PARAMOUNT






Paramount Care of Michigan

Small Group HMO
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.

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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.

In Case of Emergency

For Emergency Medical 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. Prior Authorization is not required.

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 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

ProMedica

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

Your health. Our mission.

TABLE OF CONTENTS

MEMBER HANDBOOK

SECTION ONE: 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?

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. All Covered Services except Preventive Health Services and Covered Services requiring a specific fixed-dollar Copayment are subject to the Deductible.

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. **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 benefits for those Covered Services that apply to the limit during the remainder of the Contract Year. 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 degreepossible.

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 o 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.

SECTION TWO: 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.

SECTION THREE: 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 facility and physician services inside or outside the Service Area for an Emergency Medical Condition treated in any hospital emergency department without Prior Authorization. Services will be covered at the in-network cost sharing level. Paramount will pay for out-of-network emergency services at the greater of:

1. The median in-network rate
2. The usual customary and reasonable rate
3. The Medicare rate.

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

1. Ambulance Services - Ground or Air

The Benefit plan covers Emergency ground ambulance transportation by a licensed ambulance service to the nearest Hospital where Emergency Health Services can be performed.

Air ambulance transport by a licensed ambulance service is covered when you have a potentially life-threatening condition that does not permit the use of another form of transportation. Your condition must be such that the time needed to transport you by ground, or the instability of transportation by ground, poses a threat to your survival or seriously endangers your health. Transportation must be to the nearest Hospital where appropriate treatment of your condition can be performed. The list below includes examples of medical conditions in which air ambulance transport may be necessary. This list does not guarantee coverage nor is it intended to be all inclusive. Diagnosis alone does not guarantee coverage.

- Intracranial bleeding requiring neurosurgical intervention
- Cardiogenic shock Burns requiring treatment in a burn center
- Conditions requiring treatment in a hyperbaric Oxygen unit
- Multiple severe injuries
- Life-threatening trauma

Your symptoms at the time of transport must meet Paramount's established criteria for coverage. We may ask for verification by requesting the records of the attending Physician and the ambulance company.

Air ambulance transport must be to the nearest suitable Hospital. Air ambulance services are not covered for transport to a facility that is not an acute care Hospital. Transport to a nursing facility, a Physician's office, or your home by air ambulance is not covered.

The Benefit plan covers Medically Necessary non-Emergency ambulance transportation services when those services are recommended by the attending Physician and coordinated by us.

Non-Emergency Medically Necessary ambulance transportation by a licensed ambulance service between facilities is covered when the following criteria are met:

- The patient's condition must be such that any other form of transportation would not be medically recommended and
- Any of the following circumstances exists:
  - ➢ Transfer from an acute care facility to a patient's home or Skilled Nursing Facility; or
  - ➢ Transfer to and from a patient's home to an acute care facility to obtain Medically Necessary diagnostic or therapeutic services (such as MRI, CT scan, dialysis, etc.).
- Transportation to or from one acute care facility to another acute care facility, Skilled Nursing Facility or free-standing dialysis center in order to obtain Medically Necessary diagnostic or therapeutic services (such as MRI, CT scan, intensive care services including neonatal ICU, acute interventional cardiology, radiation therapy, etc.), provided such services are:
  - ➢ Not available at the transferring facility where the patient is being treated; and
  - ➢ The patient cannot be safely transported in another way; and
  - ➢ The patient requires continued acute inpatient medical care.
- Ground ambulance for a deceased patient in the following circumstances:
  - ➢ The patient was pronounced dead while in route or upon arrival at the Hospital or final destination; or
  - ➢ The patient was pronounced dead by a legally authorized individual (Physician or medical examiner) after the ambulance call was made, but prior to pick-up.

2. Antineoplastic Therapy (Chemotherapy)

The Benefit plan covers federal Food and Drug Administration (FDA) approved Medically Necessary drugs used in antineoplastic therapy and the reasonable cost of administration of the drug. Benefits are 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 FDA, if all of the following are true:

- The drug is ordered by or under the direction of a Physician for the treatment of a specific type of neoplasm and
- Current medical literature substantiates its efficacy and recognized oncology organizations generally accept the treatment; and
- The drug is approved by the federal FDA for use in antineoplastic therapy; and
- The drug is used as part of an antineoplastic drug regimen; and
- The Physician has obtained informed consent from the patient for the treatment regimen, which includes federal FDA approved drugs for off-label indications.

3. Autism Spectrum Disorders Treatment

Authorization Requirements
Authorization must be obtained from us by your provider prior to receiving treatment for Autism Spectrum Disorders.

If your provider does not obtain authorization for Autism Spectrum Disorders services, no Benefits will be paid. You may be responsible for any charges not covered due to non-authorization penalties.

Description
The Benefit plan covers the diagnosis and treatment of certain Autism Spectrum Disorders for children under the age of nineteen (19).

Diagnosis of Autism Spectrum Disorders includes assessments, evaluations, or tests, including the Autism Diagnostic Observation Schedule, performed by a licensed Network Physician or a licensed Network psychologist to diagnose whether an individual has one of the Autism Spectrum Disorders.

Treatment of covered Autism Spectrum Disorders involves Medically Necessary, evidence-based treatment that includes the following care prescribed or ordered for an individual diagnosed with one of the Autism Spectrum Disorders by a licensed Network Physician, licensed Network psychologist or board certified Network Behavioral Analyst:

- Behavioral health treatment (evidenced-based counseling and treatment programs, including Applied Behavioral Analysis [ABA], that are both 1) necessary to develop maintain, or restore, to the maximum extent practicable, the functioning of an individual; and 2) are provided or supervised by a board certified Behavior Analyst or a licensed psychologist so long as the services performed are commensurate with the psychologist's formal university training and supervised experience);
- Pharmacy management (Medically Necessary services related to medications prescribed by a Physician to determine the need or effectiveness of the medications);
- Psychiatric care (evidence-based direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices);
- Psychological care (evidence-based direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices);
- Therapeutic care (evidence-based services provided by a licensed or certified speech therapist, occupational therapist, physical therapist, or social worker).

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.

4. 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.

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.

5. Clinical Trials

Please contact us to discuss specific services if you participate in an approved clinical trial and to request authorization to ensure coverage of these services.

If you or your provider does not obtain authorization from us, Benefits will not be paid and you may be responsible for all non-covered charges.

Description

If you are a participant in an approved clinical trial, the Benefit plan will cover routine care costs for services such as doctor visits, lab tests, X-rays and scans, and hospitalizations related to treating the patient's condition, if the services are otherwise Covered Services under this Handbook and the clinical trial meets all of the following criteria:

- The purpose of the trial is to test whether the intervention potentially improves the trial participant's health or the treatment is given with the intention of improving the trial participants health, and is not designed simply to test toxicity or disease pathophysiology;

- The trial does one of the following:
  1. Tests how to administer a health care service, item, or drug for treatment;
  2. Tests responses to a health care service, item, or drug for treatment;
  3. Compares the effectiveness of health care services, items, or drugs for treatment; or
  4. Studies new uses of health care services, items, or drugs for treatment;

- The trial is approved or funded by one or more of the following:
  1. The National Institute of Health
  2. The Centers for Disease Control and Prevention.
  3. The Agency for Health Care Research and Quality.
  4. The Centers for Medicare & Medicaid Services.
  5. Cooperative group or center of any of the entities described in clauses 1-4 or the Department of Defense or the Department of Veterans Affairs.
  6. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Heatlh for center support grants.

Benefits do not, however, include the following:

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

6. Dental Anesthesia

NOTE: It is recommended that you or your provider call us to verify coverage prior to receiving dental-related anesthesia services.

The Benefit plan covers dental-related anesthesia and associated Hospital and facility charges provided at a Network Hospital to a Dependent or adult member when, in the opinion of the treating dentist or oral surgeon, treatment in a dental office under local anesthesia would be ineffective or compromised; and any of the following criteria apply:

- A total of six (6) or more teeth are extracted in various quadrants.
- Dental treatment needs for which local anesthesia is ineffective because of acute infection, anatomic variation, or allergy.
- Multiple extractions or multiple restorations if the patient is a child under the age of seven (i.e., through the end of the sixth year).
- Patients with a concurrent hazardous medical condition.
- Extensive oral-facial and/or dental trauma for which treatment under local anesthesia would be ineffective or compromised.

Benefits under this section are provided only for the anesthesia and related Hospital and facility charge. Benefits are not available for any other related dental procedure (including but not limited to extractions) except as described below. Benefits are provided only if the services are provided by a Network provider at a Network facility.

