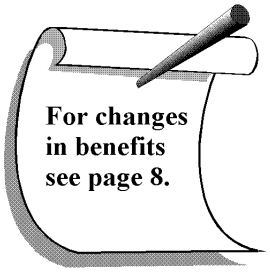
Paramount Health Care

http://www.promedica.org

2001

A Health Maintenance Organization



Serving: Northwest and North Central Ohio

Enrollment in this Plan is limited; see page 7 for requirements.

This Plan has commendable accreditation from the NCQA. See the 2001 Guide for more information on NCQA.

Enrollment codes for this Plan:

U21 Self Only
U22 Self and Family

Special notice: This Plan has eliminated a portion of its Service Area for 2001. If you are enrolled in this Plan and live or work in one of the following areas, you must select another plan during Open Season to continue to receive full Plan benefits: the **Ohio** counties of Ashland, Crawford, Hardin, Knox, Lorain, Marion, Morrow, Richland, and Wyandot. If you live or work in one of these areas and do not select another FEHB plan, you will be covered only for emergency services received outside the Service Area. In order to receive full Plan benefits, you must travel to a county in the remaining Service Area, and be seen by a Plan provider.

Authorized for distribution by the:

UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
RETIREMENT AND INSURANCE SERVICE
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Table of Contents

Introduction

Paramount Health Care
1901 Indian Wood Circle
Maumee, OH 43537-4068

This brochure describes the benefits of Paramount Health Care under its contract (CS 2672) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitation, and exclusions of this brochure.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled for Self and Family coverage, each eligible member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2001, unless those benefits are also shown in this brochure.

OPM negotiates benefits and premiums with each plan annually. Benefit changes are effective January 1, 2001, and are shown on page 8. Rates are shown at the end of this brochure.

Plain Language

The President and Vice President are making the Government's communication more responsive, accessible, and understandable to the public by requiring agencies to use plain language. In response, a team of health plan representatives and OPM staff worked cooperatively to make this brochure clearer. Except for necessary technical terms, we use common words. "You" means the enrollee or family member; "we" means Paramount Health Care.

The plain language team reorganized the brochure and the way we describe our benefits. When you compare this Plan with other FEHB plans, you will find that the brochures have the same format and similar information to make comparisons easier.

If you have comments or suggestions about how to improve this brochure, let us know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail us at fehbwebcomments@opm.gov or write to OPM at Insurance Planning and Evaluation Division, P.O. Box 436, Washington, DC 20044-0436.

Section 1. Facts about this HMO plan

This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services.

HMO's emphasize preventive care such as routine office visits, physical exams, well-baby care, and immunizations, in addition to treatment for illness and injury. Our providers follow generally accepted medical practice when prescribing any course of treatment.

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You only pay the copayments, coinsurance, and deductibles described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

You should join an HMO because you prefer the plan's benefits, not because a particular provider is available. You cannot change plans because a provider leaves our Plan. We cannot guarantee that any one physician, hospital, or other provider will be available and/or remain under contract with us.

How we pay providers

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your copayments or coinsurance.

Who provides my health care?

Paramount Health Care is an Individual Practice Association (IPA) type HMO. IPA means that plan providers are in independent practice throughout the service area. All covered services must be provided by in-network providers and facilities, unless it is an emergency medical condition, or authorized in advance by Paramount.

Paramount has over 590 primary care physicians (PCP). Your PCP will be your first contact when you are in need of medical care. All female members will have open access to all participating OB/GYNs for treatment of an OB/GYN condition without a referral from their primary care physician. Paramount has over 1,200 specialists in our network. If you need to be seen by a specialist, your primary care physician will make a referral to the appropriate specialist. Paramount has 36 hospitals and 3 Centers of Excellence.

Each member may have a different primary care physician and will receive their own Paramount Health Care ID card which indicates who the primary care physician is, along with the doctor's phone number and appropriate copayment amounts. Payment of your copayment is expected at the time medical services are delivered.

Patients' Bill of Rights

OPM requires that all FEHB Plans comply with the Patients' Bill of Rights, recommended by the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. You may get information about us, our networks, providers, and facilities. OPM's FEHB website (www.opm.gov/insure) lists the specific types of information that we must make available to your.

If you want information about us, call 419/887-2525 or 1-800/462-3589, or write to Paramount Health Care, 1901 Indian Wood Circle, Maumee, OH 43537. You may also contact us by fax at 419/887-2018 or visit our website at www.promedica.org.

Service Area

To enroll in this Plan, you must live in or work in our Service Area. This is where our providers practice.
Our service area is:

The **Ohio** counties of Defiance, Erie, Fulton, Hancock, Henry, Huron, Lucas, Ottawa, Putnam, Sandusky, Seneca, Williams and Wood and portions of Allen, Delaware, and Paulding as described by the following zip codes:

Allen County: 45801,45804, 45805, 45806, 45807, 45817, 45820, 45833, 45850;

Delaware County: 43003, 43015, 43066;

Paulding County: 45813, 45821, 45849, 45855, 45861, 45873, 45879, 45886.

Section 2. How we change for 2001

Program-wide changes

?? The plain language team reorganized the brochure and the way we describe our benefits. We hope this will make it easier for you to compare plans.

?? This year, the Federal Employees Health Benefits Program is implementing network mental health and substance abuse parity. This means that your coverage for mental health, substance abuse, medical, surgical, and hospital services from providers in our plan network will be the same with regard to deductibles, coinsurance, copays, and day and vis it limitations when you follow a treatment plan that we approve. Previously, we placed shorter day or visit limitations on mental health and substance abuse services than we did on services to treat physical illness, injury, or disease.

?? Many healthcare organizations have turned their attention this past year to improving healthcare quality and patient safety. OPM asked all FEHB plans to join them in this effort. You can find specific information on our patient safety activities by calling our Member Service Department at 419/887-2823 or 800/462-3589, or checking our website www.promedica.org. You can find out more about patient safety on the OPM website, www.opm.gov/insure. To improve your healthcare, take these five steps:

??Speak up if you have questions or concerns.

??Keep a list of all the medicines you take.

??Make sure you get the results of any test or procedure.

??Talk with your doctor and health care team about your options if you need hospital care.

??Make sure you understand what will happen if you need surgery.

?? We clarified the language to show that anyone who needs a mastectomy may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure. Previously, the language referenced only women.

Changes to this Plan

?? Your share of the non-Postal premium will increase by 5.7% for Self Only and decrease by 3.2% for Self and Family.

?? There are no benefit changes.

