- Inpatient detoxification from abusive chemicals or substances that is limited to medical services for physical detoxification when necessary to protect your physical health and well-being.
- Residential Treatment Program for substance use disorders.
- Partial hospitalization.
- Day treatment.
- Electroconvulsive therapy (ECT).
- Neuro/cognitive/psycho-diagnostic testing.
- Sexual and gender identity and functional disorders.
- Personality disorders (including specific psychological testing to clarify the diagnosis of personality disorder).

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

Covered treatment settings are as follows:

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

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

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

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

Attention deficit hyperactivity disorders are covered for initial evaluation, and follow-up psychiatric medication management. Outpatient behavioral health therapy is covered for children age 12 and under.

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

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

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

NOTE: The Benefit plan is intended to comply with the federal Mental Health Parity and Addictions Equity Act. Behavioral Health Services are covered for inpatient and outpatient care subject to the same Deductible, Copayments and/or Coinsurance as any other physical disease or condition medical/surgical benefit within the same classification or sub classification. Outpatient office visits are subject to the Primary Care Physician Copayment/Coinsurance.

Blood (C/L) The cost of administration and storage of blood and blood products, when a volunteer program is not available.

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

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

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 only of the upper and/or lower jawbone
- Medical treatment for temporomandibular joint syndrome or dysfunction (TMJ)

Diabetic counseling and supplies (C/L) Covered from Participating Providers.

Diagnostic services (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 PCPor Participating Specialist. Coverage for breast cancer screening mammography is in accordance with MCL 500.3406d
- Imaging/Nuclear cardiology studies when preauthorized by PCP or Participating Specialist

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

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

Durable medical equipment (C/L) The item must serve only a medical purpose and can be able to withstand repeated use. Paramount covers medical equipment and supplies that are consistent with Medicare Part B guidelines. This includes but is not limited to: oxygen, crutches, wheelchairs, hospital beds, Prescription medical support hose, etc. Coverage of rental or purchase and repair or replacement is consistent with Medicare Part B guidelines.

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) Services from a Participating Specialist are 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 (C/L) for terminally ill patients.

Hospital and other facility services

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

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

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

Professional services: (C/L) The services of physicians and other professionals are 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 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.

Morbid obesity surgery (C/L) Surgery for the purpose of weight reduction or control when specifically approved in advance by Paramount as medically necessary for severely obese Members with documented high-risk co-morbidities. Prior Authorization from Paramount must be obtained and the surgery must be performed by Participating Providers authorized by Paramount to perform morbid obesity surgery. To obtain Prior Authorization, the

Member must qualify under Paramount's Morbid Obesity Surgery medical policy. If approved for coverage, services related to this surgery will be subject to a $1,000 annual Copayment. Unless Medically/Clinically Necessary, a second bariatric surgery is not Covered, even if the initial bariatric surgery occurred prior to Coverage under this plan.

Office visits (C/L) Covered for:

- Your Primary Care Provider (PCP)
- Participating OB/GYNs and other Participating Specialists
- Eligible services provided during each visit, including:
  - 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 (C/L) 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 Health Services include, as an example, the following:

- Well-baby care from birth and newborn screenings,
- Routine adult and pediatric immunizations,
- 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
- 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,
- 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, RH(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,
- Prostate screening (PSA),
- Colorectal cancer screening (fecal occult blood testing, sigmoidoscopy, or colonoscopy).
- 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.paramountcareofmichigan.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 (C/L) A Prosthetic Device is an artificial substitute that replaces all or part of a missing body part and its adjoining tissues. Paramount covers the purchase, fitting, adjustment, repair and replacement of prosthetic devices consistent with Medicare Part B guidelines.

Reconstructive surgery when required for: (C/L)

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

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

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

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

Therapy services (C/L) Covered for:

- Radiotherapy, radiation therapy and chemotherapy.
- A Food and Drug Administration (FDA) approved drug used in antineoplastic therapy and the cost of administration. 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:
    1. The drug is approved by the FDA for use in antineoplastic therapy;
    2. The drug is ordered by a physician for the treatment of a neoplasm;
    3. The drug is part of an antineoplastic drug regimen and current medical literature substantiates its efficacy and recognized oncology organizations generally accept the treatment.
    4. 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.
- Outpatient speech therapy.
- Inpatient Rehabilitation

Transplants (C/L) Transplants for certain clinical indications with written Prior Authorization at a Paramount approved Center of Excellence for heart, lung, kidney, liver, pancreas, heart-lung, kidney-pancreas, cornea, bowel and bone marrow transplants. Antineoplastic drugs, in accordance with MCL 500.3406e, 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.

