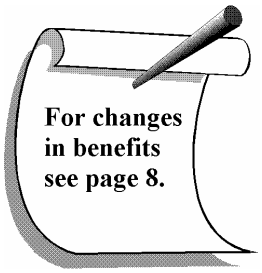
Paramount Health Care 2003

http://www.paramounthealthcare.com

A Health Maintenance Organization



Serving: Northwest Ohio

Enrollment in this Plan is limited. You must live or work in our Geographic service area to enroll. See pages 6 - 7 for requirements.

This plan has commendable accreditation from the NCQA. See the 2002 Guide for more information on accreditation.

Enrollment codes for this Plan:

U21 Self Only
U22 Self and Family

Authorized for distribution by the:

United States
Office Of Personnel Management

Retirement And Insurance Service
http://www.opm.gov/insure

FEHB
Federal Employees
Health Benefits Program

RI 73-609

UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
WASHINGTON, DC 20415-0001

OFFICE OF THE DIRECTOR

Dear Federal Employees Health Benefits Program Participant:

I am pleased to present this Federal Employees Health Benefits (FEHB) Program plan brochure for 2003. The brochure explains all the benefits this health plan offers to its enrollees. Since benefits can vary from year to year, you should review your plan's brochure every Open Season. Fundamentally, I believe that FEHB participants are wise enough to determine the care options best suited for themselves and their families.

In keeping with the President's health care agenda, we remain committed to providing FEHB members with affordable, quality health care choices. Our strategy to maintain quality and cost this year rested on four initiatives. First, I met with FEHB carriers and challenged them to contain costs, maintain quality, and keep the FEHB Program a model of consumer choice and on the cutting edge of employer-provided health benefits. I asked the plans for their best ideas to help hold down premiums and promote quality. And, I encouraged them to explore all reasonable options to constrain premium increases while maintaining a benefits program that is highly valued by our employees and retirees, as well as attractive to prospective Federal employees. Second, I met with our own FEHB negotiating team here at OPM and I challenged them to conduct tough negotiations on your behalf. Third, OPM initiated a comprehensive outside audit to review the potential costs of federal and state mandates over the past decade, so that this agency is better prepared to tell you, the Congress and others the true cost of mandated services. Fourth, we have maintained a respectful and full engagement with the OPM Inspector General (IG) and have supported all of his efforts to investigate fraud and waste within the FEHB and other programs. Positive relations with the IG are essential and I am proud of our strong relationship.

The FEHB Program is market-driven. The health care marketplace has experienced significant increases in health care cost trends in recent years. Despite its size, the FEHB Program is not immune to such market forces. We have worked with this plan and all the other plans in the Program to provide health plan choices that maintain competitive benefit packages and yet keep health care affordable.

Now, it is your turn. We believe if you review this health plan brochure and the FEHB Guide you will have what you need to make an informed decision on health care for you and your family. We suggest you also visit our web site at www.opm.gov/insure.

Sincerely,

Kay Coles James
Director

Notice of the Office of Personnel Management's

Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

By law, the Office of Personnel Management (OPM), which administers the Federal Employees Health Benefits (FEHB) Program, is required to protect the privacy of your personal medical information. OPM is also required to give you this notice to tell you how OPM may use and give out ("disclose") your personal medical information held by OPM.

OPM **will** use and give out your personal medical information:

- To you or someone who has the legal right to act for you (your personal representative),
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected,
- To law enforcement officials when investigating and/or prosecuting alleged or civil or criminal actions, and
- Where required by law.

OPM **has the right** to use and give out your personal medical information to administer the FEHB Program. For example:

- To communicate with your FEHB health plan when you or someone you have authorized to act on your behalf asks for our assistance regarding a benefit or customer service issue.
- To review, make a decision, or litigate your disputed claim.
- For OPM and the General Accounting Office when conducting audits.

