

Paramount Health Care

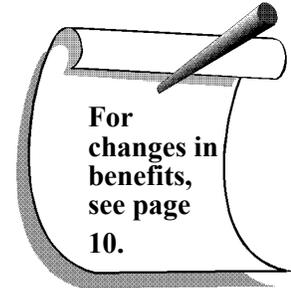
<http://www.paramounthealthcare.com>

2009

A Health Maintenance Organization and a High Deductible Health Plan

Serving: Northwest Ohio

Enrollment in this plan is limited. You must live or work in our Geographic service area to enroll. See page 9 for requirements.



Enrollment code for this plan:

U21 High Option - Self Only

U22 High Option - Self and Family

U24 High Deductible Health Plan (HDHP) – Self Only

U25 High Deductible Health Plan (HDHP) – Self and Family

Authorized for distribution by the:



**United States
Office of Personnel Management**

Center for
Retirement and Insurance Services
<http://www.opm.gov/insure>



RI 73-609

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

OPM has determined that the Paramount Health Care prescription drug coverage is, on average, comparable to Medicare Part D prescription drug coverage; thus you do not need to enroll in Medicare Part D and pay extra for prescription drug benefits. 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 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, you will have to pay a higher Part D premium if you go without equivalent prescription drug coverage for a period of 63 days or longer. If you enroll in Medicare Part D at a later date, your premium will increase 1 percent per month for each month you did not have equivalent prescription drug 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 most other people pay. You may also have to wait until the next open enrollment period to enroll 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 users should call 1-877-486-2048.

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Introduction

This brochure describes the benefits of Paramount Health Care under our contract (CS 2672) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. The address for Paramount Health Care administrative offices is:

Paramount Health Care
1901 Indian Wood Circle
Maumee, OH 43537

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

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2009, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2009, and changes are summarized on page 10. Rates are shown at the end of this brochure.

Plain Language

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

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

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM’s “Rate Us” feedback area at www.opm.gov/insure or e-mail OPM at fehwebcomments@opm.gov. You may also write to OPM at the U.S. Office of Personnel Management, Insurance Services Programs, Program Planning & Evaluation Group, 1900 E Street, NW, Washington, DC20415-3650.

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 to 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 (EOBs) forms that you receive from us.

- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

Call the provider and ask for an explanation. There may be an error.

If the provider does not resolve the matter, call us at 419-887-2525 and explain the situation.

If we do not resolve the issue:

CALL - THE HEALTH CARE FRAUD HOTLINE

202-418-3300

OR WRITE TO:

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); or

Your child over age 22 (unless he/she is disabled and incapable of self support).

- 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.
- You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.

Preventing medical mistakes

An influential report from the Institute of Medicine estimates that up to 98,000 Americans die every year from medical mistakes in hospitals alone. That's about 3,230 preventable deaths in the FEHB Program a year. 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. By asking questions, learning more and understanding your risks, you can improve the safety of your own health care, and that of your family members. 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 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 that you take, including non-prescription (over-the-counter) medicines.
- Tell them about any drug allergies you have.

- 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 your pharmacist about the medication 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.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures.
- Don't assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
- Call your doctor and ask for your results.
- Ask what the results mean for your care.

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

- Ask your doctor about which hospital has the best care and results for your condition if you have more than one hospital 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.

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 you are taking.

Visit these Web sites for more information about patient safety.

- www.ahrq.gov/path/beactive.htm. 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.

- www.quic.gov/report. Find out what federal agencies are doing to identify threats to patient safety and help prevent mistakes in the nation's health care delivery system.

Section 1. Facts about this HMO Plan

This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. The Plan is solely responsible for the selection of these providers in your area. Contact the Plan for a copy of their most recent provider directory. We give you a choice of enrollment in a High Option, or a High Deductible Health Plan (HDHP).

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 claim forms or pay bills. You pay only the copayments, coinsurance, and deductibles described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

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

How we pay providers

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

General features of our High Deductible Health Plan (HDHP)

HDHPs have higher annual deductibles and annual out-of-pocket maximum limits than other types of FEHB plans. FEHB Program HDHPs also offer health savings accounts or health reimbursement arrangements. Please see below for more information about these savings features.

Preventive care services

Preventive care services are generally paid as first dollar coverage or after a small deductible or copayment. First dollar coverage may be limited to a maximum dollar amount each year.

Annual deductible

The annual deductible must be met before Plan benefits are paid for care other than preventive care services.

Health Savings Account (HSA)

You are eligible for an HSA if you are enrolled in an HDHP, not covered by any other health plan that is not an HDHP (including a spouse's health plan, but does not include specific injury insurance and accident, disability, dental care, vision care, or long-term coverage), not enrolled in Medicare, not received VA benefits within the last three months, not covered by your own or your spouse's flexible spending account (FSA), and are not claimed as a dependent on someone else's tax return.

- You may use the money in your HSA to pay all or a portion of the annual deductible, copayments, coinsurance, or other out-of-pocket costs that meet the IRS definition of a qualified medical expense.
- Distributions from your HSA are tax-free for qualified medical expenses for you, your spouse, and your dependents, even if they are not covered by a HDHP.
- You may withdraw money from your HSA for items other than qualified medical expenses, but it will be subject to income tax and, if you are under 65 years old, an additional 10% penalty tax on the amount withdrawn.
- For each month that you are enrolled in an HDHP and eligible for an HSA, the HDHP will pass through (contribute) a portion of the health plan premium to your HSA. In addition, you (the account holder) may contribute your own money to your HSA up to an allowable amount determined by IRS rules. Your HSA dollars earn tax-free interest.

· You may allow the contributions in your HSA to grow over time, like a savings account. The HSA is portable – you may take the HSA with you if you leave the Federal government or switch to another plan.

Health Reimbursement Arrangement (HRA)

If you are not eligible for an HSA, or become ineligible to continue an HSA, you are eligible for a Health Reimbursement Arrangement (HRA). Although an HRA is similar to an HSA, there are major differences.

- An HRA does not earn interest.
- An HRA is not portable if you leave the Federal government or switch to another plan.

Catastrophic protection

We protect you against catastrophic out-of-pocket expenses for covered services. Your annual out-of-pocket expenses for covered services, including deductibles and copayments, cannot exceed \$1,500 for Self Only enrollment, or \$3,000 family coverage.

Your rights

OPM requires that all FEHB Plans provide certain information to their FEHB members. You may get information about us, our networks, and our providers, and facilities. OPM's FEHB Web site (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.

- This Plan has excellent accreditation from The National Committee for Quality Assurance (NCQA)
- This Plan is a for profit organization
- This Plan has been in existence for 20 years

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

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.

Service Area

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

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

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

Delaware County: 43003, 43015, 43066

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

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

If you or a covered family member moves 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 moves, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

Section 2. How We Change for 2009

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

Changes to this Plan

- Your share of the non-Postal premium will increase for Self Only and increase for Self and Family. See page 95.
- This plan now offers an HDHP option.

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 us at (419) 887-2525 or 800-462-3589 or write to us at P.O. Box 928, Toledo, OH 43697-0928. You may also request replacement cards through our Web site: www.paramounthealthcare.com
- 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 periodically. The list is also on our website.
- **Plan facilities** Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in our provider directory, which we update periodically. This list is also on our website.
- What you must do to get covered care** It depends on the type of care you need. First, you and each family member must choose a primary care physician. This decision is important since your primary care physician provides or arranges for most of your health care.
- **Primary Care** Your primary care physician can be a family practitioner, internist or pediatrician. Your primary care physician will provide most of your health care, or give you a referral to see a specialist.
- If you want to change primary care physicians or if your primary care physician leaves the Plan, call us. We will help you select a new one.
- **Specialty care** Your primary care physician will refer you to a specialist for needed care. However, you do not need a referral for the following: a visit to an OB/GYN, Ophthalmologist, Retinologist, Dermatologist, Allergist, Pediatric Pulmonologist, Hematologist, Oncologist, have a routine eye exam, are treated for medical emergencies, or go to another doctor when a primary care physician has designated another physician to see his or her patients. Referral to a participating specialist is given at the primary care physician's discretion; if non-Plan specialists or consultants are required, the primary care physician will arrange appropriate referrals. When you receive a referral from your primary care physician, you must return to the primary care physician after the consultation unless your physician authorizes additional visits. All follow-up care must be provided or authorized by the primary care physician. Do not go to the specialist for a second visit unless your primary care physician has arranged for, and the Plan has issued an authorization for, the referral in advance.
- Here are some other things you should know about specialty care:

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician will develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your primary care physician will use our criteria when creating your treatment plan. Your PCP will consult with your specialist regarding a plan of treatment. The specialist will send regular consultation reports to keep your PCP advised of your progress. The PCP may authorize the referral for up to a twelve (12) month period. Once this has been approved, you will receive a “Referral Confirmation.” If further services are required beyond the twelve (12) month period, you, your PCP and the specialist should agree to a new treatment plan.
- If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. Your primary care physician will decide what treatment you need. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.
- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.
- If you have a chronic or disabling condition and lose access to your specialist because we:
 - Terminate our contract with your specialist for other than cause; or
 - Drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB Plan; or
 - Reduce our service area and you enroll in another FEHB Plan,

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

If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist until the end of your postpartum care, even if it is beyond the 90 days.

• **Hospital care**

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

• **If you are 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 our Member Service Department immediately at 419-887-2525 or 800-462-3589. If you are new to the FEHB Program, we will arrange for you to receive care 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; or
- 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.

- **Circumstances beyond our control** Under certain extraordinary circumstances, such as natural disasters, we may have to delay your services or we may be unable to provide them. In that case, we will make all reasonable efforts to provide you with the necessary care.
- **Service requiring our prior approval** Your primary care physician has authority to refer you for most services. For certain services, however, your physician must obtain approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice.

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

- Growth Hormone Treatment (GHT)
- Medical and surgical treatment of morbid obesity
- Transplant procedures
- Sleep studies
- Nuclear Radiology

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

Section 4. Your costs for covered services

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

Copayments

A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive certain services.

Example: When you see your primary care physician you pay a copayment of \$15 per office visit, when you see a specialist you pay a copayment of \$25 per office visit. If you go in the hospital, you pay \$500 per admission.

Coinsurance

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

Example: In our Plan, you pay 20% of charges for nicotine patches or other smoking deterrents, as well as for charges for durable medical equipment and orthopedic and prosthetic devices, and 30% of charges for diagnosis and treatment of infertility.

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.

Your catastrophic protection out-of-pocket maximum

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

- Prescription drugs
- Durable Medical Equipment
- Orthopedic and prosthetic devices
- Infertility services
- Vision Care Services

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

When Government Facilities Bill Us

Facilities of the Department of Government Affairs, the Department of Defense and the Indian Health Services are entitled to seek reimbursement for certain services and supplies they provide to you or a family member. They may not seek more than the governing laws allow.

Section 5. Benefits

(See page 10 for our benefits change this year and pages 92-94 for benefit summary.)

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 claim forms, claims filing advice, or more information about our benefits, contact us at 419-887-2525 or our Web site at www.paramounthealthcare.com.

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

Here are some 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.

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.