Trimming of nails, calluses and corns (C/L) Covered for diabetic conditions only when approved in advance by Paramount.

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 or disease of the eyes. One routine vision exam every twelve (12) months to monitor refractory disorders of the eyes is covered unless a separate vision program is available.

Exclusions

These services and supplies are not covered:

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

2. Any service received from any nonparticipating physician, hospital, person, institution or organization unless:
   a. Prior approval is obtained through Paramount by the Participating Provider or member, 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 unless determined to be Medically Necessary and rendered by a Participating Provider.

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

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

7. Care provided to Members by relatives.

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

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

10. Self-help audio cassettes, videos, DVDs and books.

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

12. 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 (vasectomy), 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.

13. Elective abortions are excluded. See Terms and Definitions.

14. 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.

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

16. Cosmetic Therapy or Surgery to reshape normal structures of the body primarily for the purpose of altering or improving appearance and/or self-esteem. Including but not limited to:

- Breast augmentation. Breast reduction, except when medically necessary
- Face lifts, tummy tucks, panniculectomy, liposuction
- 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

17. 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.

18. 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.

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

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.

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

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

22. Experimental medical, surgical or other health procedures including experimental drugs as determined by Paramount. Paramount will make this determination based on the recommendation of the Medical Advisory

Committee and the most recent HAYES Medical Technology Directory. Pharmaceuticals and devices which have not received FDA approval are considered experimental. Experimental organ transplants.

23. Outpatient prescription drugs, unless the Group has purchased an optional drug rider. FDA approved contraceptive methods for women are covered under Preventive Health Services.

24. Medical equipment and supplies that do not meet Medicare Part B guidelines, disposable medical supplies (except for diabetic and ostomy supplies), exercise equipment, air conditioners, wigs, 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).

25. Prosthetic Devices that do not meet Medicare Part B guidelines, replacement of Prosthetic Devices due to misuse.

26. 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) program,s 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.

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

28. Contact and corrective lenses and eyeglasses, unless the Group has purchased an optional rider. Orthoptic training and radial keratotomy refractive surgery (e.g., LASIK).

29. Sleep studies for sexual dysfunction.

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

31. Trimming and/or scraping of calluses, corns and nails for all conditions, except diabetes.

32. Foot orthotics including shoes, shoe molds and inserts, unless the Member's condition meets Medicare Part B criteria. Extra Corporeal Shock Wave Therapy (ESWT).

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

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

If the Dependent does not meet these requirements, he or she may be eligible for continuation coverage under the Group's Health Benefit Plan. See your benefits officer with questions.

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

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

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 coverage.

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. 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. 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 officer.

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 Services 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 for new employees will not be more than sixty (60) days and not more than ninety (90) days for late enrollees. See your benefits officer for details.

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

Certificate of Creditable Coverage

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

Privacy and Confidentiality

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

Insurance Fraud

Insurance fraud significantly increases the cost of health care. Paramount encourages you to let us know if you have any questions or concerns about Paramount providers and/or the services you receive. Please contact the Paramount Member Services Department for confidential handling at 734-529-7800, or toll-free at 1-888-241-5604. TTY

services for the hearing-impaired are available at 1-800-740-5670. You may also contact the ProMedica Health System Compliance Hotline for confidential investigation. That hotline number is 1-800-807-2693.

Any person who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud under Michigan law and is subject to immediate termination of benefits.

WHAT HAPPENS WITH YOUR PLAN

When You Have Other Coverage - How Coordination of Benefits Works

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

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

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

Plans That Do Not Coordinate

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

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

How Paramount Pays as Your Primary Plan

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

How Paramount Pays as a Secondary Plan

- Our payments will be based on the balance left after the primary plan has paid. We will pay no more than that balance. In no event will we pay more than we would have paid had we been primary.
- We will pay only for health care expenses that are covered by Paramount.