OPM **may** use or give out your personal medical information for the following purposes under limited circumstances:

- For Government healthcare oversight activities (such as fraud and abuse investigations),
- For research studies that meet all privacy law requirements (such as for medical research or education), and
- To avoid a serious and imminent threat to health or safety.

By law, OPM must have your written permission (an "authorization") to use or give out your personal medical information for any purpose that is not set out in this notice. You may take back ("revoke") your written permission at any time, except if OPM has already acted based on your permission.

By law, you **have the right** to:

- See and get a copy of your personal medical information held by OPM.
- Amend any of your personal medical information created by OPM if you believe that it is wrong or if information is missing, and OPM agrees. If OPM disagrees, you may have a statement of your disagreement added to your personal medical information.
- Get a listing of those getting your personal medical information from OPM in the past 6 years. The listing will not cover your personal medical information that was given to you or your personal representative, any information that you authorized OPM to release, or that was given out for law enforcement purposes or to pay for your health care or a disputed claim.
- Ask OPM to communicate with you in a different manner or at a different place (for example, by sending materials

to a P.O. Box instead of your home address).

- ? Ask OPM to limit how your personal medical information is used or given out. However, OPM may not be able to agree to your request if the information is used to conduct operations in the manner described above.
- ? Get a separate paper copy of this notice.

For more information on exercising your rights set out in this notice, look at www.opm.gov/insure on the web. You may also call 202-606-0191 and ask for OPM's FEHB Program privacy official for this purpose.

If you believe OPM has violated your privacy rights set out in this notice, you may file a complaint with OPM at the following address:

Privacy Complaints
Office of Personnel Management
P.O. Box 707
Washington, DC 20004-0707

Filing a complaint will not affect your benefits under the FEHB Program. You also may file a complaint with the Secretary of the Department of Health and Human Services.

By law, OPM is required to follow the terms in this privacy notice. OPM has the right to change the way your personal medical information is used and given out. If OPM makes any changes, you will get a new notice by mail within 60 days of the change. The privacy practices listed in this notice will be effective April 14, 2003.

Table of Contents

Introduction

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. The address for Paramount Health Care administrative office is:

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

This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health benefits.

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, 2003, unless those benefits are also shown in this brochure.

OPM negotiates benefits and premiums with each plan annually. Benefit changes are effective January 1, 2003, and are summarized on page 8. Rates are shown at the end of this brochure.

Plain Language

All FEHB brochures are written in plain language to make them responsive, accessible, and understandable to the public. For instance,

? Except for necessary technical terms, we use common words. For instance, "you" means the enrollee or family member; "we" means Paramount Health Care.

? We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the Office of Personnel Management. If we use others, we tell you what they mean first.

? Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

If you have comments or suggestions about how to improve this brochure, let OPM know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail OPM at fehbwebcomments@opm.gov. You may also write to OPM at the Office of Personnel Management, Office of Insurance Planning and Evaluation Division, 1900 E Street, NW, Washington, DC 20415-3650.

Stop Health Care Fraud!

Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits (FEHB) Program premium.

OPM's Office of the Inspector General investigates all allegations of fraud, waste, and abuse in the FEHB Program regardless of the agency that employs you or from which you retired.

Protect Yourself From Fraud – Here are some things you can do to prevent fraud:

? Be wary of giving your plan identification (ID) number over the telephone or to people you do not know, except to your doctor, other provider, or authorized plan or OPM representative.
? Let only the appropriate medical professionals review your medical record or recommend services.
? Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
? Carefully review explanations of benefits (EOBs) that you receive from us.
? Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.

? If you suspect that a provider 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, DC 20415

- ? Do not maintain as a family member on your policy:
  - ? Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
  - ? Your child over age 22 (unless he/she is disabled and incapable of self support).
- ? If you have questions about the eligibility of a dependent, check with your personnel office if you are employed or with OPM if you are retired.
- ? You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.

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. The Plan is solely responsible for the selection of these providers in your area. Contact the Plan for a copy of their most recent provider directory.