?? This Plan has eliminated a portion of its Service Area for 2001. If you are enrolled in this Plan and live or work in one of the following areas, you must select another plan during Open Season to continue to receive full Plan benefits: the **Ohio** counties of Ashland, Crawford, Hardin, Knox, Lorain, Marion, Morrow, Richland, and Wyandot. If you live or work in one of these areas and do not select another FEHB plan, you will be covered only for emergency services received outside the Service Area. In order to receive full Plan benefits, you must travel to a county in the remaining Service Area, and be seen by a Plan provider (See cover and page xx).

Section 3. How you get care

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive you ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation (for annuitants), or your Employee Express confirmation letter.

If you do not receive you ID cards within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 419/887-2525 or 1-800/462-3589.

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay copayments, and/or coinsurance, and you will not have to file claims.

?? **Plan providers**

Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We credential Plan providers according to national standards.

We list plan providers in the provider directory, which we update periodically. The list is also on our website.

?? **Plan facilities**

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in our provider directory, which we update periodically. This list is also on our website.

What you must do to get covered care

It depends on the type of care you need. First, you and each family member must choose a primary care physician. This decision is important since you primary care physician provides or arranges for most of your health care.

If you need information about the qualifications of any participating physicians, you may call the Academy of Medicine. You also can call Paramount Health Care Member Services Department at 419/887-2525 or 1-800-462-3589.

?? **Primary care**

Your primary care physician can be a family practitioner, internist or pediatrician. Your primary care physician will provide most of your health care, or give you a referral to see a specialist.

If you want to change primary care physicians or if your primary care physician leaves the Plan, call us. We will help you select a new one.

?? **Specialty care**

Your primary care physician will refer you to a specialist for needed care. However, you may see an OB/GYN, have a routine eye exam, be treated for medical emergencies, or when a primary care physician has designated another physician to see his or her patients without a referral. Referral to a participating specialist is given at the primary care physician's discretion; if non-Plan specialists or consultants are required, the primary care physician will arrange appropriate referrals. When you receive a referral from your primary care physician, you must return to the primary care physician after the consultation unless your physician authorizes additional visits. All follow-up care must be provided or authorized by the primary care physician. Do not go to the specialist for a second visit unless your primary care physician has arranged for, and the Plan has issued an authorization for, the referral in advance.

Here are other things you should know about specialty care:

?? If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician will develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your primary care physician will use our criteria when creating your treatment plan. Your PCP will consult with your specialist regarding a plan of treatment. The specialist will send regular consultation reports to keep your PCP advised of your progress. The PCP may authorize the referral for up to a twelve (12) month period. Once this has been approved, you will receive a "Referral Confirmation." If further services are required beyond the twelve (12) month period, you, your PCP and the specialist should agree to a new treatment plan.

?? If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. Your primary care physician will decide what treatment you need. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.

?? If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.

?? If you have a chronic or disabling condition and lose access to your specialist because we:

?? terminate our contract with your specialist for other than cause; or
?? drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB Plan; or
?? reduce our service area and you enroll in another FEHB Plan,

you may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us or, if we drop out of the Program, contact your new plan.

If you are in the second or third trimester of pregnancy and you lose access to your specialist

based on the above circumstances, you can continue to see your specialist until the end of your postpartum care, even if it is beyond the 90 days.

?? **Hospital care** Your Plan primary care physician or specialist will make the necessary hospital arrangements and supervise your care. This includes admission to a skilled nursing or other type of facility.

If you are in the hospital when your enrollment in our Plan begins, call our Member Service Department immediately at 419/887-2525 or 800/462-3589. If you are new to the FEHB Program, we will arrange for you to receive care.

If you changed from another FEHB plan to us, your former plan will pay for the hospital stay until:

?? You are discharged, not merely moved to an alternative care center; or
?? The day your benefits from your former plan run out; or
?? The 92nd day after you became a member of this Plan, whichever happens first.

These provisions apply only to the benefits of the hospitalized person.

Circumstances beyond our control

Under certain extraordinary circumstances, such as natural disasters, we may have to delay your services or we may be unable to provide them. In that case, we will make all reasonable efforts to provide you with the necessary care.

Services requiring our prior approval

Your primary care physician has authority to refer you for most services. For certain services, however, your physician must obtain approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice.

We call this review and approval process prior authorization. Your physician must obtain prior authorization for the following services:

?? Growth Hormone Treatment
?? Surgical treatment of morbid obesity

Before giving approval, we consider if the service is medically necessary, and if it follows generally accepted medical practice. A service is "medically necessary" if: 1) It is needed to prevent, diagnose and/or treat a specific condition; 2) It is specifically related to the condition being treated or evaluated and; 3) It is provided in the mo st medically appropriate setting; that is, an outpatient setting must be used rather than a hospital or inpatient facility, unless the services cannot be provided safely in an outpatient setting. It is the responsibility of the Plan physician or provider to obtain authorization when required.

Section 4. Your costs for covered services

You must share in the cost of some services. You are responsible for:

?? **Copayments**

A copayment is a fixed amount of money you pay to the provider when you receive services.

Example: When you see your primary care physician you pay a copayment of $10 per office visit.

?? **Deductible**

We do not have a deductible.

NOTE: If you change plans during open season, you do not have to start a new deductible under your old plan between January 1 and the effective date of your new plan. If you change plans at another time during the year, you must begin a new deductible under your new plan.

?? **Coinsurance**

Coinsurance is the percentage of our negotiated fee that you must pay for your care.

Example: In our Plan, you pay 20% of charges for nicotine patches or other smoking deterrents; 30% of charges for diagnosis and treatment of infertility; and 50% of charges for durable medical equipment after we pay the first $750 per member per calendar year.

Your out-of-pocket maximum for copayments and coinsurance

After your copayments and coinsurance total $1,500 per person or $3,000 per family enrollment in any calendar year, you do not have to pay any more for covered services. However, copayments and coinsurance for the following services do not count toward your out-of-pocket maximum, and you must continue to pay copayments and coinsurance for these services:

?? Durable medical equipment
?? Vision care
?? Dental care
?? Prescription drugs

Be sure to keep accurate records of your copayments and coinsurance since you are responsible for informing us when you reach the maximum.

Section 5. Benefits – OVERVIEW

(See page 8 for how our benefits changed this year and page 47 for a benefits summary.)

NOTE: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about our benefits, contact us at 419/887-2525 or 800/462-3589 or at our website at www.promedica.org.

