

Paramount Health Care

www.paramounthealthcare.com

(419) 887-2525 or 800-462-3589



PARAMOUNT

2017

A Health Maintenance Organization (High Option)

This plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See page 7 for details.

Serving: *Northwest Ohio*

Enrollment in this Plan is limited. You must live or work in our geographic service area to enroll. See page 12 for requirements.

IMPORTANT

- Rates: Back Cover
- Changes for 2017: Page 14
- Summary of benefits: Page 75

Enrollment codes for this Plan:

N81 High Option - Self Only

N83 High Option - Self Plus One

N82 High Option - Self and Family



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United States
Office of Personnel Management

Healthcare and Insurance
<http://www.opm.gov/insure>

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Notes

**Important Notice from Paramount About
Our Prescription Drug Coverage and Medicare**

The Office of Personnel Management (OPM) has determined that Paramount's prescription drug coverage is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all plan participants and is considered Creditable Coverage. This means you do not need to enroll in Medicare Part D and pay extra for prescription drug coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and your FEHB plan will coordinate benefits with Medicare.

Remember: If you are an annuitant and you cancel your FEHB coverage, you may not re-enroll in the FEHB program.

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly Medicare Part D premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what many other people pay. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (October 15th through December 7th) to enroll in Medicare Part D.

Medicare's Low Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at 1-800-772-1213 (TTY: 1-800-325-0778).

You can get more information about Medicare prescription drug plans and the coverage offered in your area from these places:

- Visit www.medicare.gov for personalized help,
- Call **1-800-MEDICARE (1-800-633-4227) (TTY: 1-877-486-2048)**

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Introduction

This brochure describes the benefits of Paramount Health Care (d/b/a Paramount) under our contract (CS 2951) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. If you want more information about us, you can call Member Services at 800-462-3589 (TTY: 888-740-5670) or through our website <http://www.paramounthealthcare.com>. The address for Paramount's administrative office is:

Paramount Health Care

1901 Indian Wood Circle

Maumee, OH 43537

This brochure is the official statement of benefits. No verbal 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 in Self and Family coverage, each eligible family member is also entitled to these benefits. If you are enrolled in Self Plus One coverage, you and one eligible family member that you designate when you enroll are entitled to these benefits.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2017, and changes are summarized on page 24. Rates are shown at the end of this brochure.

Coverage under this plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

The ACA establishes a minimum value for the standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). The health coverage of this plan does meet the minimum value standard for the benefits the plan provides.

Plain Language

All FEHB brochures are written in plain language to make them easy to understand. Here are some examples.

- Except for necessary technical terms, we use common words. For instance, “you” means the enrollee or family member; “we” or “Plan” means Paramount.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

Stop Health Care Fraud!

Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits 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 that you can do to prevent fraud:

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except for your health care providers, authorized health benefits 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 (EOB) statements that you receive from us.
- Periodically review your claim history for accuracy to ensure we have not been billed for services that you did not receive.
- 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 800-462-3589 (TTY 888-740-5670) and explain the situation.
 - If we do not resolve the issue:

**CALL - THE HEALTH CARE FRAUD HOTLINE
877-499-7295**

OR go to www.opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse/complaint-form/

The online reporting form is the desired method of reporting fraud in order to ensure accuracy, and a quicker response time.

You can also write to:

**United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street NW Room 6400
Washington, DC 20415-1100**

- 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)
 - Your child age 26 or over (unless he/she was disabled and incapable of self-support prior to age 26)
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include, falsifying a claim to obtain FEHB benefits, trying to or obtaining service or coverage for yourself or for someone else who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage (i.e., you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed by your provider for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

Discrimination is Against the Law

Paramount complies with all applicable Federal civil rights laws, to include both Title VII and Section 1557 of the ACA. Pursuant to Section 1557 Paramount does not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, age, disability, or sex (including pregnancy and gender identity).

Preventing Medical Mistakes

Medical mistakes continue to be a significant cause of preventable deaths within the United States. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. Medical mistakes and their consequences also add significantly to the overall cost of healthcare. Hospitals and healthcare providers are being held accountable for the quality of care and reduction in medical mistakes by their accrediting bodies. You can also improve the quality and safety of your own health care and that of your family members by learning more about and understanding your risks. Take these simple steps:

1. Ask questions if you have doubts or concerns.

- Ask questions and make sure you understand the answers.
- Choose a doctor with whom you feel comfortable talking.
- Take a relative or friend with you to help you take notes, ask questions, and understand answers.

2. Keep and bring a list of all the medicines you take.

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines and dosage that you take, including non-prescription (over-the-counter) medicines and nutritional supplements.
- Tell your doctor and pharmacist about any drug, food, and other allergies you have, such as to latex.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medicine is what the doctor ordered. Ask the pharmacist about your medicine if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.
- Understand both the generic and brand names of your medication. This helps ensure you don't receive double dosing from taking both a generic and a brand. It also helps prevent you from taking a medication to which you are allergic.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures. Will it be in person, by phone, mail, through the Plan or Provider's portal?
- Don't assume the results are fine if you do not get them when expected. Contact your healthcare provider and ask for your results.
- Ask what the results mean for your care.

4. Talk to your doctor about which hospital or clinic is best for your health needs.

- Ask your doctor about which hospital or clinic has the best care and results for your condition if you have more than one hospital or clinic to choose from to get the health care you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital or clinic.

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

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.

- Ask your doctor, “Who will manage my care when I am in the hospital?”
- Ask your surgeon:
 - "Exactly what will you be doing?"
 - "About how long will it take?"
 - "What will happen after surgery?"
 - "How can I expect to feel during recovery?"
- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reactions to anesthesia, and any medications or nutritional supplements you are taking.

Patient Safety Links

For more information on patient safety, please visit

- <http://www.jointcommission.org/speakup.aspx>. The Joint Commission’s Speak Up™ patient safety program.
- http://www.jointcommission.org/topics/patient_safety.aspx The Joint Commission helps health care organizations to improve the quality and safety of the care they deliver.
- www.ahrq.gov/patients-consumers/. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.
- www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
- www.talkaboutrx.org. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.

Preventable Healthcare Acquired Conditions ("Never Events")

When you enter the hospital for treatment of one medical problem, you don’t expect to leave with additional injuries, infections or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, too often patients suffer from injuries or illnesses that could have been prevented if the doctors or hospital had taken proper precautions. Errors in medical care that are clearly identifiable, preventable and serious in their consequences for patients, can indicate a significant problem in the safety and credibility of a health care facility. These conditions and errors are sometimes called “Never Events” or “Serious Reportable Events.”

We have a benefit payment policy that encourages hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores and fractures, and reduce medical errors that should never happen. These conditions and errors are called "Never Events"- When a never event occurs, neither your FEHB plan nor you will incur cost to correct the medical error.

You will not be billed for inpatient services related to treatment of specific hospital-acquired conditions or for inpatient services needed to correct Never Events, if you use Paramount's preferred providers. This policy helps to protect you from preventable medical errors and improve the quality of care you receive.

FEHB Facts

Coverage information

- **No pre-existing condition limitation** We will not refuse to cover the treatment of a condition you had before you enrolled in this Plan solely because you had the condition before you enrolled.
- **Minimum essential coverage (MEC)** Coverage under this plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.
- **Minimum value standard** Our health coverage meets the minimum value standard of 60% established by the ACA. This means that we provide benefits to cover at least 60% of the total allowed costs of essential health benefits. The 60% standard is an actuarial value; your specific out-of-pocket costs are determined as explained in this brochure.
- **Where you can get information about enrolling in the FEHB Program** See www.opm.gov/healthcare-insurance for enrollment information as well as:
 - Information on the FEHB Program and plans available to you
 - A health plan comparison tool
 - A list of agencies that participate in Employee Express
 - A link to Employee Express
 - Information on and links to other electronic enrollment systems

Also, your employing or retirement office can answer your questions, and give you 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
- What happens when your enrollment ends
- When the next Open Season for enrollment begins

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. For information on your premium deductions, you must also contact your employing or retirement office.

- **Types of coverage available for you and your family** Self Only coverage is for you alone. Self Plus One coverage is an enrollment that covers you and one eligible family member. Self and Family coverage is for you, your spouse, and your dependent children under age 26, including any foster children authorized for coverage by your employing agency or retirement office. Under certain circumstances, you may also continue coverage for a disabled child 26 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 or Self Plus One 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 Plus one or 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 Plus One or 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 benefits, however, we will send you a letter notifying you when a dependent reaches the age limit. Please tell us immediately of changes in family member status, including your marriage, divorce, annulment, or when your child reaches age 26.

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.

If you have a qualifying life event (QLE) - such as marriage, divorce, or the birth of a child - outside of the Federal Benefits Open Season, you may be eligible to enroll in the FEHB Program, change your enrollment, or cancel coverage. For a complete list of QLEs, visit the FEHB website at www.opm.gov/healthcare-insurance/life-events. If you need assistance, please contact your employing agency, Tribal Benefits Officer, personnel/payroll office, or retirement office.

• **Family member coverage**

Family members covered under your Self and Family enrollment are your spouse (including a valid common law marriage) and children as described in the chart below. A Self Plus One enrollment covers you and your spouse, or one other eligible family member as described in the chart below.

Children	Coverage
Natural children, adopted children, and stepchildren	Natural, adopted children and stepchildren are covered until their 26 th birthday.
Foster children	Foster children are eligible for coverage until their 26 th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contact your human resources office or retirement system for additional information.
Children incapable of self-support	Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.
Married children	Married children (but NOT their spouse or their own children) are covered until their 26 th birthday.
Children with or eligible for employer-provided health insurance	Children who are eligible for or have their own employer-provided health insurance are covered until their 26 th birthday.

Newborns of covered children are insured only for routine nursery care during the covered portion of the mother's maternity stay.

You can find additional information at www.opm.gov/healthcare-insurance.

- **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 Plus One or Self and Family coverage in the 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 in Self Plus One or 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 Plus One or Self and Family coverage, as appropriate, in 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, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate, 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 Plus One or Self and Family, as appropriate, in 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 cancel your coverage, change to Self Only, or change to a plan that doesn’t serve the area in which your children live as long as the court/administrative order is in effect. Similarly, you cannot change to Self Plus One if the court/administrative order identifies more than one child. Contact your employing office for further information.

- **When benefits and premiums start**

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2017 benefits of your old plan or option.** However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan’s 2016 benefits until the effective date of your coverage with your new plan. Annuitants’ coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

If your enrollment continues after you are no longer eligible for coverage, (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received directly from your provider. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you, or a family member, are no longer eligible to use your health insurance 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.

Any person covered under the 31 day extension of coverage who is confined in a hospital or other institution for care or treatment on the 31st day of the temporary extension is entitled to continuation of the benefits of the Plan during the continuance of the confinement but not beyond the 60th day after the end of the 31 day temporary extension.

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

- **Upon divorce** 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 provide health coverage for you. However, you may be eligible for your own FEHB coverage under either 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 information about your coverage choices. You can also visit OPM's website at <http://www.opm.gov/healthcare-insurance/healthcare/plan-information/>.

- **Temporary Continuation of Coverage (TCC)** If you leave Federal service, Tribal employment, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). The Affordable Care Act (ACA) did not eliminate TCC or change the TCC rule. For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal or Tribal job, if you are a covered dependent child and you turn 26, etc.

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

Enrolling in TCC. Get the RI 79-27, which describes TCC, from your employing or retirement office or from www.opm.gov/healthcare-insurance. It explains what you have to do to enroll.