- We will pay only if you have followed all of our procedural requirements, including care obtained from or arranged by your Primary Care Provider or Participating Specialists, Prior Authorizations, etc.
- In determining the amount to be paid on a claim if Paramount is a secondary plan, Paramount will calculate the benefits it would have paid on the claim in the absence of other health care coverage and apply the calculated amount to any allowable expense under the health plan that is unpaid under the primary plan. Paramount will then reduce its payment by the calculated amount so that, when combined with the amount paid under the primary plan, the total benefits paid or provided under all plans for the claim do not exceed 100% of the allowable expense for the claim.

  "Allowable Expenses" means a healthcare expense, including coinsurance or copayments and without reduction for any applicable deductible that is covered in full or in part by any of the plans covering the Covered Person. The amount of a reduction may be excluded from allowable expenses if a Covered Person's benefits are reduced under a primary plan for either of the following reasons:

  - Because the Covered Person does not comply with the plan provisions concerning second surgical opinions or precertification of admissions or services.
  - Because the Covered Person has a lower benefit because the Covered Person did not use a preferred provider.

Which Plan Is Primary?

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

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

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

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

4. If there is no court order or judgment allocating responsibility for the child's health care coverage, the order of benefits for the child are as follows:

   I) The plan covering the custodial parent.
   II) The plan covering the custodial parent's spouse.
   III) The plan covering the non-custodial parent.
   IV) The plan covering the non-custodial parent's spouse.

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

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

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

Coordination Disputes

If 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 the Section of this Subscriber Certificate entitled, ***What to do When You Have Questions, Problems or Grievances***.

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 Workers' 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 Workers' 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 the Section of this Subscriber Certificate entitled, ***Who is Eligible?***, may be eligible for continuation coverage under the employer group's health benefits plan. See your benefits officer 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 officer for details.

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

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

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

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

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

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

- ▶ The covered Subscriber and Dependents may continue coverage for up to 24 months
- ▶ Covered Dependents may continue coverage for up to 36 months if any of the following events occurs during that 24 month period:
  a. The death of the reservist
  b. The divorce or separation of a reservist from the reservist's spouse
  c. A covered Dependent child's eligibility under this coverage ends
- ▶ Continuation coverage will end on the date any of the following occurs:
  a The subscriber or Dependent becomes covered by another group plan without any pre-existing condition restriction.
  b. The maximum period of months expires.
  c. The Subscriber or Dependent does not make the required payment
  d. The group contract with Paramount is terminated.

If Paramount Ends Operations

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

WHAT TO DO WHEN YOU HAVE QUESTIONS, PROBLEMS OR GRIEVANCES

Paramount's Member Services Department welcomes your questions from 8:00 A.M. to 4:30 P.M., Monday through Friday. The Member Service staff can be reached by calling (734) 529-7800 or use our toll-free number 1-888-241-5604. You can contact us by e-mail at: member.services@promedica.org. Written and oral communications will be given in an appropriate language upon request.

If you call the Member Services Department after hours, you may leave a message and you will receive a return call on the next working day.

The Member Services 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 as well as translation services for Members who do not speak English. If a Member needs foreign language translation services, he/she should call the Member Services Department. If you have any suggestions for improving our service or if you wish to recommend changes in procedures or benefits please write us or call us.

How to Handle a Problem

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

Filing a Grievance

Under Michigan Compiled Laws (MCL), 500.2213, a "grievance" means a complaint by the Member concerning any of the following:

a. The availability, delivery, or quality of health care services, including a complaint regarding an Adverse Determination (denial) made by utilization review,
b. Benefits or claims payment, handling, or reimbursement for health care services,
c. Matters concerning the contractual relationship between a Member and Paramount.

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

- A determination of an individual's eligibility for coverage;
- A determination that a benefit is not a covered benefit;
- The imposition of a preexisting condition exclusion, source-of-injury exclusion, network exclusion, or other limitation on otherwise covered benefits;
- A determination that a benefit is experimental, investigational, or not medically necessary or appropriate; or
- Any rescission of coverage, whether or not there is an adverse effect on any particular benefit at that time.

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

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

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

For grievances, you should follow the steps outlined below:

Internal Grievance – Level 1

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

Internal Grievance – Level 2

If the first level grievance is not resolved to your satisfaction, you will be informed of your right to file 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, Michigan 48131-1016
(734) 529-7800
Toll-free 1-888-241-5604
Fax (419) 887-2047

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. If you cannot attend the hearing, you may participate by teleconference or submit a written statement. 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.