Section 5 (a) Medical services and supplies provided by physicians and other health care professionals

IMPORTANT

Here are some important things to keep in mind about these benefits.

?? Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
?? Plan physicians must provide or arrange your care.
?? Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

Benefit Description	You pay
Diagnostic and treatment services	
Professional services of physicians ?? In physician's office	$10 per visit
Professional services of physicians ?? In an urgent care center ?? During a hospital stay ?? In a skilled nursing facility ?? Initial examination of a newborn child covered under a family enrollment ?? Office medical consultations ?? Second surgical opinion	Nothing
At home	$10 per visit
Lab, X-ray and other diagnostic tests	
Tests, such as: ?? Blood tests ?? Urinalysis ?? Non-routine pap tests ?? Pathology ?? X-rays ?? Non-routine Mammograms ?? Cat Scans/MRI ?? Ultrasound ?? Electrocardiogram and EEG	Nothing if you receive these services during your office visit: otherwise, $10 per visit

Preventive care, adult	**You pay**
?? Annual routine vision exam ?? Annual GYN exam ?? Blood lead level – One annually ?? Total Blood Cholesterol – One annually ?? Colorectal Cancer Screening ?? Prostate Specific Antigen (PSA) test – one annually ?? Routine pap test	$10 per visit
Routine mammogram – covered for women age 35 and older, as follows: ?? From age 35 through 39, one during this five year period ?? From age 40 through 64, one every calendar year ?? At age 65 and older, one every two consecutive calendar years	$10 per visit
Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.	*All charges.*
Routine Immunizations, limited to: ?? Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations) ?? Influenza/Pneumococcal vaccines, annually, age 65 and over	$10 per visit
Preventive care, children	
?? Childhood immunizations recommended by the American Academy of Pediatrics	$10 per visit
?? Examinations, such as: ??Eye exams through age 17 to determine the need for vision correction. ??Ear exams through age 17 to determine the need for hearing correction. ??Examinations done on the day of immunizations (through age 22 ?? Well-child care charges for routine examinations, immunizations and care (through age 22)	$10 per visit

Maternity care	You pay
Complete maternity (obstetrical) care, such as: ?? Prenatal care ?? Delivery ?? Postnatal care Note: Here are some things to keep in mind: ?? You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend you inpatient stay if medically necessary. ?? Routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. ?? We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b)	Nothing
Not covered: Routing sonograms to determine fetal age, size or sex	*All charges.*
Family planning	
?? Voluntary sterilization ?? Surgically implanted contraceptives ?? Injectable contraceptive devices ?? Intrauterine devices (IUDs) ?? Diaphragms	$10 per visit
Not covered: reversal of voluntary surgical sterilization, genetic counseling.	*All charges.*
Infertility services	
Diagnosis and treatment of infertility, such as: ?? Artificial insemination: ??intrauterine insemination (IUI) ?? Fertility drugs Note: Outpatient self-administered fertility drugs are not covered under the Prescription Drug Benefit, but fertility drugs administered in the physician's office are covered	30% of charges
Not covered: ?? *Assisted reproductive technology (ART) procedures, such as:* *??in vitro fertilization* *??embryo transfer and GIFT* ?? *Services and supplies related to excluded ART procedures* ?? *Cost of donor sperm*	*All charges.*

Allergy care	You pay
Testing	$25 per visit
Allergy injection	$10 per visit
Allergy serum	Nothing
Not covered: provocative food testing and sublingual allergy desensitization	*All charges.*
Treatment therapies	
?? Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed under Organ/Tissue Transplants on page 23. ?? Respiratory and inhalation therapy ?? Dialysis – Hemodialysis and peritoneal dialysis ?? Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy ?? Growth hormone therapy (GHT) Note: - We will only cover GHT when we preauthorize the treatment. The treatment must be ordered by a Plan Endocrinologist. The specialist must call our Utilization Review department for prior authorization. If prior authorization is not requested or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See *Services requiring our prior approval* in Section 3.	$10 per visit
Rehabilitative therapies	
Physical therapy, occupational therapy and speech therapy ?? 60 visits per condition for the services of each of the following: ??qualified physical therapists; ??speech therapists; and ??occupational therapists. . Note: We only cover therapy to restore bodily function or speech when there has been a total or partial loss of bodily function or functional speech due to illness or injury.	$10 per visit
?? Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is covered at a Plan facility	Nothing

Not covered: ?? *Long-term rehabilitative therapy* ?? *exercise programs*	*All charges.*
Hearing services (testing, treatment, and supplies)	**You pay**
?? First hearing aid and testing only when necessitated by accidental injury ?? Hearing testing for children through age 17 (see *Preventive care, children*)	$10 per visit
Not covered: ?? *All other hearing testing* ?? *Hearing aids, testing and examinations for them*	*All charges.*
Vision services (testing, treatment, and supplies)	
?? Eye exam to determine the need for vision correction for children through age 17 (see preventive care) ?? Annual eye refractions	$10 per visit
Not covered: ?? *Eye exercises and orthoptics* ?? *Corrective lenses and frames* ?? *Radial keratotomy and other refractive surgery*	*All charges.*
Foot care	
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. See orthopedic and prosthetic devices for information on podiatric shoe inserts.	$10 per visit
Not covered: ?? *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* ?? *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges.*

Orthopedic and prosthetic devices	You pay
?? Artificial limbs and lenses following cataract removal (only initial prosthetic device following surgery) ?? Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy. Note: See 5(b) for coverage of the surgery to insert the device. ?? Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.	Nothing up to $5000 per member per calendar year
Not covered: ?? *Orthopedic and corrective shoes* ?? *Arch supports* ?? *Foot orthotics* ?? *Heel pads and heel cups* ?? *Lumbosacral supports and braces* ?? *Corsets and trusses* ?? *Repair and/or replacement of Prosthetic devices*	*All charges.*
Durable medical equipment (DME)	
Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician, such as oxygen and dialysis equipment. Under this benefit, we also cover: ?? Hospital beds; ?? Standard wheelchairs; ?? Crutches; ?? Walkers; ?? Ostomy supplies; ?? Blood glucose monitors; ?? Lancets; ?? Chem strips; and ?? Medical support hose	Nothing up to $750 per member per calendar year; 50% of charges after the first $750 per member per calendar year.
Not covered: ?? *Motorized wheelchairs* ?? *Exercise equipment* ?? *Bite plates* ?? *TENS units* ?? *Disposable medical supplies*	*All charges.*