Alternatively, you can buy coverage through the Health Insurance Marketplace where, depending on your income, you could be eligible for a new kind of tax credit that lowers your monthly premiums. Visit www.HealthCare.gov to compare plans and see what your premium, deductible, and out-of-pocket costs would be before you make a decision to enroll. Finally, if you qualify for coverage under another group health plan (such as your spouse's plan) you may be able to enroll in that plan, as long as you apply within 30 days of losing FEHB Program coverage.

We also want to inform you that the Patient Protection and Affordable Care Act (ACA) did not eliminate TCC or change the TCC rules.

- **Finding replacement coverage** In lieu of offering a non-FEHB plan for conversion purposes, we will assist you, as we would assist you in obtaining a plan conversion policy, in obtaining health benefits coverage inside or outside the Affordable Care Act's Health Insurance Marketplace. For assistance in finding coverage, please contact us at 1-800-462-3589, or visit our website at <http://www.paramounthealthcare.com/marketplace>.

- **Health Insurance Marketplace**

If you would like to purchase health insurance through the Affordable Care Act's Health Insurance Marketplace, please visit www.HealthCare.gov. This is a website provided by the U.S. Department of Health and Human Services that provides up-to-date information on the Marketplace.

Section 1. How this Plan works

This Plan is a health maintenance organization (HMO). We require you to see specific physicians, and use hospitals and other providers that contract with us. These Plan providers coordinate your health care services. We are solely responsible for the selection of these providers in your area. Contact us for a copy of our most recent Provider Directory, or visit www.paramounthealthcare.com/FindAProvider and click on the Paramount logo. Select HMO-Ohio as the product.

HMOs 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 claims or pay bills. You pay only 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.

General features of our High Option

How we pay providers

We contract with 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 cost-sharing.

Your rights and responsibilities

OPM requires that all FEHB plans provide certain information to their FEHB members. You may get information about us, our networks, our providers, and our facilities. OPM's FEHB Website (www.opm.gov/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- We are a health maintenance organization that has provided health care services to northwest Ohio areas since 1988.
- Paramount is an affiliate of ProMedica a nonprofit healthcare organization serving northwest Ohio and southeast Michigan.

As a Member of this Plan, you have certain rights that you can expect from us and our contracted providers. You have the right to:

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

If you want more information about us, call 1-800-462-3589 (TTY: 1-888-740-5670) or write to Paramount, Member Services, P.O. Box 928, Toledo, Ohio 43697-0928. You may also fax us at 419-887-2047 or visit our website at www.paramounthealthcare.com.

By law, you have the right to access your personal health information (PHI). For more information regarding access to PHI, visit our Paramount website at www.paramounthealthcare.com. You can also contact us to request that we mail a copy regarding access to PHI.

Your medical and claims records are confidential

We will keep your medical and claims records confidential. Please note that we may disclose your medical and claims information (including your prescription drug utilization) to any of your treating physicians or dispensing pharmacies.

Language interpretation services

Language interpretation services are available to non-English speaking members. Please ask an English speaking friend or relative to call Member Services at 1-800-462-3589 (TTY: 1-888-740-5670).

Service Area

To enroll in this Plan, you must live or work in our service area. The service area is where our providers practice.

Our service area includes the following counties:

The Ohio counties of Crawford, Defiance, Erie, Fulton, Hancock, Henry, Huron, Lucas, Ottawa, Putnam, Richland, Sandusky, Seneca, Williams, and Wood. Also portions of Allen, Delaware, Hardin, Knox, Lorain and Paulding as described by the following zip codes:

Allen: 45801, 45802, 45804, 45805, 45806, 45807, 45809, 45817, 45820, 45833, 45850

Delaware: 43003, 43015, 43066

Hardin: 43326, 45810, 45812, 45843

Knox: 43011, 43014, 43019, 43022, 43050

Lorain: 44001, 44035, 44039, 44044, 44050, 44052, 44053, 44054, 44055, 44074, 44090

Paulding: 45813, 45821, 45849, 45855, 45861, 45873, 45879

Ordinarily, you must receive your care from physicians, hospitals, and other 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. Changes for 2017

Changes to this Plan

- Your share of the non-Postal premium will increase for Self, Self Plus One and Family. See page 77.
- We have no benefit changes or service area changes.

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 letter (for annuitants), or your electronic enrollment system (such as Employee Express) confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call Member Services at 1-800-462-3589 (TTY: 1-888-740-5670) or write to us at: Paramount, Member Services, P.O. Box 928, Toledo, OH 43697-0928. After registering on our website at www.MyParamount.org you may also request replacement cards electronically.

Where you get covered care

You get care from “Plan providers” and “Plan facilities.” You will only pay copayments, deductibles, and/or coinsurance.

- **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 regularly. Directories are available at the time of enrollment or upon request by calling Member Services at 1-800-462-3589 (TTY: 1-888-740-5670). The list is also on our Website at www.paramounthealthcare.com/FindAProvider.

- **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 Plan facilities in our Provider Directory, with their locations and phone numbers. Directories are updated regularly and are available at the time of enrollment or upon request by calling Member Services at 1-800-462-3589 (TTY: 1-888-740-5670). The list is also on our website at www.paramounthealthcare.com/FindAProvider.

What you must do to get covered care

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

To choose or change your primary care physician, you can call our Member Services department at 1-800-462-3589 (TTY: 1-888-740-5670) or log into your personal account at www.MyParamount.org.

- **Primary care**

Primary Care Provider means a physician or other provider who specializes in family practice, internal medicine or pediatrics and is designated by Paramount as a Primary Care Provider. We encourage you to choose a primary care physician when you enroll. If you do not select a primary care physician, one will be selected for you based on geographic location.

You may change your Primary Care Provider. You must notify Paramount first, before you see any new Primary Care Provider. Call Member Services at 1-800-462-3589 (TTY: 1-888-740-5670) or log into your account at www.MyParamount.org. The change can be made effective the same day. You will receive a new identification card with your new physician's name. If you need to see the doctor before your card arrives, your doctor can call Member Services to check your membership.

- **Specialty care**

Most of your health care needs can and should be handled by your Primary Care Provider. If your Primary Care Provider believes you need to see a specialist - a cardiologist, orthopedist or others - your Primary Care Provider will recommend a Participating Specialist. Or you may choose a Participating Specialist you wish to see and make an appointment. Referrals are not required for Participating Specialists.

Newly enrolled members of the Plan who are already seeing a specialist should verify that the specialist is participating with this Plan. Call Member Services at 1-800-462-3589 (TTY: 1-888-740-5670) or log into your account at www.MyParamount.org to verify participation.

Here are some other things you should know about specialty care:

- 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 recommend 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 necessary hospital arrangements and supervise your care. This includes admission to a skilled nursing or other type of facility.

- **If you are hospitalized when your enrollment begins**

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call Member Services immediately at 1-800-462-3589 (TTY: 1-888-740-5670). If you are new to the FEHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

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;
- the day your benefits from your former plan run out; or
- the 92nd day after you become a member of this Plan, whichever happens first.

These provisions apply only to the benefits of the hospitalized person. If your plan terminates participation in the FEHB Program in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such cases, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

You need prior Plan approval for certain services

For certain services your Plan provider must obtain approval from us. Before giving approval, we may consider if the service or item is medically necessary and meets other coverage requirements. We call this review and approval process "precertification" or "prior authorization."

Your Plan provider must obtain precertification for services such as, but not limited to:

- Out of network services (except emergency services)
- Bariatric surgery
- BRCA testing
- Home health care
- Hospice
- Imaging procedures
- Inpatient hospital admissions
- Skilled nursing facility admission
- Sleep studies
- Transplant procedures
- Transgender surgeries

To see a full list of services that require precertification, please visit www.paramounthealthcare.com/priorauth.

When you receive medical services for which you do not have precertification or that you receive from non-Plan providers or from non-Plan facilities that have not been referred by a Plan provider and approved by us, we will not pay for them except in an emergency. Charges for these medical services will be your financial responsibility.

To confirm if your service or item requires precertification, please call Member Services at 1-800-462-3589 (TTY: 1-888-740-5670).

Precertification determinations are made based on the information available at the time the service or item is requested. We will not cover the service or item unless you are a Plan member on the date you receive the service or item.

How to request precertification for an admission or get prior authorization for other services

Your physician, your hospital, you, or your representative, must call Paramount's Utilization/Case Management Department at 419-887-2520 or toll-free 1-800-891-2520. Electronic submissions are preferred. Fax prior authorization request to 419-887-2028 or toll-free 1-866-214-2024. Prior authorizations can be e-mailed to Paramount's Utilization Management staff at PHCReferralManagement@ProMedica.org. Imaging procedures can be submitted through the web-based prior authorization submission tool (McKesson Clear Coverage).

Certain information will be required, such as:

- enrollee's name and Plan identification number;
- patient's name, birth date, identification number and phone number;
- reason for hospitalization, proposed treatment or surgery;
- name and phone number of admitting physician;
- name of hospital or facility; and

- number of days requested for hospital stay.

- **Non-urgent care claims**

For non-urgent care claims, we will tell the physician and/or hospital the number of approved inpatient days, or the care that we approve for other services that must have prior authorization. We will make our decision within 15 days of receipt of the pre-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you of the need for an extension of time before the end of the original 15 day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

- **Urgent care claims**

If you have an urgent care claim (i.e., when waiting for the regular time limit for your medical care or treatment could seriously jeopardize your life, health, or ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without this care or treatment), we will expedite our review and notify you of our decision within 72 hours. If you request that we review your claim as an urgent care claim, we will review the documentation you provide and decide whether it is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to let you know what information we need to complete our review of the claim. You will then have at least 48 hours to provide the required information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) the end of the time frame, whichever is earlier.

We may provide our decision orally within these time frames, but we will follow up with written or electronic notification within three days of oral notification.

You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us at 1-800-462-3589 (TTY: 1-888-740-5670). You may also call OPM's Health Insurance 3 at (202) 606-0755 between 8 a.m. and 5 p.m. Eastern Time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, call us at 1-800-462-3589 (TTY: 1-888-740-5670). If it is determined that your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim).

- **Concurrent care claims**

A concurrent care claim involves care provided over a period of time or over a number of treatments. We will treat any reduction or termination of our pre-approved course of treatment before the end of the approved period of time or number of treatments as an appealable decision. This does not include reduction or termination due to benefit changes or if your enrollment ends. If we believe a reduction or termination is warranted we will allow you sufficient time to appeal and obtain a decision from us before the reduction or termination takes effect.

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, then we will make a decision within 24 hours after we receive the claim.

- **Emergency inpatient admission** Emergency services do not require precertification. However, an emergency admission to a nonparticipating hospital must be called in to Paramount within 24 hours (or as soon as reasonably possible). If and when your medical condition allows, your Primary Care Provider and Paramount may arrange for you to be transferred to a Participating Hospital.
 - **If your treatment needs to be extended** If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, then we will make a decision within 24 hours after we receive the claim.
- What happens when you do not follow the precertification rules** If you or your Plan physician do not obtain prior authorization from us for services or items that require prior authorization, we will not pay any amount for those services or items and you may be liable for the full price of those services or items. This also includes any residual amounts, such as deductibles, copayments or coinsurance, that are not covered or not paid by any other insurance plan you use to pay for those services or items.
- Circumstances beyond our control** Under 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.
- If you disagree with our pre-service claim decision** If you have a **pre-service claim** and you do not agree with our prior approval decision, you may request a review in accord with the procedures detailed below.
- If you have already received the service, supply, or treatment, then you have a **post-service claim** and must follow the entire disputed claims process detailed in Section 8.
- **To reconsider a non-urgent care claim** Within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.
- In the case of a pre-service claim and subject to a request for additional information, we have 30 days from the date we receive your written request for reconsideration to do one of the following:
1. Precertify your hospital stay or, if applicable, arrange for the health care provider to give you the care or grant your request for prior approval for a service, drug, or supply.
 2. Ask you or your provider for more information.
- 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.
3. Write to you and maintain our denial.
- **To reconsider an urgent care claim** In the case of an appeal of a pre-service urgent care claim, within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.
- Unless we request additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will expedite the review process, which allows oral or written request for appeals and the exchange of information by telephone, electronic mail, facsimile, or other expeditious methods.
- **To file an appeal with OPM** After we reconsider your **pre-service claim**, if you do not agree with our decision, you may ask OPM to review it by following Step 3 of the disputed claims process detailed in Section 8 of this brochure.