Internal Grievance – Expedited Review

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. 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.

If Paramount does not issue a written decision to you or your authorized representative within 35 calendar days for a grievance or within seventy-two (72) hours for an expedited grievance, it is considered a denial, and you have the right to request an external review with the Director of the Department of Insurance and Financial Services (DIFS), and shall be considered to have exhausted Paramount's internal grievance process.

In addition, concurrent internal grievance and external review is allowed for claims involving urgent care or an ongoing course of treatment. A member may file an internal grievance and external review at the same time if the Covered Person has a medical condition such that the time frame for completion of an Expedited Internal Grievance would seriously jeopardize the life and health of the Member, or would jeopardize the Members ability to regain maximum function. If a member meets this requirement, they will be considered to have exhausted Paramount's internal grievance process.

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

Rights on Grievance

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

- may submit written comments, documents, records, and other information relating to the claim for benefits;
- may request free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits;
- will receive no reduction or termination of an ongoing course of treatment without advance notice from Paramount or an opportunity for advance review;
- will receive a review of the determination that takes into account all comments, documents, records, and other information that you submit relating to the claim, without regard to whether this information was submitted or considered in the initial benefit determination;
- will receive a review that does not afford deference to the initial adverse benefit determination and that is conducted by a grievance representative of Paramount who is neither the individual who made the adverse benefit determination that is the subject of the grievance, nor his or her subordinate;
- will receive a review from the grievance representative of Paramount in consultation with a Health Care Professional who has appropriate training and experience in the field of medicine involved in the medical judgment of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug , or other item is experimental, investigational, or not medically necessary or appropriate;
- will receive a review in a manner designed to avoid conflicts of interest by ensuring the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual will not be made based upon the likelihood that the individual will support the denial of benefits;
- will receive, free of charge, any new or additional evidence or rationale considered, relied upon, or generated

by Paramount sufficiently in advance of the date on which the notice of benefit determination on review is required to be provided to allow you a reasonable opportunity to respond prior to 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 within 10 days after a determination, a review by the Director of the Department of Insurance and Financial Services, an external review and/or bring an action under section 502(a) of ERISA. If 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 three (3) days after the oral notice. The notice will be provided in an appropriate language upon request.

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
Fax (517) 335-4978

Instructions for Requesting an External Independent Review

Not later than ***60 days (120 days after December 31, 2016)*** after the date you receive a notice of an Adverse Determination or Final Adverse Determination, you or your Authorized Representative may file a request for an external review with DIFS. If you request an external review, you will be required to authorize the release of any medical records that may be required to be reviewed for the purpose of reaching a decision on the external review.

If DIFS accepts the request for an external independent review, you will receive an acknowledgement from DIFS. (If DIFS does not accept the request, DIFS will notify you of the reason.) DIFS will select a state-approved Independent Review Organization (IRO) to conduct a review. The IRO will review all pertinent records available and notify DIFS

of its recommendation. DIFS will then review the recommendation and notify the Member and Paramount of the DIFS decision. If DIFS requests additional information from the Member, or the Members Authorized Representative, the information must be provided within thirty (30) days after receiving notification.

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 independent 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 independent 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 independent 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

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

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

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

AUTHORIZED REPRESENTATIVE - means any of the following:

(i) A person to whom a Covered Person has given express written consent to represent the Covered Person in an external review.

(ii) A person authorized by law to provide substituted consent for a Covered Person.

(iii) If the Covered Person is unable to provide consent, a family member of the Covered Person or the Covered Person's treating Health Care Professional.

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

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

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

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

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

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

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

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

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

COVERED BENEFITS OR BENEFITS means those Health Care Services to which a Covered Person is entitled under the terms of a Health Benefit Plan.

COVERED PERSON means a policyholder, subscriber, member, enrollee, or other individual participating in a Health Benefit Plan.

COVERED SERVICES are authorized services shown in our list of services covered and rendered by a provider for which Paramount will provide payment. A Covered Service may be subject to a Deductible, Copayment/Coinsurance or other limitations.

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 you must pay for Covered Services within each Contract Year before benefits will be paid by Paramount. The single Deductible is the amount each Member must pay, the family Deductible is the total amount any two or more covered family members must pay.

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

EFFECTIVE DATE is the date your coverage begins.