Benefit Description	High Option
Diagnostic and treatment services	High Option
Professional services of physicians <ul style="list-style-type: none"> • In physician's office 	\$15 per visit to your primary care physician \$25 per visit to a specialist
Professional services of physicians <ul style="list-style-type: none"> • In an urgent care center • During a hospital stay • In a skilled nursing facility • Office medical consultation • Second surgical opinion 	Nothing
At home	\$15 per visit by your primary care physician \$25 per visit by a specialist
Lab, X-ray and other diagnostic tests	High Option
Tests, such as: <ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine Mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG 	Nothing if you receive these services during your office visit; otherwise, \$15 per visit at your primary care physician; \$25 per visit at a specialist

Benefit Description	
Preventive care, adult	High Option
Routine screenings, such as: <ul style="list-style-type: none"> • Total Blood Cholesterol • Colorectal Cancer Screening, including <ul style="list-style-type: none"> - Fecal occult blood test - Sigmoidoscopy, screening – every five years starting at age 50 - - Double contrast barium enema – every five years starting at age 50 - Colonoscopy screening – every ten years starting at age 50 	\$15 per visit at your primary care physician \$25 per visit at a specialist
Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older	\$15 per visit at your primary care physician \$25 per visit at a specialist
Routine Pap Test Note: The office visit is covered if pap test is received on the same day; see <i>Diagnosis and Treatment</i> above	\$15 per visit at your primary care physician \$25 per visit at a specialist
Routine mammogram – covered for women age 35 and older, as follows: <ul style="list-style-type: none"> • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years 	\$15 per visit at your primary care physician \$25 per visit at a specialist
Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC)	\$15 per visit
<i>Not covered: Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, or travel.</i>	<i>All charges</i>
Preventive care, children	High Option
<ul style="list-style-type: none"> • Childhood immunizations recommended by the American Academy of Pediatrics 	\$15 per office visit
<ul style="list-style-type: none"> • Examinations done on the day of immunizations (up to age 22) <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 - Ear exams through age 17 to determine the need for hearing correction 	\$15 per visit at your primary care physician \$25 per visit at a specialist
Maternity care	High Option
Complete maternity (obstetrical) care, such as: <ul style="list-style-type: none"> • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: <ul style="list-style-type: none"> • You do not need to precertify your normal delivery; see page 27 for other circumstances, such as extended stays for you or your baby. 	Nothing \$500 per admission

Maternity care - continued on next page

Benefit Description	
Maternity care (cont.)	High Option
<ul style="list-style-type: none"> • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • 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 and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision. <p>We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b).</p>	<p>Nothing</p> <p>\$500 per admission</p>
<i>Not covered: Routine sonograms to determine fetal age, size or sex.</i>	<i>All charges</i>
Family planning	High Option
<p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> • Voluntary sterilization (See Surgical procedures Section 5 (b)) • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms <p>Note: We cover oral contraceptives under the prescription drug benefit.</p>	<p>\$15 per visit at your primary care physician</p> <p>\$25 per visit at a specialist</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary surgical sterilization</i> • <i>Genetic counseling</i> 	<i>All charges</i>
Infertility services	High Option
<p>Diagnosis and treatment of infertility such as:</p> <ul style="list-style-type: none"> • Artificial insemination: • intrauterine insemination (IUI) <p>Fertility drugs administered in physician's office</p>	30% of charges
<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> • <i>in vitro fertilization</i> • <i>embryo transfer, 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> <p><i>Self administered fertility drugs</i></p>	<i>All charges</i>

Benefit Description	
Allergy care	High Option
<ul style="list-style-type: none"> • Testing and treatment <ul style="list-style-type: none"> -Allergy injections 	\$15 per visit at your primary care physician \$25 per visit at a specialist
Allergy serum	Nothing
<i>Not covered: Provocative food testing and sublingual allergy desensitization</i>	<i>All charges</i>
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 Organ/Tissue Transplants on pages 24 and 25.</p> <ul style="list-style-type: none"> • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) <p>Note: - We will only cover GHT when we preauthorize the treatment. The treatment must be ordered by a Plan Endocrinologist. The specialist must call our Utilization Review department for prior authorization. If prior authorization is not requested or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See <i>Services requiring our prior approval</i> in Section 3.</p>	\$25 per visit
Physical and occupational therapies	High Option
<ul style="list-style-type: none"> • 30 visits combined per condition for the services of each of the following: <ul style="list-style-type: none"> • - qualified physical therapists and • - occupational therapists. <p>Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury.</p> <p>Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is covered at a Plan facility</p>	\$10 per outpatient visit Nothing per visit during covered inpatient admission Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Long-term rehabilitative therapy</i> • <i>Exercise programs</i> 	<i>All charges</i>
Speech therapy	High Option
30 visits per condition for the services of qualified speech therapists	\$10 per outpatient visit Nothing per visit during covered inpatient admission

Benefit Description	
Hearing services (testing, treatment, and supplies)	High Option
<ul style="list-style-type: none"> • Hearing testing for children through age 17 (see <i>Preventive care, children</i>) <ul style="list-style-type: none"> - First hearing aid and testing only when necessitated by accidental injury 	\$15 per visit at your primary care physician \$25 per visit at a specialist
<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>
Vision services (testing, treatment, and supplies)	High Option
<ul style="list-style-type: none"> • Annual eye refractions <ul style="list-style-type: none"> - Eye exam to determine the need for vision correction for children through age 17 (see <i>Preventive care, children</i>) 	\$25 per visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Eyeglasses or contact lenses and after age 17, examinations for them</i> • <i>Eye exercises and orthoptics</i> • <i>Radial keratotomy and other refractive surgery</i> 	<i>All charges</i>
Foot care	High Option
<p>Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.</p> <p>Note: See Orthopedic and prosthetic devices for information on podiatric shoe inserts.</p>	\$25 per visit
<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"> • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome <ul style="list-style-type: none"> - Artificial limbs and lenses following cataract removal (only initial prosthetic device required as a result of surgery) - Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy - Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy. Note: See 5(b) for coverage of the surgery to insert the device. 	20% of charges
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Orthopedic and corrective shoes</i> • <i>Arch supports</i> 	<i>All charges</i>

Orthopedic and prosthetic devices - continued on next page

Benefit Description	
Orthopedic and prosthetic devices (cont.)	High Option
<ul style="list-style-type: none"> • <i>Foot orthotics</i> • <i>Heel pads and heel cups</i> • <i>Lumbosacral supports</i> • <i>Corsets, trusses, elastic stockings, support hose, and other supportive devices</i> • <i>Repair and/or replacement of Prosthetic devices</i> • <i>The cost of a cochlear implanted device</i> • <i>The cost of a penile implanted device</i> 	<i>All charges</i>
Durable medical equipment (DME)	High Option
<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"> • Hospital beds; • Standard wheelchairs; • Crutches; • Walkers; • Ostomy supplies; • Blood glucose monitors; • Lancets; • Chem strips; and • Medical support hose <p>NOTE: We follow Medicare Part B Guidelines for DME</p>	20% of charges
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Exercise equipment</i> • <i>Bite plates</i> • <i>Disposable medical supplies</i> • <i>Services not in accordance with Medicare Part B guidelines</i> • <i>Tens units</i> • <i>Motorized wheelchairs</i> 	<i>All charges</i>
Home health services	High Option
<ul style="list-style-type: none"> • Services include oxygen therapy, intravenous therapy, medications, physician services, skilled nursing care, physical, occupation and other related therapies, supplies and equipment. - 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. 	Nothing
<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>

Benefit Description	
Chiropractic	High Option
<ul style="list-style-type: none"> • <i>No benefit</i> 	<i>All charges</i>
Alternative treatments	High Option
<ul style="list-style-type: none"> • <i>No benefit</i> 	<i>All charges</i>
Educational classes and programs	High Option
<p>Coverage is limited to:</p> <ul style="list-style-type: none"> • Smoking Cessation – Up to \$300 for one smoking cessation program per member per lifetime, including all related expenses such as drugs. • Diabetes self-management 	<p>20% of charges for nicotine patches or other smoking deterrents furnished on a prescription basis, if you have completed a smoking cessation class approved by the Plan.</p> <p>Nothing</p>

Benefit Description	
<p>Surgical procedures (cont.)</p> <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. • 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> <ul style="list-style-type: none"> • Voluntary sterilization (e.g., Tubal ligation, Vasectomy) • Treatment of burns 	<p>High Option</p> <p>\$25 per office visit; nothing for hospital visits</p>
<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> 	<p><i>All charges</i></p>
<p>Reconstructive surgery</p> <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; birth marks; webbed fingers; and webbed toes. 	<p>High Option</p> <p>\$25 per office visit; nothing for hospital visits</p>

Reconstructive surgery - continued on next page

Benefit Description	
Reconstructive surgery (cont.)	High Option
<ul style="list-style-type: none"> · All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> - surgery to produce a symmetrical appearance of breasts; - treatment of any physical complications, such as lymphedemas; - breast prostheses and surgical bras and replacements (see Prosthetic devices) <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>	\$25 per office visit; nothing for hospital visits
<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 repair of accidental injury</i> • <i>Surgeries related to sex transformation</i> 	<i>All charges</i>
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 incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures. • Non-dental medical and surgical treatment of temporomandibular joint (TMJ) 	\$25 per office visit; nothing for hospital visits
<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, gingiva, and alveolar bone)</i> • <i>Dental treatment of temporomandibular joint syndrome (TMJ)</i> 	<i>All charges</i>

Benefit Description	
Organ/tissue transplants	High Option
<p>Solid organ transplants are limited to:</p> <ul style="list-style-type: none"> • Bowel • Cornea • Heart • Heart/lung • Kidney • Kidney/Pancreas • Liver • Single, double or lobar lung • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Intestinal transplants <p>Blood or marrow stem cell transplants limited to the stages of the following diagnosis. The medical necessity limitation is considered satisfied if the patient meets the staging description.</p> <ul style="list-style-type: none"> • Allogeneic transplants for • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin's lymphoma,- Advanced non-Hodgkin's lymphoma • Chronic myelogenous leukemia,- Severe combined immunodeficiency • Severe or very severe aplastic anemia • Allogeneic transplants for • Phagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome • Advanced forms of myelodysplastic syndromes,- Advanced Neuroblastoma • Infantile malignant osteoporosis,- Kostmann's syndrome • Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, -- Sanfilippo's syndrome, <p>Maroteaux-Lamy syndrome variants)</p> <ul style="list-style-type: none"> • Myeloproliferative disorders- Sickle cell anemia • Thalassemia major (homozygous beta-thalassemia) • X-linked lymphoproliferative syndrome <p>Autologous transplants for</p> <ul style="list-style-type: none"> • Multiple myeloma- Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors 	<p>\$25 per office visit to evaluate the need for transplant; nothing for hospital visits</p>

Organ/tissue transplants - continued on next page

Benefit Description	
Organ/tissue transplants (cont.)	High Option
<ul style="list-style-type: none"> • Ewing’s sarcoma, - Medulloblastoma, - Pineoblastoma <p>Blood or marrow stem cell transplants covered only in a National Cancer Institute or National Institutes of Health approved clinical trial at a Plan-designated center of excellence and if approved by the Plan’s medical director in accordance the Plan’s protocols for:</p> <ul style="list-style-type: none"> • Allogeneic transplants for – Breast cancer, - Epithelial ovarian cancer • National Transplant Program (NTP) – <p>Note: We cover related medical and hospital expenses of the donor when we cover the recipient.</p>	\$25 per office visit to evaluate the need for transplant; nothing for hospital visits
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Donor screening tests and donor search expenses, except those performed for the actual donor</i> • <i>Implants of artificial organs</i> • <i>Transplants not listed as covered</i> 	<i>All charges</i>
Anesthesia	High Option
<p>Professional services provided in –</p> <ul style="list-style-type: none"> • Hospital (inpatient) 	Nothing
<p>Professional services provided in –</p> <ul style="list-style-type: none"> • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office 	\$25 per visit

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

Here are some 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.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery care. Any costs associated with the professional charge (i.e., physicians, etc.) are covered in Sections 5 (a) or (b).

YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR HOSPITAL STAYS. Please refer to Section 3 to be sure which services require precertification.

Benefit Description	High Option
<p>Inpatient hospital</p> <p>Room and board, such as</p> <ul style="list-style-type: none"> • Ward, semiprivate, or intensive care accommodations; • General nursing care; and • Meals and special diets. <p>Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.</p>	\$500 per admission
<p>Other hospital services and supplies, such as:</p> <ul style="list-style-type: none"> • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home 	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Custodial care</i> • <i>Non-covered facilities, such as nursing homes, schools</i> 	<i>All charges</i>

Inpatient hospital - continued on next page

Benefit Description	
Inpatient hospital (cont.)	High Option
<ul style="list-style-type: none"> • <i>Personal comfort items, such as telephone, television, barber services, guest meals and beds</i> • <i>Private nursing care, except when medically necessary</i> 	<i>All charges</i>
Outpatient hospital or ambulatory surgical center	High Option
<ul style="list-style-type: none"> • Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service <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>	\$150 copay
<i>Not covered: Blood and blood derivatives not replaced by the member</i>	<i>All charges</i>
Extended care benefits/Skilled nursing care facility benefits	High Option
<p>Extended care benefit: We provide a comprehensive range of benefits for up to 100 days per calendar year when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan physician and approved by the Plan.</p>	Nothing
<i>Not covered: Custodial care</i>	<i>All Charges</i>
Hospice care	High Option
<p>Supportive and palliative care for a terminally ill member is covered in the home or hospice facility. Services include inpatient and outpatient care, and family counseling; these services are provided under the direction of a Plan physician who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less.</p>	Nothing
<i>Not covered: Independent nursing, homemaker services</i>	<i>All charges</i>

Benefit Description	
Ambulance	High Option
Local professional ambulance service when medically appropriate	Nothing

Section 5(d). Emergency services/accidents

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

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

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:

Call your Primary Care Physician first, unless you believe the situation to be life threatening. Follow the doctor's instructions.

Emergencies within our service area:

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

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

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

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

Emergencies outside our service area:

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

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

Benefit Description	
Emergency within our service area	High Option
<ul style="list-style-type: none"> • Emergency care at a doctor’s office • Emergency care at a specialist’s office • Emergency care at an urgent care center • Emergency care as an outpatient or inpatient at a hospital, including doctors’ services 	<ul style="list-style-type: none"> • \$15 per visit at your primary care physician • \$25 per visit at a specialist • \$35 per visit • \$100 per visit, waived if admitted to a hospital
<i>Not covered: Elective care or non-emergency care</i>	<i>All charges</i>
Emergency outside our service area	High Option
<ul style="list-style-type: none"> • Emergency care at a doctor’s office • Emergency care at a specialist’s office • Emergency care at an urgent care center • Emergency care as an outpatient or inpatient at a hospital, including doctors’ services 	<ul style="list-style-type: none"> • \$15 per visit at your primary care physician • \$25 per visit at a specialist • \$35 per visit • \$100 per visit, waived if admitted to a hospital
Ambulance	High Option
Professional ambulance service, including air ambulance, when medically appropriate. Note: See 5(c) for non-emergency service.	Nothing

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

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

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

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

YOU MUST GET PREAUTHORIZATION FOR THESE SERVICES. See the instructions after the benefits description below.

Benefit Description	You pay
Mental health and substance abuse benefits	High Option
<p>All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure.</p> <p>Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.</p>	<p>Your cost sharing responsibilities are no greater than for other illnesses or conditions.</p>
<ul style="list-style-type: none"> • Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management 	<p>\$10 per visit</p>
<p>Diagnostic tests</p> <ul style="list-style-type: none"> • Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, full-day hospitalization, facility based intensive outpatient treatment 	<p>\$10 per visit Nothing</p>
<p><i>Not covered: Services we have not approved.</i></p> <p><i>Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.</i></p>	<p><i>All charges</i></p>

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

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

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

Section 5(f). Prescription drug benefits

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

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

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

- **Who can write your prescription.** A plan physician or licensed dentist must write the prescription.
- **Where you can obtain them.** You must fill the prescription at a Plan pharmacy.
- **We use a preferred drug list.** In the wake of dramatic increases in drug costs, employer groups, physicians and members challenged us to develop an innovative prescription drug benefit that helps reduce drug benefit costs while maintaining physicians' freedom to select the most appropriate drugs. In response to this request, we have introduced the *Three-Tier Preferred Drug* prescription benefit with the following copay structure:
 - Generic drugs at the lowest copay - \$10
 - Preferred name brand drugs at a mid-level copay - \$25
 - Non-preferred name brand drugs at the highest copay - \$45

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.

- **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?** Generic drugs offer a safe and economic way to meet your prescription drug needs. The generic name of a drug is its chemical name; the name brand is the name under which the manufacturer advertises and sells a drug. Under federal law, generic and name brand drugs must meet the same standards for safety, purity, strength, and effectiveness. You can save money by using generic drugs. However, you and your physician have the option to request a name brand if a generic option is available. Using the most cost-effective medication saves money.
- **When you do have to file a claim.** Send your claim to Paramount Health Care, P.O. Box 928, Toledo, OH 43697.

Benefit Description	You pay
Covered medications and supplies	High Option
<p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program:</p> <ul style="list-style-type: none"> • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as <i>Not covered</i>. • Insulin • Disposable needles and syringes for the administration of covered medications • Drugs for sexual dysfunction (see Prior authorization below) • Contraceptive drugs and devices • Speciality pharmacy for up to 30 day supply 	<p>Retail pharmacy for up to a 30-day supply:</p> <p>A \$10 copay per prescription unit or refill for generic drugs;</p> <p>A \$25 copay per prescription unit or refill for preferred name brand drugs; and</p> <p>A \$45 copay per prescription unit or refill for non-preferred name brand drugs.</p> <p>A \$10% coinsurance per prescription for Speciality Drug Program</p> <p>Mail order for up to a 90-day supply:</p> <p>A \$20 copay per prescription unit or refill for generic drugs;</p> <p>A \$50 copay per prescription unit or refill for preferred name brand drugs; and</p> <p>A \$135 copay per prescription unit or refill for non-preferred name brand drugs.</p> <p>Note: If there is no generic equivalent available, you will still have to pay the brand name copay.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Drugs and supplies for cosmetic purposes</i> • <i>Drugs to enhance athletic performance</i> • <i>Fertility drugs</i> • <i>Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies</i> • <i>Vitamins, nutrients and food supplements even if a physician prescribes or administers them</i> • <i>Nonprescription medicines</i> <p><i>Fertility drugs, except those administered in a doctor's office (See Section 5(a)—Infertility services)</i></p>	<p><i>All Charges</i></p>

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 are payable 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 payer 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 only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefits 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.	Nothing
Dental benefits	High Option
We have no other dental benefits.	<i>All charges</i>

Section 5(h). Special features

Feature	Description
College Student Coverage	Out-of-Area Coverage includes emergency, urgent and follow-up care services and Rx. If your child needs medical care away from home, simply contact our Utilization Management Department at 800-891-2520 for prior authorizations.

High Deductible Health Plan Benefits

See page 10 for how our benefits changed this year and pages 92-94 for a benefits summary.

This HDHP focuses on you, the health care consumer, and gives you greater control in how you use your health care benefits. With this plan, eligible in-network medical and preventive care is covered in full, and you can use the Medical Fund for any covered care. If you use up your Medical Fund, the Traditional Medical Coverage begins after you satisfy your deductible. If you don't use up your Medical Fund for the year, you can roll it over to the next year, up to the maximum rollover amount, as long as you continue to be enrolled in this HDHP.

The HDHP includes:

More choices: Choose health savings accounts (HSA) or a health reimbursement accounts (HRA).

More freedom:

- No referrals needed
- No primary care physician required
- Preventive care is 100% covered – including preventive medications! Use in-network or out-of-network providers - each person decides how best to use his or her health care dollars.

Easy and affordable: Reduced premiums for employers and employees compared to traditional plans. Debit card for prescriptions make it easy. And pharmacies and providers share a single, common deductible.

Visit us online for more information – www.paramounthealthcare.com/hdhp.

Section 5. High Deductible Health Plan Benefits Overview

This Plan offers a High Deductible Health Plan (HDHP). The HDHP benefit package is described in this section. Make sure that you review the benefits that are available under the benefit product in which you are enrolled.

HDHP Section 5, which describes the HDHP benefits, is divided into subsections. Please read *Important things you should keep in mind about these benefits* at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about HDHP benefits, contact us at 866-380-8900 or at our Web site at www.paramounthealthcare.com.

Our HDHP option provides comprehensive coverage for high-cost medical events and a tax-advantaged way to help you build savings for future medical expenses. The Plan gives you greater control over how you use your health care benefits.

When you enroll in this HDHP, we establish either a Health Savings Account (HSA) or a Health Reimbursement Arrangement (HRA) for you. We automatically pass through a portion of the total health Plan premium to your HSA or credit an equal amount to your HRA based upon your eligibility. Your full annual HRA credit will be available on your effective date of enrollment.

With this Plan, preventive care is covered in full. As you receive other non-preventive medical care, you must meet the Plan's deductible before we pay benefits according to the benefits described on page 94. You can choose to use funds available in your HSA to make payments toward the deductible or you can pay toward your deductible entirely out-of-pocket, allowing your savings to continue to grow.

This HDHP includes five key components: preventive care; traditional medical coverage health care that is subject to the deductible; savings; catastrophic protection for out-of-pocket expenses; and health education resources and account management tools.

- **Preventive care** The Plan covers preventive care services, such as periodic health evaluations (e.g., annual physicals), screening services (e.g., mammograms), routine prenatal and well-child care, child and adult immunizations, tobacco cessation programs, obesity weight loss programs, disease management and wellness programs. These services are covered at 100% per person per year if you use a network provider and the services are described in Section 5 *Preventive care*. *You do not have to meet the deductible before using these services.*
- **Traditional medical coverage** After you have paid the Plan's deductible, we pay benefits under traditional medical coverage described in Section 5. The Plan typically pays 100% for in-network and 60% for out-of-network care.

Covered services include:

 - Medical services and supplies provided by physicians and other health care professionals
 - Surgical and anesthesia services provided by physicians and other health care professionals
 - Hospital services; other facility or ambulance services
 - Emergency services/accidents
 - Mental health and substance abuse benefits
 - Prescription drug benefits
- **Savings** Health Savings Accounts or Health Reimbursement Arrangements provide a means to help you pay out-of-pocket expenses (see page 8 for more details).