Section 4. Your cost for covered services

This is what you will pay out-of-pocket for covered care:

Cost-sharing

Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.

Copayments

A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive certain services. The amount of copayment will depend upon the type of provider, and the service or supply that you receive.

You pay a primary care provider copayment when you visit any primary care provider as described in Section 3, *How you get care*. You pay a specialist copayment when you receive care from a specialist as described in Section 3.

For example, for diagnostic and treatment services as described in Section 5(a):

- You pay a \$20 copayment when you receive diagnostic and treatment services from a primary care provider or a \$30 copayment for a specialty care provider.

Deductible

A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for them. Copayments do not count toward any deductible.

- The calendar year deductible is \$400 under High Option. Under a Self Only enrollment, the deductible is considered satisfied and benefits are payable for you when your covered expenses applied to the calendar year deductible for your enrollment reach \$400 under High Option. Under a Self Plus One enrollment, the deductible is considered satisfied and benefits are payable for you and one other eligible family member when the combined covered expenses applied to the calendar year deductible for your enrollment reach \$800 under High Option. Under a Self and Family enrollment, the deductible is considered satisfied and benefits are payable for all family members when the combined covered expenses applied to the calendar year deductible for family members reach \$1,200 under High Option.

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 allowance that you must pay for certain services you receive.

Example: In our Plan, you pay 30% of our allowance for infertility services and 20% of our allowance for durable medical equipment.

Your catastrophic protection out-of-pocket maximum

After your out-of-pocket expenses, including any applicable deductibles, copayments and coinsurance total \$4,400 for Self Only, or \$8,800 for a Self Plus One or \$13,200 for Self and Family enrollment in any calendar year, you do not have to pay any more for covered services. ***The maximum annual limitation on cost sharing listed under Self Only of \$4,400 applies to each individual, regardless of whether the individual is enrolled in Self Only, Self Plus One, or Self and Family.***

Example Scenario: Your plan has a \$4,400 Self Only maximum out-of-pocket limit and a \$8,800 Self Plus One or \$13,200 Self and Family maximum out-of-pocket limit. If you or one of your eligible family members has out-of-pocket qualified medical expenses of \$4,400 or more for the calendar year, any remaining qualified medical expenses for that individual will be covered fully by your health plan. With a Self and Family enrollment out-of-pocket maximum of \$13,200, a second family member, or an aggregate of other eligible family members, will continue to accrue out-of-pocket qualified medical expenses up to a maximum of \$13,200 for the calendar year before their qualified medical expenses will begin to be covered in full.

However, copayments and coinsurance, if applicable for the following services do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay copayments and coinsurance for these services:

- Expenses from utilizing out-of-network providers

Be sure to keep accurate records and receipts of your copayments and coinsurance to ensure the plan's calculation of your out-of-pocket maximum is reflected accurately.

Carryover

If you changed to this Plan during Open Season from a plan with a catastrophic protection benefit and the effective date of the change was after January 1, any expenses that would have applied to that plan's catastrophic protection benefit during the prior year will be covered by your old plan if they are for care you received in January before your effective date of coverage in this Plan. If you have already met your old plan's catastrophic protection benefit level in full, it will continue to apply until the effective date of your coverage in this Plan. If you have not met this expense level in full, your old plan will first apply your covered out-of-pocket expenses until the prior year's catastrophic level is reached and then apply the catastrophic protection benefit to covered out-of-pocket expenses incurred from that point until the effective date of your coverage in this Plan. Your old plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.

When Government facilities bill us

Facilities of the Department of Veterans Affairs, the Department of Defense and the Indian Health Services are entitled to seek reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow. You may be responsible to pay for certain services and charges. Contact the government facility directly for more information.

Section 5. High Option Benefits

Section 5 is divided into subsections. Please read 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 more information about our benefits, contact us at 419-887-2525 or 1-800-462-3589 or our Web site at www.paramounthealthcare.com.

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Section 5. High Option Benefits Overview

This Plan offers a High Option. The benefit package is described in Section 5.

The High Option Section 5 is divided into subsections. Please read *Important things you should keep in mind* at the beginning of the subsections. Also read the general exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claims filing advice, or more information about High Option benefits, contact us at 419-887-2525 or 1-800-462-3589. TTY users may call toll-free at 1-888-740-5670 or on our Website at <http://www.paramounthealthcare.com>.

Paramount was established in July 1988 as a locally owned insurance company serving six counties surrounding Toledo, Ohio. Today it has approximately 200,000 members, serves both northwest Ohio and southeast Michigan and, in 2013, we began serving Medicaid recipients in all 88 Ohio counties. Paramount is accredited by NCQA (National Committee for Quality Assurance) for its Ohio HMO, Elite and Advantage products. Paramount HMO (health maintenance organization) is a cost-effective health insurance plan that can provide you with a balance of rich benefits. Paramount HMO plans are different than most HMOs in that no referrals are required to visit a specialist, although some specific services still require prior authorization. Paramount HMO offers a strong value to you and has an extensive network of doctors, hospitals and other providers, so you can choose the provider you prefer – often your current doctor.

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

Important things you should 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.
- The calendar year deductible is: \$400 per person (\$800 per Self Plus One enrollment, or \$1,200 per Self and Family enrollment). The calendar year deductible applies to almost all benefits in this Section. We added “(No deductible)” to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your cost for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare. **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR SOME MEDICAL PROCEDURES.** Please refer to the precertification information shown in Section 3 to be sure which services and supplies require precertification.

Benefit Description	You pay
Diagnostic and treatment services	High Option
Professional services of physicians and other health care professionals <ul style="list-style-type: none"> • In a physician’s office • Office medical consultations • Second surgical opinions • Advanced care planning 	\$20 per visit to your primary care physician \$30 per visit to a specialist
Professional services of physicians and other health care professionals <ul style="list-style-type: none"> • In ambulatory surgical centers 	20% of charges after deductible is met
Professional services of physicians and other health care professionals <ul style="list-style-type: none"> • In an urgent care center 	\$45 per visit
Professional services of physicians and other health care professionals <ul style="list-style-type: none"> • During a hospital stay • In a skilled nursing facility 	20% of charges after deductible is met
<ul style="list-style-type: none"> • At home by a physician 	20% of charges after deductible is met
Telehealth Services	High Option
<ul style="list-style-type: none"> • Primary care • Urgent care 	\$20 per visit

Benefit Description	You pay
Lab, X-ray and other diagnostic tests	
<p>Tests, such as:</p> <ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • CT scans/MRI • Ultrasound • Electrocardiogram and EEG • Nuclear medicine • PET scans <p>Note: Tests related to infertility are covered under the infertility services benefit. See Section 5(a), <i>Infertility services</i>.</p>	<p>20% of charges after deductible is met</p>
Preventive care, adult	
<p>Routine physical exam</p>	<p>Nothing</p>
<p>Routine screenings, such as:</p> <ul style="list-style-type: none"> • Total blood cholesterol • Lung cancer Screening • Colorectal cancer screening, including <ul style="list-style-type: none"> - Fecal occult blood test - Sigmoidoscopy screening – every five years starting at age 50, or at an earlier age or frequency when determined by a Plan physician to be medically necessary - Colonoscopy screening – every ten years starting at age 50, or at an earlier age or frequency when determined by a Plan physician to be medically necessary • Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older • Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC) 	<p>Nothing</p>
<p>Well woman care; including, but not limited to:</p> <ul style="list-style-type: none"> • Routine Pap test • Human papillomavirus testing for women age 30 and up • Counseling for sexually transmitted infections • Counseling and screening for human immune-deficiency virus 	<p>Nothing</p>

Benefit Description	You pay
Preventive care, adult (cont.)	High Option
<ul style="list-style-type: none"> • Contraceptive methods and counseling • Screening and counseling for interpersonal and domestic violence • Screening and counseling for women at higher risk for breast and ovarian cancer, if requested after counseling, BRCA testing. • Women’s preventive services: https://www.healthcare.gov/preventive-care-women/ 	Nothing
<p>Routine mammogram – covered for women age 35 and older, as follows:</p> <ul style="list-style-type: none"> • Age 35 through 39, one during this five-year period • Age 40 through 64, one every calendar year • Age 65 and older, once every two consecutive calendar years 	Nothing
<p>Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force is available (USPSTF) is available online at: http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/</p> <p>HHS: https://www.healthcare.gov/preventive-care-benefits/</p> <p>CDC: http://www.cdc.gov/vaccines/schedules/index.html</p> <p>Women’s preventive services: https://www.healthcare.gov/preventive-care-women/</p>	
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Physical exams and immunizations required for:</i> <ul style="list-style-type: none"> - <i>Obtaining or continuing employment</i> - <i>Insurance or licensing</i> - <i>Participation in employee programs</i> - <i>Court ordered parole or probation</i> 	<i>All charges</i>

Benefit Description	You pay
Preventive care, children	High Option
<ul style="list-style-type: none"> Childhood immunizations recommended by the Centers for Disease Control and Prevention (CDC) 	Nothing
<ul style="list-style-type: none"> Well-child care charges for routine examinations, immunizations and care (up to age 22) Examinations, such as: <ul style="list-style-type: none"> Eye exams through age 17 to determine the need for vision correction Hearing exams through age 17 to determine the need for hearing correction Examinations done on the day of immunizations (up to age 22) Examinations for amblyopia and strabismus – limited to one screening examination (ages 3 through 5) 	Nothing
<p>Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force is available (USPSTF) is available online at http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ and HHS at https://www.healthcare.gov/preventive-care-benefits/</p>	
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Physical exams and immunizations required for:</i> <ul style="list-style-type: none"> <i>Obtaining or continuing employment</i> <i>Insurance or licensing</i> <i>Participating in employee programs</i> <i>Court ordered parole or probation</i> <i>All other hearing testing, except as may be covered in Section 5(a), Diagnostic and treatment services and Section 5(a), Hearing services</i> 	<i>All charges</i>
Maternity care	High Option
<p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> Prenatal care Screening for gestational diabetes for pregnant women between 24-28 weeks gestation or first prenatal visit for women at a high risk. Postnatal Care Delivery Postpartum care <p>Breastfeeding support, supplies and counseling for each birth</p>	<p>Nothing for prenatal care and postnatal care</p> <p>20% of charges for inpatient professional delivery services after deductible is met</p> <p>Nothing</p>