Home health services	You pay
?? Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. ?? Services include oxygen therapy, intravenous therapy, medications, physician services, skilled nursing care, physical, occupation and other related therapies, supplies and equipment.	Nothing
Not covered: ?? *Convalescent and custodial services;* ?? *Nursing care primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication;* ?? *Nursing care requested by, or for the convenience of, the patient or the patient's family.*	*All charges.*
Alternative treatments	
Not covered: ?? *Chiropractic services* ?? *Naturopathic services* ?? *Acupuncture* ?? *Hypnotherapy* ?? *Biofeedback*	*All charges.*
Educational classes and programs	
Coverage is limited to: ?? Smoking Cessation – Up to $300 for one smoking cessation program per member per lifetime, including all related expenses such as drugs.	20% of charges for nicotine patches or other smoking deterrents furnished on a prescription basis, if you have completed a smoking cessation class approved by the Plan..
?? Diabetes self-management	Nothing

Section 5 (b). Surgical and anesthesia services provided by physicians and other health care professionals

IMPORTANT

Here are some important things to keep in mind about these benefits.

?? Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
?? Plan physicians must provide or arrange your care.
?? Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
?? The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e., hospital, surgical center, etc.).
?? YOUR PLAN DOCTOR MUST GET PRECERTIFICATION OF SOME SURGICAL PROCEDURES. Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

IMPORTANT

Benefit Description	You pay
Surgical procedures	
?? Treatment of fractures, including casting ?? Normal pre- and post-operative care by the surgeon ?? Correction of amblyopia and strabismus ?? Endoscopy procedure ?? Biopsy procedure ?? Removal of tumors and cysts ?? Correction of congenital anomalies (see reconstructive surgery) ?? Surgical treatment of morbid obesity – a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over ?? Insertion of internal prosthetic devices. See 5 (a) – Orthopedic and prosthetic devices for device coverage information.	$10 per office visit; nothing for hospital visits
?? Voluntary sterilization ?? Norplant (a surgically implanted contraceptive) and intrauterine devices (IUDs) Note: Devices are covered under 5 (a). ?? Treatment of burns Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.	$10 per office visit; nothing for hospital visits
Not covered: ?? *Reversal of voluntary sterilization* ?? *Routine treatment of conditions of the foot; see Foot care* ?? *The cost of a cochlear implanted device* ?? *The cost of a penile implanted device*	*All charges.*

Reconstructive surgery	You pay
?? Surgery to correct a functional defect ?? Surgery to correct a condition caused by injury or illness if: ??the condition produced a major effect on the member's appearance and ??the condition can reasonably be expected to be corrected by such surgery ?? Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes. ?? All stages of breast reconstruction surgery following a mastectomy, such as: ??surgery to produce a symmetrical appearance on the other breast; ??treatment of any physical complications, such as lymphedemas; ??breast prostheses and surgical bras and replacements (see Prosthetic devices) Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	$10 per office visit; nothing for hospital visits
Not covered: ?? *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury* ?? *Surgeries related to sex transformation*	*All charge.*
Oral and maxillofacial surgery	
Oral surgical procedures, limited to: ?? Reduction of fractures of the jaws or facial bones; ?? Surgical correction of cleft lip, cleft palate or severe functional malocclusion; ?? Removal of stones from salivary ducts; ?? Excision of leukoplakia or malignancies; ?? Excision of cysts and incision of abscesses when done as independent procedures; and ?? Other surgical procedures that do not involve the teeth or their supporting structures.	$10 per office visit; nothing for hospital visits
Not covered: ?? *Oral implants and transplants* ?? *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All charges.*

Organ/tissue transplants	**You pay**
Limited to: ?? Bowel ?? Cornea ?? Heart ?? Heart/lung ?? Kidney ?? Kidney/Pancreas ?? Liver ?? Lung: Single – Double ?? Pancreas ?? Allogeneic (donor) bone marrow transplants ?? Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin's lymphoma; advanced non-Hodgkin's lymphoma; advanced neuroblastoma; breast cancer, multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors Note: We cover related medical and hospital expenses of the donor when we cover the recipient.	Nothing
Not covered: ?? *Donor screening tests and donor search expenses, except those performed for the actual donor* ?? *Implants of artificial organs* ?? *Transplants not listed as covered*	*All charges.*
Anesthesia	
Professional services provided in – ?? Hospital (inpatient) ?? Hospital outpatient department ?? Skilled nursing facility ?? Ambulatory surgical center ?? Office	$10 per visit

Section 5 (c). Services provided by a hospital or other facility, and ambulance services

IMPORTANT

Here are some important things to keep in mind about these benefits:

?? Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
?? Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
?? Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
?? The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery care. Any costs associated with the professional charge (i.e., physicians, etc.) are covered in Section 5 (a) or (b).

IMPORTANT

Benefit Description	You pay
Inpatient hospital	
Room and board, such as ?? Ward, semiprivate, or intensive care accommodations; ?? General nursing care; and ?? Meals and special diets. Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	Nothing
Other hospital services and supplies, such as: ?? Operating , recovery, maternity, and other treatment rooms ?? Prescribed drugs and medicines ?? Diagnostic laboratory tests and X-rays ?? Administration of blood and blood products ?? Blood or blood plasma, if not donated or replaced ?? Dressings, splints, casts, and sterile tray services ?? Medical supplies and equipment, including oxygen ?? Anesthetics, including nurse anesthetist services ?? Take-home items ?? Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home	Nothing
Not covered: ?? *Custodial care* ?? *Non-covered facilities, such as nursing homes, extended care facilities, schools* ?? *Personal comfort items, such as telephone, television, barber services, guest meals and beds* ?? *Private nursing care*	*All charges.*

Outpatient hospital or ambulatory surgical center	You pay
?? Operating, recovery, and other treatment rooms ?? Prescribed drugs and medicines ?? Diagnostic laboratory tests, X-rays, and pathology services ?? Administration of blood, blood plasma, and other biologicals ?? Blood or blood plasma, if not donated or replaced ?? Pre-surgical testing ?? Dressings, casts, and sterile tray services ?? Medical supplies, including oxygen ?? Anesthetics and anesthesia service NOTE: - We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	Nothing
Not covered: blood and blood derivatives not replaced by the member	*All charges.*
Extended care benefits/skilled nursing care facility benefits	
Extended care benefit: We provide a comprehensive range of benefits for up to 100 days per calendar year when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan physician and approved by the Plan.	Nothing
Not covered: custodial care	*All charges.*
Hospice care	
Supportive and palliative care for a terminally ill member is covered in the home or hospice facility. Services include inpatient and outpatient care, and family counseling; these services are provided under the direction of a Plan physician who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less.	Nothing
Not covered: Independent nursing, homemaker services	*All charges.*
Ambulance	
Local professional ambulance service when medically appropriate	Nothing

Section 5 (d). Emergency services/accidents

IMPORTANT	**Here are some important things to keep in mind about these benefits.** ?? Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure. ?? Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.	IMPORTANT

What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that the Plan may determine are medical emergencies -- what they all have in common is the need for quick action.