Health Savings Accounts (HSA)

By law, HSAs are available to members who are not enrolled in Medicare, cannot be claimed as a dependent on someone else's tax return, have not received VA benefits within the last three months or do not have other health insurance coverage other than another high deductible health plan. In 2009, for each month you are eligible for an HSA premium pass through, we will contribute to your HSA \$41.67 per month for a Self Only enrollment or \$83.33 per month for a Self and Family enrollment. In addition to our monthly contribution, you have the option to make additional tax-free contributions to your HSA, so long as total contributions do not exceed the limit established by law, which is \$3,000 for an individual and \$5,950 for a family. See maximum contribution information on page 44. You can use funds in your HSA to help pay your health plan deductible. You own your HSA, so the funds can go with you if you change plans or employment.

Federal tax tip: There are tax advantages to fully funding your HSA as quickly as possible. Your HSA contribution payments are fully deductible on your Federal tax return. By fully funding your HSA early in the year, you have the flexibility of paying medical expenses from tax-free HSA dollars or after tax out-of-pocket dollars. If you don't deplete your HSA and you allow the contributions and the tax-free interest to accumulate, your HSA grows more quickly for future expenses.

HSA features include:

- Your HSA is administered by National City Bank
- Your contributions to the HSA are tax deductible
- You may establish pre-tax HSA deductions from your paycheck to fund your HSA up to IRS limits using the same method that you use to establish other deductions (i.e., Employee Express, MyPay, etc.)
- Your HSA earns tax-free interest
- You can make tax-free withdrawals for qualified medical expenses for you, your spouse and dependents (see IRS publication 502 for a complete list of eligible expenses)
- Your unused HSA funds and interest accumulate from year to year
- It's portable - the HSA is owned by you and is yours to keep, even when you leave Federal employment or retire
- When you need it, funds up to the actual HSA balance are available.

Important consideration if you want to participate in a Health Care Flexible Spending Account (HCFSA): If you are enrolled in this HDHP with a Health Savings Account (HSA), and start or become covered by a HCFSA health care flexible spending account (such as FSAFEDS offers – see Section 12), this HDHP cannot continue to contribute to your HSA. Similarly, you cannot contribute to an HSA if your spouse enrolls in an HCFSA. Instead, when you inform us of your coverage in an HCFSA, we will establish an HRA for you.

Health Reimbursement Arrangements (HRA)

If you aren't eligible for an HSA, for example you are enrolled in Medicare or have another health plan, we will administer and provide an HRA instead. You must notify us that you are ineligible for an HSA.

In 2009, we will give you an HRA credit of \$500 per year for a Self Only enrollment and \$1,000 per year for a Self and Family enrollment. You can use funds in your HRA to help pay your health plan deductible and/or for certain expenses that don't count toward the deductible.

HRA features include:

- For our HDHP option, the HRA is administered by Paramount and their HRA partner.

- Entire HRA credit (prorated from your effective date to the end of the plan year) is available from your effective date of enrollment
- Tax-free credit can be used to pay for qualified medical expenses for you and any individuals covered by this HDHP
- Unused credits carryover from year to year
- HRA credit does not earn interest
- HRA credit is forfeited if you leave Federal employment or switch health insurance plans.
- An HRA does not affect your ability to participate in an FSAFEDS Health Care Flexible Spending Account (HCFSA). However, you must meet FSAFEDS eligibility requirements.

• Catastrophic protection for out-of-pocket expenses

When you use network providers, your annual maximum for out-of-pocket expenses (deductibles, coinsurance and copayments) for covered services is limited to \$ 1,500 per person or \$ 3,000 per family enrollment. However, certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the Plan’s allowable amount or benefit maximum). Refer to Section 4 Your catastrophic protection out-of-pocket maximum and HDHP Section 5 *Traditional medical coverage subject to the deductible* for more details.

Health education resources and account management tools

HDHP Section 5(i) describes the health education resources and account management tools available to you to help you manage your health care and your health care dollars.

Section 5. Savings – HSAs and HRAs

Feature Comparison	Health Savings Account (HSA)	Health Reimbursement Arrangement (HRA)
Administrator	The Plan will establish an HSA for you with National City Bank, this HDHP’s fiduciary (an administrator, trustee or custodian as defined by Federal tax code and approved by IRS)	Paramount will establish an HRA for you with their HRA partner
Fees	Set-up fee is paid by the HDHP	None, set-up fee is paid by the HDHP
Eligibility	<p>You must:</p> <ul style="list-style-type: none"> • Enroll in this HDHP • Have no other health insurance coverage (does not apply to specific injury, accident, disability, dental, vision or long-term care coverage) • Not be enrolled in Medicare • Not be claimed as a dependent on someone else’s tax return • Not have received VA benefits in the last three months • Complete and return all banking paperwork 	<p>You must enroll in this HDHP</p> <p>Eligibility is determined on the first day of the month following your effective day of enrollment and will be prorated for length of enrollment.</p>
Funding	<p>If you are eligible for HSA contributions, a portion of your monthly health plan premium is deposited to your HSA each month. Premium pass through contributions are based on the effective date of your enrollment in the HDHP.</p> <p>In addition, you may establish pre-tax HSA deductions from your paycheck to fund your HSA up to IRS limits using the same method that you use to establish other deductions (i.e., Employee Express, MyPay, etc.).</p>	<p>Eligibility for the annual credit will be determined on the first day of the month and will be prorated for length of enrollment. The entire amount of your HRA will be available to you upon your enrollment.</p>
<ul style="list-style-type: none"> • Self Only enrollment 	<p>For 2009, a monthly premium pass through of \$41.67 will be made by the HDHP directly into your HSA each month.</p>	<p>For 2009, your HRA annual credit is \$500 per year for a Self Only enrollment and \$1,000 per year for a Self and Family enrollment. (prorated for mid-year enrollment).</p>
<ul style="list-style-type: none"> • Self and Family enrollment 	<p>For 2009, a monthly premium pass through of \$83.33 will be made by the HDHP directly into your HSA each month.</p>	<p>For 2009, your HRA annual credit is \$500 per year for a Self Only enrollment and \$1,000 per year for a Self and Family enrollment. (prorated for enrollment)</p>

<p>Contributions/credits</p>	<p>The maximum that can be contributed to your HSA is an annual combination of HDHP premium pass through and enrollee contribution funds, which when combined, do not exceed the maximum contribution amount set by the IRS of \$3,000 for an individual and \$5,950 for a family.</p> <p>If you enroll during Open Season, you are eligible to fund your account up to the maximum contribution limit set by the IRS. To determine the amount you may contribute, subtract the amount the Plan will contribute to your account for the year from the maximum allowable contribution.</p> <p>You are eligible to contribute up to the IRS limit for partial year coverage as long as you maintain your HDHP enrollment for 12 months following the last month of the year of your first year of eligibility. To determine the amount you may contribute, take the IRS limit and subtract the amount the Plan will contribute to your account for the year.</p> <p>If you do not meet the 12 month requirement, the maximum contribution amount is reduced by 1/12 for any month you were ineligible to contribute to an HSA. If you exceed the maximum contribution amount, a portion of your tax reduction is lost and a 10% penalty is imposed. There is an exception for death or disability.</p> <p>You may rollover funds you have in other HSAs to this HDHP HSA (rollover funds do not affect your annual maximum contribution under this HDHP).</p> <p>HSAs earn tax-free interest (does not affect your annual maximum contribution).</p> <p>Catch-up contribution discussed on page 12.</p>	<p>The full HRA credit will be available, subject to proration, on the effective date of enrollment. The HRA does not earn interest.</p>
<ul style="list-style-type: none"> • Self Only enrollment 	<p>You may make an annual maximum contribution of \$2,500.</p>	<p>You cannot contribute to the HRA.</p>
<ul style="list-style-type: none"> • Self and Family enrollment 	<p>You may make an annual maximum contribution of \$4,950.</p>	<p>You cannot contribute to the HRA.</p>
<p>Access funds</p>	<p>You can access your HSA by the following methods:</p> <ul style="list-style-type: none"> • Debit card 	

	<ul style="list-style-type: none"> • Withdrawal form • Checks 	For qualified medical expenses under your HDHP, payment will be made directly to the provider of medical services and you will have a debit card to use at the pharmacy for prescriptions only. Manual claims can be made online for prompt reimbursement. For expenses not covered by the HDHP, such as orthodontia, a reimbursement form will be sent to you upon your request.
Distributions/withdrawals <ul style="list-style-type: none"> • Medical 	<p>You can pay the out-of-pocket expenses for yourself, your spouse or your dependents (even if they are not covered by the HDHP) from the funds available in your HSA.</p> <p>See IRS Publication 502 for a list of eligible medical expenses, including over-the-counter drugs.</p>	<p>You can pay the out-of-pocket expenses for qualified medical and prescriptions expenses for individuals covered under the HDHP.</p> <p>Non-reimbursed qualified medical expenses are allowable if they occur after the effective date of your enrollment in this Plan.</p> <p>See <i>Availability of funds</i> below for information on when funds are available in the HRA.</p>
<ul style="list-style-type: none"> • Non-medical 	<p>If you are under age 65, withdrawal of funds for non-medical expenses will create a 10% income tax penalty in addition to any other income taxes you may owe on the withdrawn funds.</p> <p>When you turn age 65, distributions can be used for any reason without being subject to the 10% penalty, however they will be subject to ordinary income tax.</p>	Not applicable – distributions will not be made for anything other than non-reimbursed qualified medical expenses.
Availability of funds	<p>Funds are not available for withdrawal until all the following steps are completed:</p> <ul style="list-style-type: none"> • Your enrollment in this HDHP is effective (effective date is determined by your agency in accord with the event permitting the enrollment change). • The HDHP receives record of your enrollment and initially establishes your HSA account with the fiduciary by providing information it must furnish and by contributing the minimum amount required to establish an HSA. • The fiduciary sends you HSA paperwork for you to complete and the fiduciary receives the completed paperwork back from you. 	The entire amount of your HRA will be available to you upon your enrollment in the HDHP.
Account owner	FEHB enrollee	HDHP

Feature Comparison	Health Savings Account (HSA)	Health Reimbursement Arrangement (HRA)
Portable	<p>You can take this account with you when you change plans, separate or retire.</p> <p>If you do not enroll in another HDHP, you can no longer contribute to your HSA. See page 8 for HSA eligibility.</p>	<p>If you retire and remain in this HDHP, you may continue to use and accumulate credits in your HRA.</p> <p>If you terminate employment or change health plans, only eligible expenses incurred while covered under the HDHP will be eligible for reimbursement subject to timely filing requirements. Unused funds are forfeited.</p>
Annual rollover	Yes, accumulates without a maximum cap.	Yes, accumulates without a maximum cap.

If you have an HRA

Why an HRA is established

If you don't qualify for an HSA when you enroll in this HDHP, or later become ineligible for an HSA, we will establish an HRA for you. If you are enrolled in Medicare, you are ineligible for an HSA and we will establish an HRA for you. You must tell us if you become ineligible to contribute to an HSA.

How an HRA differs

Please review the chart on pages 43-46 which details the differences between an HRA and an HSA. The major differences are:

- You cannot make contributions to an HRA
- Funds are forfeited if you leave the HDHP
- An HRA does not earn interest, and
- HRAs can only pay for qualified medical expenses, such as deductibles, copayments, and coinsurance expenses, for individuals covered by the HDHP. FEHB law does not permit qualified medical expenses to include 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.