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, and coinsurance 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 individual 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 (PCPs). 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 PCP. Paramount has over 1,200 specialists in our network. If you need to be seen by a specialist, your PCP will make a referral to the appropriate specialist. Paramount has 36 hospitals and 3 Centers of Excellence.

Each member may have a different PCP and will receive their own Paramount Health Care ID card that indicates who the PCP 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.

Your Rights

OPM requires that all FEHB Plans to provide certain information to their FEHB members. 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 you.

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.paramounthealthcare.com.

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.

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care benefits. We will not pay for any other health care services out of our service area unless the services have prior plan approval.

If you or a covered family member move outside of our service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office

Section 2. How we change for 2003

Do not rely on these change descriptions; this page is not an official statement of benefits. For that, go to Section 5 Benefits. Also, we edited and clarified language throughout the brochure; any language change not shown here is a clarification that does not change benefits.

Program-wide changes

? A Notice of the Office of Personnel Management's Privacy Practices is included.
? A section on the Children's Equity Act describes when an employee is required to maintain Self and Family coverage.
? Program information on TRICARE and CHAMPVA explains how annuitants or former spouses may suspend their FEHB Program enrollment.
? Program information on Medicare is revised.
? By law, the DoD/FEHB Demonstration project ends on December 31, 2002.

? We changed the address for sending disputed claims to OPM. (Section 8)

Changes to this Plan

? Your share of the non-Postal premium will increase by 8.0% for Self Only or 0.8% for Self and Family.
? There will now be a $300 copay per inpatient hospital admission (Section 5(c).
? The copay for an emergency room visit has increased to $75 per visit (Section 5(d).

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 your 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 your 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 or write to us at P.O. Box 928, Toledo, OH 43697-0928. You may also request replacement cards through our website at www.paramounhealthcare.com

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 your 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 any of the physician referral services listed in the *Participating Physicians and Facilities* directory.

? **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 do not need a referral for the following: a visit to an OB/GYN, have a routine eye exam, are treated for medical emergencies, or go to another doctor when a primary care physician has designated another physician to see his or her patients. 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 (GHT)
- Surgical treatment of morbid obesity
- Transplant procedures
- Sleep studies

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 most medically appropriate setting; that is, an outpatient setting must be used rather than a hospital or inpatient facility, unless the services cannot be provided safely in an outpatient setting. 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, when you see a specialist you pay a copayment of $20 per visit and when you go in the hospital, you pay $300 per admission.

? **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, as well as for charges for durable medical equipment and orthopedic and prosthetic devices, and 30% of charges for diagnosis and treatment of infertility.

Your catastrophic protection out-of-pocket maximum for coinsurance and copayments

After your copayments and/or 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/or coinsurance for the following services do not count toward your out-of-pocket maximum and you must continue to pay copayments and/or coinsurance for these services:

? Prescription drugs
? Durable Medical Equipment
? Orthopedic and prosthetic devices
? Infertility services
? Vision Care Services
? Office Visits
? Urgent Care Visits
? Emergency Room Visits

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

Section 5. Benefits – OVERVIEW

(See page 8for how our benefits changed this year and page 48 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 1-800/462-3589 or at our website at www.paramounthealthcare.com.

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 to your primary care physician $20 per visit to a specialist
Professional services of physicians ? In an urgent care center ? During a hospital stay ? In a skilled nursing facility ? Office medical consultations ? Second surgical opinion	Nothing
At home	$10 per visit by your primary care physician $20 per visit by a specialist

Lab, X-ray and other diagnostic tests	You pay
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 at your primary care physician; $20 per visit at a specialist
Preventive care, adult	
Routine screenings, such as: ? Annual routine vision exam ? Annual GYN exam ? Total Blood Cholesterol – One annually ? Colorectal Cancer Screening ? Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older ? Routine pap test Note: The office visit is covered if pap test is received on the same day; see Diagnosis and Treatment, above.	$10 per visit at your primary care physician $20 per visit at a specialist
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 at your primary care physician $20 per visit at a specialist
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 vaccine annually, ? Pneumococcal vaccine, annually, age 65 and over	$10 per visit