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

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

a. 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;
b. Serious impairment to bodily functions; or
c. 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 BENEFITS is defined under federal law (PPACA) as including benefits in at least the following categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. Your plan may contain some or all of these types of benefits 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, as provided in this Member Handbook.

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

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

EXPERIMENTAL is any treatment, procedure, facility, equipment, drug, device or supply which Paramount does not recognize as accepted medical practice or which did not have required governmental approval when you received it. This includes treatments and procedures which:

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

Antineoplastic drugs in accordance with MCL Section 21054b are covered benefits.

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

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 non-payment 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.

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

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

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

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

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

HEALTH CARRIER means a person that is subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the director, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance

organization, a nonprofit health care corporation, a nonprofit dental care corporation operating under 1963 PA 125, MCL 550.351 to 550.373, or any other person providing a plan of health insurance, health benefits, or health services. Health Carrier does not include a state department or agency administering a plan of medical assistance under the social welfare act, 1939 PA 280, MCL 400.1 to 400.119b.

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

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

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

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

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 the Section, ***Who Is Eligible***.

MICHIGAN SERVICE AREA means Lenawee and Monroe County in Michigan.

OUT-OF-POCKET COPAYMENT/COINSURANCE LIMIT is the maximum amount of Copayments/Coinsurance you pay every Contract Year including Deductible. The single Out-of-Pocket Copayment /Coinsurance Limit is the maximum amount each Member must pay, and the family Out-of-Pocket Copayment/Coinsurance Limit is the maximum amount two or more family members must pay. Once the Out-of-Pocket Copayment/Coinsurance Limit is met, there will be no additional Copayments/Coinsurance on Basic Health Services during the remainder of the Contract Year. Specific fixed-dollar Copayments and Copayments/Coinsurance for Supplemental Health Services do not count toward the Out-of-Pocket Copayment/Coinsurance Limit.

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 Lenawee and Monroe County in Michigan.

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

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

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

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

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

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

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

PROTECTED HEALTH INFORMATION means health information that identifies an individual who is the subject of the information or with respect to which there is a reasonable basis to believe that the information could be used to identify an individual.

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

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

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

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

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.

UTILIZATION REVIEW means a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, or retrospective review.

UTILIZATION REVIEW ORGANIZATION means a person that conducts utilization review, other than a health carrier performing a review for its own health plans.

OPTIONAL RIDER

The following coverage may be part of your benefit plan, if purchased by your employer group. If you have a Prescription Drug Program it is stated on your Schedule of Benefits.

Prescription Drugs - Outpatient

Pharmacy and Therapeutics (P&T) Committee

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

Pharmacy Benefits Manager

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

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

Covered Prescription Drug Benefits

A valid prescription is required to obtain all prescription drug benefits. Prescription Drugs, unless otherwise stated, must be Medically Necessary and not Experimental/Investigative, in order to be Covered Services. For certain Prescription Drugs, the prescribing Physician may be asked to provide additional information before the Health Plan can determine Medical Necessity. The Health Plan may establish quantity and/or age limits for specific Prescription Drugs which the PBM will administer. Covered Services will be limited based on Medical Necessity, quantity and/or age limits established by the Heatlh Plan, or utilization guidelines.

- Prescription Legend Drugs.
- Specialty Drugs.
- Injectable insulin and syringes used for administration of insulin.
- Contraceptive Drugs, oral immunizations, and biological, although they are federal legend drugs, may be payable as medical supplies based on where the service is performed or the item is obtained. If such items are over the counter drugs, devices or products, they are not Covered Services unless prescribed by a physician and covered as a preventive service, as required by federal and state law.
- Certain supplies and equipment obtained by Mail Service or from a Network Pharmacy (such as those for diabetes and asthma) are covered. Contact Paramount to determine approved covered supplies. If certain supplies, equipment or appliances are not obtained by Mail Service or from a Network Pharmacy then they are covered as Medical Supplies, Equipment and Appliances instead of under Prescription Drug benefits.
- Off label use of FDA approved drugs. Paramount shall not limit or exclude coverage for any drug approved by the United States food and drug administration on the basis that the drug has not been approved by the

United States food and drug administration for the treatment of the particular indication for which the drug has been prescribed, provided the drug has been recognized as safe and effective for treatment of that indication in one or more of the standard medical reference compendia adopted by the United States department of health and human services.