Section 5. Preventive care

Important things you should keep in mind about these benefits:

- Preventive care services listed in this Section are not subject to the deductible. You must use providers that are part of our network.
- For all other covered expenses, please see Section 5 – *Traditional medical coverage subject to the deductible.*

Benefit Description	You pay
Preventive care, adult	
<p>Routine screenings, such as:</p> <ul style="list-style-type: none"> • Blood tests • Urinalysis • Total Blood Cholesterol • Routine Prostate Specific Antigen (PSA) test — one annually for men age 50 and older • Colorectal Cancer Screening, including <ul style="list-style-type: none"> - Fecal occult blood test yearly starting at age 50, - Sigmoidoscopy screening — every five years starting at age 50, - Double contrast barium enema — every five years starting at age 50; - Colonoscopy screening — every 10 years starting at age 50 • Routine annual digital rectal exam (DRE) for men age 40 and older • Routine well-woman exam including Pap test, one visit every 12 months from last date of service • Routine mammogram — covered for women age 35 and older, as follows: <ul style="list-style-type: none"> - From age 35 through 39, one during this five year period - From age 40 through 64, one every calendar year - At age 65 and older, one every two consecutive calendar years 	<p>In-network - Covered in full ~ not subject to deductible</p> <p>Out-of-network – 40% coinsurance ~ not subject to deductible</p>
<ul style="list-style-type: none"> • Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC): • Routine physicals which include: <ul style="list-style-type: none"> - One exam every 24 months up to age 65 - One exam every 12 months age 65 and older • Routine exams limited to: <ul style="list-style-type: none"> - 1 routine eye exam every 12 months - 1 routine OB/GYN exam every 12 months including 1 Pap smear and related services - 1 routine hearing exam every 24 months 	<p>In-network - Covered in full ~ not subject to deductible</p> <p>Out-of-network – 40% coinsurance ~ not subject to deductible</p>

Benefit Description	You pay
Preventive care, adult (cont.)	
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams or travel.</i> • <i>Immunizations, boosters, and medications for travel or work-related exposure.</i> 	<p><i>All Charges</i></p>
Preventive care, children	
<ul style="list-style-type: none"> • Professional services, such as: • Well-child visits for routine examinations, immunizations and care (up to age 22) • Childhood immunizations recommended by the American Academy of Pediatrics • Examinations, such as: • Eye exam through age 17 to determine the need for vision correction • Hearing exams through age 17 to determine the need for hearing correction 	<p>In-network - Covered in full ~ not subject to deductible</p> <p>Out-of-network – 40% coinsurance ~ not subject to deductible</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.</i> • <i>Immunizations, boosters, and medications for travel.</i> 	<p>All charges</p>
Dental Preventive Care	
<p>Preventive care limited to:</p> <ul style="list-style-type: none"> • Prophylaxis (cleaning of teeth) – limited to 2 treatments per calendar year • Fluoride applications (limited to 1 treatment per calendar year and for children under age 16) • Sealants – (once every 3 years, from the last date of service, on permanent molars for children under age 16) • Space maintainer (primary teeth only) • Bitewing x-rays (one set per calendar year) • Complete series x-rays (one complete series every 3 years) • Periapical x-rays • Routine oral evaluations (limited to 2 per calendar year) 	<p>Not Covered ~ All charges</p>

Section 5. Traditional medical coverage subject to the deductible

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.
- In-network preventive care is covered at 100% (see page 40) and is not subject to the calendar year deductible. After the annual limit on in-network preventive care has been reached, additional preventive care is covered under Traditional medical coverage subject to the deductible.
- The deductible is \$1,500 per person or \$3,000 per family enrollment. The family deductible can be satisfied by one or more family members. The deductible applies to almost all benefits under Traditional medical coverage. You must pay your deductible before your Traditional medical coverage may begin.
- Under Traditional medical coverage, you are responsible for your deductible and for non-covered services.
- When you use network providers, you are protected by an annual catastrophic maximum on out-of-pocket expenses for covered services. After your deductible total \$1,500 per person or \$3,000 per family enrollment in any calendar year, you do not have to pay any more for covered services from network providers. However, certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the Plan’s benefit maximum, or if you use out-of-network providers, amounts in excess of the Plan allowance).
- In-network benefits apply only when you use a network provider. When a network provider is not available, out-of-network benefits apply.
- 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.

Benefit Description	You pay After the calendar year deductible...
Deductible before Traditional medical coverage begins	
The deductible applies to almost all benefits in this Section. In the You pay column, we say “No deductible” when it does not apply. When you receive covered services from network providers, you are responsible for paying the allowable charges until you meet the deductible.	100% of allowable charges until you meet the deductible of \$1,500 per person or \$3,000 per family enrollment
After you meet the deductible, we pay the allowable charge (less your coinsurance or copayment) until you meet the annual catastrophic out-of-pocket maximum.	<p>In-network: First you meet the deductible, you may choose to pay the deductible from your HSA or HRA, or you can pay for them out-of-pocket.</p> <p>Out-of-network: After you meet the deductible, you pay the indicated coinsurance based on our Plan allowance and any difference between our allowance and the billed amount.</p>

**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 deductible is \$1,500 for Self Only enrollment and \$3,000 for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section unless we indicate differently.
- After you have satisfied your deductible, coverage begins for traditional medical services.
- 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.

Benefit Description	You pay After the calendar year deductible...
Diagnostic and treatment services	
Professional services of physicians <ul style="list-style-type: none"> • In physician’s office • In an urgent care center • During a hospital stay • In a skilled nursing facility • Office medical consultations • Second surgical opinion 	In-network - Subject to deductible then covered in full Out-of-network – 40% coinsurance ~ after deductible is met
Lab, X-ray and other diagnostic tests	
Tests, such as: <ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine Pap test s • Pathology • X-rays • Non-routine mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG 	In-network - Subject to deductible then covered in full Out-of-network – 40% coinsurance ~ after deductible is met

Benefit Description	You pay After the calendar year deductible...
Maternity care	
<p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> • Prenatal care • Delivery • Postnatal care <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> • You do not need to precertify your normal delivery; see page 33 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • 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 and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See <i>Hospital benefits</i> (Section 5c) and <i>Surgery benefits</i> (Section 5b). 	<p>In-network - Subject to deductible then covered in full</p> <p>Out-of-network – 40% coinsurance ~ after deductible is met</p>
Family planning	
<p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> • Voluntary sterilization (See Surgical procedures Section 5 (b)) • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms <p>Note: We cover oral contraceptives under the prescription drug benefit.</p>	<p>In-network - Subject to deductible then covered in full</p> <p>Out-of-network – 40% coinsurance ~ after deductible is met</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary surgical sterilization</i> • <i>Genetic counseling.</i> 	<p><i>All charges</i></p>

Benefit Description	You pay After the calendar year deductible...
Infertility services	
<p>Diagnosis and treatment of infertility such as:</p> <ul style="list-style-type: none"> • Artificial insemination: • intravaginal insemination (IVI) • intracervical insemination (ICI) • intrauterine insemination (IUI) • Fertility drugs <p>Note: We cover injectible fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefit.</p>	Not Covered
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Assisted reproductive technology (ART) procedures, such as:</i> <ul style="list-style-type: none"> - <i>in vitro fertilization</i> - <i>embryo transfer, 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>All charges</i>
Allergy care	
<ul style="list-style-type: none"> • Testing and treatment • Allergy injections 	<p>In-network - Subject to deductible then covered in full</p> <p>Out-of-network – 40% coinsurance ~ after deductible is met</p>
Allergy serum	Nothing
<i>Not covered: Provocative food testing and sublingual allergy desensitization</i>	<i>All charges</i>
Treatment therapies	
<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 Organ/Tissue Transplants on page 73.</p> <ul style="list-style-type: none"> • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) <p>Note: Growth hormone is covered under the prescription drug benefit.</p>	<p>In-network - Subject to deductible then covered in full</p> <p>Out-of-network – 40% coinsurance ~ after deductible is met</p>

Treatment therapies - continued on next page

Benefit Description	You pay After the calendar year deductible...
Treatment therapies (cont.)	
<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; otherwise, we will only cover GHT services from the date you submit the information. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See <i>Services requiring our prior approval</i> in Section 3.</p>	<p>In-network - Subject to deductible then covered in full</p> <p>Out-of-network – 40% coinsurance ~ after deductible is met</p>
Physical and occupational therapies	
<p>60 days for inpatient and 50 visits for outpatient for the services of each of the following:</p> <ul style="list-style-type: none"> • qualified physical therapists and • occupational therapists <p>Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury.</p> <ul style="list-style-type: none"> • Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided for up to 60 days for inpatient and 50 visits for outpatient. 	<p>In-network - Subject to deductible then covered in full</p> <p>Out-of-network – 40% coinsurance ~ after deductible is met</p> <p>(The number of days/visits for PT/OT/ST/and cardiac rehabilitation are combined)</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Long-term rehabilitative therapy</i> • <i>Exercise programs</i> 	<p><i>All charges</i></p>
Speech therapy	
<p>60 days for inpatient and 50 visits for outpatient</p>	<p>In-network - Subject to deductible then covered in full</p> <p>Out-of-network – 40% coinsurance ~ after deductible is met</p> <p>(The number of days/visits for PT/OT/ST/and cardiac rehabilitation are combined)</p>
Hearing services (testing, treatment, and supplies)	
<ul style="list-style-type: none"> • First hearing aid and testing only when necessitated by accidental injury • Hearing exams for children through age 17, which include: (see <i>Preventive care, children</i>) 	<p>In-network - Subject to deductible then covered in full</p> <p>Out-of-network – 40% coinsurance ~ after deductible is met</p>
<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> 	<p><i>All charges</i></p>

Benefit Description	You pay After the calendar year deductible...
Vision services (testing, treatment, and supplies)	
<ul style="list-style-type: none"> One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts) 	Not covered
<ul style="list-style-type: none"> Annual eye refractions 	In-network - covered in full - not subject to deductible Out-of-network - 40% coinsurance - not subject to deductible
<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	
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	In-network - Subject to deductible then covered in full Out-of-network – 40% coinsurance ~ after deductible is met
<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	
<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 Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: See 5(b) for coverage of the surgery to insert the device. 	In-network - Subject to deductible then covered in full Out-of-network – 40% coinsurance ~ after deductible is met (subject to a \$10,000 maximum)
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Orthopedic and corrective shoes</i> <i>Arch supports</i> <i>Foot orthotics</i> <i>Heel pads and heel cups</i> <i>Lumbosacral supports</i> 	<i>All charges</i>

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay After the calendar year deductible...
Orthopedic and prosthetic devices (cont.)	
<ul style="list-style-type: none"> • Corsets, trusses, elastic stockings, support hose, and other supportive devices • Prosthetic replacements subject to Medicare Part B guidelines • The cost of a cochlear implanted device • The cost of a penile implanted device 	<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; • Wheelchairs; • Crutches; • Walkers; • Blood glucose monitors; and • Insulin pumps. <p>Note: We follow Medicare Part B Guidelines for DME</p> <p>Note: Call us at 800-462-3589 as soon as your Plan physician prescribes this equipment. We will arrange with a health care provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.</p>	<p>In-network - Subject to deductible then covered in full</p> <p>Out-of-network – 40% coinsurance ~ after deductible is met (subject to a \$10,000 maximum)</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Exercise equipment • Bite plates • Disposable medical supplies • Services not in accordance with Medicare Part B guidelines • Tens units • Motorized wheelchairs 	<p><i>All charges</i></p>

Benefit Description	You pay After the calendar year deductible...
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 and medications. 	<p>In-network - Subject to deductible then covered in full</p> <p>Out-of-network – 40% coinsurance ~ after deductible is met</p>
<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> 	<p><i>All charges</i></p>
Chiropractic	
<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 	<p>In-network - Subject to deductible then covered in full</p> <p>Out-of-network – 40% coinsurance ~ after deductible is met</p> <p>(Chiropractic has a 12 visit limit)</p>
Alternative treatments	
<p>Acupuncture – by a doctor of medicine or osteopathy for: anesthesia, pain relief</p>	<p>Not covered</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Naturopathic services</i> • <i>Hypnotherapy</i> • <i>Biofeedback</i> 	<p><i>All charges</i></p>
Educational classes and programs	
<p>Coverage is limited to:</p> <ul style="list-style-type: none"> • Diabetes self management • Smoking cessation 	<p>Nothing</p>

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 deductible is \$1,500 for Self Only enrollment and \$3,000 for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to almost 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 deductible amount.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOUR 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 and identify which surgeries require precertification.