Preventive care, children	You pay
? Childhood immunizations recommended by the American Academy of Pediatrics	$10 per visit
? Well-child care charges for routine examinations, immunizations and care (through to age 22) ? 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 to age 22).	$10 per visit at your primary care physician $20 per visit at a specialist
Maternity care	
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: Routine sonograms to determine fetal age, size or sex	*All charges.*
Family planning	
A range of voluntary family planning services, limited to ? Voluntary sterilization ? Surgically implanted contraceptives (such as Norplant) ? Injectable contraceptive devices (such as Depo provera) ? Intrauterine devices (IUDs) ? Diaphragms NOTE: We cover oral contraceptives under the prescription drug benefit.	$10 per visit at your primary care physician $20 per visit at a specialist

Family planning *(Continued)*	**You pay**
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 administered in physician's office	30% of charges
Not covered: ? *Intracervical insemination (ICI)* ? *Intravaginal insemination (IVI)* ? *Assisted reproductive technology (ART) procedures, such as:* *-- in vitro fertilization* *-- embryo transfer, gamete GIFT and zygote ZIFT* *-- Zygote transfer* ? *Services and supplies related to excluded ART procedures* ? *Cost of donor sperm* ? *Cost of donor egg* ? *Self administered fertility drugs*	*All charges.*
Allergy care	
Testing and treatment	$25 per visit
Allergy injection	$10 per visit at your primary care physician $20 per visit at a specialist
Allergy serum	Nothing
Not covered: provocative food testing and sublingual allergy desensitization	*All charges.*

Treatment therapies	You pay
? 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 24. ? 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.	$20 per visit
Physical and occupational therapies	
? 30 visits combined per condition for the services of each of the following: -- qualified physical therapists and -- occupational therapists . . Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury.	$10 per visit $10 per outpatient visit Nothing per visit during covered inpatient admission
? 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.*
Speech therapy	
? 30 visits per condition for the services of qualified speech therapists	$10 per visit $10 per outpatient visit Nothing per visit during covered inpatient admission

Hearing services (testing, treatment, and supplies)	You pay
? First hearing aid and testing only when necessitated by accidental injury	$20 per visit
? Hearing testing for children through age 17 (see *Preventive care, children)*	$10 per visit at your primary care physician $20 per visit at a specialist
Not covered: ? *All other hearing testing* ? *Hearing aids, testing and examinations for them, except as above.*	*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, children) ? Annual eye refractions	$20 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.	$20 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 required as a result of surgery) ? Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy ? 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.	20% of charges
Not covered: ? *Orthopedic and corrective shoes* ? *Arch supports* ? *Foot orthotics* ? *Heel pads and heel cups* ? *Lumbosacral supports and braces* ? *Corsets and trusses* ? *The cost of a cochlear implanted device* ? *The cost of a penile implanted device* ? *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 NOTE: We follow Medicare Part B Guidelines for DME	20% of charges
Not covered: ? *Exercise equipment* ? *Bite plates* ? *Disposable medical supplies* ? *Services not covered by Medicare Part B* ? *Tens units* ? *Motorized wheelchairs*	*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: ? *Nursing care requested by, or for the convenience of, the patient or the patient's family;* ? *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative;* ? *Convalescent and custodial services.*	*All charges.*
Chiropractic	
No benefit	*All charges.*
Alternative treatments	
Not covered: ? *Naturopathic services* ? *Acupuncture* ? *Hypnotherapy* ? *Biofeedback* ? *Massage therapy*	*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	
A comprehensive range of services, such as: ? Operative procedures ? Treatment of fractures, including casting ? Normal pre - and post-operative care by the surgeon ? Correction of amblyopia and strabismus ? Endoscopy procedures ? Biopsy procedures ? 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. ? Voluntary sterilization (e.g., Tubal ligation, Vasectomy) ? 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.	$20 per office visit; nothing for hospital visits
Not covered: ? *Reversal of voluntary sterilization* ? *Routine treatment of conditions of the foot; see Foot care*	*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.
	$20 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 charges.*
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.	$20 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 ? Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas Note: We cover related medical and hospital expenses of the donor when we cover the recipient.	$20 per office visit to evaluate the need for a transplant; nothing for hospital visits
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)	Nothing
Professional services provided in - ? Hospital outpatient department ? Skilled nursing facility ? Ambulatory surgical center ? Office	$20 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 Sections 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. Other hospital services and supplies, such as: ? Operating , recovery, matemity, 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	$300 per admission
Not covered: ? *Custodial care* ? *Non-covered facilities, such as nursing homes, 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 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 at your primary care physician $20 per visit at a specialist $25 per visit $75 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 at your primary care physician $20 per visit at a specialist $25 per visit $75 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, including air ambulance, when medically appropriate See 5 (c) for non-emergency service.	Nothing