7. Dental Services – Accidental Injury and Other Medical Services of the Mouth

Description
The Benefit plan covers Medically Necessary Covered Health Services provided by a Physician or dentist including:

- Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
- Excision of benign or malignant bony growths of the jaw and hard palate.
- External incision and drainage of cellulitis.
- Incision of sensory sinuses, salivary glands or ducts.
- Removal of sound natural teeth required in preparation for other medical procedures that are covered under the Benefit plan.
- Rebuilding or repair of soft tissues of the mouth or lip needed to correct anatomical functional impairment caused by congenital birth defect or accidental Injury. This includes treatment for abnormalities such as cleft lip or cleft palate, among other things.
- Treatment of fractures of facial bones.
- Medical and surgical services required to correct accidental Injuries, including Emergency care to stabilize dental structures following Injury to sound natural teeth.
- Treatment for oral and/or facial cancer.
- Treatment for conditions affecting the mouth other than the teeth.

Benefits are not available for dental and oral surgical procedures involving repair or rebuilding for cosmetic purposes, orthodontic care of the teeth, periodontal disease, or preparing the mouth for the fitting of or continued use of dentures.

NOTE: Pediatric stand-alone dental plans are available. Contact the Paramount Marketing Department for information.

8. Diabetes Services

Diabetes includes gestational diabetes, insulin-dependent diabetes and non-insulin-dependent diabetes.

The Benefit plan covers equipment, supplies and educational training for the treatment of diabetes when ordered by or under the direction of a Physician. The Benefit plan covers diabetes equipment that meets the minimum specifications for your needs. If you choose to purchase diabetes equipment that exceeds these minimum specifications, we will pay only the amount that we would have paid for equipment that meets the minimum specifications, and you will be responsible for paying any difference in cost.

The Benefit plan covers diabetes self-management training when it is provided by a diabetes outpatient training program that is certified to receive Medicaid or Medicare reimbursement or certified by the Michigan Department of Community Health. Benefits for diabetes self-management training are limited to completion of a certified diabetes education program:

- Upon the diagnosis of diabetes if the services are needed under a comprehensive plan of care to ensure therapy compliance or to provide necessary skills and knowledge.
- Upon the diagnosis of a significant change, with long-term implications, in the patient's symptoms or conditions that results in a need for changes to the patient's self-management, or a significant change in medical protocol or treatment modalities.

The Benefit plan covers shoe inserts for members with peripheral diabetic neuropathy and specialty shoes prescribed for a person with diabetes.

NOTE: Insulin is covered when obtained from a Network Pharmacy.

9. Durable Medical Equipment

NOTE: It is recommended that you or your provider call us to verify coverage prior to receiving Durable Medical Equipment that costs over $500 to rent or purchase.

The Benefit plan covers Durable Medical Equipment that meets each of the following criteria:

- Medically Necessary, as determined by Paramount medical policy and nationally recognized guidelines; and
- Ordered or provided by a Physician for outpatient use; and
- Used for medical purposes; and
- Not consumable or disposable; and
- Of use to a person only in the presence of a disease or physical disability.

If more than one piece of Durable Medical Equipment can meet your functional needs, Benefits are available only for the equipment that meets the minimum specifications that are Medically Necessary for your needs. If you choose to rent or purchase Durable Medical Equipment that exceeds these minimum specifications, we will pay only the amount that we would have paid for equipment that meets the minimum specifications, and you will be responsible for paying any difference in cost.

Examples of Durable Medical Equipment include:

- Equipment to assist mobility, such as a standard wheelchair.
- Benefits may be provided for power operated wheelchairs if you are capable of safely operating the controls of a power operated wheelchair, have adequate upper body stability to ride safely, and are able to transfer in and out of the wheelchair.
- A standard Hospital-type bed.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Delivery pumps for tube feedings (including tubing and connectors).
- Bi-pap and C-pap machines (including tubing, connectors and masks).
- Braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize a body part affected by an Injury, Sickness or Congenital Anomaly are considered Durable Medical Equipment and are a Covered Health Service. Dental braces are excluded from coverage.
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items are excluded from coverage).
- Burn garments.
- Insulin pumps and all related necessary supplies as described under Diabetes Services earlier in this section.

Benefits will never be available for some items and types of equipment. Refer to the Section titled ***Exclusions*** in this handbook. Benefits under this section do not include any device, appliance, pump, machine, stimulator, or monitor that is fully implanted into the body.

Coverage of rental or purchase and repair or replacement of Durable Medical Equipment is consistent with Medicare Part B guidelines.

10. Emergency Department Health Services – Outpatient/Observation Stay

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.

Description
The Benefit plan covers Emergency Department health services that are required to stabilize or initiate treatment in an Emergency. The Emergency Department health services Benefit also covers an outpatient observation stay regardless of the length of the observation stay for the purpose of monitoring your condition (rather than being admitted to a Hospital for an Inpatient Stay). Both outpatient and observation stay services for Emergency Department health services are subject to the Emergency Department visit Copayment.

NOTE: Some Covered Health Services received during the same Emergency Department visit may be subject to the Annual Deductible and Coinsurance. Ancillary services such as Physician professional fees are described elsewhere in this section.

Benefits for emergent/urgent health services received in a Physician's office or in an Urgent Care Center are described later in this section.

NOTE: The Copayment is waived if admitted for an Inpatient Stay within 24 hours for the same condition.

11. Facility Services (Non Hospital)

Hospice Care

NOTE: It is recommended that you or your provider call us to verify coverage prior to receiving hospice care.

Hospice care must be ordered by a Physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill. Hospice care includes physical, psychological, social and spiritual care for the terminally ill person, and short-term grief counseling for immediate family members. The Benefit plan covers hospice care when it is received from a licensed hospice agency.

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Description
The Benefit plan covers an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits are available when Medically Necessary for:
- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-Private Room (a room with two or more beds).

Please note that Benefits are available only if both of the following are true:
- If the initial confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a cost effective alternative to an Inpatient Hospital Stay; and
- You will receive skilled care services that are not primarily Custodial Care.

Benefits are available only when skilled care is required. Skilled care is defined as skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true:
- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient; and
- It is ordered by a Physician; and
- It is not delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing or transferring from a bed to a chair; and
- It requires clinical training in order to be delivered safely and effectively; and
- It is not Custodial Care.

Our determination of available Benefits is based on whether or not skilled care is required by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver. These criteria to determine skilled care may differ from criteria used by other payors.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation/habilitation services or if discharge rehabilitation/habilitation goals have previously been met.

Limitations
Benefits for non-Hospital facility services are limited to 45 days per calendar year.

12. Genetic Testing

NOTE: It is recommended that you or your provider call us to verify coverage prior to genetic testing.

The Benefit plan covers certain Medically Necessary Genetic Tests, including genetic testing for pregnant women.

13. Home Health Care

NOTE: It is recommended that you or your provider call us to verify coverage prior to receiving home health care services.

The Benefit plan covers services received from a Home Health Agency that are all of the following:
- Medically Necessary as determined by Paramount medical policy and nationally recognized guidelines; and
- Ordered by a Physician; and
- Provided by or supervised by a registered nurse in your home.

Benefits are available only when the Home Health Agency services are provided on a part-time, intermittent schedule and when skilled care is required.

Skilled care is defined as skilled nursing, skilled teaching, skilled rehabilitation/habilitation, and home infusion services when all of the following are true:
- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient; and
- It is ordered by a Physician; and
- It is not delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing or transferring from a bed to a chair; and
- It requires clinical training in order to be delivered safely and effectively; and
- It is not Custodial Care.

Our determination of available Benefits is based on whether or not skilled care is required by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits for outpatient rehabilitation/habilitation services provided in your home are described under *Rehabilitation/Habilitation Services – Outpatient Therapy* later in this section.

Benefits for home health care services are limited to 45 days per calendar year.

14. Home Infusion Therapy

NOTE: It is recommended that you or your provider call us to verify coverage prior to receiving home infusion therapy services.

The Benefit plan covers home infusion therapy services that are all of the following:
- Provided to manage an incurable or chronic condition; and
- Provided to treat a condition that requires acute care if it can be managed safely at home; and
- Medically Necessary as determined by Paramount medical policy and nationally recognized guidelines; and
- Ordered by a Physician; and
- Provided by or supervised by a registered nurse on an intermittent basis in your home.

Benefits are available when provided by a home infusion therapy provider for medical IV therapy, injectable therapy or total parenteral nutrition therapy; including nursing services, supplies, prescription drugs and solutions, and family education.

The Benefit plan covers nursing visits needed to:
- Administer home infusion therapy or parenteral nutrition.
- Instruct patient or caregivers on infusion administration techniques.
- Provide IV access care (catheter care).

When appropriate, Covered Person and/or caregiver will learn to administer home infusion therapy medications.

Benefits for home health care services provided in conjunction with home infusion therapy are described above under *Home Health Care* earlier in this section.

15. Hospital - Inpatient Stay

Description

The Benefit plan covers a Medically Necessary Inpatient Stay in a Hospital for:
- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-Private Room (a room with two or more beds).
- Long-term acute inpatient services.
- Medically Necessary surgery

Benefits for Physician services are described under Professional Fees for Surgical and Medical Services later in this section.