How to Obtain Prescription Drug Benefits

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

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

Non-Network Pharmacy - You will be charged the full retail price of the prescription at the point of purchase. Refer to your Summary of Benefits for coverage of non-network pharmacies. If you have non-network pharmacy coverage, ask your pharmacist for an itemized receipt and submit it to Paramount with a written request for refund. Prior Authorizations and limitations to coverage will still apply prior to refunds when non-network pharmacy benefits are present.

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

Specialty Pharmacy Network

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

Days Supply

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

DAW Status

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

Payment of Benefits

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

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

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

Deductible/Coinsurance/Copayment

Each Prescription Order may be subject to a Deductible and Coinsurance/Copayment. If the Prescription Order includes more than one covered Drug, a separate Coinsurance/Copayment will apply to each covered Drug. Your Prescription Drug Coinsurance/Copayment will be the lesser of your Copayment/Coinsurance amount or the cost of the Drug. Please see the Summary of Benefits for any applicable Deductible and Coinsurance/Copayment.

Tier and Formulary Assignment Process

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

The determination of tiers and formulary assignment is made by the Plan with assistance by the Plan's P&T Committee based upon clinical information, treatment options, and Drug costs relative to other Drugs used to treat the same or similar condition.

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

Copay Type

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

- Generic Mandate means when an identical generic is available for a prescribed brand drug, only the generic drug will be covered on the formulary. The brand name drug will no longer be considered a covered formulary drug when the generic becomes available. If the physician believes the brand name drug is medically necessary they may submit a non-formulary medication request on your behalf. If Paramount approves the request for the brand name medication you will pay the copay associated with the highest cost brand tier on your benefit. If the request is denied by Paramount and you still wish to receive the brand name medication, you will be required to pay the entire retail cost of the medication.

- Generic Substitution means generic drugs, when available, will be dispensed in place of a brand name drug.

    - *Single, 2-tier and 3-tier Copay* - If the Physician has specified “Dispense as Written” (“DAW”), the Member will pay the Copayment required for a Brand Name Drug. If the Member requests a Brand Name Drug and the Physician has not specified "DAW", the Member will pay the amount by which the Brand Name Drug price exceeds the Generic Drug price, plus the highest Drug Copay within the Copayment arrangement.
    - *4-tier Copay* - If the Physician has specified "Dispense as Written" ("DAW"), or the Member requests a Brand Name Drug for which a Generic Drug is available, the Member will pay the Multi Source Drug Copayment. A Multi Source Drug is a drug that has a generic, over-the-counter or isomeric brand drug equivalent. An isomeric brand drug is a drug with a molecular structure similar to an existing drug already on the market (e.g. enantiomer having a mirror image relationship to a drug already on the market.). Examples include Clarinex (desloratadine) is an isomeric brand drug of Claritin (loratadine) and Xopenex (levalbuterol) is an isomeric brand drug of Proventil (albuterol).
    - *Specialty Drug* - If the Physician has specified “Dispense as Written” (“DAW”), the Member will pay the Specialty Drug Copay/Coinsurance. If the Member requests a Brand Name Drug and the Physician has not specified "DAW", the Member will pay the amount by which the Brand Name Drug price exceeds the Generic Drug price, plus the Specialty Drug Copay/Coinsurance.

Preferred Brand Drug List

Members can obtain a copy of the Plan’s Preferred Brand Drug List by calling the Member Services telephone number on the back of their ID card, or is available for review on the internet at www.paramountcareofmichigan.com. The Preferred Brand Drug list is subject to periodic review and amendment. Inclusion of a Drug or related item on the covered Prescription Drug list is not a guarantee of coverage.

Prior Authorization

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

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

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

Step Therapy

Step therapy protocol means that a Member may need to use other medication(s) before a certain medication may be authorized. Paramount monitors some Prescription Drugs to control utilization, to ensure that appropriate prescribing

guidelines are followed, and to help Members access high quality yet cost effective Prescription Drugs. If a Physician decides that the monitored medication is needed the Prior Authorization process is applied.