What to do in case of emergency: Call your Primary Care Physician first, unless you believe the situation to be life-threatening. Follow the doctor's instructions.

Emergencies within our service area:

If you are in an emergency situation, please call your primary care physician. In extreme emergencies, if you are unable to contact your physician, contact the local emergency system (e.g., the 911 telephone system) or go to the nearest hospital emergency room. Be sure to tell the emergency room personnel that you are a Plan member so they can notify the Plan. You or a family member should notify the Plan unless it was not reasonably possible to do so. It is your responsibility to ensure that the Plan has been timely notified.

If you need to be hospitalized in a non-Plan facility, the Plan must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If you are hospitalized in non-Plan facilities and Plan doctors believe care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

Benefits are available for care from non-Plan providers in a medical emergency only if delay in reaching a Plan provider would result in death, disability or significant jeopardy to your condition.

To be covered by this Plan, any follow-up care recommended by non-Plan providers must be approved by the Plan or provided by Plan providers.

Emergencies outside our service area:

Benefits are available for any medically necessary health service that is immediately required because of injury or unforeseen illness. If you need to be hospitalized, you or a family member must notify the Plan within 48 hours or on the first working day following your admission, unless it was not reasonably possible to do so. If a Plan physician believes care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

To be covered by this Plan, any follow-up care recommended by non-Plan providers must be approved by the Plan or provided by Plan providers.

Benefit Description	You pay
Emergency within our service area	
?? Emergency car at a doctor's office ?? Emergency care at an urgent care center ?? Emergency care as an outpatient or inpatient at a hospital, including doctors' services	$10 per visit $25 per visit $50 per visit, waived if admitted to a hospital
Not covered: Elective care or non-emergency care	*All charges.*
Emergency outside our service area	
?? Emergency care at a doctor's office ?? Emergency care at an urgent care center ?? Emergency care as an outpatient or inpatient at a hospital, including doctors' services	$10 per visit $25 per visit $50 per visit, waived if admitted to a hospital
Not covered: ?? *Elective care or non-emergency care* ?? *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* ?? *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	*All charges.*
Ambulance	
?? Professional ambulance service when medically appropriate. See 5 (c) for non-emergency service. ?? Air ambulance	Nothing

Section 5 (e). Mental health and substance abuse benefits

IMPORTANT

Parity

Beginning in 2001, all FEHB plans' mental health and substance abuse benefits will achieve "parity" with other benefits. This means that we will provide mental health and substance abuse benefits differently than in the past.

When you get our approval for services and follow a treatment plan we approve, cost-sharing and limitations for Plan mental health and substance abuse benefits will be no greater than for similar benefits for other illnesses and conditions.

Here are some important things to keep in mind about these benefits:

?? All benefits are subject to the definitions, limitations, and exclusions in this brochure.

?? Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

?? **YOU MUST GET PREAUTHORIZATION OF THESE SERVICES**. See the instructions after the benefits description below.

IMPORTANT

Benefit Description	You pay
Mental health and substance abuse benefits	
All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.	Your cost sharing responsibilities are no greater than for other illnesses or conditions.
?? Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers ?? Medication management	$10 per visit
?? Diagnostic tests	$10 per visit
?? Services provided by a hospital or other facility ?? Services in approved alternative care settings such as partial hospitalization, full-day hospitalization, facility based intensive outpatient treatment	Nothing
Not covered: Services we have not approved. *Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.*	*All charges.*

Preauthorization To be eligible to receive these benefits you must follow your treatment plan and all the following authorization processes:

Members must get a referral from their primary care physician (PCP) to access mental health services. Members may also contact their Employee Assistance Program (EAP), if available, for a referral. Yet another alternative, is that members may contact the Plan's Utilization/Case Management Department at 419/887-2420, or toll-free at 1-800-891-2520.

Special transitional benefit If a mental health or substance abuse professional provider is treating you under our plan as of January 1, 2001, you will be eligible for continued coverage with your provider for up to 90 days under the following condition:

?? If your mental health or substance abuse professional provider with whom you are currently in treatment leaves the plan at our request for other than cause.

If this condition applies to you, we will allow you reasonable time to transfer your care to a Plan mental health or substance abuse professional provider. During the transitional period, you may continue to see your treating provider and will not pay any more out-of-pocket than you did in the year 2000 for services. This transitional period will begin with our notice to you of the change in coverage and will end 90 days after you receive our notice. If we write to you before October 1, 2000, the 90-day period ends before January 1 and this transitional benefit does not apply.

Limitation We may limit your benefits if you do not follow your treatment plan.

Section 5 (f). Prescription drug benefits

IMPORTANT

Here are some important things to keep in mind about these benefits:

?? We cover prescribed drugs and medications, as described in the chart beginning on the next page.

?? All benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.

?? Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

There are important features you should be aware of. These include:

?? **Who can write your prescription.** A Plan physician or licensed dentist must write the prescription.

?? **Where you can obtain them.** You must fill the prescription at a Plan pharmacy.

?? **These are the dispensing limitations.** Prescription drugs obtained at a Plan pharmacy will be dispensed for up to a 30-day supply. Specific maintenance legend drugs may be dispensed for up to a 30-day supply or 100-unit supply, whichever is greater. The maintenance list is reviewed periodically, and the Plan reserves the right to change the maintenance list. When generic substitution is permissible (i.e., a generic drug is available and the prescribing doctor does not require the use of a name brand drug), but you request the name brand drug, you pay the price difference between the generic and name brand drug as well as the $10 copay per name brand prescription unit or refill.

?? **When you have to file a claim.** Send your claim to Paramount Health Care, P.O. Box 928, Toledo, OH 43697.