16. Injections/Infusions Received in a Physician's Office

NOTE: The list of approved Specialty Pharmaceuticals is subject to change and includes drugs received in an office or ambulatory facility or from a pharmacy. Please contact us for current information.

Description

The Benefit plan covers approved Specialty Pharmaceuticals. Specialty Pharmaceuticals are biotech drugs including high cost infused, injectable, oral and other drugs related to specialty disease categories or other categories. We determine which specific drugs are Covered Health Services and this list is subject to change. The list may include vaccines and chemotherapy drugs used in the treatment of cancer but excludes injectable insulin, which does not require authorization. Please contact us for current information and to request authorization.

The Benefit plan covers certain injections and infusions received in a Physician's office when no other health service is received, for example allergy immunotherapy.

17. Mammography (Diagnostic)/Breast Cancer Services

The Benefit plan covers diagnostic mammography, breast cancer diagnostic services, breast cancer outpatient treatment services, and breast cancer rehabilitative services provided by or under the direction of your Physician.

The Benefit plan covers routine screening mammography as described under *Preventive Health Services* later in this section.

18. Maternity Care and Family Planning

Description

The Benefit plan covers Pregnancy including all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications. We will pay Benefits for an Inpatient Stay of at least:

- 48 hours for the mother and newborn child following a normal vaginal delivery.
- 96 hours for the mother and newborn child following a cesarean section delivery.

NOTE: No Prior Authorization required for the minimum hospital stay. Hospital length of stay begins at the time of delivery if delivery occurs in a hospital and at time of admission in connection with childbirth if delivery occurs outside the hospital.

If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames.

The Benefit plan covers diagnostic, counseling, and planning services for treatment of the underlying cause of infertility. Examples of Covered Health Services are sperm count, endometrial biopsy, hysterosalpingography, and diagnostic laparoscopy.

Certain prenatal tests and screenings are covered with no member cost share (see *Preventive Health Services* later in this section).

The Benefit plan covers certain maternity classes. Call Member Services for details.

19. Morbid Obesity Treatment – Weight Management Program

Description

The Benefit plan covers Medically Necessary Covered Health Services provided during participation in a 24-week weight management program through a Designated Facility. Benefits include charges for weekly group sessions, weekly clinic visits, dietician visit, lab and EKG.

Benefits are available only if participation in the weight management program is ordered by a Physician, provided in a Designated Facility, determined to be Medically Necessary by us and if the Covered Person qualifies under our current "Morbid Obesity Policy." Contact Member Services if you have any questions. Nutritional supplies are not covered. Body fat testing, and educational materials that are not included in the weight management program fees are not Covered Health Services under the weight management program, and you will responsible for the full cost of such supplies and services.

20. Morbid Obesity Treatment – Surgery

Description

The Benefit plan covers Medically Necessary Covered Health Services, including room and board and other services and supplies provided in a Designated Facility, for the surgical treatment of morbid obesity. Benefits are available only if surgical treatment is ordered by a Physician and provided by a Network Physician or designated Physician in a Designated Facility, if the Covered Person qualifies under our current "Morbid Obesity Policy" and if the services are determined to be Medically Necessary by us. Contact Member Services if you have any questions.

Surgical treatment of obesity is limited to once per lifetime unless Medically Necessary to correct or reverse complications from a previous bariatric procedure.

21. Nutritional Counseling Services

The Benefit plan covers nutritional counseling services provided by a Network Hospital-based registered dietician. Covered Health Services must be provided under the direction of a Physician. Conditions for which nutritional counseling is a Covered Health Service include, but are not limited to:

- Weight management.
- Diabetes mellitus.
- Coronary artery disease.
- Congestive heart failure.
- Severe obstructive airway disease.
- Gout.
- Renal failure.
- Phenylketonuria.
- Hyperlipidemias.

Additional services may be covered under *Preventive Health Services* later in this section.

Benefits are available when nutritional counseling is provided during an individual session. Benefits are limited to six (6) sessions of nutritional counseling per calendar year.

22. Nutritional Therapy

The Benefit plan covers enteral feeding administered via tube. Formulas intended for this type of feeding as well as supplies, equipment, and accessories needed to administer this type of nutrition therapy are covered.

The Benefit plan covers parenteral nutrition administered via an IV. Nutrients, supplies, and equipment needed to administer this type of nutrition are covered.

NOTE: Except for formula specifically intended for tube feeding and nutrients necessary for IV feeding, all food, formula and nutritional supplements are not covered. This includes, but is not limited to, infant formula, protein or caloric boosting supplements, vitamins, Ensure, Osmolyte and herbal preparations or supplements, even if approved by the federal FDA.

23. Orthognathic Therapy

Description

The Benefit plan covers Medically Necessary orthognathic therapy involving the repositioning (but not removal) of an individual tooth, arch segment, or entire arch, if the surgery is provided along with a course of orthodontic treatment to correct bodily dysfunction. We will only cover the following orthognathic therapy services:

- Office visits for evaluation and orthognathic treatment.
- Cephalometric study and X-rays.
- Orthognathic surgery and post-operative care.
- Hospitalization.

NOTE: Orthodontic treatment is not covered.

24. Ostomy Supplies

The Benefit plan covers only the following ostomy supplies required as a result of a colostomy, ileostomy or urostomy:

- Pouches, face plates and belts.
- Irrigation sleeves, bags and catheters.
- Skin barriers.

Benefits are not available for gauze, filters, lubricants, tape, appliance cleaners, adhesive, adhesive removers, deodorant, pouch covers, or other items not listed above.

25. Outpatient Diagnostic Services

The Benefit plan covers Medically Necessary diagnostic services received on an outpatient basis at a Hospital or Alternate Facility including but not limited to:

- Laboratory tests.
- Radiology (including X-ray and diagnostic mammography testing).
- Endoscopic procedures, such as colonoscopy and esophagogastroduodenoscopy (EGD).
- Cardiac procedures, such as Holter monitoring and cardiac catheterization.

Benefits under this category include the facility charge, the charge for required services, supplies and equipment, and all related professional fees.

When these procedures and services are performed in a Physician's office, Benefits are described under *Physician's Office Services* later in this section.

When these procedures and services are performed on a routine, screening basis, they are covered under *Preventive Health Services* later in this section.

This category does not include Benefits for CT scans, PET scans, MRIs, MRAs or nuclear medicine, which are described immediately below.

26. Outpatient Advanced Diagnostic Imaging and Nuclear Medicine

The Benefit plan covers Medically Necessary CT scans, PET scans, MRIs, MRAs and nuclear medicine received on an outpatient basis in a Physician's office or at a Hospital or Alternate Facility.

Benefits under this category include the facility charge, the charge for required services, supplies and equipment, and all related professional fees.

27. Outpatient Surgery Services

The Benefit plan covers Medically Necessary surgery and related services received on an outpatient basis at a Hospital or Alternate Facility such as an ambulatory surgical center.

Benefits under this category include only the facility charge and the charge for required Hospital-based professional services, supplies and equipment. Benefits for the surgeon's fees related to outpatient surgery are described under *Professional Fees for Surgical and Medical Services* below.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* below.

28. Outpatient Therapeutic Treatment Services

NOTE: The list of approved Specialty Pharmaceuticals is subject to change and includes drugs received in an office or ambulatory facility or from a pharmacy. Please contact us for current information.

Description

The Benefit plan covers approved Specialty Pharmaceuticals. Specialty Pharmaceuticals are biotech drugs including high cost infused, injectable, oral and other drugs related to specialty disease categories or other categories. We determine which specific drugs are Covered Health Services and this list is subject to change. The list may include vaccines and chemotherapy drugs used in the treatment of cancer but excludes injectable insulin, which does not require authorization. Please contact us for current information and to request authorization.

The Benefit plan covers therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility, including dialysis, intravenous chemotherapy or other intravenous infusion therapy, and radiation therapy

Benefits under this category include the facility charge, the charge for required services, supplies and equipment, and all related professional fees. When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* below.

29. Pain Management

The Benefit plan covers the evaluation and treatment of chronic pain, when provided by or under the direction of your Physician. Chronic pain is unremitting and has been present for a long period of time without relief.

30. Physician's Office Services Illness/Injury

The Benefit plan covers services received in a Physician's office, including Primary Care Physician and specialist, regardless of whether the Physician's office is freestanding, located in a clinic or located in a Hospital, including but are not limited to:

- Radiology
- Pathology
- Diagnostic testing and services (including allergy testing)

- Consultations
- Medical education services by appropriately licensed or registered healthcare professionals, including to manage chronic disease states such as diabetes or asthma, when both of the following are true:
  - ➢ Education is required for a disease in which patient self-management is an important component of treatment; and
  - ➢ There exists a knowledge deficit regarding the disease, which requires the intervention of a trained health professional.

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

Network Benefits are also available for Covered Health Services received at a Non-Network Physician's office outside the state of Michigan to treat emergent or urgent conditions that require immediate medical attention to limit severity and prevent complications. Network Benefits for follow-up care are available only when provided by a Network provider.