Quantity Limits

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

Specialty Drug Program

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

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

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

Standard & Expedited Exceptions Process (for closed and modified open formulary Prescription Drug Programs)

An enrollee or physician can submit a standard exception request of a clinically appropriate non-formulary drug in non-exigent circumstances and receive a decision within 72 hours of a request. For expedited exception requests based on Exigent Circumstances determination and notification will be provided no later than 24 hours following receipt of the request. If request is approved, coverage continues for a duration determined to be appropriate for the specific medication. If the request is denied, members may appeal to an accredited Independent Review Organization (IRO). Enrollee and physician will be notified of the IRO's decision no later than 24 hours following receipt of request for expedited exception request and 72 hours following receipt of a standard request. An exigent circumstance (Expedited Exception Request) exist when a member is suffering from a health condition that may seriously jeopardize the enrollee's life, health, or ability to regain maximum function or when a member is undergoing a current course of treatment using a non-formulary drug.

For more information, to request coverage of a non-formulary drug or appeal a denial, contact the Member Services Department.

Member Services Department
(419) 887-2531
Toll-Free 1-866-452-6128
TTY (419) 887-2526
TTY Toll-Free 1-888-740-5670

See Definitions section for additional information on Exigent Circumstances.

Special Promotions

From time to time we may initiate various programs to encourage the use of more cost-effective or clinically-effective Prescription Drugs including, but not limited to, Generic Drugs, Mail Service Drugs, over the counter or preferred products. Such programs may involve reducing or waiving Copayments or Coinsurance for certain Drugs or preferred products for a limited period of time.

Prescription Drug Exclusions:

1. Prescription Drugs dispensed by any Mail Service program other than the PBM's Mail Service, unless prohibited by law.
2. Drugs, devices and products, or Prescription Legend Drugs with over the counter equivalents and any Drugs, devices or products that are therapeutically comparable to an over the counter Drug, device, or product except as described in Covered Services under the heading Preventive Health Services.
3. Off label use, except as otherwise prohibited by law or as approved by Paramount or the PBM.
4. Drugs in quantities exceeding the quantity prescribed, or for any refill dispensed later than one year after the date of the original Prescription Order.
5. Drugs not approved by the FDA.
6. Charges for the administration of any Drug.
7. Drugs consumed at the time and place where dispensed or where the Prescription Order is issued, including but not limited to samples provided by a Physician. This does not apply to Drugs used in conjunction with a Diagnostic Service, with Chemotherapy performed in the office or Drugs eligible for coverage under the Medical Supplies benefit; they are Covered Services.
8. Any Drug which is primarily for weight loss unless specified in Additional Benefits and Programs.
9. Human Growth Hormone unless specified in Additional Benefits and Programs.
10. Drugs not requiring a prescription by federal law (including Drugs requiring a prescription by state law, but not by federal law), except for injectable insulin.
11. Drugs in quantities which exceed the limits established by the Health Plan, or which exceed any age limits established by Paramount.
12. Drugs for treatment of sexual or erectile dysfunctions or inadequacies, regardless of origin or cause unless specified in Additional Benefits and Programs.
13. Fertility Drugs unless specified in Additional Benefits and Programs.
14. Contraceptive devices, oral immunizations, and biologicals, although they are federal legend Drugs, are payable as medical supplies based on where the service is performed or the item is obtained. If such items are over the counter Drugs, devices or products, they are not Covered Services.
15. Drugs in quantities which exceed the limits established by the Health Plan.
16. Compound Drugs without at least one ingredient that requires a prescription.
17. Compound Drugs with an equivalent commercially available product.
18. Certain Prescription Legend Drugs are not Covered Services when any version or strength becomes available over the counter. Please contact Paramount for additional information on these Drugs.
19. Refills of lost or stolen medications.
20. Certain Prescription Drugs may not be covered when clinically equivalent alternatives are available, unless otherwise required by law. "Clinically equivalent" means Drugs that, for the majority of Members, can be expected to produce similar therapeutic outcomes for a disease or condition. If you have questions regarding whether a particular drug is covered and which drugs fall into this category, please call the member services number on the back of your Identification Card, or visit our website at www.paramountcareofmichigan.com. If you or your Physician believe you require continued coverage for a certain Prescription Drug, please have your Physician or Pharmacist contact Paramount. We will cover your current Prescription Drug only if we agree that it is Medically Necessary and appropriate over its clinically equivalent alternative. Continued coverage of the Prescription Drug will be subject to periodic review by Paramount.

PARAMOUNT CARE
OF MICHIGAN, INC.

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