Benefit Description	You pay
Covered medications and supplies	
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy: ?? Drugs and medicines that by State law or Federal law of the United States require a physician's prescription for their purchase, except as excluded below. ?? Insulin; a copay charge applies to each vial ?? Disposable needles and syringes for the administration of covered medications, including insulin ?? Oral contraceptive drugs Intravenous fluids and medication for home use, implantable drugs,such as Norplant, and some injectable drugs, such as Depo Provera, contraceptive devices; diabetic supplies, other than disposable needles and syringes; smoking cessation drugs and medications, and drugs received in the physician's office for treatment of infertility are covered under Medical and Surgical Benefits. Sexual dysfunction drugs are subject to dosage limits set by the Plan. Contact the Plan for details. Here are some things to keep in mind about our prescription drug program: ?? A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally-approved generic drug is available, and your physician has not specified Dispense as Written for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic, as well as the copay for a name brand drug.	$5 copay per prescription unit or refill for generic drugs $10 copay per prescription unit or refill for name brand drugs Note: If there is no generic equivalent available, you will still have to pay the name brand copay.
Not covered: ?? *Drugs and supplies for cosmetic purposes* ?? *Drugs available without a prescription or for which there is a nonprescription equivalent available* ?? *Drugs obtained at a non-Plan pharmacy except for out-of-area emergencies* ?? *Vitamins and nutritional substances that can be purchased without a prescription* ?? *Medical supplies such as dressings and antiseptics* ?? *Drugs to enhance athletic performance* ?? *Fertility drugs, except those administered in a doctor's office (See Section 5(a)—Infertility services)*	*All charges.*

Section 5 (g). Dental benefits

IMPORTANT

Here are some important things to keep in mind about these benefits:

?? Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.

?? We cover hospitalization for dental procedures only when a nondental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient; we do not cover the dental procedure unless it is described below.

?? Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

Benefit Description	You pay
Accidental injury benefit	
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury. Treatment must be received within 48 hours of the accident, unless the member's medical condition indicates the dental care must be delayed.	Nothing
Dental benefits	
We have no other dental benefits.	

Section 5 (h). Non-FEHB benefits available to Plan members

The benefits on this page are not part of the FEHB contract or premium, **and you cannot file an FEHB disputed claim about them.** Fees you pay for these services do not count toward FEHB deductibles or out-of-pocket maximums.

Preventive Dental Care Coverage-Paramount Health Care will reimburse up to a maximum of $100 to each eligible member toward the cost of preventive dental care every twelve (12) months. To receive this benefit, send a copy of the paid itemized receipt from any dental provider to the address below. Clearly indicate on the receipt the members health plan identification number.

Paramount Health Care
Dental Plan
P.O. Box 928
Toledo, Ohio 43697-0928

Reimbursement will be sent directly to the Member. If submitted charges do not exceed $100, the reimbursement will be for the amount submitted. **Not covered:** x-rays and new dentures.

Vision Hardware Coverage- Paramount Health Care will reimburse expenses up to a maximum of $100 to each eligible member toward the cost of prescription lenses, contact lenses, and/or frames every twenty-four (24) months. To receive this benefit, send a copy of the paid itemized receipt from any vision provider, to the address below. Clearly indicate on the receipt the members health plan identification number.

Paramount Health Care
Vision Plan
P.O. Box 928
Toledo, Ohio 43697-0928

Reimbursement will be sent directly to the member. If submitted charges will not exceed $100, the reimbursement will be the amount submitted. **Not Covered:** Lenses, contact lenses or frames ordered more than every twenty-four (24) months or purchased before this coverage began on or after this coverage ended.

Fitness Programs-All members of Paramount Health Care are eligible to obtain a 15% discount on annual YMCA of Greater Toledo memberships.

Section 6. General exclusions -- things we don't cover

The exclusions in this section apply to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless your Plan physician determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition and we agree, as discussed under *What Services Require Our Prior Approval* on page 11.**

We do not cover the following:

?? Care by non-Plan providers except for authorized referrals or emergencies (see Emergency Benefits);

?? Services, drugs, or supplies you receive while you are not enrolled in this Plan;

?? Services, drugs or supplies that are not medically necessary;

?? Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;

?? Experimental or investigational procedures, treatments, drugs or devices;

?? Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest;

?? Services, drugs, or supplies related to sex transformations; or

?? Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program.

Section 7. Filing a claim for covered services

When you see Plan physicians, receive services at Plan hospitals and facilities, or fill your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment, or coinsurance.

You will only need to file a claim when you receive emergency services from non-plan providers. Sometimes, these providers bill us directly. Check with the provider. If you need to file the claim, here is the process:

Medical, Hospital and Drug benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Facilities will file on the UB-92 form. For claims questions and assistance, call us at 419/887-2525 or 1-800-462-3589.

When you must file a claim – such as for out-of-area care – submit it on the HCFA-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

?? Covered member's name and ID number;

?? Name and address of the physician or facility that provided the service or supply;

?? Dates you received the services or supplies;

?? Diagnosis;

?? Type of each service or supply;

?? The charge for each service or supply;

?? A copy of the explanation of benefits, payments, or denial from any primary payer – such as the Medicare Summary Notice (MSN); and

?? Receipts, if you paid for your services.

Submit your claims to: Paramount Health Care Claims Department, P.O. Box 928, Toledo, OH 43697.

Deadline for filing your claim

Send us all of the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

When we need more information

Please reply promptly when we ask for additional information. We may delay processing or deny your claim if you do not respond.

Section 8. The disputed claims process

Follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your claim or request for services, drugs, or supplies – including a request for preauthorization:

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: (a) Write to us within 6 months from the date of our decision; and (b) Send your request to us at: Paramount Health Care Claims Department, P.O. Box 928, Toledo, OH 43697. (c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and (d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	We have 30 days from the date we receive your request to: (a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or (b) Write to you and maintain our denial – go to step 4; or (c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request – go to step 3.
3	You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
4	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: ?? 90 days after the date of our letter upholding our initial decision; or ?? 120 days after you first wrote to us – if we did not answer that request in some way within 30 days; or ?? 120 days after we asked for additional information. Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Contracts Division 3, P.O. Box 436, Washington, DC 20044-0436. Send OPM the following information: ?? A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure; ?? Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms; ?? Copies of all letters you sent to us about the claim; ?? Copies of all letters we sent to you about the claim; and ?? Your daytime phone number and the best time to call.

Note: If you want OPM to review different claims, you must clearly identify which documents apply to which claim.

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must provide a copy of your specific written consent with the review request.

Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.

5 OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within 60 days. There are no other administrative appeals.

6 If you do not agree with OPM's decision, your only recourse is to sue. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies. This is the only deadline that may not be extended.

OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record.