Refer to *Injections/Infusions Received in Physician's Office* (earlier in this section) for coverage information for injections/infusions received in the Physician's office.

When Preventive Health Services are provided in a Physician's office, Benefits are available as described under *Preventive Health Services* below.

31. 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.
- 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 as defined in ORC 1751.66. 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.paramountinsurancecompany.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.

1-Tier/Single Copayment or Coinsurance

Refer to the Summary of Benefits for exceptions that may apply to drugs subject to DAW Status or Additional Benefits and Programs.

- Tier 1 Prescription Drugs have one Coinsurance or Copayment.

2-Tier Copayment or Coinsurance

Refer to the Summary of Benefits for exceptions that may apply to drugs subject to DAW Status or Additional Benefits and Programs.

- Tier 1 Generic Prescription Drugs with a lower Coinsurance or Copayment.
- Tier 2 Brand Prescription Drugs with a higher Coinsurance or Copayment than those in Tier 1.

3-Tier Copayment

Refer to the Summary of Benefits for exceptions that may apply to drugs subject to DAW Status or Additional Benefits and Programs.

- Tier 1 Generic Prescription Drugs with a lower Coinsurance or Copayment.
- Tier 2 Preferred Brand Prescription Drugs with a higher Coinsurance or Copayment than those in Tier 1.
- Tier 3 Non-Preferred Brand Prescription Drugs with a higher Coinsurance or Copayment than those in Tier 2.

4-Tier Copayment

Refer to the Summary of Benefits for exceptions that may apply to drugs subject to Additional Benefits and Programs.

- Tier 1 Generic Prescription Drugs have the lowest Coinsurance or Copayment.
- Tier 2 Preferred Brand Prescription Drugs will have a higher Coinsurance or Copayment than those in Tier 1.
- Tier 3 Non-Preferred Brand Prescription Drugs will have a higher Coinsurance or Copayment than those in Tier 2.
- Tier 4 Multi-Source Brand Prescription Drugs will have a higher Coinsurance or Copayment than those in Tier 3.

5-Tier Copayment

Refer to the Summary of Benefits for exceptions that may apply to drugs subject to Additional Benefits and Programs.

- Tier 1 Preferred Generic Prescription Drugs have the lowest Coinsurance or Copayment.
- Tier 2 Non-Preferred Generic Prescription Drugs will have a higher Coinsurance or Copayment than those in Tier 1.
- Tier 3 Preferred Brand Prescription Drugs will have a higher Coinsurance or Copayment than those in Tier 2.
- Tier 4 Non-Preferred Brand Prescription Drugs will have a higher Coinsurance or Copayment than those in Tier 3.
- Tier 5 Specialty and Injectable Prescription Drugs will have a higher Coinsurance or Copayment than those in Tier 4.

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.paramountinsurancecompany.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.paramountinsurancecompany.com.

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.

32. Preventive Health Services

The Benefit plan coverspreventive medical care when provided by a Network provider including, but not limited to, the following as may be appropriate based on your age and/or gender:

Covered Preventive Services for Adults

- Annual routine physical exams
- Screenings such as:
  - ➢ Abdominal Aortic Aneurysm one-time screening for men of specified ages who have ever smoked
  - ➢ Alcohol Misuse screening
  - ➢ Allergy testing and serum
  - ➢ Blood Pressure screening for all adults
  - ➢ Cholesterol screening for adults of certain ages or at higher risk
  - ➢ Colorectal Cancer screening for adults over 50, including a select group of Prescription Drug Products for bowel prep (for adults ages 50 to 75)
  - ➢ Depression screening for adults
  - ➢ Type 2 Diabetes screening for adults with high blood pressure
  - ➢ HIV screening for all adults at higher risk
  - ➢ Obesity screening for all adults
  - ➢ Tobacco Use screening for all adults
  - ➢ Syphilis screening for all adults at higher risk

- Counseling such as:
  - ➢ Aspirin use for men and women of certain ages
  - ➢ Alcohol Misuse counseling
  - ➢ Diet counseling for adults at higher risk for chronic disease
  - ➢ Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk
  - ➢ Obesity counseling for all adults

- Immunization vaccines for adults--doses, recommended ages, and recommended populations vary:
  - ➢ Hepatitis A
  - ➢ Hepatitis B
  - ➢ Herpes Zoster
  - ➢ Human Papillomavirus
  - ➢ Influenza
  - ➢ Measles, Mumps, Rubella
  - ➢ Meningococcal
  - ➢ Pneumococcal
  - ➢ Tetanus, Diphtheria, Pertussis
  - ➢ Varicella

- Other services such as cessation interventions for tobacco users

Covered Preventive Services for Women, Including Pregnant Women

- Annual routine physical exams
- Annual well-woman visits
- HPV DNA testing for women 30 years and older
- Screenings such as:
  - ➢ Gestational diabetes for pregnant women
  - ➢ HIV screening
  - ➢ Interpersonal and domestic violence screening
  - ➢ Anemia screening on a routine basis for pregnant women
  - ➢ Bacteriuria urinary tract or other infection screening for pregnant women

- Breast Cancer Mammography screenings (one screening per calendar year regardless of age).
  - ➢ Cervical Cancer screening for sexually active women
  - ➢ Chlamydia Infection screening for younger women and other women at higher risk
  - ➢ Gonorrhea screening for all women at higher risk
  - ➢ Hepatitis B screening for pregnant women at their first prenatal visit
  - ➢ Osteoporosis screening for women over age 60 depending on risk factors
  - ➢ Rh Incompatibility screening for all pregnant women and follow-up testing for women at higher risk
  - ➢ Tobacco Use screening for all women, and expanded counseling for pregnant tobacco users
  - ➢ Syphilis screening for all pregnant women or other women at increased risk

- Counseling such as:
  - ➢ Sexually-transmitted infection counseling
  - ➢ HIV counseling
  - ➢ Contraceptive counseling
  - ➢ Breastfeeding support and counseling
  - ➢ Interpersonal and domestic violence counseling
  - ➢ BRCA counseling about genetic testing for women at higher risk
  - ➢ Breast Cancer Chemoprevention counseling for women at higher risk
  - ➢ Use of Folic Acid supplements for women who may become pregnant

- Other services such as:
  - ➢ Tobacco Use interventions for all women
  - ➢ Breast Feeding interventions to support and promote breast feeding , including breast pumps supplied by our designated vendor
  - ➢ Select federal FDA-approved contraceptive methods

Covered Preventive Services for Children

- Annual routine physical exams including well baby and well child visits
- Screenings such as:
  - ➢ Autism screening for children at 18 and 24 months
  - ➢ Allergy testing and serum
  - ➢ Cervical Dysplasia screening for sexually active females
  - ➢ Congenital Hypothyroidism screening for newborns
  - ➢ Developmental screening for children under age 3, and surveillance throughout childhood
  - ➢ Dyslipidemia screening for children at higher risk of lipid disorders
  - ➢ Hearing screening for all newborns
  - ➢ Hematocrit or Hemoglobin screening for children
  - ➢ Hemoglobinopathies or sickle cell screening for newborns
  - ➢ HIV screening for adolescents at higher risk
  - ➢ Lead screening for children at risk of exposure
  - ➢ Obesity screening
  - ➢ Phenylketonuria (PKU) screening for this genetic disorder in newborns
  - ➢ Vision screening for all children

- Assessments such as:
  - ➢ Alcohol and Drug Use assessments for adolescents
  - ➢ Behavioral assessments for children of all ages
  - ➢ Height, Weight and Body Mass Index measurements for children
  - ➢ Medical History for all children throughout development

- ➢ Oral Health risk assessment for young children

- Counseling such as:
  - ➢ Use of Fluoride Chemoprevention supplements for children without fluoride in their water source
  - ➢ Use of Iron supplements for children ages 6 to 12 months at risk for anemia
  - ➢ Obesity counseling
  - ➢ Sexually Transmitted Infection (STI) prevention counseling for adolescents at higher risk

- Immunization vaccines for children from birth to age 18 —doses, recommended ages, and recommended populations vary:
  - ➢ *Diphtheria, Tetanus, Pertussis*
  - ➢ *Haemophilus influenzae type b*
  - ➢ *Hepatitis A*
  - ➢ *Hepatitis B*
  - ➢ Human Papillomavirus
  - ➢ Inactivated Poliovirus
  - ➢ Influenza
  - ➢ Measles, Mumps, Rubella
  - ➢ Meningococcal
  - ➢ Pneumococcal
  - ➢ Rotavirus
  - ➢ Varicella

- Other services such as:
  - ➢ Tuberculin testing for children at higher risk of tuberculosis
  - ➢ Gonorrhea preventive medication for the eyes of all newborns

Network Benefits are available when Preventive Health Services are provided in a Network Physician's office, at a Network Alternate Facility or at a Network Hospital.

NOTE: This Benefit plan is intended to comply with the Affordable Care Act. The Preventive Health Services Benefit is subject to change.