Benefit Description	You pay After the calendar year deductible...
Surgical procedures	
<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>) • Surgical treatment of morbid obesity (bariatric surgery) • Insertion of internal prosthetic devices . See 5(a) <i>Orthopedic and prosthetic devices</i> for device coverage information • Voluntary sterilization (e.g., tubal ligation, vasectomy) • Treatment of burns <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>	<p>In-network - Subject to deductible then covered in full</p> <p>Out-of-network – 40% coinsurance ~ after deductible is met</p>

Surgical procedures - continued on next page

Benefit Description	You pay After the calendar year deductible...
Surgical procedures (cont.)	
<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> 	<p><i>All charges</i></p>
Reconstructive surgery	
<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; birth marks; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> • surgery to produce a symmetrical appearance of breasts; • treatment of any physical complications, such as lymphedemas; • breast prostheses and surgical bras and replacements (see Prosthetic devices) <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>In-network - Subject to deductible then covered in full</p> <p>Out-of-network – 40% coinsurance ~ 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 repair of accidental injury</i> • <i>Surgeries related to sex transformation</i> 	<p><i>All charges</i></p>

Benefit Description	You pay After the calendar year deductible...
Oral and maxillofacial surgery	
<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 incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures. 	<p>In-network - Subject to deductible then covered in full</p> <p>Out-of-network – 40% coinsurance ~ after deductible is met</p>
<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, gingiva, and alveolar bone)</i> 	<p><i>All charges</i></p>
Organ/tissue transplants	
<p>Solid organ transplants are subject to medical necessity and experimental/investigational review. Refer to <i>Other services</i> in Section 3 for prior authorization procedures. The medical necessity limitation is considered satisfied for other tissue transplants if the patient meets the staging description.</p> <ul style="list-style-type: none"> • Cornea • Heart • Heart/lung • Single, double or lobar lung • Kidney • Liver • Pancreas • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Intestinal transplants • Small intestine • Small intestine with multiple organs, such as the liver, stomach, and pancreas <p>Blood or marrow stem cell transplants limited to the stages of the following diagnoses:</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 	<p>In-network - Subject to deductible then covered in full</p> <p>Out-of-network – 40% coinsurance ~ after deductible is met</p>

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible...
Organ/tissue transplants (cont.)	
<ul style="list-style-type: none"> - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Advanced Hodgkin’s lymphoma - Advanced non-Hodgkin’s lymphoma - Chronic myelogenous leukemia - Hemoglobinopathy (i.e. Fanconi’s, Thalessemia major) - Myelodysplasia/Myelodysplastic syndromes - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Amyloidosis <ul style="list-style-type: none"> - Autologous transplants for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin’s lymphoma - Advanced non-Hodgkin’s lymphoma - Neuroblastoma - Amyloidosis • Autologous tandem transplants for <ul style="list-style-type: none"> - Recurrent germ cell tumors (including testicular cancer) - Muliple myeloma <p>De-novo myeloma</p>	
<p>Blood or marrow stem cell transplants for</p> <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Advanced neuroblastoma - Infantile malignant osteopetrosis - Kostmann’s syndrome - Leukocyte adhesion deficiencies - Mucopolipidosis (e.g., Gaucher’s disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucopolysaccharidosis (e.g., Hunter’s syndrome, Hurler’s syndrome, Sanfilippo’s syndrome, Maroteaux-Lamy syndrome variants) - Myeloproliferative disorders - Sickle cell anemia - X-linked lymphoproliferative syndrome 	<p>In-network - Subject to deductible then covered in full</p> <p>Out-of-network – 40% coinsurance ~ after deductible is met</p>

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible...
Organ/tissue transplants (cont.)	
<ul style="list-style-type: none"> • Autologous transplants for <ul style="list-style-type: none"> - Multiple myeloma - Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors - Breast cancer - Epithelial ovarian cancer - Ependyoblastoma - Ewing’s sarcoma - Medulloblastoma - Pineoblastoma - Waldenstrom’s macroglobulinemia 	
Mini-transplants (non-myeloblastic, reduced intensity conditioning) for covered transplants: Subject to medical necessity	In-network - Subject to deductible then covered in full Out-of-network – 40% coinsurance ~ after deductible is met
Tandem transplants for covered transplants: Subject to medical necessity	In-network - Subject to deductible then covered in full Out-of-network – 40% coinsurance ~ after deductible is met
Blood or marrow stem cell transplants covered only in a National Cancer Institute or National Institutes of Health approved clinical trial or a Plan-designated center of excellence and if approved by the Plan’s medical director in accordance with the Plan’s protocols for: <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> - Chronic lymphocytic leukemia - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Myelodysplasia/Myelodysplastic syndromes - Multiple myeloma - Multiple sclerosis • Nonmyeloablative allogeneic transplants for <ul style="list-style-type: none"> - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Myelodysplasia/myelodysplastic syndromes - Advanced Hodgkin’s lymphoma - Advanced non-Hodgkin’s lymphoma - Breast cancer - Chronic lymphocytic leukemia - Chronic myelogenous leukemia - Colon cancer 	In-network - Subject to deductible then covered in full Out-of-network – 40% coinsurance ~ after deductible is met

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible...
Organ/tissue transplants (cont.)	
<ul style="list-style-type: none"> - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Chronic lymphocytic leukemia /small lymphocytic lymphoma (CLL/SLL) - Multiple myeloma - Multiple sclerosis - Myeloproliferative disorders - Non-small cell lung cancer - Ovarian cancer - Prostate cancer - Renal cell carcinoma • Autologous transplants for <ul style="list-style-type: none"> - Chronic lymphocytic leukemia - Chronic myelogenous leukemia - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Small cell lung cancer - Multiple sclerosis - Systemic lupus erythematosus - Systemic sclerosis • National Transplant Program (NTP) - <p>Note: We cover related medical and hospital expenses of the donor when we cover the recipient.</p>	<p>In-network - Subject to deductible then covered in full</p> <p>Out-of-network – 40% coinsurance ~ after deductible is met</p> <p>In-network - Subject to deductible then covered in full</p> <p>Out-of-network – 40% coinsurance ~ after deductible is met</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Donor screening tests and donor search expenses, except those performed for the actual donor • Implants of artificial organs • Transplants not listed as covered 	<p><i>All charges</i></p>
Anesthesia	
<p>Professional services provided in –</p> <ul style="list-style-type: none"> • Hospital (inpatient) 	<p>In-network - Subject to deductible then covered in full</p> <p>Out-of-network – 40% coinsurance ~ after deductible is met</p>
<p>Professional services provided in –</p> <ul style="list-style-type: none"> • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office 	<p>In-network - Subject to deductible then covered in full</p> <p>Out-of-network – 40% coinsurance ~ after deductible is met</p>

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.
- The deductible is \$1,500 for Self Only enrollment and \$3,000 for Self and Family enrollment each calendar year. The Self and Family deductible 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 deductible amount.
- 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
<p>Inpatient hospital</p> <p>Room and board, such as</p> <ul style="list-style-type: none"> • Ward, semiprivate, or intensive care accommodations; • General nursing care; and • Meals and special diets. <p>Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.</p> <p>Other hospital services and supplies, such as:</p> <ul style="list-style-type: none"> • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Blood or blood plasma, if not donated or replaced • Dressings , splints , casts , and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home (Note: calendar year deductible applies.) 	<p>In-network - Subject to deductible then covered in full</p> <p>Out-of-network – 40% coinsurance ~ after deductible is met</p>

Inpatient hospital - continued on next page

Benefit Description	You pay
Inpatient hospital (cont.)	
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Custodial care • Non-covered facilities, such as nursing homes, schools • Personal comfort items, such as telephone, television, barber services, guest meals and beds • Private nursing care, except when medically necessary 	<p><i>All charges</i></p>
Outpatient hospital or ambulatory surgical center	
<ul style="list-style-type: none"> • Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays , and pathology services • Administration of blood, blood plasma, and other biologicals • Pre-surgical testing • Dressings, casts , and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service <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>In-network - Subject to deductible then covered in full</p> <p>Out-of-network – 40% coinsurance ~ after deductible is met</p>
<p><i>Not covered: Blood and blood derivatives not replaced by the member</i></p>	<p><i>All charges</i></p>
Extended care benefits/Skilled nursing care facility benefits	
<p>Extended care benefit:</p>	<p>In-network - Subject to deductible then covered in full</p> <p>Out-of-network – 40% coinsurance ~ after deductible is met</p>
<p>Skilled nursing facility (SNF):</p>	<p>In-network - Subject to deductible then covered in full</p> <p>Out-of-network – 40% coinsurance ~ after deductible is met</p> <p>(There is a 100 day limit for SNF)</p>
<p><i>Not covered: Custodial care</i></p>	<p><i>All charges</i></p>

Benefit Description	You pay
Hospice care	
<p>Supportive and palliative care for a terminally ill member is covered in the home or hospice facility. Services include inpatient and outpatient care, and family counseling; these services are provided under the direction of a Plan physician who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less.</p>	<p>In-network - Subject to deductible then covered in full Out-of-network – 40% coinsurance ~ after deductible is met</p>
<p><i>Not covered: Independent nursing, homemaker services</i></p>	<p><i>All charges</i></p>
Ambulance	
<p>Local professional ambulance service when medically appropriate</p>	<p>In-network - Subject to deductible then covered in full Out-of-network – 40% coinsurance ~ after deductible is met</p>

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 \$1,500 for Self Only enrollment and \$3,000 for Self and Family enrollment each calendar year. The Self and Family deductible 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 deductible amount.
- 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.

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:

Call your Primary Care Physician first, unless you believe the situation to be life threatening. Follow the doctor’s instructions.