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

IMPORTANT

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	
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 ? Diagnostic tests	$20 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 obtain a treatment plan and follow all of 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 800/891-2520.

Limitation

We may limit your benefits if you do not obtain a 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.

We use a preferred drug list. In the wake of dramatic increases in drug costs, employer groups, physicians and members challenged us to develop an innovative prescription drug benefit that helps reduce drug benefit costs while maintaining physicians' freedom to select the most appropriate drugs. In response to this request, we have introduced the *Three-Tier Preferred Drug* prescription benefit with the following copay structure:

? Generic drugs at the lowest copay - $5

? Preferred name brand drugs at a mid-level copay - $15

? Non-preferred name brand drugs at the highest copay - $25

When generic pharmaceuticals are used, you are assured the lowest copay. A preferred name brand drug is a brand name drug found on the Paramount Health Care Preferred Drug List. Preferred drugs are selected name brand medications that are periodically reviewed and updated by a committee of physicians, pharmacists and other allied health professionals (Pharmacy and Therapeutics Working Group) to ensure the highest level of clinical efficacy and cost effectiveness. Non-preferred name brand medications are also covered (subject to any benefit limits), but at a higher copay.
We have an open formulary. If your physician believes a name brand drug product is necessary or there is no generic available, your physician may prescribe a name brand drug from a preferred drug list (formulary) list. This list of name brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost. To order a preferred prescription drug list, call 1-800/462-3589 or 419/887-2525.

? **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 applicable copay.

A generic equivalent will be dispensed unless the prescribing physician has specified on the prescription, "Dispense as Written" or DAW".

Why use generic drugs? Generic drugs offer a safe and economic way to meet your prescription drug needs. The generic name of a drug is its chemical name; the name brand is the name under which the manufacturer advertises and sells a drug. Under federal law, generic and name brand drugs must meet the same standards for safety, purity, strength, and effectiveness.

You can save money by using generic drugs. However, you and your physician have the option to request a name brand if a generic option is available. Using the most cost-effective medication saves money.

? **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 those listed as *Not covered.* ? Insulin; a copay charge applies to each 30 day supply ? Disposable needles and syringes for the administration of covered medications, including insulin ? Oral contraceptive drugs ? Sexual dysfunction drugs are subject to dosage limits set by the Plan. Contact the Plan for details.	For up to a 30-day supply: A $5 copay per prescription unit or refill for generic drugs; A $15 copay per prescription unit or refill for preferred name brand drugs; and A $25 copay per prescription unit or refill for non-preferred name brand drugs. Note: If there is no generic equivalent available, you will still have to pay the applicable brand name 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)* ? *Growth Hormones*	*All charges.*

Section 5 (g). Special features

Feature	Description
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. ? We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. ? Alternative benefits are subject to our ongoing review. ? By approving an alternative benefit, we cannot guarantee you will get it in the future. ? The decision to offer an alternative benefit is solely ours, and we may withdraw i at any time and resume regular contract benefits. ? Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.