33. Professional Fees for Surgical and Medical Services

The Benefit plan covers professional fees for surgical procedures and other medical care received on an outpatient or inpatient basis in a Physician's office, Hospital (including the Emergency Department), Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility, or for Physician house calls.

34. Prosthetic and Orthotic/Support Devices

NOTE: It is recommended that you or your provider call us to verify coverage prior to receiving prosthetic or orthotic/support devices.

The Benefit plan covers surgically implanted and externally worn prosthetic devices that replace a limb or body part including but not limited to:

- Replacement hip.
- Heart pacemaker.
- Artificial limbs.
- Artificial face, eyes, ears and noses.

- Speech aid prosthetics and tracheo-esophageal voice prosthetics.
- Breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998. This includes mastectomy bras (up to 4 per calendar year) and lymphedema stockings for the arm.

The prosthetic or orthotic device must be Medically Necessary, as determined by Paramount medical policy and nationally recognized guidelines and ordered or provided by, or under the direction of a Physician. Benefits are not provided for repair, replacement or duplicate devices that result from misuse, abuse or lost or stolen devices. Benefits may be provided for repair or replacement when necessitated due to a change in your medical condition, or a change in body size due to growth, or to improve physical function.

35. Reconstructive Procedures

NOTE: It is recommended that you or your provider call us to verify coverage prior to reconstructive procedures.

The Benefit plan covers Medically Necessary services for reconstructive procedures, when a physical impairment exists and the primary purpose of the procedure is to improve or restore physiologic function. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The fact that physical appearance may change or improve as a result of a reconstructive procedure does not classify such surgery as a Cosmetic Procedure when a physical impairment exists, and the surgery restores or improves function.

Cosmetic Procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery or other procedures done to relieve such consequences or behavior as a reconstructive procedure.

Examples of procedures that may or may not be considered cosmetic include breast reduction and reconstruction (except for after cancer surgery when it is always considered a Covered health Service or for surgical treatment of male gynecomastia when considered Medically Necessary); vein stripping, ligation and sclerotherapy, upper lid blepharoplasty, panniculectomy, rhinoplasty and septorhinoplasty.

NOTE: Benefits for reconstructive procedures include breast reconstruction following a mastectomy, and reconstruction of the non-affected breast to achieve symmetry. Other services required by the Women's Health and Cancer Rights Act of 1998, including treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service. You can contact us for more information about Benefits for mastectomy-related services.

36. Rehabilitation/Habilitation Services – Outpatient Therapies

Physical Therapy, Occupational Therapy, Speech Therapy, Pulmonary Rehabilitation Therapy and Cardiac Rehabilitation Therapy

Description

The Benefit plan covers outpatient rehabilitation/habilitation services for:
- Physical therapy.
- Occupational therapy.
- Speech therapy, including post-cochlear implant aural therapy (subject to specific restrictions and exclusions).
- Pulmonary rehabilitation therapy.
- Phase I and II cardiac rehabilitation therapy.

Rehabilitation/habilitation services must be performed by a licensed therapy provider, under the direction of a Physician. Rehabilitation/habilitation services must be performed at a Hospital, Skilled Nursing Facility, Alternate Facility, or through a Home Health Agency.

Benefits are not available for inpatient or outpatient Recreational Therapy.

Benefits are available only for rehabilitation/habilitation services that are expected to result in significant improvement in your condition within a time frame established by Paramount medical policy for your condition. Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation/habilitation services or if discharge rehabilitation/habilitation goals have previously been met.

Spinal Treatment

The Benefit plan covers Spinal Treatment (chiropractic or osteopathic manipulation treatment) when provided by a Spinal Treatment provider (Chiropractor or Doctor of Osteopathy, "D.O."). Benefits include the following:

- Services and supplies for analysis and adjustment of spinal subluxations(s) and spinal misalignment(s).
- Diagnosis and treatment by manipulation of the skeletal structure.
- Muscle stimulation by any means (except treatment of fractures and dislocations of the extremities).
- Rehabilitative exercise related to spinal subluxations(s) or spinal misalignment(s).
- X-rays of the spine.

Limitations

Benefits for any combination of physical therapy, occupational therapy, and Spinal Treatment received on an outpatient basis are limited to 30 visits per calendar year.

Benefits for speech therapy received on an outpatient basis are limited to 30 visits per calendar year.

Benefits for pulmonary rehabilitation therapy and Phase I and II cardiac rehabilitation therapy received on an out patient basis is limited to 30 visits per calendar year.

NOTES: If the therapies described under this category are available on both a rehabilitative and habilitative basis, there are separate limits, as stated above, for each type (e.g., 30 visits per calendar year for rehabilitative speech therapy and 30 visits per calendar year for habilitative speech therapy; and 30 combined visits per calendar year for rehabilitative physical therapy, occupational therapy and Spinal Treatment and 30 combined visits per calendar year for habilitative physical therapy, occupational therapy and Spinal Treatment (as applicable).

Outpatient rehabilitation/habilitation therapy for autism will not be included in the limits specified above.

37. Surgical Sterilization - Female

The Benefit plan covers female surgical sterilization procedures and related services received in a Physician’s office or on an outpatient basis at a Hospital or Alternate Facility.

Benefits under this category include the facility charge, the charge for required Hospital-based professional services, supplies and equipment and for the surgeon’s fees.

38. Surgical Sterilization - Male

The Benefit plan covers male surgical sterilization procedures and related services received in a Physician’s office or on an outpatient basis at a Hospital or Alternate Facility.

Benefits under this category include the facility charge, the charge for required Hospital-based professional services, supplies and equipment and for the surgeon's fees.

39. Telemedicine Services

The Benefit plan covers Telemedicine Services for certain Medically Necessary Covered Health Services. "Telemedicine" means the use of an electronic medium to link patients with healthcare professionals in different locations. The healthcare professionals would have to be able to examine the patient via a real-time, interactive audio and/or video telecommunications system and the patient must be able to interact with the offsite professional at the time the services are provided. Telemedicine Services must be provided by healthcare professionals who are licensed, registered, or otherwise authorized to engage in his/her healthcare profession in the state where the patient is located.

Not all Covered Health Services are covered telemedically such as, but not limited to, new patient examinations, Preventive Health Services and surgery.

40. Temporomandibular Joint Dysfunction or Syndrome

Description

The Benefit plan covers professional fees for Medically Necessary care or services to treat temporomandibular joint dysfunction or syndrome (TMJ) resulting from a medical cause or Injury. TMJ means muscle tension and spasms related to the temporomandibular joint, facial, and cervical muscles, causing pain, loss of function and neurological dysfunction. Covered Health Services include:

- Office visits for medical evaluation and treatment.
- X-ray of the temporomandibular joint including contrast studies, but not dental X-rays.
- Myofunctional therapy.
- Surgery to the temporomandibular joint, such as condylectomy, meniscectomy, arthrotomy, and arthrocentesis.

NOTE: Bite splints, orthodontic treatment, or other dental services to treat TMJ dysfunction or syndrome are not covered.

41. Tobacco Cessation Program

Description

A Tobacco Cessation Program is offered to Benefit plan members over the age of eighteen (18) that includes participation in a select credentialed counseling program and coverage for Preferred Tobacco Cessation Products.

Preferred Tobacco Cessation Products must be prescribed by a Physician and obtained from a Network retail Pharmacy, even if the product is available as an over-the-counter product. You must enroll and participate in the program to receive Preferred Tobacco Cessation Products.

Call the Member Services Department for complete details on enrolling in the counseling program, the current list of Preferred Tobacco Cessation Products and any applicable Copayments and Coinsurance.

Premium Rates for Tobacco Users

A tobacco user is someone who is age 21 or older who has regularly used tobacco (smoking or chewing) at least four or more times per week in the past six months. Religious or ceremonial uses of tobacco, for example, by

American Indians and Alaskan Natives are specifically exempt.

Your plan has different premium rates for tobacco users and non-tobacco users. If you are a tobacco user, by participating in this Tobacco Cessation Program, you can have your premium rates reduced to the non-tobacco user rate. You may decide at any time during your coverage period to participate in this program.

How the premium rate reduction works

If you are a tobacco user paying the tobacco user rate and enroll in this program, your premium rate will be adjusted to the non-tobacco user rate. If you are a tobacco user and you do not participate in this program, your premium rate will remain at the tobacco-user premium rate.

To have the tobacco-user rate adjusted you will be required to submit a signed attestation to Paramount certifying your enrollment in the Tobacco Cessation Program. You can obtain a copy of the attestation form by contacting Paramount or visiting our website.

42. Transplantation Services

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 t ransplants. 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.

43. Urgent Care Center Services

The Benefit plan covers services received at an Urgent Care Center. When services to treat urgent health care needs are provided in a Physician's office, Benefits are available as described under Physician's Office Services earlier in this section.