Emergencies within our service area:

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

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

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

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

Emergencies outside our service area:

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

Benefit Description	You pay After the calendar year deductible...
Emergency within our service area	
<ul style="list-style-type: none"> • Emergency care at a doctor’s office • Emergency care at an urgent care center • Emergency care as an outpatient in a hospital, including doctors’ services 	Subject to deductible then covered in full.
<i>Not covered: Elective care or non-emergency care</i>	<i>All charges</i>
Emergency outside our service area	
<ul style="list-style-type: none"> • Emergency care at a doctor’s office • Emergency care at an urgent care center • Emergency care as an outpatient in a hospital, including doctors’ services 	Subject to deductible then covered in full.
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Elective care or non-emergency care and 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>
Ambulance	
<p>Professional ambulance service when medically appropriate.</p> <p>Note: See 5(c) for non-emergency service.</p>	<p>In-network - Subject to deductible then covered in full</p> <p>Out-of-network – 40% coinsurance ~ after deductible is met</p>

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

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

Important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The deductible is \$1,500 for Self Only enrollment and \$3,000 for Self and Family enrollment each calendar year. The Self and Family deductible 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 deductible amount.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION FOR THESE SERVICES.** See the instructions after the benefits description below.

Benefit Description	You pay After the calendar year deductible...
Mental health and substance abuse benefits	
<p>All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure.</p> <p>Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.</p>	<p>In-network - Subject to deductible then covered in full</p> <p>Out-of-network – 40% coinsurance ~ after deductible is met</p>
<ul style="list-style-type: none"> • Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management 	<p>In-network - Subject to deductible then covered in full</p> <p>Out-of-network – 40% coinsurance ~ after deductible is met</p>
<ul style="list-style-type: none"> • Diagnostic tests 	<p>In-network - Subject to deductible then covered in full</p> <p>Out-of-network – 40% coinsurance ~ after deductible is met</p>
<ul style="list-style-type: none"> • Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment 	<p>In-network - Subject to deductible then covered in full</p> <p>Out-of-network – 40% coinsurance ~ after deductible is met</p>
<p><i>Not covered: Services we have not approved.</i></p>	<p><i>All charges</i></p>

Mental health and substance abuse benefits - continued on next page

Benefit Description	You pay After the calendar year deductible...
Mental health and substance abuse benefits (cont.)	
<i>Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.</i>	<i>All charges</i>

Preauthorization

To be eligible to receive these benefits you must obtain a treatment plan and follow all of the following network authorization processes:

You obtain pre-authorization by calling Paramount at 419-887-2549 or toll free 1-800-891-2549 before (preferable two weeks in advance) obtaining any of the following:

A. Services requiring pre-authorization:

1. Inpatient admission to a Hospital, including Inpatient admissions for Mental Illness, drug abuse or alcohol abuse treatment and Inpatient admissions at rehabilitation facilities; or
2. Inpatient admission to a Skilled Nursing Facility; or
3. Hospice or Home Health services; or
4. Organ/Bone Marrow Transplant services.

B. Procedures requiring pre-authorization:

1. Enhanced External Counterpulsation (EECP);
2. Prophylactic Mastectomy;
3. BRCA Testing;
4. Orthognathic and maxillofacial surgery;
5. Eyelid surgery/lifts (blepharoplasty); and
6. Cochlear implants.

C. Equipment requiring pre-authorization:

1. Bone stimulators and supplies;
2. Power operated vehicles and power wheelchairs;
3. Chest wall oscillation vest (ThAIRapy Vest System); and
4. Enteral nutrition.

Even if You obtain a referral from an In-Network Physician or an Out-of-Network Physician, **pre-authorization is always required before obtaining the above services, procedures and equipment.** If You obtain pre-authorization, these services, procedures and equipment will be covered at the appropriate benefit level indicated in Your Schedule of Benefits. Pre-authorization is required to avoid a potential denial or reduction in payment of benefits.

If You do not obtain the required pre-authorization, Paramount will conduct a retrospective review to determine if your care was Medically Necessary. You are responsible for all charges for services Paramount determines are not Medically Necessary.

If You ***do not obtain pre-authorization*** and the services are Medically Necessary, any benefit payment for a ***facility fee (including inpatient facility services under Section Three, 2,A and outpatient facility services under Section Three, 2,B)*** will be reduced by 50% up to a maximum of \$500 of the Allowable Amount. The services are then subject to the applicable Deductible, Copayment and/or Coinsurance. The 50% penalty does not count toward the Out-of-Pocket Maximum.

Limitation

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

Section 5(f). Prescription drug benefits

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

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- 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 \$1,500 for Self Only enrollment and \$3,000 for Self and Family enrollment each calendar year. The Self and Family deductible 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 deductible amount.
- 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.

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

- **Who can write your prescription.** A licensed physician must write the prescription – or – A plan physician or licensed dentist must write the prescription.
- **Where you can obtain them.** You may fill the prescription at a participating pharmacy, a non-network pharmacy, or by mail. We pay a higher level of benefits when you use a network pharmacy. – or – You must fill the prescription at a plan pharmacy, or by mail for a maintenance medication
- **We use a formulary.** We cover non-formulary drugs prescribed by a Plan doctor.

We have an open formulary. If your physician believes a name brand product is necessary or there is no generic available, your physician may prescribe a name brand drug from a 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 prescription drug brochure, call 800-462-3589 or 419-887-2525.

- **These are the dispensing limitations.** Prescription drugs obtained at a Plan pharmacy will be dispensed for up to a 30-day supply. Specific maintenance legend drugs may be dispensed for up to a 30-day supply or 100-unit supply, whichever is greater. The maintenance list is reviewed periodically, and the Plan reserves the right to change the maintenance list. When generic substitution is permissible (i.e., a generic drug is available and the prescribing doctor does not require the use of a name brand drug), but you request the name brand drug, you pay the price difference between the generic and name brand drug as well as the applicable copay. A generic equivalent will be dispensed unless the prescribing physician has specified on the prescription, “Dispense as Written” or DAW”.
- **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?** Generic drugs offer a safe and economic way to meet your prescription drug needs. The generic name of a drug is its chemical name; the name brand is the name under which the manufacturer advertises and sells a drug. Under federal law, generic and name brand drugs must meet the same standards for safety, purity, strength, and effectiveness. You can save money by using generic drugs. However, you and your physician have the option to request a name brand if a generic option is available. Using the most cost-effective medication saves money
- **When you do have to file a claim.** Send your claim to Paramount Health Care, P.O. Box 928, Toledo, OH 43697.

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 are payable 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 payer of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 Coordinating benefits with other coverage.
- Plan dentists must provide or arrange your care.
- The deductible is \$1,500 for Self Only enrollment and \$3,000 for Self and Family enrollment each calendar year. The Self and Family deductible 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 deductible amount.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You pay
Accidental injury benefit	
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury.	In-network - Subject to deductible then covered in full Out-of-network – 40% coinsurance ~ after deductible is met
Dental benefits	
We have no other dental benefits	All charges

Section 5(h). Special features

Feature	Description
Flexible benefits option	<p>Under the flexible benefits option, we determine the most effective way to provide services.</p> <ul style="list-style-type: none"> • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular benefits will resume if we do not approve your request. <p>Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.</p>
24 hour Nurse Line	<p>For any of your health concerns, 24 hours a day, 7 days a week, you may call 866-668-9764 and talk with a registered nurse who will discuss treatment options and answer your health questions.</p>
Better Health for Life	<p>Paramount’s online wellness center includes access to My Place HRA, Paramount’s new Health Risk Assessment platform. This interactive platform gives members easy access to Wellness and Disease Management information.</p>
Disease Management	<p>Members can go to www.paramounthealthcare.com to explore specific information regarding disease management course of treatment compliance, cost and quality approaches, and healthy lifestyle choices along with other pertinent information related to health care. Members may also call 800-462-3589 and ask questions or those who are at great risk may receive a call for aggressive health coaching.</p>
Health Risk Assessment	<p>Health Risk Assessment – gives members the ability to take a confidential test to determine their current health condition and potential risk for other health conditions. Members may go to www.paramounthealthcare.com to complete their HRA</p>
Centers of excellence	<p>University of Michigan, Kellogg Eye Center, Michigan Ear Institute, Motts Children’s Hospital, The Cleveland Clinic Foundation, Ohio State University, Arthur James Cancer Center, Cincinnati Children’s Hospital, Karmanos Cancer Center</p>

Section 5(i). Health education resources and account management tools

Special Feature	Description
Health education resources	<p>Visit our on our Web site at www.paramounthealthcare.com for information on:</p> <ul style="list-style-type: none"> • General health topics • Links to health care news • Cancer and other specific diseases • Drugs/medication interactions • Kids’ health • Patient safety information • and several helpful Web site links.
Account management tools	<p>For each HSA and HRA account holder, we maintain a complete claims payment history online through Paramount Direct.</p> <p>Your HSA or HRA account will be managed discreetly thru National City Bank or ConnectYourCare, respectively. Your balance will be available online with your respective account holder.</p> <p>If you have an HSA,</p> <ul style="list-style-type: none"> • You will receive statement of your account outlining all activity each month, access to balance information via telephone and online through National City Bank. • Access your HSA account with National City Bank on-line at www.nationalcity.com/hsa <p>If you have an HRA,</p> <ul style="list-style-type: none"> • Your HRA balance will be available online through www.paramounthealthcare.com/hdhp • Your balance will also be shown on your EOB’s sent to you for the medical payments made from your HRA.
Consumer choice information	<p>As a member of this HDHP, you may choose any provider. However, you will receive discounts when you see a network provider. Directories are available online at www.paramounthealthcare.com.</p> <p>Pricing information for medical care is available at www.paramounthealthcare.com. Pricing information for prescription drugs is available at www.paramounthealthcare.com</p> <p>Link to online pharmacy through www.paramounthealthcare.com.</p> <p>Educational materials on the topics of HSAs, HRAs and HDHPs are available at www.paramounthealthcare.com/hdhp.</p>
Care support	<p>Patient safety information is available online at www.paramounthealthcare.com. Case Management Coordinator will assure that medically appropriate services are provided in a supportive, cost-effective environment.</p>

Section 6. General exclusions – things we don't 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 your Plan physician determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition and we agree, as discussed under *What Services Require Our Prior Approval* on page 13.**

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies (see Emergency Benefits);
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs or supplies that are not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices;
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest;
- Services, drugs, or supplies related to sex transformations;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program; or
- Services, drugs or supplies you receive without charge while in active military service.

Section 7. Filing a claim for covered services

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

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

Medical, and hospital benefits

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

When you must file a claim – such as for services you received outside the Plan’s service area – submit it on the HCFA-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Covered member’s name and ID number;
- Name and address of the physician or facility that provided the service or supply;
- Dates you received the services or supplies;
- Diagnosis;
- Type of each service or supply;
- The charge for each service or supply;
- A copy of the explanation of benefits, payments, or denial from any primary payer – such as the Medicare Summary Notice (MSN); and
- Receipts, if you paid for your services.

Prescription drugs

Submit your claims to: Paramount Health Care Claims Department, P.O. Box 928, Toledo, OH 43697-0928.

Deadline for filing your claim

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

When we need more information

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

Section 8. The Disputed Claims process

Follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your claim or request for services, drugs, or supplies - including a request for preauthorization/prior approval required by Section 3.

- 1** Ask us in writing to reconsider our initial decision. You must:
 - a) Write to us within 6 months from the date of our decision; and
 - b) Send your request to us at: Paramount Health Care Claims Department, P.O. Box 928 Toledo, OH 43697; and
 - c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and
 - d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.