Benefit Description	You pay
Maternity care (cont.)	High Option
<p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> You do not need to precertify your vaginal delivery; see page 17 for other circumstances, such as extended stays for you or your baby. You may remain in the hospital up to 48 hours after a vaginal delivery and 96 hours after a cesarean delivery. We cover 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 Plus One or Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision. We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury. Hospital services are covered under Section 5(c) and Surgical benefits Section 5(b). 	
Family planning	High Option
Contraceptive counseling on an annual basis	Nothing
<p>A range of family planning services for women, limited to:</p> <ul style="list-style-type: none"> Female voluntary sterilization (See Section 5(b), <i>Surgical procedures</i>) Surgically implanted contraceptive drugs Injectable contraceptive drugs (such as Depo provera) Intrauterine devices (IUDs) Diaphragms Family planning counseling Contraceptives counseling <p>Notes:</p> <ul style="list-style-type: none"> We cover contraceptive drugs and devices under Prescription drug benefits. See Section 5(f). 	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Reversal of voluntary surgical sterilization</i> 	<i>All charges</i>

Benefit Description	You pay
Infertility services	High Option
Diagnosis and treatment of involuntary infertility, including Intrauterine insemination (IUI), a form of artificial insemination	30% of charges after deductible is met
Infertility drugs administered in the office	30% of charges after deductible is met
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Intracervical insemination (ICI)</i> • <i>Intravaginal insemination (IVI)</i> • <i>Assisted reproductive technology (ART) procedures, such as:</i> <ul style="list-style-type: none"> - <i>In vitro fertilization (IVF)</i> - <i>Embryo transfer and gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)</i> • <i>Services and supplies related to ART procedures</i> • <i>Cost of donor sperm</i> • <i>Cost of donor egg</i> • <i>Self administered fertility drugs</i> 	<i>All charges</i>
Allergy care	High Option
<ul style="list-style-type: none"> • Testing and treatment • Injections 	\$20 per visit for your primary care physician \$30 per visit for specialist
<ul style="list-style-type: none"> • Serum 	Nothing
Treatment therapies	High Option
<ul style="list-style-type: none"> • Chemotherapy and radiation therapy <p>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Section 5(b), <i>Organ/ Tissue transplants</i>.</p> <ul style="list-style-type: none"> • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotictherapy • Growth hormone therapy (GHT) • Applied Behavior Analysis (ABA) - children with autism spectrum disorder <p>Note: Growth hormone is covered under the prescription drug benefit.</p>	20% of charges after deductible is met

Treatment therapies - continued on next page

Benefit Description	You pay
Treatment therapies (cont.)	High Option
<p>Note: We only cover GHT when we preauthorize the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment. We will only cover GHT services and related services and supplies that we determine are medically necessary. See <i>Other services under You need prior Plan approval for certain services in Section 3.</i></p>	20% of charges after deductible is met
Physical and occupational therapies	High Option
<p>60 visits combined per condition for the services of each of the following:</p> <ul style="list-style-type: none"> • Qualified physical therapists • Occupational therapists <p>Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided.</p>	\$30 per outpatient office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Long-term therapy</i> • <i>Exercise programs</i> 	<i>All charges</i>
Speech therapy	High Option
Unlimited visits	\$30 per outpatient office visit
Hearing services (testing, treatment, and supplies)	High Option
<ul style="list-style-type: none"> • For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by M.D., D.O., or audiologist • Hearing testing for children through age 17 (see Preventive care, children) <p>Note: For routine hearing screening performed during a child’s preventive care visit, see Section 5(a) <i>Preventive care, children.</i></p>	20% of charges after deductible is met
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>All other hearing testing</i> • <i>Hearing aids, testing and examinations for them</i> 	<i>All charges</i>

Benefit Description	You pay
Vision services (testing, treatment, and supplies)	High Option
<ul style="list-style-type: none"> • Annual eye refractions • Eye exam to determine the need for vision correction for children through age 17 (see Preventive care, children) 	\$30 office visit for specialty care
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Eyeglasses or contact lenses, except as shown above</i> • <i>Eye exercises and orthoptics</i> • <i>Radial keratotomy and other refractive surgery</i> 	<i>All charges</i>
Foot care	High Option
<ul style="list-style-type: none"> • Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes 	\$30 per office visit for specialist
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>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</i> • <i>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)</i> 	<i>All charges</i>
Orthopedic and prosthetic devices	High Option
<ul style="list-style-type: none"> • Artificial limbs and eyes • Stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants • Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy. 	20% of charges after deductible is met

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay
Orthopedic and prosthetic devices (cont.)	
<p>Note: For information on the professional charges for the surgery to insert an implant, see Section 5(b) Surgical procedures. For information on the hospital and/or ambulatory surgery center benefits, see Section 5(c) Services provided by a hospital or other facility, and ambulance services.</p>	<p>20% of charges after deductible is met</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Orthopedic and corrective shoes, arch supports, foot orthotics, heel pads and heel cups</i> • <i>Lumbosacral supports</i> • <i>Corsets, trusses, elastic stockings, support hose, and other supportive devices</i> 	<p><i>All charges</i></p>
Durable medical equipment (DME)	
<p>We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include:</p> <ul style="list-style-type: none"> • Oxygen • Dialysis equipment • Hospital beds • Standard wheelchairs • Crutches • Walkers • Ostomy supplies • Blood glucose monitors • Lancets • Chem strips • Medical support hose • Insulin pumps 	<p>20% of charges after deductible is met</p>
<p>Notes:</p> <ul style="list-style-type: none"> • Durable medical equipment (DME) is equipment that is prescribed by a Plan physician; obtained through sources designated by the Plan; consistent with Medicare guidelines; intended for repeated use; primarily and customarily used to serve a medical or therapeutic purpose in the treatment of an illness or injury; designed for prolonged use and appropriate for use in the home. • We cover only those standard items that are adequate to meet the medical needs of the member. 	
<p>Breastfeeding pump, including any equipment required for pump functionality</p>	<p>Nothing</p>
<p><i>Not covered</i></p>	<p><i>All charges</i></p>

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay
Durable medical equipment (DME) (cont.)	
<ul style="list-style-type: none"> • <i>Medical equipment and supplies not covered by Medicare Part B</i> • <i>Disposable supplies (except for ostomy supplies), test kits (except for diabetic supplies), etc.</i> • <i>Exercise equipment, air conditioners</i> • <i>Hearing aids</i> • <i>Penile implants, erectile devices</i> • <i>Shoes including molds and inserts (foot orthotics) unless covered by Medicare Part B</i> • <i>Wigs</i> • <i>Bite plates, retainers, snore guards, splints or any appliance or device which is fitted to the mouth</i> 	<i>All charges</i>
Home health services	
<ul style="list-style-type: none"> • 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. 	20% of charges for inpatient services after deductible is met
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Nursing care requested by, or for the convenience of, the patient or the patient's family</i> • <i>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative</i> • <i>Convalescent and custodial services</i> 	<i>All charges</i>
Chiropractic	
<p>Up to 20 visits per calendar year, limited to:</p> <ul style="list-style-type: none"> • Manipulation of the spine and extremities • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application 	\$30 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Services rendered by non-participating chiropractors.</i> • <i>Services in excess of benefit or visit limits.</i> 	<i>All charges</i>

Benefit Description	You pay
Alternative treatments	High Option
<i>No benefit</i>	<i>All charges</i>
Educational classes and programs	High Option
Coverage is provided for: <ul style="list-style-type: none"> • Tobacco Cessation programs, including individual/group/telephone counseling, over-the-counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence. 	Nothing for counseling for up to two quit attempts per year. Nothing for OTC and prescription drugs approved by the FDA to treat tobacco dependence.
Note: <ul style="list-style-type: none"> • Paramount partners with the Ohio Quit Line to provide free NRT and counseling for our members. Call 1-800-784-8669 (1-800-QuitNow) to sign up. 	
Diabetes self management	Nothing
Childhood obesity education	Nothing

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

Important things you should 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.
- The calendar year deductible is: \$400 per person (\$800 per Self Plus One enrollment, or \$1,200 per Self and Family enrollment). The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your cost 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 services listed below are for the charges billed by a physician or other health care professional for your surgical care. See Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR SOME SURGICAL PROCEDURES.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification.

Benefit Description	You pay
Surgical procedures	High Option
<p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> • 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 <i>Reconstructive surgery</i>) • Transgender surgery • Surgical treatment of morbid obesity (bariatric surgery) <ul style="list-style-type: none"> - Medical and surgical treatment of morbid obesity – The following criteria must be met: - 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 - A documented body mass index > 40 for 5 years, or 	<p>20% of charges for inpatient services after deductible is met</p>

Surgical procedures - continued on next page

Benefit Description	You pay
Surgical procedures (cont.)	High Option
<ul style="list-style-type: none"> - A documented body mass index > 35 for 5 years with serious documented co-morbidities such as hypertension, diabetes, cardiovascular disease, sleep apnea and degenerative joint disease, and - History of failure of dietary and other conservative therapies, and - Psychological consult to rule out serious mental illness and demonstrate ability to comply with post-op regimens, and - Nutritional counseling, and - Strong support system - No history of eating disorder that has been successfully addressed with a therapist and has been in remission for at least one year. <ul style="list-style-type: none"> • Insertion of internal prosthetic devices. See 5(a) – Orthopedic and prosthetic devices for device coverage information <p>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.</p>	20% of charges for inpatient services after deductible is met
<ul style="list-style-type: none"> • Male voluntary sterilization (e.g., vasectomy) • Treatment of burns • Implanted time-release drugs except contraceptive drugs and devices 	20% of charges after deductible is met
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary sterilization</i> • <i>Routine treatment of conditions of the foot (see Foot care)</i> • <i>Implants or devices related to the treatment of sexual dysfunction</i> 	<i>All charges</i>
<ul style="list-style-type: none"> • Female Voluntary sterilization, including a hysterosalpingogram following tubal occlusion • Insertion of surgically implanted time-release contraceptive drugs and intrauterine devices (IUDs) 	Nothing

Benefit Description	You pay
Reconstructive surgery	High Option
<ul style="list-style-type: none"> • Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> - 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; birthmarks; and webbed fingers and toes. • Surgery for treatment of a form of congenital hemangioma known as port wine stains on the face of members 18 years or younger • All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> - surgery and reconstruction on the other breast to produce a symmetrical appearance; - treatment of any physical complications, such as lymphedemas; - breast prostheses and surgical bras and replacements (see <i>Prosthetic devices</i>) • Gender reassignment surgery requires prior authorization <p>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.</p>	<p>20% of charges for inpatient services after deductible is met</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except as otherwise specified above</i> 	<p><i>All charges</i></p>
Oral and maxillofacial surgery	High Option
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> • 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 tumors; 	<p>20% of charges for inpatient services after deductible is met</p>

Oral and maxillofacial surgery - continued on next page

Benefit Description	You pay
Oral and maxillofacial surgery (cont.)	High Option
<ul style="list-style-type: none"> • Medical and surgical treatment of temporomandibular joint (TMJ) disorder (non-dental); and • Other surgical procedures that do not involve the teeth or their supporting structures. 	20% of charges for inpatient services after deductible is met
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Oral implants and transplants</i> • <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingival, and alveolar bone), except for procedures related to accidental injury of teeth</i> 	<i>All charges</i>
Organ/tissue transplants	High Option
<p>These solid organ transplants are subject to medical necessity and experimental/investigational review by the Plan. Refer to Section 3, <i>How you get care</i> for precertification procedures. Solid organ tissue transplants are limited to:</p> <ul style="list-style-type: none"> • Cornea • Heart • Heart/lung • Intestinal transplants <ul style="list-style-type: none"> - Isolated Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • Kidney-Pancreas • Liver • Lung: Single/bilateral/lobar • Pancreas • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis. 	20% of charges for inpatient services after deductible is met
<p>These tandem blood or marrow stem cell transplants for covered transplants are subject to medical necessity review by the Plan. Refer to <i>Other services</i> in Section 3 for prior authorization procedures.</p> <ul style="list-style-type: none"> • Autologous tandem transplants for <ul style="list-style-type: none"> - AL Amyloidosis - Multiple myeloma (de novo and treated) 	20% of charges for inpatient services after deductible is met