NOTE: Some Covered Health Services received during the same urgent care center visit may be subject to the Annual Deductible and Coinsurance. Ancillary services such as Physician professional fees are described else where in this section.

44. Vision Benefits Information

A. Diagnostic Services

Diagnostic Services are available for **all Covered Persons when care is obtained from Participating Providers in the Paramount Network.** Coverage includes vision treatment or services of medical conditions and diseases of the eye. Only Emergency care and treatment is covered when obtained from Non-Network providers, unless otherwise noted.

The Benefit plan covers.

- ➢ Eye exam, includes dilation, if professionally indicated – limited to 1 per calendar year
- ➢ Eye exams can be new or established patient exams, and new and established routine ophthalmologic exams with refraction.

B. Pediatric Vision Benefit

Benefits are only available for **Covered Persons until the end of the calendar year in which they turn age nineteen (19). Services must be obtained through Superior Vision's network of providers.** Benefits are

subject to the Network Annual Deductible and Network Annual Out-of-Pocket Maximum listed under earlier in this Certificate of Coverage.

1. Eyeglasses

The Benefit plan covers prescription lenses and frames.

Lenses – limited to one pair per calendar year:

- ➢ Single vision
- ➢ Conventional (Lined) Bifocal
- ➢ Conventional (Lined) Trifocal
- ➢ Lenticular

Lenses include choice of glass, plastic, or polycarbonate lenses; all lens powers (single vision, bifocal, trifocal, lenticular); fashion and gradient tinting; oversize; and glass-grey #3 prescription sunglass lenses. All lenses include scratch resistant coating.

Frames – covered once every calendar year.

We cover a select group of frames. If you purchase a pair outside of this group, you may be billed the price difference.

2. Contact Lenses

Elective contact lenses are covered once every calendar year in lieu of eyeglasses. Benefits include evaluation, materials, fitting and follow-up care.

Medically Necessary contact lenses are covered once every calendar year in lieu of any other eyewear (eyeglasses or elective contact lenses). Benefits include evaluation, materials, fitting and follow-up care.

NOTE: Medically Necessary contact lenses require prior authorization for Benefit coverage. Contact lenses may be determined to be Medically Necessary and appropriate in the treatment of patients affected by certain conditions. In general, contact lenses may be Medically Necessary and appropriate when the use of contact lenses, in lieu of eyeglasses, will result in significantly better visual and/or improved binocular function, including avoidance of diplopia or suppression. Contact lenses may be determined to be Medically Necessary in the treatment of the following conditions: Keratoconus, Pathological Myopia, Aphakia, Anisometropia, Aniseikonia, Aniridia, Corneal disorders, Post-traumatic Disorders, Irregular Astigmatism. Medically Necessary contact lenses are dispensed in lieu of other eyewear.

3. Other Vision Services

Optional Lenses and Treatments:

- ➢ Ultraviolet Protective Coating
- ➢ Blended Segment Lenses
- ➢ Intermediate Vision Lenses
- ➢ Standard Progressives
- ➢ Premium Progressives
- ➢ Photochromic Glass Lenses
- ➢ Plastic Photosensitive Lenses
- ➢ Polarized Lenses
- ➢ Standard Anti-Reflective (AR) coasting
- ➢ Premium AR Coating
- ➢ Ultra AR Coasting
- ➢ Hi-Index Lenses

Low Vision Services:
Low vision is a significant loss of vision but not total blindness. Ophthalmologists and optometrists specializing in low vision care can evaluate and prescribe optical devices, and provide training and instruction to maximize the remaining usable vision for our members with low vision. You must obtain authorization for coverage of these services. Covered low vision services include one comprehensive low vision evaluation every 5 years; items such as high-power spectacles, magnifiers and telescopes; and follow-up care (limited to 4 visits in any five-year period.

EXCLUSIONS

We Do Not Pay Benefits for Exclusions

We will not pay Benefits for any of the services, treatments, items or supplies described in this section, even if either of the following is true:

- It is recommended or prescribed by a Physician; or
- It is the only available treatment for your condition.
- The services, treatments, items or supplies listed in this section are not Covered Health Services, except as may be specifically provided for in ***Covered Services*** Section.

Benefit Limitations

When Benefits are limited within any of the Covered Health Service categories described in Covered Services Section, those limits are stated in the corresponding Covered Health Service category. Limits may also apply to some Covered Health Services that fall under more than one Covered Health Service category. Please review all limits carefully, as we will not pay Benefits for any of the services, treatments, items or supplies that exceed these Benefit limits.

Please note that in listing services or examples, when we say "this includes," it is not our intent to limit the description to that specific list. When we do intend to limit a list of services or examples, we state specifically that the list "is limited to."

A. Alternative Testing and Treatment

1. Acupressure and acupuncture
2. Aromatherapy
3. Hypnotism
4. Massage therapy
5. Rolfing
6. Herbal or vitamin therapies
7. Hair testing and analysis
8. Saliva testing and analysis
9. Environmental testing and analysis
10. Body fat testing and analysis, unless qualifies under our Morbid Obesity Treatment Benefit.
11. Clinical ecology and environmental medicine. “Clinical ecology” and “environmental medicine” are defined here as medical practice that is based on the belief that exposure to low levels of numerous common substances in the environment can be responsible for a variety of symptoms affecting numerous body systems.
12. Other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM), a component of the National Institutes of Health.

B. Behavioral Health

1. Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.

2. Behavioral Health Services as treatment for neurological disorders and other disorders with a known physical basis when such conditions are solely medical in nature.
3. Treatment for conduct and impulse control disorders, and paraphilias.
4. Services utilizing methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents.
5. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements, unless authorized by the Behavioral Health Designee.
6. Residential Treatment Programs for mental health conditions.
7. Services provided outside of an inpatient, intermediate or outpatient setting.
8. Behavioral Health Services for the following:
   - ➢ Sexual and gender identity and functional disorders
   - ➢ Personality disorders (except for specific psychological testing to clarify the diagnosis of personality dis order)
   - ➢ Sleep disorders
   - ➢ Delirium, dementia, and amnesic and other cognitive disorders (except as provided under *Behavioral Health Services* in ***Covered Services*** Section)
   - ➢ Therapy for pervasive developmental disorders, except for treatment of certain Autism Spectrum Disorders
   - ➢ Psychotherapy for feeding, tic, and elimination disorders (except as provided under *Behavioral Health Services* in ***Covered Services*** Section)
   - ➢ Marital counseling
   - ➢ Transitional living centers, wrap-around care services, halfway or three-quarter-way houses, non-licensed programs, therapeutic boarding schools or milieu therapies
   - ➢ Sex therapy
   - ➢ Psychotherapy for Attention Deficit Disorder and disruptive behavior disorders (except as provided under *Behavioral Health Services* in ***Covered Services*** Section)
   - ➢ Mental disorders due to a general medical condition

9. Services or supplies for the diagnosis or treatment of Mental Illness, alcoholism or substance use disorders that, in the reasonable judgment of the Behavioral Health Designee, are any of the following:
   - ➢ Not consistent with prevailing national standards of clinical practice for the treatment of such conditions.
   - ➢ Not consistent with prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome.
   - ➢ Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective.
   - ➢ Not consistent with the Behavioral Health Designee's level of care guidelines or best practices as modified from time to time.

NOTE: The Behavioral Health Designee may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information regarding whether a service or supply meets any of these criteria.

C. Dental and Related Oral/Mouth Conditions

1. Dental care and all associated expenses except as specifically described in Covered Services Section under the heading *Dental Services – Accidental Injury and Other Medical Services of the Mouth*.
2. Preventive care, diagnosis, treatment of or related to the teeth or gums. Examples include all of the following:
   - ➢ Extraction, restoration and replacement of teeth, except as described in Covered Services Section under the heading *Dental Services – Accidental Injury and Other Medical Services of the Mouth*.
   - ➢ Medical or surgical treatments of dental conditions except as described in Covered Services Section under the heading *Dental Services – Accidental Injury and Other Medical Services of the Mouth*.
   - ➢ Services to improve dental clinical outcomes.
3. Tooth implants and related services, bone grafts and other implant-related procedures and related services, even when required as a result of an Injury.

4. Orthodontic services, including braces.
5. Dental X-rays, all hospitalization charges, facility charges, and anesthesia charges related to dental care. The only exceptions to this are for any of the following:
   - ➢ Transplant preparation.
   - ➢ Initiation of immunosuppressives.
   - ➢ The direct treatment of acute traumatic Injury, cancer or cleft palate.
   - ➢ Dental-related anesthesia and associated Hospital facility charges provided as described under the category, *Dental Anesthesia* in ***Covered Services*** Section.
6. Supplies and appliances and all associated expenses (including occlusal splints, dental prosthetics and dental orthotics). Mouth rehabilitation. Bridges. Partial plates. Dentures.
7. Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a Congenital Anomaly.
8. Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), when the services are provided as part of a treatment for documented dental conditions.

D. Drugs

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.paramountinsurancecompany.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.