Section 5 (h). 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

Accidental injury benefit	You pay
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 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; or
- Services, drugs or supplies you receive without charge while in active military service.

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 services you receive outside of the Plan's service area – 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 43697-0928.

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, 1900 E Street, NW, Washington, DC 20415-3630

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 more than one claim, 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 include 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 or from the year in which you were denied precertification or prior approval. 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 may 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 or a family member have coverage 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. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (Someone who was a Federal employee on January 1, 1983 or since automatically qualifies.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE for more information.

??Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare + Choice 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 (Part A or Part B)

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

When you are enrolled in Original Medicare along with this Plan, 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.

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

? 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 then provide secondary benefits for covered charges. You will not need to do anything. To find out if you need to do something to file your claims, call us at 419/887-2525 or 800/462-3589 or visit our website at www.paramounthealthcare.com.

We do not waive any costs if the Original Medicare Plan is your primary payer. **(Primary payer chart begins on next page).**

The following chart illustrates whether **the Original Medicare Plan** 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),		US
2) Are an annuitant,	US	
3) Are a reemployed annuitant with the Federal government 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.)	US	US
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),	US	
5) Are enrolled in Part B only, regardless of your employment status,	US (for Part B services)	US (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,	US (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,		US
2) Have completed the 30-month ESRD coordination period and are still eligible for Medicare due to ESRD,	US	
3) Become eligible for Medicare due to ESRD after Medicare became primary for you under another provision.	US	
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	US	
b) Are an active employee, or		US
c) Are a former spouse of an annuitant, or	US	
d) Are a former spouse of an active employee		US

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

?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 provide all the benefits that Original Medicare covers. 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 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. If you enroll in a Medicare managed care plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare managed care plan so we can correctly coordinate benefits with Medicare.

Suspended FEHB coverage to enroll in a Medicare managed care plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage and 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.

? If you do not enroll in Medicare Part A or Part B

If you do not have one or both Parts of Medicare, you can still be covered under the FEHB Program. We will not require you to enroll in Medicare Part B and, if you can't get premium-free Part A, we will not ask you to enroll in it.

TRICARE and CHAMPVA

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

Suspended FEHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) 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 under the program.

Workers' Compensation

We do not cover services that:

- ? you need because of a workplace-related illness 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 care. You must use our providers.

Medicaid

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

Suspended FEHB coverage to enroll in Medicaid or a similar State-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a one of these State programs, eliminating your FEHB premium. For information on suspending your FEHB enrollment, contact your retirement office. If you later want to e-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the State program.

When other Government agencies are responsible for your care

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

Coinsurance

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

Copayment

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

Covered services

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

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. Plans determine their allowances in different ways. We determine our allowances as follows: base Plan allowance on the reasonable and customary charge. Plan providers accept the plan allowance as payment in full.

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 your FEHB coverage. These materials tell you:

- 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 begins 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.

Children's Equity Act

OPM has implemented the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self and Family coverage in the Federal Employees Health Benefits (FEHB) Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll for Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no FEHB coverage, your employing office will enroll you for Self and Family coverage in the option of the Blue Cross and Blue Shield Service Benefit Plan's Basic Option
- if you have a Self only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, you employing office will change your enrollment to Self and Family in the same option of the same plan; or
- if you are enrolled in an HMO that does not serve the area where the children live, your

employing office will change your enrollment to Self and Family in the lower option of the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that doesn't serve the area in which your children live, unless you provide documentation that you have other coverage for the children. If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot make any changes after retirement. Contact your employing office for further information.