You may not sue until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

NOTE: If you have a serious or life threatening condition (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and

(a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 419/887-2525 and we will expedite our review; or
(b) We denied your initial request for care or preauthorization/prior approval, then:

?? If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
?? You can call OPM's Health Benefits Contracts Division 3 at 202/606-0755 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

You must tell us if you are covered or a family member is covered under another group health plan or have automobile insurance that pays health care expenses without regard to fault. This is called "double coverage."

When you have double coverage, one plan normally pays its benefits in full as the primary payer and the other plan pays a reduced benefit as the secondary payer. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' guidelines.

When we are the primary payer, we will pay the benefits described in this brochure.

When we are the secondary payer, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance.

?What is Medicare?

Medicare is a Health Insurance Program for:

??People 65 years of age and older.
??Some people with disabilities, under 65 years of age.
??People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has two parts:

??Part A (Hospital Insurance). Most people do not have to pay for Part A.
??Part B (Medical Insurance). Most people pay monthly for Part B.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare managed care plan is the term used to describe the various health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on the type of Medicare managed care plan you have.

?The Original Medicare Plan

The Original Medicare Plan is available everywhere in the United States. It is the way most people get their Medicare Part A and Part B benefits. You may go to any doctor, specialist, or hospital that accepts Medicare. Medicare pays its share and you pay your share. Some things are not covered under Original Medicare, like prescription drugs.

When you are enrolled in this Plan and Original Medicare, you still need to follow the rules in this brochure for us to cover your care. Your care must continue to be authorized by your Plan PCP.

We will not waive any of our copayments or coinsurance.

(Primary payer chart begins on next page).

The following chart illustrates whether Original Medicare or this Plan should be the primary payer for you according to your employment status and other factors determined by Medicare. It is crucial that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly.

Primary Payer Chart		
A. When either you – or your covered spouse – are age 65 or over and …	**Then the primary payer is…**	
	Original Medicare	**This Plan**
1) Are an active employee with the Federal government (including when you or a family member are eligible for Medicare solely because of a disability),		?
2) Are an annuitant,	?	
3) Are a reemployed annuitant with the Federal govemment when… a) The position is excluded from FEHB, or b) The position is not excluded from FEHB Ask your employing office which of these applies to you.	?	?
4) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge),	?	
5) Are enrolled in Part B only, regardless of your employment status,	? (for Part B services)	? (for other services)
6) Are a former Federal employee receiving Workers' Compensation and the Office of Workers' Compensation Programs has determined that you are unable to return to duty,	? (except for claims related to Worker's Compensation)	
B. When you – or a covered family member – have Medicare based on end stage renal disease (ESRD) and…		
1) Are within the first 30 months of eligibility to receive Part A benefits solely because of ESRD,		?
2) Have completed the 30-month ESRD coordination period and are still eligible for Medicare due to ESRD,	?	
3) Become eligible for Medicare due to ESRD after Medicare became primary for you under another provision.	?	
C. When you or a covered family member have FEHB and…		
1) Are eligible for Medicare based on disability, and a) Are an annuitant, or b) Are an active employee	?	?

Please note, if your Plan physician does not participate in Medicare, you will have to file a claim with Medicare.

Claims process – You probably will never have to file a claim form when you have both our Plan and Medicare.

?? When we are the primary payer, we process the claim first.

?? When Original Medicare is the primary payer, Medicare processes the claim first. In most cases, your claims will be coordinated automatically and we will pay the balance of covered charges. You will not need to do anything. To find out if you need to do something about filing your claims, call us at 419/887-2525 or 800/462-3589 or visit our website at www. Promedica.org.

? **Medicare managed care plan**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare managed care plan. These are health care choices (like HMO's) in some areas of the country. In most Medicare managed care plans, you can only go to doctors, specialists, or hospitals that are part of the plan. Medicare managed care plans cover all Medicare Part A and B benefits. Some cover extras, like prescription drugs. To learn more about enrolling in a Medicare managed care plan, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov. If you enroll in a Medicare managed care plan, the following options are available to you:

This plan and our Medicare managed care plan: You may enroll in our Medicare managed care plan and also remain enrolled in our FEHB plan. In this case, we do not waive any of our copayments or coinsurance for your FEHB coverage.

This Plan and another Plan's Medicare managed care plan: You may enroll in another plan's Medicare managed care plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare managed care plan is primary, even out of the managed care plan's network and/or service area (if you use our Plan providers), but we will not waive any of our copayments or coinsurance.

Suspended FEHB coverage and a Medicare managed care plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare managed care Plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare managed care plan premium.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next open season unless you involuntarily lose coverage or move out of the Medicare managed care plan's service area.

? **Enrollment in Medicare Part B**

Note: If you choose not to enroll in Medicare Part B, you can still be covered under the FEHB Program. We cannot require you to enroll in Medicare.

TRICARE

TRICARE is the health care program for eligible dependents of military persons and retirees of the military. TRICARE includes the CHAMPUS program. If both TRICARE and this Plan cover you, we pay first. See your TRICARE Health Benefits Advisor if you have questions about TRICARE coverage.

Workers' Compensation

We do not cover services that:

? You need because of a workplace-related disease or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determine they must provide; or

?? OWCP or a similar agency pays for through a third party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your benefits. You must use our providers.

Medicaid

When you have this Plan and Medicaid, we pay first.

When other Government agencies

We do not cover services and supplies when a local, State, or Federal

are responsible for your care Government agency directly or indirectly pays for them.

When others are responsible for injuries

When you receive money to compensate you for medical or hospital care for injuries or illness caused by another person, you must reimburse us for any expenses we paid. However, we will cover the cost of treatment that exceeds the amount you received in the settlement.

If you do not seek damages you must agree to let us try. This is called subrogation. If you need more information, contact us for our subrogation procedures.

Section 10. Definitions of terms we use in this brochure

Calendar year — January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.

Copayment — A copayment is a fixed amount of money you pay when you receive covered services. See page 12.

Coinsurance — Coinsurance is the percentage of our allowance that you must pay for your care. See page 12.

Covered services — Care we provide benefits for, as described in this brochure.

Deductible — A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page 12.

Experimental or investigational services — Paramount investigates all requests for coverage of new technology using the HAYES Medical Technology Directory as a guide. If further information is needed, Paramount utilizes additional sources including Medicare and Medicaid policy, Food and Drug Administration (FDA) releases and current medical literature. This information is evaluated by Paramount's Medical Director and other physician advisors.

Plan allowance — Plan allowance is the amount we use to determine our payment and your coinsurance for covered services.

Us/We — Us and we refer to Paramount Health Care.

You — You refers to the enrollee and each covered family member.