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	High Option
<ul style="list-style-type: none"> - Recurrent germ cell tumors (including testicular cancer) 	20% of charges for inpatient services after deductible is met
<p>Blood or marrow stem cell transplants</p> <p>The plan extends coverage for the diagnosis as indicated below.</p> <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin’s lymphoma with recurrence (relapsed) - Advanced non-Hodgkin’s lymphoma with recurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy 	20% of charges for inpatient services after deductible is met
<ul style="list-style-type: none"> - Marrow failure and related disorders (i.e., Fanconi’s, PNH, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for <ul style="list-style-type: none"> - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin’s lymphoma with recurrence (relapsed) - Advanced non-Hodgkin’s lymphoma with recurrence (relapsed) - Amyloidosis - Breast Cancer - Epithelial ovarian cancer - Multiple myeloma 	20% of charges for inpatient services after deductible is met

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	High Option
<ul style="list-style-type: none"> - Neuroblastoma - Testicular, Mediastinal, Retroperitoneal, and ovarian germ cell tumors 	20% of charges for inpatient services after deductible is met
<p>Mini-transplants performed in a clinical trial setting (non-myeloablative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan.</p> <p>Refer to <i>Other services</i> in Section 3 for prior authorization procedures:</p> <p>Refer to in Section 3 for prior authorization procedures:</p> <ul style="list-style-type: none"> • Allogeneic transplants for: <ul style="list-style-type: none"> - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute myeloid leukemia - Advanced Hodgkin’s lymphoma with recurrence (relapsed) - Advanced non-Hodgkin’s lymphoma with recurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Amyloidosis • Autologous transplants for: <ul style="list-style-type: none"> - Advanced Childhood kidney cancers - Advanced Ewing sarcoma - Childhood rhabdomyosarcom - Epithelial Ovarian Cancer - Mantle Cell (Non-Hodgkin lymphoma) 	20% of charges for inpatient services after deductible is met
<p>Notes:</p> <p>We cover related medical and hospital expenses of the donor when we cover the recipient. We cover donor testing for the actual solid organ donor or up to four bone marrow/stem cell transplant donors in addition to the testing of family members.</p> <p>We cover donor testing for the actual solid organ donor or up to four bone marrow/stem cell transplant donors in addition to the testing of family members</p>	
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Donor screening tests and donor search expenses, except those listed above</i> • <i>Implants of non-human artificial organs</i> 	<i>All charges</i>

Benefit Description	You pay
Organ/tissue transplants (cont.)	High Option
<ul style="list-style-type: none"> • <i>Transplants not listed as covered</i> 	<i>All charges</i>
Anesthesia	High Option
Professional services provided in – <ul style="list-style-type: none"> • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center 	20% of charges for inpatient services after deductible is met
Professional services provided in – <ul style="list-style-type: none"> • Office 	\$20 per office visit to your primary care physician \$30 per office visit to a specialist

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

Important things you should 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.
- In this Section, unlike Sections 5(a) and 5(b), the calendar year deductible applies to only a few benefits. We added "(calendar year deductible applies)" when it applies. The calendar year deductible is: \$400 per person (\$800 per Self Plus One enrollment, or \$1,200 per Self and Family enrollment).
- 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 or care. Any costs associated with the professional charge (i.e., physicians, etc.) are in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.

Benefit Description	You pay
Inpatient hospital	High Option
Room and board, such as: <ul style="list-style-type: none"> • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets Notes: <ul style="list-style-type: none"> • If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate. 	20% of charges for inpatient services after deductible is met
Other hospital services and supplies, such as: <ul style="list-style-type: none"> • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Dressings, splints, plaster casts, and sterile tray services • Medical supplies, appliances, 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 (Note: calendar year deductible applies.) 	20% of charges for inpatient services after deductible is met

Benefit Description	You pay
Inpatient hospital (cont.)	High Option
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Custodial care and care in an intermediate care facility • Non-covered facilities, such as nursing homes • Personal comfort items, such as telephone, television, barber services, and guest meals and beds • Private nursing care, except when medically necessary 	<p><i>All charges</i></p>
Outpatient hospital or ambulatory surgical center	High Option
<ul style="list-style-type: none"> • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Dressings, splints, plaster casts, and sterile tray services • Medical supplies, appliances, and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items <p>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.</p>	<p>20% of charges for inpatient services after deductible is met</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Blood and blood derivatives not replaced by the member 	<p><i>All charges</i></p>
Skilled nursing care facility benefits	High Option
<p>Extended care benefit</p>	<p>20% of charges for inpatient services after deductible is met</p>
<p>Up to 100 days per calendar year</p> <ul style="list-style-type: none"> • When you need full-time skilled nursing care <p>All necessary services are covered, including:</p> <ul style="list-style-type: none"> • Room and board • General nursing care • Medical social services • Prescribed drugs, biologicals, supplies, and equipment, including oxygen, ordinarily provided or arranged by the skilled nursing facility 	<p>20% of charges for inpatient services after deductible is met</p>
<p><i>Not covered:</i></p>	<p><i>All charges</i></p>

Skilled nursing care facility benefits - continued on next page

Benefit Description	You pay
Skilled nursing care facility benefits (cont.)	High Option
<ul style="list-style-type: none"> • <i>Custodial care and care in an intermediate care facility</i> • <i>Personal comfort items, such as telephone, television, barber services, and guest meals and beds.</i> 	<i>All charges</i>
Hospice care	High Option
<p>Supportive and palliative care for a terminally ill member:</p> <ul style="list-style-type: none"> • You must reside in the service area • Services are provided: <ul style="list-style-type: none"> - in the home, when a Plan physician determines that it is feasible to maintain effective supervision and control of your care in your home, or - in a Plan-approved hospice facility, if approved by a Plan physician <p>Services include inpatient care, outpatient care, and family counseling. A Plan physician must certify that you have a terminal illness, with a life expectancy of approximately six months or less.</p>	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Independent nursing (private duty nursing)</i> • <i>Homemaker services</i> 	<i>All charges</i>
Ambulance	High Option
<ul style="list-style-type: none"> • Local licensed ambulance service when medically necessary <p>Note: See Section 5(d) for emergency services</p>	20% of charges for services after deductible is met
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Transportation by car, taxi, bus, gurney van, wheelchair van, and any other type of transportation (other than a licensed ambulance), even if it is the only way to travel to a Plan Provider</i> 	<i>All charges</i>

Section 5(d). Emergency services/accidents

Important things you should 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.
- The deductible is \$400 for Self Only enrollment, \$800 per Self Plus One enrollment and \$1,200 Self and Family enrollment each calendar year. The Self and Family and Self Plus One deductibles can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts and copayments for eligible medical expenses and prescriptions.
- Be sure to read Section 4, *Your cost for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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 we may determine are medical emergencies – what they all have in common is the need for quick action.

What to do in case of emergency:

In a life-threatening emergency, call 911 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 us. You or a family member must notify us within 24 hours unless it is not reasonable to do so. It is your responsibility to be sure we have been timely notified.

Emergencies within our service area:

If you are unsure whether you are experiencing an emergency, call your Primary Care Physician at the number listed in the Provider Directory. To better coordinate your emergency care, if you are inside the Service Area, you should go to a Plan facility if possible. 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.

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.

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	High Option
<ul style="list-style-type: none"> Urgent care at a Plan urgent care center 	\$45 per visit
<ul style="list-style-type: none"> Emergency care as an outpatient at an emergency facility, including physicians' services <p>Notes:</p> <ul style="list-style-type: none"> We waive your emergency room copayment if you are directly admitted to a hospital as an inpatient. 	\$150 per visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Elective care or non-emergency care</i> <i>Urgent care at a non-Plan urgent care center</i> 	<i>All charges</i>
Emergency outside our service area	High Option
<ul style="list-style-type: none"> Urgent care at an urgent care center 	\$45 per visit
<ul style="list-style-type: none"> Emergency care as an outpatient in a hospital, including physicians' services 	\$150 per visit
<p>Notes:</p> <ul style="list-style-type: none"> We waive your emergency room copayment if you are directly admitted to a hospital as an inpatient. Transfers to an observation bed or observation status do not qualify as an admission to a hospital and your emergency copayment will not be waived. See Section 5(h) for travel benefit coverage of continuing or follow-up care. 	
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Elective care or non-emergency care</i> <i>Follow-up care recommended by non-Plan providers that has not been approved by the Plan or provided by Plan providers</i> <i>Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area</i> <i>Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area</i> 	<i>All charges</i>

Benefit Description	You pay
Ambulance	High Option
Licensed ambulance when medically necessary Notes: <ul style="list-style-type: none"> • See Section 5(c) for non-emergency service. • Trip means anytime an ambulance is summoned on your behalf. 	20% of charges for services after deductible is met
<i>Not covered:</i> <ul style="list-style-type: none"> • <i>Trips we determine are not medically necessary</i> 	<i>All charges</i>

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

Important things you should 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.
- The calendar year deductible is: \$400 per person (\$800 per Self Plus One enrollment, or \$1,200 per Self and Family enrollment). The calendar year deductible applies to almost all benefits in this Section. We added“ (No deductible)” to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your cost for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare
- We cover the services only when we determine that the care is clinically appropriate to treat your condition, and only when you receive the care as part of a treatment plan developed by a mental health or substance abuse Plan provider.
- 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 in favor of another.

Benefit Description	You pay
Professional services	High Option
We cover professional services recommended by a mental health or substance abuse 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.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions
Diagnosis and treatment of mental illness. Services include: <ul style="list-style-type: none"> • Diagnostic evaluation • Treatment and counseling (including individual and group therapy visits) • Crisis intervention and stabilization for acute episodes • Psychological testing necessary to determine the appropriate psychiatric treatment 	\$20 per office visit for outpatient services 20% of charges for inpatient services after deductible is met
Diagnosis and treatment of alcoholism and drug abuse. Services include: <ul style="list-style-type: none"> • Detoxification (medical management of withdrawal from the substance) • Treatment and counseling (including individual and group therapy visits) Notes:	\$20 per office visit for outpatient services 20% of charges for inpatient services after deductible is met

Professional services - continued on next page

Benefit Description	You pay
Professional services (cont.)	High Option
<ul style="list-style-type: none"> You may see an outpatient mental health or substance abuse Plan provider for outpatient services without a referral from your primary care physician. See Section 3, <i>How you get care</i>, for information about services requiring our prior approval. Your mental health or substance abuse Plan provider will develop a treatment plan to assist you in improving or maintaining your condition and functional level, or to prevent relapse and will determine which diagnostic and treatment services are appropriate for you. 	<p>\$20 per office visit for outpatient services</p> <p>20% of charges for inpatient services after deductible is met</p>
Inpatient hospital or other covered facility	High Option
<ul style="list-style-type: none"> Inpatient psychiatric or substance abuse care <p>Note: All inpatient admissions require approval by a mental health or substance abuse Plan physician.</p>	<p>20% of charges for inpatient services after deductible is met</p>
Outpatient hospital or other covered facility	High Option
<ul style="list-style-type: none"> Hospital alternative services, such as partial hospitalization, day and night care, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment 	<p>20% of charges for inpatient services after deductible is met</p>

Section 5(f). Prescription drug benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart in this section.
- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and we cover them only when we determine they are medically necessary.
- Federal law prevents the pharmacy from accepting unused medications.
- Members must make sure their physicians obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically.
- We have no calendar year deductible for the prescription drug benefit.
- Be sure to read Section 4, *Your cost for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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

- **Who can write your prescription.** A licensed physician or dentist, and in states allowing it, licensed or certified Physician Assistant, Nurse Practitioner and Psychologist must prescribe your medication.
- **Where you can obtain them.** You must fill the prescription at a plan pharmacy, or by mail for a maintenance medication
- **We use a preferred drug list (formulary).** Faced with the challenge of bringing costs down as much as possible to our employers and members while giving our physicians the freedom to prescribe the most appropriate drugs, we have developed the Three-Tier Preferred Drug prescription benefit. Our Preferred Drug prescription benefit features the following copay structure:
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 800-462-3589 or 419-887-2525.
 - Generic drugs at the lowest copay
 - Preferred brand name drugs at a mid-level copay
 - Non-preferred brand name drugs at a higher brand copay
- **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". Prescription drugs obtained through the mail order program will be dispensed for up to a 90-day supply. Plan members called to active military duty (or members in time of national emergency) who need to obtain prescribed medications should call our Member Services Department at 800-462-3589.
- **A generic equivalent will be dispensed if it is available,** unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally-approved generic drug is available, and your physician has not specified Dispense as Written for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic.