When benefits and premiums start

The benefits in this brochure are effective on January 1. If you joined this Plan during Open Season, your coverage and premiums begin on the first day of your first pay period that starts on or after January 1. Annuitants' coverage and premiums begin January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

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. This is the case even when the court has ordered your former spouse to supply health coverage to you. But, you may be eligible for your own FEHB coverage under the spouse equity law or Temporary Continuation of Coverage (TCC). 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. You can also download the guide from OPM's website, www.opm.gov/insure.

Temporary Continuation of Coverage (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, if you lose your job, if you are a covered dependent child and you turn 22 or marry, etc.

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. It explains what you have to do to enroll.

?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

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal law that offers limited Federal protections for health coverage availability and continuity to people who lose employer group 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.

For more information, get OPM pamphlet RI79-27, Temporary Continuation of Coverage (TCC) under the FEHB Program. See also the FEHB web site (www.opm.gov/insure/health): refer to the "TCC and HIPAA" frequently asked questions. These highlight HIPAA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and have information about Federal and State agencies you can contact for more information.

Long Term Care Insurance Is Coming Later in 2002!

Open Season for Long Term Care Insurance

- You can protect yourself against the high cost of long term care by applying for insurance in the Federal Long Term Care Insurance Program.
- Open Season to apply for long term care insurance through LTC Partners ends on December 31, 2002.
- If you're a Federal employee, you and your spouse need only answer a few questions about your health during Open Season.
- If you apply during the Open Season, your premiums are based on your age as of July 1, 2002. After Open Season, your premiums are based on your age at the time LTC Partners receives your application.

FEHB Doesn't Cover It

- Neither FEHB plans nor Medicare cover the cost of long term care. Also called "custodial care", long term care helps you perform the activities of daily living such as bathing or dressing yourself. It can also provide help you may need due to a severe cognitive impairment such as Alzheimer's disease.

You Can Also Apply Later, But…

- Employees and their spouses can still apply for coverage after the Federal Long Term Care Insurance Program Open Season ends, but they will have to answer more health-related questions.
- For annuitants and other qualified relatives, the number of health-related questions that you need to answer is the same during and after the Open Season.

You Must Act to Receive an Application

- Unlike other benefit programs, YOU have to take action – you won't receive an application automatically. You must request one through the toll-free number or website listed below.
- Open Season ends December 31, 2002 – act NOW so you won't miss the abbreviated underwriting available to employees and their spouses, and the July 1 "age freeze"!

Find Out More – Contact LTC Partners by calling **1-800-LTC-FEDS (1-800-582-3337) (TDD for the hearing impaired: 1-800-843-3557)** or visiting www.ltcfeds.com to get more information and to request an application.

Index

Do not rely on this page; it is for your convenience and may not show all pages where the terms appear.

Summary of benefits for Paramount Health Care – 2002

- **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; $20 specialist	14
Services provided by a hospital: ? Inpatient..... ? Outpatient	$300 per admission Nothing	25 26
Emergency benefits: ? In-area..... ? Out-of-area	$75 per visit; waived if admitted $75 per visit; waived if admitted	28 28
Mental health and substance abuse treatment.....	Regular cost sharing	29
Prescription drugs..... Up to a 30-day supply per prescription unit or refill	$5 copay for generic drugs $15 copay for preferred name brand drugs $25 copay for non-preferred name brand drugs	30
Dental Care ..... Accidental injury benefit only	Nothing	33
Vision Care ..... Annual eye refractions from Plan providers	$10 copay per visit	19
Special features: Flexible benefits option		32
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

2003 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 th 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 fo United States Postal Service Employees, RI 70-2. Different postal rates apply and a special FEHB guide is published for Postal Service Inspectors and Office of Inspector General (OIG) employees (see RI70-2IN).

Postal rates do not apply to non-career postal employees, postal retirees, or associate members of any postal employee organization who are not career postal employees. 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**	**$105.15**	**$35.05**	**$227.83**	**$75.94**	**$124.43**	**$15.77**
Self and Family	**U22**	**$249.62**	**$121.57**	**$540.84**	**$263.41**	**$294.70**	**$76.49**