E. Experimental, Investigational or Unproven Services

Experimental, Investigational and Unproven Services are excluded. The fact that an Experimental, Investigational, or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.

NOTE: This Exclusion does not apply to antineoplastic drugs for which Benefits are available as described in *Antineoplastic Therapy (Chemotherapy)* in ***Covered Services*** Section. These terms are defined in Terms and Definitions.

F. Medical Supplies, Appliances and Equipment

1. Devices used specifically as safety items and/or to affect performance in sports-related activities.
2. Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:
   - ➢ Elastic, surgical and compression stockings (for example TEDs and JOBST stockings)
   - ➢ Ace bandages
   - ➢ Disposable dressings used for wound care
   - ➢ Syringes, except as Benefits are provided in *Diabetes Services* in ***Covered Services*** Section

NOTE: This Exclusion does not apply for diabetes supplies for which Benefits are provided in *Diabetes Services* in ***Covered Services*** Section or supplies necessary for proper functioning or application of covered DME.

3. Shoe orthotics, except for shoe inserts for peripheral neuropathy, or those determined to be habilitative
4. Shoes, except for specialty shoes prescribed for a person with diabetes, or those determined to be habilitative
5. Cranial helmets

G. Nutrition

1. Megavitamin and nutrition based therapy.
2. All food, formula and nutritional supplements are not covered. This includes, but is not limited to, infant formula, donor breast milk, protein or caloric boosting supplements, vitamins, Ensure, Osmolyte and herbal preparations or supplements, even if approved by the federal FDA, except for formula specifically intended for tube feeding and nutrients necessary for IV feeding as provided in *Nutritional Therapy* in ***Covered Services*** Section.

H. Personal Services, Comfort or Convenience

1. Custodial care, domiciliary care or basic care, including room and board, provided in a residential, institutional or other setting that is, for the purpose of meeting your personal needs, and that could be provided by persons without professional skills or training.
2. Personal comfort and convenience items, including but not limited to, telephone and television services during an Inpatient Stay, and home or vehicle modifications or appliances.
3. Lodging and/or meals necessary while receiving healthcare services.
4. Services of personal care attendants.
5. Beauty/barber services.
6. Guest services.
7. Supplies, equipment and similar incidental services and supplies for personal comfort, or for the convenience of either the Covered Person or his or her Physician.

I. Physical Appearance

1. Cosmetic Procedures. See the definition in Terms and Definitions. Examples include:
   - ➢ Pharmacological regimens, nutritional procedures or treatments.
   - ➢ Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
   - ➢ Skin abrasion procedures and other dermatological treatment that is cosmetic in nature.
   - ➢ Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.
   - ➢ Treatment for skin wrinkles or any treatment to improve the appearance of the skin.
   - ➢ Treatment for spider veins.
   - ➢ Hair removal by any means.
   - ➢ Plastic surgery.
   - ➢ Collagen implants
   - ➢ Diastasis recti repair.
2. Removal or replacement of an existing breast implant if it was initially performed as a Cosmetic Procedure, unless due to Medically Necessary complications.

NOTE: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See the category, *Reconstructive Procedures* in ***Covered Services*** Section.

3. Treatment of benign gynecomastia (abnormal breast enlargement in males), unless Medically Necessary per Paramount medical policy.
4. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation.
5. Any hair replacement product or process, including wigs, regardless of the reason for the hair loss.

J. Providers

1. Services performed by a provider who is a family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.
2. Services performed by a provider with your same legal residence.
3. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services that are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider:
   - ➢ Has not been actively involved in your medical care prior to ordering the service, or
   - ➢ Is not actively involved in your medical care after the service is received.

NOTE: This Exclusion does not apply to mammography screening.

4. Foreign language and sign language interpreters.
5. Telephone consultations that do not meet the criteria as described in Telemedicine Services in ***Covered Services*** Section.
6. Academic services including tuition for or services that are school-based for children or adolescents provided under the Individuals With Educational Disabilities Act (IDEA).

K. Reproduction

1. All services and supplies relating to elective abortions
2. Health services and associated expenses for Assisted Reproductive Technology (ART) including but not limited to: artificial insemination, in vitro fertilization, gamete intrafallopian transfer (GIFT) procedures, zygote intrafallopian transfer (ZIFT) procedures or any other treatment or procedure designed to create a Pregnancy, and any related prescription medication treatment. Embryo transport. Donor ovum and semen and related costs including collection and preparation.

3. The reversal of surgical sterilization.
4. Cryo-preservation and other forms of preservation of reproductive materials.
5. Long-term storage of reproductive materials such as sperm, eggs, embryos, ovarian tissue and testicular tissue.

L. Services Provided under Another Plan

1. Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. This includes, but is not limited to, coverage required by workers' compensation or similar legislation. This applies whether or not you choose to file a claim.

   NOTE: This Exclusion does not apply to no-fault automobile insurance.

   If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness or Mental Illness that would have been covered under workers' compensation or similar legislation had that coverage been elected.

2. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.
3. Health services while on active military duty.

M. Spinal Treatment

1. Any Spinal Treatment service not related to the spine.
2. Any service not included in the scope of services defined in the Michigan Public Health Code, Chapter 333, Part 164.
3. Laboratory services.
4. Consultations.
5. Rehabilitative exercise not related to spinal subluxations or spinal misalignments.
6. Nutritional advice or supplements, drugs, medical equipment, or supplies dispensed by or prescribed by a Spinal Treatment provider.
7. Inpatient hospitalization.
8. Treatment of fractures and dislocations of the extremities.

N. Transplants

1. Health services for organ and tissue transplants, except those described in ***Covered Services*** Section.
2. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs for removal are payable for a transplant through the organ recipient's Benefits under the Policy).
3. Health services for transplants involving mechanical or animal organs.
4. Transplant services that are not performed at a Designated Facility.
   NOTE: This Exclusion does not apply to cornea transplants.
5. Any solid organ transplant that is performed as a treatment for cancer.
6. Any multiple organ transplant not listed as a Covered Health Service under the heading *Transplantation Services* in ***Covered Services*** Section.

O. Travel

1. Health services provided in a foreign country, unless required as Emergency Health Services.
2. Travel, lodging, room and board or transportation expenses, even though prescribed by a Physician or necessitated due to where treatment is received.

P. Vision and Hearing

1. Purchase and fitting of eye glasses, or refractive contact lenses for Dependent Children after the end of the calendar year in which they turn age nineteen (19).
2. Purchase and fitting of hearing aids.

3. Eye exercise therapy or visual therapy.
4. Surgery that is intended to allow you to see better without glasses or other vision correction including radial keratotomy, laser, and other refractive eye surgery.
5. Special lens designs or coatings other than those described in ***Covered Services*** Section under *Vision Benefits*.
6. Replacement of lost/stolen eyewear; non-prescription (Plano) lenses; two pairs of eyeglasses in lieu of bifocals; services not performed by licensed personnel; or insurance of contact lenses.
7. Any other vision treatment or services except for treatment of medical conditions and diseases of the eye as provided under each applicable Covered Health Service category in ***Covered Services*** Section.

Q. All Other Exclusions

1. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in Terms and Definitions.
2. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments when:
   - ➢ Required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage or adoption.
   - ➢ Related to judicial or administrative proceedings or orders.
   - ➢ Conducted for purposes of medical research.
   - ➢ Required to obtain or maintain a license of any type.

3. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.
4. Health services received after the date your coverage under the Policy ends, including health services for medical conditions arising before the date your coverage under the Policy ends.
5. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Policy.
6. Services and supplies, which are provided while member is in the custody of any law enforcement authorities or while incarcerated in a facility such as a youth home or charges involving a member's medical condition, which arise out of the commission of a felony by such a member, if convicted, unless resulting from an underlying medical condition or act of domestic violence.
7. In the event that a provider waives Copayments, Coinsurance amounts and/or the Annual Deductible for a particular health service, no Benefits are provided for the health service for which the Copayments, Coinsurance and/or Annual Deductible are waived.
8. Charges in excess of Eligible Expenses or in excess of any specified limitation.
9. Surgical treatment of morbid obesity that is not provided at a Designated Facility.
10. Weight loss programs whether or not they are under medical supervision, unless the Covered Person qualifies under our current "Morbid Obesity Policy."
11. Ambulance services that are provided by an Emergency responder that does not provide transportation except in the event of an Emergency Medical Condition.
12. Services provided by fire departments, rescue squads, or other Emergency transport providers that are supported by a government or where fees are in the form of a voluntary donation.
13. Ambulance transport (ground or air) that is not to the closest Hospital equipped to treat the condition, including transport to a preferred Hospital or for the convenience of being closer to your home or someone to provide continuing care to you.
14. Services and supplies for home births.
15. Freestanding birthing centers.
16. Sex transformation operations.
17. Private duty nursing.
18. Respite care, except as allowed under Paramount medical policy as part of hospice services.
19. Rest cures.
20. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