- **Why use generic drugs?** Typically generic drugs cost you and us less money than a brand-name drug. Under federal law, generic and brand-name drugs must meet the same standards for safety, purity, strength, and effectiveness.
- **When do you have to file a claim?** You do not need to file a claim when you receive drugs from a Plan or affiliated pharmacy. You have to file a claim when you receive drugs from a non-Plan pharmacy for covered out-of-area emergency and out-of-area urgent care as specified in Section 5(d), *Emergency services/accidents*. For information about how to file a claim, see Section 7, *Filing a claim for covered services*.

Benefit Description	You pay
Covered medications and supplies	High Option
<p>We cover the following medications and supplies prescribed by a licensed health care professional and obtained from a Plan pharmacy or through our direct mail services:</p> <ul style="list-style-type: none"> • Drugs and medicines that, by federal law, require a prescription for their purchase, except those listed as <i>Not covered</i> • Certain over-the-counter medications prescribed by a provider and listed on the Plan’s formulary • Insulin • Diabetic supplies limited to: <ul style="list-style-type: none"> - Disposable needles and syringes for the administration of covered medications • Drugs for sexual dysfunction • Speciality pharmacy for up to 30 day supply • Oral chemotherapy 	<p>Retail pharmacy for up to a 30-day supply:</p> <p>\$10 copay per prescription unit or refill for generic drugs;</p> <p>\$30 copay per prescription unit or refill for preferred name brand drugs; and</p> <p>\$50 copay per prescription unit or refill for non-preferred name brand drugs.</p> <p>20% coinsurance per prescription for Speciality Drug Program.</p> <p>20% coinsurance per prescription up to a maximum of \$100 for Oral Chemotherapy Drugs. Not subject to deductible.</p> <p>Mail order for up to a 90-day supply:</p> <p>\$20 copay per prescription unit or refill for generic drugs;</p> <p>\$60 copay per prescription unit or refill for preferred name brand drugs; and</p> <p>\$150 copay per prescription unit or refill for non-preferred name brand drugs.</p> <p>Specialty Drugs are not covered under mail order.</p> <p>Note: If there is no generic equivalent available, you will still have to pay the brand name copay.</p>
<p>Women's contraceptive drugs and devices:</p> <ul style="list-style-type: none"> • Diaphragms and cervical caps • Intrauterine devices (IUDs) • Injectable contraceptive drugs • Implanted time-release contraceptive drugs • Oral contraceptive drugs • Prescribed FDA approved over-the-counter women's contraceptives and devices • Women's breast cancer preventative medications 	Nothing
<p>Over-the-counter and prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco cessation benefit.</p>	Nothing
<i>Not covered:</i>	<i>All charges</i>

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	High Option
<ul style="list-style-type: none"> • <i>Drugs and supplies for cosmetic purposes</i> • <i>Drugs to enhance athletic performance</i> • <i>Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies</i> • <i>Nonprescription medicines</i> 	<i>All charges</i>
Preventive Care	High Option
<p>Medications to promote better health as recommended by ACA.</p> <p>The following drugs and supplements are covered without cost-share, even if over-the-counter, are prescribed by a health care professional and filled at a network pharmacy.</p> <ul style="list-style-type: none"> • Aspirin (81 mg) for men age 45-79 and women age 55-79 and women of childbearing age • Folic acid supplements for women of childbearing age 400 & 800 mcg • Liquid iron supplements for children age 0-1year • Vitamin D supplements (prescription strength) (400 & 1000 units) for members 65 or older • Fluoride tablets, solution (not toothpaste, rinses) for children age 0-6 <p>Note: To receive this benefit a prescription from a doctor must be presented to pharmacy</p>	Nothing

Section 5(g). Dental benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and we pay them only when we determine they are medically necessary.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9, *Coordinating benefits with other coverage*.
- We cover hospitalization for dental procedures at Plan facilities only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c), *Hospital benefits*, for inpatient hospital benefits. We do not cover dental procedures except as described below.
- Be sure to read Section 4, *Your cost for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You Pay
Accidental injury benefit	High Option
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.	20% of charges for inpatient services after deductible is met
Dental benefits	High Option
We have no other dental benefits.	<i>All charges</i>

Section 5(h). Special features

Feature	Description
Feature	High Option
Ask Paramount 24-hour Nurse Line	You may call toll free 877-336-1616 24 hours a day, 7 days a week for any of your health concerns. You may talk with a registered nurse who can help assess medical symptoms and provide advice over the phone, when medically appropriate. For additional information, visit AskParamount@promedica.org .
MyParamount	<p>When you create a MyParamount.org account, you get:</p> <ul style="list-style-type: none"> • At-a-glance summaries of your benefits, deductible, out-of-pocket counters, claims and recent providers • Your digital ID card, which can be faxed and mailed • Quick access to Find a Provider and Preferred Drug Lists • A secure message center for contacting Paramount • Electronic explanation of benefits (EOBs) for faster claims information • Access Paramount Perks showcased throughout the year • Wellness reminders, recent health news and other helpful links • Mobile friendly functionality for easy navigation on your cell phone or tablet <p>And if you have any questions once you login, just start a Live Chat to get immediate assistance.</p>
Paramount Health Care Wellness Program	<p>Paramount's Wellness program is a robust, effective wellness program because as a member you will be able to complete a questionnaire, an easy and engaging online health risk assessment. It will allow you to tailor a wellness program to fit your lifestyle and health status, identify risk factors, set goals, track your progress, and will also allow you to share the results with your Primary Care Physician. For more information, please visit</p> <p>http://www.paramounthealthcare.com/PreventionandWellnessResources</p>
Personal Call Center Representative	As a member of this Plan, you can have your very own Personal Call Center Representative (PCCR). When you sign up for a PCCR, you will speak to the same person in Member Services every time you call. Members who have PCCRs enjoy the personalized experience of hearing a familiar voice every time they call. You can call 800-462-3589 to request a PCCR. As soon as you are registered, we will call you with all the necessary information on how to contact your PCCR.
Silver Sneakers (Medicare Part B enrollees only)	The Healthways SilverSneakers Fitness Program is the nation's leading wellness program, designed exclusively for Medicare beneficiaries. Eligible members receive a basic fitness membership with access to amenities and fitness classes, including the signature SilverSneakers classes designed to improve muscular strength and endurance, mobility, flexibility, range of motion, balance, agility, and coordination.
Steps2Care mobile app	The Steps2Care mobile app is a free app for your smartphone or tablet. Steps2Care offers advice and guidance on medical issues and parenting worries.

Section 6. General exclusions – services, drugs and supplies we do not cover

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. **Although we may list a specific service as a benefit, we will not cover it unless it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition. For information on obtaining prior approval for specific services, such as transplants, see Section 3, *You need prior Plan approval for certain services.***

We do not cover the following:

- Care by non-Plan providers, except for authorized referrals, emergencies, travel benefit, (see Emergency services/accidents)
- Services, drugs, or supplies you receive while you are not enrolled in this Plan
- Services, drugs, or supplies 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 (see specifics regarding transplants)
- 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 you receive from a provider or facility barred from the FEHB Program
- Services, drugs, or supplies you receive without charge while in active military service

Section 7. Filing a claim for covered services

This section primarily deals with post-service claims (claims for services, drugs, or supplies you have already received). See Section 3 for information on pre-service claims procedures (services, drugs, or supplies requiring prior Plan approval), including urgent care claims procedures. 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, coinsurance, or deductible.

You may need to file a claim when you receive emergency services from a non-Plan provider or at a non-Plan facility. Check with the provider to determine if they can bill us directly. Filing a claim does not guarantee payment.

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 CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 form. For claims questions and assistance, call us at 1-800-462-3589 (TTY :1-888-740-5670).

When you must file a claim – such as for services you received outside of the Plan’s service area – submit it on the CMS-1500 or an invoice or billing statement from the provider that includes the information shown below. Bills and receipts should be itemized and show:

- Covered member’s name, date of birth, address, phone number 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
- Follow up services rendered out-of-area
- A copy of the explanation of benefits, payments, or denial from any primary payor – such as the Medicare Summary Notice (MSN)
- Receipts, if you paid for your services

Note: Canceled checks, cash register receipts, or balance due statements are not acceptable substitutes for itemized bills.

Submit your claims to:

Paramount
Member Services
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.

Post-Service Claims

We will notify you of our decision within 30 days after we receive your post-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you before the expiration of the original 30-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

If you do not agree with our initial decision, you may ask us to review it by following the disputed claims process detailed in Section 8 of this brochure.

**Authorized
Representative**

You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, we will permit a health care professional with knowledge of your medical condition to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.

Notice Requirements

If you live in a county where at least 10 percent of the population is literate only in a non-English language (as determined by the Secretary of Health and Human Services), we will provide language assistance in that non-English language. You can request a copy of your Explanation of Benefits (EOB) statement, related correspondence, oral language services (such as telephone customer assistance), and help with filing claims and appeals (including external reviews) in the applicable non-English language. The English versions of your EOBs and related correspondence will include information in the non-English language about how to access language services in that non-English language.

Any notice of an adverse benefit determination or correspondence from us confirming an adverse benefit determination will include information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount, if applicable), and a statement describing the availability, upon request, of the diagnosis and procedure codes.

Section 8. The disputed claims process

You may appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7 and 8 of this brochure, please call us at 1-800-462-3589 (TTY: 1-888-740-5670) or visit www.paramounthealthcare.com.

Please follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your post-service claim (a claim where services, drugs or supplies have already been provided). In Section 3 *If you disagree with our pre-service claim decision*, we describe the process you need to follow if you have a claim for services, referrals, drugs or supplies that must have prior Plan approval, such as inpatient hospital admissions.

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please contact our Member Services department by writing Member Services, P.O. Box 928, Toledo, OH 43697-0928 or by calling 1-800-462-3589 (TTY: 1-888-740-5670).

When our initial decision is based (in whole or in part) on a medical judgment (i.e., medical necessity, experimental/investigational), we will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not involved in making the initial decision.

Our reconsideration will not take in account the initial decision. The review will not be conducted by the same person, or his/her subordinate, who make the initial decision.

We will not make our decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) based upon the likelihood that the individual will support the denial of benefits.