Section 11. FEHB Facts

No pre-existing condition limitation

We will not refuse to cover the treatment of a condition that you had before you enrolled in this Plan solely because you had the condition before you enrolled.

Where you can get information about enrolling in the FEHB Program

See www.opm.gov/insure. Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal Employees Health Benefits Plans*, brochures for other plans, and other materials you need to make an informed decision about:

- When you may change your enrollment;
- How you can cover your family members;
- What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire;
- When your enrollment ends; and
- The next Open Season for enrollment.

We don't determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office.

Types of coverage available for you and your family

Self only coverage is for you alone. Self and Family coverage is for you, your spouse, and your unmarried dependent children under age 22, including any foster children or stepchildren your employing or retirement office authorizes coverage for. Under certain circumstances, you may also continue coverage for a disabled child 22 years of age or older who is incapable of self-support.

If you have a Self Only enrollment, you may change to a Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self and Family enrollment begin on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form; benefits will not be available to your spouse until you marry.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive health benefits, nor will we. Please tell us immediately when you add or remove family members from your coverage for any reason, including divorce, or when your child under age 22 marries or turns 22.

If you or one of your family members is enrolled in one FEHB plan, that person may not be enrolled in or covered as a family member by another FEHB plan.

When benefits and premiums start

The benefits in this brochure are effective on January 1. If you are new to this Plan, your coverage and premiums begin on the first day of your first pay period that starts on or after January 1. Annuitants' premiums begin January 1.

Your medical and claims records are confidential

We will keep your medical and claims information confidential. Only the following will have access to it:

- OPM, this Plan, and subcontractors when they administer this contract;
- This plan, and appropriate third parties, such as other insurance plans and the Office of Workers' Compensation Programs (OWCP), when coordinating benefit payments and subrogating claims;
- Law enforcement officials when investigating and/or prosecuting alleged civil or criminal

actions;
?? OPM and the General Accounting Office when conducting audits;
?? Individuals involved in bona fide medical research or education that does not disclose your identity; or
?? OPM, when reviewing a disputed claim or defending litigation about a claim.

When you retire

When you retire, you can usually stay in the FEHB Program. Generally, you must have been enrolled in the FEHB Program for the last five years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as temporary continuation of coverage (TCC).

When you lose benefits

?**When FEHB coverage ends**

You will receive an additional 31 days of coverage, for no additional premium, when:
??Your enrollment ends, unless you cancel your enrollment, or
?? You are a family member no longer eligible for coverage.

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage.

?**Spouse equity coverage**

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. But, you may be eligible for your own FEHB coverage under the spouse equity law. If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees,* or other information about your coverage choices.

?**TCC**

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC).For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire.

You may not elect TCC if you are fired from your Federal job due to gross misconduct.

?**Enrolling in TCC**

Get the RI 79-27, which describes TCC, and the RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees,*from your employing or retirement office or from www.opm.gov/insure.

?**Converting to individual coverage**

You may convert to a non-FEHB individual policy if:

??Your coverage under TCC or the spouse equity law ends. If you canceled your coverage or did not pay your premium, you cannot convert;

??You decided not to receive coverage under TCC or the spouse equity law; or

??You are not eligible for coverage under TCC or the spouse equity law.

If you leave Federal service, your employing office will notify you of your right to convert. You must apply in writing to us within 31 days after you receive this notice. However, if you are a family member who is losing coverage, the employing or retirement office will **not** notify you. You must apply in writing to us within 31 days after you are no longer eligible for coverage.

Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, and we will not impose a waiting period or limit your

coverage due to pre-existing conditions.

Getting a Certificate of Group Health Plan Coverage

If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan.

If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans.

Inspector General Advisory

Stop health care fraud! Fraud increases the cost of health care for everyone. If you suspect that a physician, pharmacy, or hospital has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

- ?? Call the provider and ask for an explanation. There may be an error.
- ?? If the provider does not resolve the matter, call us at 419/887-2525 and explain the situation.
- ?? If we do not resolve the issue, call **THE HEALTH CARE FRAUD HOTLINE—202/418-3300** or write to: the United .States Office of Personnel Management, Office of the Inspector General Fraud Hotline, 1900 E Street, NW, Room 6400, Washington, D.C. 20415.

Penalties for Fraud

Anyone who falsifies a claim to obtain FEHB Program benefits can be prosecuted for fraud. Also, the Inspector General may investigate anyone who uses an ID card if the person tries to obtain services for someone who is not an eligible family member; or is no longer enrolled in the Plan and tries to obtain benefits. Your agency may also take administrative action against you.

Index

Do not rely on this page; it is for your convenience and does not explain you benefit coverage.

Summary of benefits for the Paramount Health Care – 2001

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.

Benefits	You Pay	Page
Medical services provided by physicians: - Diagnostic and treatment services provided in the office	Office visit copay: $10 primary care; $10 specialist	14
Services provided by a hospital: - Inpatient ..... - Outpatient.....	Nothing Nothing	24 25
Emergency benefits: - In-area ..... - Out-of-area	$50 per visit $50 per visit	27 27
Mental health and substance abuse treatment	Regular cost sharing	28
Prescription drugs..... Up to a 30-day supply per prescription unit or refill	$5 copay for generic drugs $10 copay for name brand drugs	31
Dental Care..... Accidental injury benefit only	Nothing	32
Vision Care..... Annual eye refractions from Plan providers	$10 copay per visit	18
Protection against catastrophic costs (your out-of-pocket maximum)	Nothing after $1,500/Self Only or $3,000/Family enrollment per year Some costs do not count toward this protection	12

2001 Rate Information for
Paramount Health Care

Non-Postal rates apply to most non-Postal enrollees. If you are in a special enrollment category, refer to the FEHB Guide for that category or contact the agency that maintains your health benefits enrollment.

Postal rates apply to career Postal Service employees. Most employees should refer to the FEHB Guide for United States Postal Service Employees, RI 70-2. Different postal rates apply and special FEHB guides are published for Postal Service Nurses and Tool & Die employees (see RI 70-2B); and for Postal Service Inspectors and Office of Inspector General (OIG) employees (see RI 70-2IN).

Postal rates do not apply to non-career postal employees, postal retirees, or associate members of any postal employee organization. Refer to the applicable FEHB Guide.

		Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
Self Only	U21	$83.50	$27.83	$180.92	$60.30	$98.81	$12.52
Self and Family	U22	$195.82	$99.36	$424.28	$215.28	$231.17	$64.01