21. Autopsy.
22. Long term (more than 30 days) storage. Examples include cryo-preservation of tissue, blood and blood products.
23. Psychosurgery.
24. Medical and surgical treatment of excessive sweating (hyperhidrosis), except for Medically Necessary Covered Health Services as allowed under Paramount medical policy.
25. Medical and surgical treatment for snoring or daytime sleepiness, except when provided as a part of treatment for documented obstructive sleep apnea.
26. Oral appliances for snoring.
27. Audio therapy.
28. All devices and computers, including electronic access/connectivity, to assist in communication, speech and Telemedicine Services, for example special TV used for closed caption and reading machines, except for speech aid prosthetics and tracheo-esophageal voice prosthetics.
29. Gym memberships. Aquatic exercise programs or classes. Personal trainers. Exercise equipment, including pools even if prescribed by a Physician.
30. Inpatient or outpatient Recreational Therapy.
31. Covered Health Services for which Benefits would otherwise be available under the Policy that are related to a specific condition, when a Covered Person has refused to comply with or has terminated the scheduled service or treatment against the advice of a Physician or the Behavioral Health Designee.
32. Penile implants for the treatment of impotence having a psychological origin.
33. Legal/court fees, copy/fax fees, late fees, shipping charges, long distance telephone charges, and fees for copying X-rays.
34. Charges for missed appointments.
35. Power operated wheel chairs if you:
    - ➢ Can walk, or
    - ➢ Can use a manual wheelchair, or
    - ➢ Only need it for leisure activities, or
    - ➢ Would not need it for use in your home.

36. Benefits are not payable for any of the following:
    Medical equipment and supplies that do not meet Medicare Part B guidelines, (except for diabetic and ostomy supplies), exercise equipment, air conditioners, wigs, and test kits (except for diabetic supplies).
37. Services for the treatment of an overbite or underbite. Maxillary and mandibulary osteotomies, unless Medically Necessary.
38 Mouth orthotics, mouth splints, mouth prosthetics and mouth appliances.
39. Medical and surgical services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), unless Medically Necessary.
40. Biofeedback training, unless for treatment of medical diagnoses when Medically Necessary, as determined according to Paramount medical policies.
41. Skin titration (Rinkle Method), cytotoxicity testing (Bryan's Test), MAST testing, urine auto-injections, bronchial or oral allergen sensitization and provocative and neutralization testing for allergies.
42. Cognitive rehabilitative/habilitative therapy (neurological training or retraining); craniosacral therapy; rehabilitation/habilitation services obtained from non-Health professionals, including massage therapists; relational, educational and sleep therapy and any related diagnostic testing; and visual training and sensory integration therapy.
43. Items or services furnished, ordered, or prescribed by any provider that involves Fraud.
44. Health services and supplies that are not Medically Necessary – see the defintion in Terms and Definitions.

SECTION FOUR: 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 or individual conversion coverage. 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 or individual conversion coverage. See your benefits officer for details.

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

Adding and Removing Members When you need to change the number of Members covered under your plan, it is your responsibility to notify your employer and Paramount within thirty-one (31) days of the event. For example, new marriage, new birth, divorce or death. **YOU MUST COMPLETE AN ENROLLMENT APPLICATION OR CHANGE FORM WHEN YOU NEED TO ADD A MEMBER TO OR REMOVE A MEMBER FROM YOUR PLAN.** Contact your benefits 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 The probationary or waiting period for new employers 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 or renew as a Subscriber, Dependent or Dependent with Disabilities will be refused enrollment by Paramount based on student status, health status, related factor, pre-exisitng condition, genetic testing or the results of such testing, 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 Member 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

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.

Notice of termination will be provided 30 days in advance and include the reason for termination. The termination may not be based, either directly or indirectly, on any health status-related factor concerning the Member.

The Subscriber may request termination by sending a written request to Paramount 14 days in advance of the desired termination date.

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.

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.

Non-assignment

Member may not assign any benefits under this contract to any person, corporation or other organization. Any such assignment will be void. Paramount may assign its rights under this contract to any corporation or other entity that controls or is under common control with Paramount. Any entity that succeeds to the rights and responsibilities is bound by this contract.

SECTION FIVE: WHAT HAPPENS WITH YOUR PLAN

When You Have Other Coverage - How Coordination of Benefits Works

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

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

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

Plans That Do Not Coordinate

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

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

How Paramount Pays as Your Primary Plan

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

How Paramount Pays as a Secondary Plan

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

Which Plan Is Primary?

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

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

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

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

3. **Children (parents not divorced or separated) and the birthday rule** When your children's health care expenses are involved, we follow the "birthday rule". The plan of the parent with the first birthday is always primary for the children. For example, if your birthday is in January and your spouse's birthday is in March, your plan will be primary for all of your children.

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

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

Coordination Disputes

If you believe that we have not paid a claim properly under coordination of benefits, you should first attempt to resolve the problem by contacting us. Please refer to 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 4 of this Subscriber Certificate entitled, ***Who is Eligible?***, may be eligible for continuation coverage under the employer group's health benefits plan or for individual conversion coverage. 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.

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

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

1. To obtain individual membership, you must meet all of the following conditions:
   - ▶ You must continue to live in the Michigan Service Area.
   - ▶ You must have been continuously covered under the group agreement for at least three (3) months prior to the termination of group coverage.
   - ▶ You must submit a complete application for conversion to an individual policy within thirty-one (31) days after the date your coverage ends.

- You must submit any prepayment required. Details of the current prepayment rates will be sent to you at your request for conversion information.

2. Conversion to individual membership is not available when:
   - The Group agreement has been terminated by the group or Paramount for any reason and has been replaced by other group coverage.
   - A Member is covered under Medicare.
   - A Member is covered by or eligible for any other pre-paid or expense-incurred policy, health plan or health insurance.
   - Termination of a Member's group coverage occurred because of nonpayment of required premiums or because of fraud.

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

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

Conditions of Individual Conversion

- Conversion to individual coverage will be available to Members who live in the Paramount Michigan Service Area, are not eligible for Medicare benefits or any other policy of insurance or health care plan providing comparable benefits and have lost eligibility due to termination of employment conditions or Dependent eligibility requirements.
- If a Member chooses to apply for conversion, the conversion will be effective retroactively from the date group or continuation coverage ended.
- If a Member chooses not to apply for conversion and receives health services or benefits during the 31-day decision period, that Member must pay for those services.
- The Member is responsible for the required payment according to the plan's prepayment schedule as detailed in the individual plan document ("Individual Medical and Hospital Service Agreement").

If Paramount Ends Operations

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

SECTION SIX: 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

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 or a Grievance

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

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

For grievances, you should follow the steps outlined below:

Internal Grievance – Level 1

If you have a 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 and seven (7) calendar days for other issues. 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.

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 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.

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*** after the date you receive a notice of an adverse determination or final adverse determination, you or your authorized representative may file a request for an external review with DIFS. If you request an external review, you will be required to authorize the release of any medical records that may be required to be reviewed for the purpose of reaching a decision on the external review.

If DIFS accepts the request for an external independent review, you will receive an acknowledgement from DIFS. (If DIFS does not accept the request, DIFS will notify you of the reason.) DIFS will select a state-approved independent review organization (IRO) to conduct a review. The IRO will review all pertinent records available and notify DIFS of its recommendation. DIFS will then review the recommendation and notify the Member and Paramount of the DIFS decision.

Expedited External Reviews

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

- The adverse determination involves a medical condition in which the timeframe for completion of an expedited internal grievance would seriously jeopardize the life or health of the Member or would jeopardize the Member's ability to regain maximum function as substantiated by a physician either orally or in writing.

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

Denials on services that have already been received do not qualify for an expedited external 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.

SECTION SEVEN: TERMS AND DEFINITIONS

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

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.

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 Commissioner of the Department of Insurance and Financial Services, if the Commissioner determines that the diagnostic measure is recognized by the health care industry and is an evidence-based diagnostic tool.

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

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

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

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

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

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

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

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.

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.

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.

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.

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 AND DEVICES – health care services and devices that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. The services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings. The devices may include Durable Medical Equipment, orthotics, prosthetics, augmentative communication devices, and other assistive technologies and supplies.

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

MEDICAL NECESSITY means the services you receive:

1. Are appropriate in terms of type, amount, frequency, level, setting, and duration to the Member's diagnosis or condition.

2. Be based on generally accepted medical or scientific evidence and consistent with generally accepted practice parameters.

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 benefits for those Covered Services that apply to the Out-of-Pocket Copayment/Coinsurance Limit during the remainder of the Contract Year.

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 SERVICES means evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (Task Force); immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (Advisory Committee); with respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and with respect to women, evidence-informed preventive care and screening provided for in comprehensive guidelines supported by HRSA (not otherwise addressed by the recommendation of the Task Force). For a complete list of recommendations and guidelines visit http;//www.HealthCare.gov/center/regulations/prevention.html.

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.

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.

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