Step	Description
1	<p>Ask us in writing to reconsider our initial decision. You must:</p> <ul style="list-style-type: none">a) Write to us within 6 months from the date of our decision; andb) Send your request to us at: Paramount, Member Services, P.O. Box 928, Toledo, OH 43697-0928; andc) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; andd) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. <p>We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.</p>
2	<p>In the case of a post-service claim, we have 30 days from the date we receive your request to:</p> <ul style="list-style-type: none">a) Pay the claim orb) Write to you and maintain our denial orc) Ask you or your provider for more information. <p>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.</p>

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.

If you do not agree with our decision, you may ask OPM to review it.

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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: United States Office of Personnel Management, Healthcare and Insurance, Federal Employee Insurance Operations, Health Insurance 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;
- Your daytime phone number and the best time to call; and
- Your email address, if you would like to receive OPM's decision via email. Please note that by providing your email address, you may receive OPM's decision more quickly.

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. However, for urgent care claims, a health care professional with knowledge of your medical condition may act as your authorized representative without your express consent.

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

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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.

If you do not agree with OPM's decision, your only recourse is to sue. If you decide to file a lawsuit, 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 file a lawsuit 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 you did not indicate that your claim was a claim for urgent care, then call us at 1-800-462-3589 (TTY: 1-888-740-5670). We will expedite our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's Health Insurance 3 at (202) 606-0755 between 8 a.m. and 5 p.m. Eastern Time.

Please remember that we do not make decisions about plan eligibility issues. For example, we do not determine whether you or a dependent is covered under this Plan. You must raise eligibility issues with your Agency personnel/payroll office if you are an employee, your retirement system if you are an annuitant or the Office of Workers' Compensation Programs if you are receiving Workers' Compensation benefits.

Section 9. Coordinating benefits with Medicare and other coverage

When you have other health coverage

You must tell us if you or a covered family member has coverage under any other health plan or has 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 payor and the other plan pays a reduced benefit as the secondary payor. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners’ (NAIC) guidelines. For more information on NAIC rules regarding the coordinating of benefits, visit our website at: www.paramounthealthcare.com/NAIC

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

When we are the secondary payor, 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. If we are the secondary payor, and you received your services from Plan providers, we may bill the primary carrier.

• 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 TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs.

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 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 TRICARE or CHAMPVA.

• Workers’ Compensation

We do not cover services that:

- You (or a covered family member) need because of a workplace-related illness or injury that the Office of Workers’ Compensation Programs (OWCP) or a similar Federal or State agency determines 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.

• 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 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 re-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

Our right to pursue and receive subrogation and reimbursement recoveries is a condition of, and a limitation on, the nature of benefits or benefit payments and on the provision of benefits under our coverage.

If you have received benefits or benefit payments as a result of an injury or illness and you or your representatives, heirs, administrators, successors, or assignees receive payment from any party that may be liable, a third party's insurance policies, your own insurance policies, or a workers' compensation program or policy, you must reimburse us out of that payment. Our right of reimbursement extends to any payment received by settlement, judgment, or otherwise.

We are entitled to reimbursement to the extent of the benefits we have paid or provided in connection with your injury or illness. However, we will cover the cost of treatment that exceeds the amount of the payment you received.

Reimbursement to us out of the payment shall take first priority (before any of the rights of any other parties are honored) and is not impacted by how the judgment, settlement, or other recovery is characterized, designated, or apportioned. Our right of reimbursement is not subject to reduction based on attorney fees or costs under the "common fund" doctrine and is fully enforceable regardless of whether you are "made whole" or fully compensated for the full amount of damages claimed.

We may, at our option, choose to exercise our right of subrogation and pursue a recovery from any liable party as successor to your rights.

If you do pursue a claim or case related to your injury or illness, you must promptly notify us and cooperate with our reimbursement or subrogation efforts.

When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP) coverage

Some FEHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com or by phone 1-877-888-3337 (TTY 1-877-889-5680), you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

Clinical trials

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application.

We will cover routine care costs not provided by the clinical trial in accordance with Section 5 when Plan physicians provide or arrange for your care.

- Routine care costs are costs for routine services, such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition whether the patient is in a clinical trial or is receiving standard therapy. We cover routine care costs not provided by the clinical trial.

The Plan does not cover extra care costs and research costs.

- Extra care costs are costs related to taking part in a clinical trial, such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care. We do not cover these costs.
- Research costs are costs related to conducting the clinical trial, such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This plan does not cover these costs.

When you have Medicare

What is Medicare?

Medicare is a health insurance program for:

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

Medicare has four 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. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983). Otherwise, if you are age 65 or older, or under age 65 and disabled, you may be able to buy it. Contact **1-800-MEDICARE (1-800-633-4227) (TTY:1-877-486-2048)**, 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.
- Part C (Medicare Advantage). You may enroll in a Medicare Advantage plan to get your Medicare benefits. In 2016 Federal Members will have the opportunity to enroll in our Paramount Elite Medicare Advantage Plan. Please review the information about Medicare managed care plans on the next page.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. However, when you are enrolled in Paramount Elite for Federal members, Part D is included in your Plan; no separate premium applies. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. For more information about this extra help, visit the Social Security Administration online at www.socialsecurity.gov, or call them at **1-800-772-1213 (TTY: 1-800-325-0778)**.

• Should I enroll in Medicare?

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 months before you turn age 65. It's easy. Just call the Social Security Administration toll-free number **1-800-772-1213 (TTY 1-800-325-0778)** to set up an appointment to apply. If you do not apply for one or more Parts of Medicare, you can still be covered under the FEHB Program.

If you can get premium-free Part A coverage, we advise you to enroll in it. Most Federal employees and annuitants are entitled to Medicare Part A at age 65 **without cost**. When you don't have to pay premiums for Medicare Part A, it makes good sense to obtain the coverage. It can reduce your out-of-pocket expenses as well as costs to the FEHB, which can help keep FEHB premiums down.

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage. If you didn't take Part B at age 65 because you were covered under FEHB as an active employee (or you were covered under your spouse's group health insurance plan and he/she was an active employee), you may sign up for Part B (generally without an increased premium) within 8 months from the time you or your spouse stop working or are no longer covered by the group plan. You also can sign up at any time while you are covered by the group plan.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare Advantage or Medicare managed care plan are the terms used to describe the various private health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on whether you are in the Original Medicare Plan or a private Medicare Advantage Plan or another Medicare managed care plan.

• **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.

All physicians and other providers are required by law to file claims directly to Medicare for members with Medicare Part B, when Medicare is primary. This is true whether or not they accept Medicare.

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.

Claims process when you have the Original Medicare Plan – You will probably not need to file a claim form when you have both our Plan and the Original Medicare Plan.

When we are the primary payor, we process the claim first.

When Original Medicare is the primary payor, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. To find out if you need to do something to file your claim, call us at 1-800-462-3589 (TTY:1-888-740-5670) or visit our website.

We do not waive any costs if the Original Medicare Plan is your primary payor.

Please review the following table it illustrates your cost share if you are enrolled in Medicare Part B. Medicare will be primary for all Medicare eligible services. Members must use providers who accept Medicare’s assignment.

Benefit Description	Member Cost Without Medicare	Member Cost with Medicare Part B
Deductible	\$400 Self Only \$800 Self Plus One \$1,200 Self Plus Family	\$400 Self Only \$800 Self Plus One \$1,200 Self Plus Family
Out of Pocket Maximum	\$4,400 Self Only \$8,800 Self Plus One \$13,200 Self Plus Family	\$4,400 Self Only \$8,800 Self Plus One \$13,200 Self Plus Family
Primary Care Physician	\$20	\$20
Specialist	\$30	\$30
Inpatient Hospital	20% coinsurance	20% coinsurance
Outpatient Hospital	20% coinsurance	20% coinsurance
RX	Generic \$10 Preferred Brand \$30 Non-Preferred Brand \$50	Generic \$10 Preferred Brand \$30 Non-Preferred Brand \$50
RX – Mail Order (90 day supply)	Generic \$20 Preferred Brand \$60 Non-Preferred Brand \$150	Generic \$20 Preferred Brand \$60 Non-Preferred Brand \$150

- **Tell us about your Medicare coverage**

You must tell us if you or a covered family member has Medicare coverage, and let us obtain information about services denied or paid under Medicare if we ask. You must also tell us about other coverage you or your covered family members may have, as this coverage may affect the primary/secondary status of this Plan and Medicare.

- **Medicare Advantage (Part C)**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage or a Medicare Managed Care plan. These are private health care choices (like HMOs and regional PPOs) in some areas of the country.

To learn more about Medicare Advantage plans, contact Medicare at **1-800-MEDICARE (1-800-633-4227) (TTY: 1-877-486-2048)** or at www.medicare.gov.

If you enroll in a Medicare Advantage plan, the following options are available to you:

This Plan and our Medicare Advantage plan: We offer a Medicare Advantage plan known as Paramount Elite. We will still provide benefits when Paramount Elite is primary, even out of the Medicare Advantage plan's network and/or service area (if you use our Plan providers), however we will not waive any of our copayments, coinsurance, or deductibles. Enrolling with Paramount Elite gives you access to Silver Sneakers gym membership free of charge.

This Plan and another plan's Medicare Advantage plan: You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area (if you use our Plan providers), however we will not waive any of our copayments, coinsurance, or deductibles. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

Suspended FEHB coverage to enroll in a Medicare Advantage plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage 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 Advantage plan's service area.

- **Medicare prescription drug coverage (Part D)**

When we are the primary payor, we process the claim first. If you enroll in another plan's Medicare Part D plan and we are the secondary payor, when you fill your prescription at a Plan pharmacy that is not owned and operated by HealthSpan Integrated Care we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan. Our HealthSpan Integrated Care owned and operated pharmacies will not consider another plan's Medicare Part D benefits. These HealthSpan Integrated Care pharmacies will only provide your FEHB HealthSpan Integrated Care benefits.

You will still need to follow the rules in this brochure for us to cover your care. We will only cover your prescription if it is written by a Plan provider and obtained at a Plan pharmacy or through our Plan mail service delivery program, except in an emergency or urgent care situation.

If you enroll in our HealthSpan Integrated Care Medicare Plus for Federal Members Plan, you will get all of the benefits of Medicare Part D plus additional drug benefits covered under your FEHB plan.

Medicare always makes the final determination as to whether they are the primary payor. The following chart illustrates whether Medicare or this Plan should be the primary payor for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

Primary Payor Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	The primary payor for the individual with Medicare is...	
	Medicare	This Plan
1) Have FEHB coverage on your own as an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have FEHB through your spouse who is an active employee		✓
4) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #3 above	✓	
5) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and...		
• You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
6) 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) and you are not covered under FEHB through your spouse under #3 above	✓	
7) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
8) Are a Federal employee receiving Workers' Compensation disability benefits for six months or more	✓ *	
B. When you or a covered family member...		
1) Have Medicare solely based on end stage renal disease (ESRD) and...		
• It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD (30-month coordination period)		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and...		
• This Plan was the primary payor before eligibility due to ESRD (for 30 month coordination period)		✓
• Medicare was the primary payor before eligibility due to ESRD	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD (for the 30 month coordination period)		✓
• Medicare based on ESRD (after the 30 month coordination period)	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse		
	✓	

*Workers' Compensation is primary for claims related to your condition under Workers' Compensation.

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.
Clinical trials cost categories	<p>An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application.</p> <ul style="list-style-type: none">• Routine care costs – costs for routine services, such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient’s condition whether the patient is in a clinical trial or is receiving standard therapy.• Extra care costs – costs related to taking part in a clinical trial, such as additional tests that a patient may need as part of the trial, but not as part of the patient’s routine care.• Research costs – costs related to conducting the clinical trial, such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This plan does not cover these costs.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. See Section 4.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See Section 4.
Cost-sharing	Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.
Covered services	Care we provide benefits for, as described in this brochure.
Custodial care	(1) Assistance with activities of daily living, for example, walking, getting in and out of bed, dressing, feeding, toileting, and taking medicine. (2) Care that can be performed safely and effectively by people who, in order to provide the care, do not require medical licenses or certificates, or the presence of a supervising licensed nurse. Custodial care that last 90 days or more is sometimes known as long term care.
Deductible	A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See Section 4.
Experimental or investigational services	<p>We do not cover a service, supply, item, or drug that we consider experimental. We consider a service, supply, item, or drug to be experimental when the service, supply, item or drug:</p> <ol style="list-style-type: none">(1) has not been approved by the FDA; or(2) is the subject of a new drug or new device application on file with the FDA; or(3) is part of a Phase I or Phase II clinical trial, as the experimental or research arm of a Phase III clinical trial; or is intended to evaluate the safety, toxicity, or efficacy of the service; or(4) is available as the result of a written protocol that evaluates the service’s safety, toxicity, or efficacy; or(5) is subject to the approval or review of an Institutional Review Board; or

(6) requires an informed consent that describes the service as experimental or investigational.

We carefully evaluate whether a particular therapy is safe and effective or offers a reasonable degree of promise with respect to improving health outcomes. The primary source of evidence about health outcomes of any intervention is peer-reviewed medical or dental literature.

Group health coverage	Health care benefits that are available as a result of your employment, or the employment of your spouse, and that are offered by an employer or through membership in an employee organization. Health care coverage may be insured or indemnity coverage, self-insured or self-funded coverage, or coverage through health maintenance organizations or other managed care plans. Health care coverage purchased through membership in an organization is also “group health coverage.”
Health care professional	A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.
Medically necessary	All benefits need to be medically necessary in order for them to be covered benefits. Generally, if your Plan physician provides the service in accord with the terms of this brochure, it will be considered medically necessary. However, some services are reviewed in advance of you receiving them to determine if they are medically necessary. When we review a service to determine if it is medically necessary, a Plan physician will evaluate what would happen to you if you do not receive the service. If not receiving the service would adversely affect your health, it will be considered medically necessary. The services must be a medically appropriate course of treatment for your condition. If they are not medically necessary, we will not cover the services. In case of emergency services, the services that you received will be evaluated to determine if they were medically necessary.
Never event	Certain Hospital Acquired Conditions, as defined by Medicare, including things like wrong-site surgeries, transfusion with the wrong blood type, pressure ulcers (bedsores), falls or trauma, and nosocomial infections (hospital-acquired infections) associated with surgeries or catheters, that are directly related to the provision of an inpatient covered service at a Plan provider.
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 based on contracted rates with participating providers. Plan providers accept the plan allowance as payment in full.
Participating Providers	Is a physician, hospital or other health professional or facility that has a contract with Paramount to provide Covered Services to Members.
Post-service claims	Any claims that are not pre-service claims. In other words, post-service claims are those claims where treatment has been performed and the claims have been sent to us in order to apply for benefits.
Pre-service claims	Those claims (1) that require precertification, prior approval, or a referral and (2) where failure to obtain precertification, prior approval, or a referral results in a reduction of benefits.
Reimbursement	A carrier's pursuit of a recovery if a covered individual has suffered an illness or injury and has received, in connection with that illness or injury, a payment from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, and the terms of the carrier's health benefits plan require the covered individual, as a result of such payment, to reimburse the carrier out of the payment to the extent of the benefits initially paid or provided. The right of reimbursement is cumulative with and not exclusive of the right of subrogation.

Subrogation A carrier's pursuit of a recovery from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, as successor to the rights of a covered individual who suffered an illness or injury and has obtained benefits from that carrier's health benefits plan.

Urgent care claims A claim for medical care or treatment is an urgent care claim if waiting for the regular time limit for non-urgent care claims could have one of the following impacts:

- Waiting could seriously jeopardize your life or health;
- Waiting could seriously jeopardize your ability to regain maximum function; or
- In the opinion of a physician with knowledge of your medical condition, waiting would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent care claims involve Pre-service claims and not Post-service claims. We will judge whether a claim is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you believe your claim qualifies as an urgent care claim, please contact Member Services at 1-800-462-3589 (TTY 1-888-740-5670). You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.

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

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

Section 11. Other Federal Programs

Please note, the following programs are not part of your FEHB benefits. They are separate Federal programs that complement your FEHB benefits and can potentially reduce your annual out-of-pocket expenses. These programs are offered independent of the FEHB Program and require you to enroll separately with no government contribution.

Important Information about three Federal programs that compliment the FEHB Program

First, the **Federal Flexible Spending Account Program**, also known as **FSAFEDS**, lets you set aside pre-tax money from your salary to reimburse you for eligible dependent care and/or health care expenses. You pay less in taxes so you save money. Participating employees save an average of about 30% on products and services they routinely pay for out-of-pocket.

Second, the **Federal Employees Dental and Vision Insurance Program (FEDVIP)**, provides comprehensive dental and vision insurance at competitive group rates. There are several plans from which to choose. Under FEDVIP you may choose self only, self plus one, or self and family coverage for yourself and any eligible dependents.

Third, the **Federal Long Term Care Insurance Program (FLTCIP)** can help cover long term care costs, which are not covered under the FEHB Program.

The Federal Flexible Spending Account Program – FSAFEDS

What is an FSA?

It is an account where you contribute money from your salary **BEFORE** taxes are withheld, then incur eligible expenses and get reimbursed. You pay less in taxes so you save money. **Annuitants are not eligible to enroll.**

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of \$100. The maximum annual election for a health care flexible spending account (HCFSA) or a limited expense health care spending account (LEX HCFSA) is \$2,550 per person. The maximum annual election for a dependent care flexible spending account (DCFSA) is \$5,000 per household.

- **Health Care FSA (HCFSA)** - Reimburses you for eligible out-of-pocket health care expenses (such as copayments, deductibles, prescriptions, **physician prescribed** over-the-counter drugs and medications, vision and dental expenses, and much more) for you and your tax dependents, including adult children. (through the end of the calendar year in which they turn 26)
- FSAFEDS offers paperless reimbursement for your HCFSA through a number of FEHB and FEDVIP plans. This means that when you or your provider files claims with your FEHB or FEDVIP plan, FSAFEDS will automatically reimburse your eligible out-of-pocket expenses based on the claim information it receives from your plan. (Note: This Plan does not currently participate in FSAFEDS paperless reimbursement. You must submit a manual claim to FSAFEDS with supporting documentation for reimbursement.)
- **Limited Expense Health Care FSA (LEX HCFSA)** - Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to dental and vision care expenses for you and your tax dependents including adult children (through the end of the calendar year in which they turn 26) which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.
- **Dependent Care FSA (DCFSA)** - Reimburses you for eligible **non-medical** day care expenses for your children under age 13 and/or for any person you claim as a dependent on your Federal Income Tax return who is mentally or physically incapable of self-care. You (and your spouse, if married) must be working, looking for work (income must be earned during the year), or attending school full-time to be eligible for a DCFSA.

- If you are a new or newly eligible employee you have 60 days from your hire date to enroll in an HCFSAs or LEX HCFSAs and/or DCFSA, but you must enroll before October 1. If you are hired or become eligible on or after October 1 you must wait and enroll during the Federal Benefits Open Season held each fall.

Where can I get more information about FSAFEDS?

Visit www.FSAFEDS.com or call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS, (877-372-3337), Monday through Friday, 9 a.m. until 9 p.m., Eastern Time. TTY: 866-353-8058

The Federal Employees Dental and Vision Insurance Program – *FEDVIP*

Important Information

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is separate and different from the FEHB Program. **This Program provides comprehensive dental and vision insurance at competitive group rates with no pre-existing condition limitations for enrollment.**

FEDVIP is available to eligible Federal and Postal Service employees, retirees, and their eligible family members on an enrollee-pay-all basis. Employee premiums are withheld from salary on a pre-tax basis.

Dental Insurance

All dental plans provide a comprehensive range of services, including:

- Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants, and x-rays.
- Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.
- Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges, and prosthodontic services such as complete dentures.
- Class D (Orthodontic) services with up to a 12-month waiting period. **Most FEDVIP dental plans adult orthodontia. Review your FEDVIP dental plan's brochure for information on this benefit.**

Vision Insurance

All vision plans provide comprehensive eye examinations and coverage for your choice of either lenses and frames or for contact lenses. Other benefits such as discounts on LASIK surgery may also be available.

Additional Information

You can find a comparison of the plans available and their premiums on the OPM website at www.opm.gov/dental and www.opm.gov/vision. These sites also provide links to each plan's website, where you can view detailed information about benefits and preferred providers.

How do I enroll?

You enroll on the Internet at www.BENEFEDS.com. For those without access to a computer, call 1-877-888-3337 (TTY: 1-877-889-5680).

The Federal Long Term Care Insurance Program – *FLTCIP*

It's important protection

The Federal Long Term Care Insurance Program (FLTCIP) can help pay for the potentially high cost of long term care services, which are not covered by FEHB plans. Long term care is help you receive to perform activities of daily living – such as bathing or dressing yourself - or supervision you receive because of a severe cognitive impairment such as Alzheimer's disease. For example, long term care can be received in your home from a home health aide, in a nursing home, in an assisted living facility, or in adult day care. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Federal and U.S. Postal Service employees and annuitants, active and retired members of the uniformed services, and qualified relatives are eligible to apply. Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. You must apply to know if you will be approved for enrollment. For more information, call 1-800-LTC-FEDS (1-800-582-3337) (TTY: 1-800-843-3557), or visit www.ltcfeds.com.

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

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Summary of benefits for Paramount Health Care High Option - 2017

- **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.
- Below, an asterisk (*) means the item is subject to the calendar year deductible.

High Option Benefits	You pay	Page
Medical services provided by physicians and other health care professionals:		
<ul style="list-style-type: none"> • Diagnostic and treatment services provided in the office 	Office visit copay: \$20 primary care; \$30 specialist	25
Services provided by a hospital:		
<ul style="list-style-type: none"> • Inpatient 	20% coinsurance per admission*	43
<ul style="list-style-type: none"> • Outpatient 	20% coinsurance per outpatient surgery*	44
Emergency benefits:		
<ul style="list-style-type: none"> • In-area 	\$150 per visit	47
<ul style="list-style-type: none"> • Out-of-area 	\$150 per visit	47
Mental health and substance abuse treatment:	Regular cost-sharing	49
Prescription drugs:	<u>Retail Pharmacy:</u> \$10 - Generic \$30 - Preferred Brand \$50 - Non-Preferred Brand 20% - Specialty Drugs <u>Mail Order Pharmacy:</u> \$20 - Generic \$60 - Preferred Brand \$150 - Non-Preferred Brand Not Covered - Specialty Drugs	52
Dental care:	No benefit.	54
Vision care:	Refractions; \$30 per office visit	32
Special features:	Ask Paramount, MyParamount, Paramount Wellness, Personal Call Center Representative, Silver Sneakers (Medicare Part B enrollees), Steps2Care	55
Protection against catastrophic costs (out-of-pocket maximum):	Nothing after \$4,400/Self Only, \$8,800/Two party or \$13,200/Family enrollment per year. Some costs do not count toward this protection.	20

Notes

To compare your FEHB health plan options please go to www.opm.gov/fehcompare.

For 2017 health premium information, please see: <https://www.opm.gov/healthcare-insurance/tribal-employers/benefits-premiums/> or contact your tribe's Human Resources department.