- 2** We have 30 days from the date we receive your request to:
 - a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or
 - b) Write to you and maintain our denial - go to step 4; or
 - c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request - go to step 3.

- 3** You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have.

We will write to you with our decision.

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

You must write to OPM within:

- 90 days after the date of our letter upholding our initial decision; or
- 120 days after you first wrote to us - if we did not answer that request in some way within 30 days; or
- 120 days after we asked for additional information.

Write to OPM at: United States Office of Personnel Management, Insurance Services Programs,
Health Insurance Group 3, 1900 E Street, NW, Washington, DC 20415-3630.

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim; and
- Your daytime phone number and the best time to call.

Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.

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

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

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

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

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

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

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

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

b) We denied your initial request for care or preauthorization/prior approval, then:

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

Section 9. Coordinating benefits with other coverage

When you have other health coverage

You must tell us if you or a 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 payer and the other plan pays a reduced benefit as the secondary payer. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners’ guidelines.

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

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

What is Medicare?

Medicare is a Health Insurance Program for:

- People 65 years of age or older:
- Some people with disabilities under 65 years of age and
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a 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 on January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We do not offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on the next page.

Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. If you have limited savings and a low income, you may be eligible for Medicare’s Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov or call them at 1-800-772-1213 (TTY 1-800-325-0778). 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. The notice will give you guidance on enrolling in Medicare Part D.

• 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 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 are eligible for Medicare, you may have choices in how you get your health care. Medicare Advantage is the term 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.

(Please refer to page 80 for information about how we provide benefits when you are age 65 or older and do not have Medicare.)

- **The Original Medicare Plan (Part A or Part B)**

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share. Some things are not covered under Original Medicare, such as most prescription drugs (but coverage through private prescription drug plans will be available starting in 2006).

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

Claims process when you have the Original Medicare Plan – You 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 payer, we process the claim first.
- When Original Medicare is the primary payer, 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 419-887-2525 or 800-462-3589 or see our Web site at www.paramounthealthcare.com.

We waive some costs if the Original Medicare Plan is your primary payer – We waive our copayment for visits to your primary care physician or authorized visits to a specialist. We waive our copayment for emergency room visits.

- **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 plan. These are private health care choices (like HMOs) in some areas of the country. In most Medicare Advantage plans, you can only go to doctors, specialists, or hospitals that are part of the plan. Medicare Advantage plans provide all the benefits that Original Medicare covers. Some cover extras, like prescription drugs. To learn more about enrolling in a Medicare Advantage plan, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov.

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

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 managed care plan's network and/or service area (if you use our Plan providers), but 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 payer, we process the claim first. If you enroll in Medicare Part D and we are the secondary payer, 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.

Medicare always makes the final determination as to whether they are the primary payer. The following chart illustrates whether Medicare or this Plan should be the primary payer 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 Payer Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	The primary payer 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 payer before eligibility due to ESRD (for 30 month coordination period)		✓
• Medicare was the primary payer 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.

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 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

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

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

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

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, 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.

Section 10. Definitions of terms we use in this brochure

Calendar year	January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 14.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See page 14.
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	Services in hospitals, nursing homes or Skilled Nursing Facilities, homes, respite care or any other setting which is determined to be custodial. Custodial care means (1) non-health related services, such as assistance in activities of daily living, or (2) health-related services which do not seek to cure or which are provided during periods when the medical condition of the patient is not changing, or (3) services which do not require continued administration by trained medical personnel. Custodial care includes, but is not limited to, help in eating, getting out of bed, bathing, dressing and toileting.
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.
Experimental or investigational services	Paramount investigates all requests for coverage of new technology using the HAYES Medical Technology Directory as a guide. If further information is needed, Paramount utilizes additional sources including Medicare and Medicaid policy, Food and Drug Administration (FDA) releases and current medical literature. This information is evaluated by Paramount's Medical Director and other physician advisors.
(HDHP):Calendar year deductible	The amount You and Your Dependents must pay for Covered Services including Prescription Drugs within a calendar year, before any benefits will be paid by the Plan. Separate limits are usually applied on a per person and per family basis.
(HDHP): Catastrophic limit (OOPM)	The maximum amount of certain covered charges you have to pay out of your pocket during the year. Setting a maximum amount protects you. Separate limits are usually applied on a per person and per family basis.
Health Reimbursement Arrangement (HRA)	The HRA is an employer-funded account that reimburses employees for qualified medical expenses incurred by the employee and his/her dependents. Your employer sets the limits for the HRA.
Health Savings Account (HSA)	A Health Savings Account (HSA) is a personal, interest-bearing account that offers a tax-free incentive to save for future medical expenses. Visit www.irs.gov for more information about eligibility, contributions to and distributions from the HSA. The IRS sets the limits for the HSA that is owned by the employee and can be funded by the employer, employee and/or by any other valid deposit.
Plan allowance	Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Plans determine their allowances in different ways. We determine our allowances as follows: base Plan allowance on the reasonable and customary charge. Plan providers accept the plan allowance as payment in full.
Us/We	Us and We refer to Paramount Health Care
You	You refers to the enrollee and each covered family member.

Section 11. FEHB Facts

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.

- **Where you can get information about enrolling in the FEHB Program**

See www.opm.gov/insure/health 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 who 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 a *Guide to Federal Employees Health Benefits Plans*, brochures for other plans, and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

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

- **Types of coverage available for you and your family**

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

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

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

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

- **Children's Equity Act**

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

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

- If you have no FEHB coverage, your employing office will enroll you for Self and Family coverage in the 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 and Family in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self and Family in the 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. 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 2009 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 2008 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.

• **When you retire**

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

When you lose benefits

• **When FEHB coverage ends**

You will receive an additional 31 days of coverage, for no additional premium, when:

- Your enrollment ends, unless you cancel your enrollment, or
- You are a family member no longer eligible for coverage.

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage (TCC), or a conversion policy (a non-FEHB individual policy.)

- **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 to 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 RI 70-5, the *Guide To Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices. You can also download the guide from OPM's Web site, www.opm.gov/insure.

- **Temporary Continuation of Coverage (TCC)**

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal job, if you are a covered dependent child and you turn 22 or marry, etc.

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

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

- **Converting to individual coverage**

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

- Your coverage under TCC or the spouse equity law ends (If you canceled your coverage or did not pay your premium, you cannot convert);
- You decided not to receive coverage under TCC or the spouse equity law; or
- You are not eligible for coverage under TCC or the spouse equity law.

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

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

- **Getting a Certificate of Group Health Plan Coverage**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal law that offers limited Federal protections for health coverage availability and continuity to people who lose employer group coverage. If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan. If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans.

For more information, get OPM pamphlet RI 79-27, *Temporary Continuation of Coverage (TCC) under the FEHB Program*. See also the FEHB Web site at www.opm.gov/insure/health; refer to the "TCC and HIPAA" frequently asked questions. These highlight HIPAA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and information about Federal and State agencies you can contact for more information.

Section 12. Three Federal Programs complement FEHB benefits

Important information

OPM wants to be sure you are aware of three Federal programs that complement the FEHB Program.

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

Second, 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. The result can be a discount of 20% to more than 40% on services/products you routinely pay for out-of-pocket.

Third, the new **Federal Employees Dental and Vision Insurance Program (FEDVIP)**, offers a variety of dental plans and vision plans to anyone who is eligible to enroll in the Federal Employees Health Benefits Program. Under **FEDVIP** you may choose self only, self plus one, or self and family coverage for yourself and any qualified dependents. Premiums are on an enrollee-pays-all basis

The Federal Long Term Care Insurance Program – *FLTCIP*

It's important protection

The Federal Long Term Care Insurance Program (FLTCIP) can help you pay for the potentially high cost of long term care services, which are not covered by FEHB plans. Long term care can help you receive care to perform activities of daily living - such as bathing, dressing yourself, or for supervision you may need to receive because of a severe cognitive impairment. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). To request an information Kit and application, Call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit www.ltcfeds.com

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 \$250 and a maximum annual election of \$5,000.

- **Health Care FSA (HCFSA)** – Pays for eligible health care expenses (such as copayments, deductibles, over-the-counter medications and products, vision and dental expenses, and much more) for you and your dependents which are not covered or reimbursed by FEHBP, FEDVIP, or other insurance.
- **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 dependents, which are not covered or reimbursed, by FEHBP, FEDVIP, or other insurance.
- **Dependent Care FSA (DCFSA)** – Pays for eligible dependent care expenses for your child(ren) under age 13 or for dependants unable to care for themselves that allow you (and your spouse if married) to work, look for work (as long as you have earned income for the year), or attend school full-time.

Where can I get more information about FSAFEDS?

Visit www.FSAFEDS.com or call an FSAFEDS Benefits Counselor toll-free at 1-877-FASFEDS (1-877-372-3337). Monday through Friday 9a.m. until 9p.m. Eastern Time. TTY: 1-800-952-0450.

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

Important Information	The Federal Employees Dental and Vision Insurance Program (FEDVIP) is a program, separate and different from the FEHB Program. This was established by the Federal Employee Dental and Vision Benefits Enhancement Act of 2004.
Dental Insurance	Dental plans will provide a comprehensive range of services, including the following: <ul style="list-style-type: none">• 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 a 24-month waiting period
Vision Insurance	Vision plans will provide comprehensive eye examinations and coverage for lenses, frames and 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/insure/dentalvision . This site also provides 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- FEDS (TTY number, 1-877-TTY-5680). If you do not have access to a computer or a phone, contact your employing office or retirement system for guidance on how to enroll.

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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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Diagnostic services.....	17,50	Non-FEHB benefits.....	80,81,82,83	Reconstructive.....	25,58
Donor expenses.....	28,62	Nurse.....	22,55	Syringes.....	39
Dressings.....	22,55	Licensed Practical Nurse (LPN).....	22,55	Temporary Continuation of Coverage (TCC)	88
Durable medical equipment.....	22,55	Nurse Anesthetist (NA).....	22,55	Transplants.....	27,59
Effective date of enrollment	11	Registered Nurse.....	22,55	Treatment therapies.....	20,53
Emergency.....	32,33,66,67	Occupational therapy	20,53	Vision care	21,54
Experimental or investigational.....	76,85	Office visits.....	17,50	Vision services.....	21,54
		Oral and maxillofacial surgical.....	26,59	Wheelchairs	22,55
				Workers Compensation.....	84
				X-rays	17,50

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Summary of benefits for Paramount Health Care - 2009

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

Benefits	You pay	Page
Protection against catastrophic costs (out-of-pocket maximum):	Nothing after \$1,500/Self Only or \$3,000/ Family enrollment per year Some costs do not count toward this protection	9
Medical services provided by physicians: Diagnostic and treatment services provided in the office	Office visit copay: \$15 primary care; \$25 specialist	17
Vision care:	\$25 copay per visit	21
Services provided by a hospital:		
• Inpatient	\$500 per admission	29
• Outpatient Surgical Facility	\$150	30
Emergency benefits:		
• In-area	\$100 per visit; waived if admitted	32
• Out-of-area	\$100 per visit; waived if admitted	32
Mental health and substance abuse treatment:	Regular cost sharing	34
• Inpatient	\$500 per admission	34
Prescription drugs:		35
• Retail pharmacy	30-day supply: \$10 copay for generic drugs; \$25 copay for preferred name brand drugs; \$45 copay for non-preferred name brand drugs	35
• Speciality pharmacy	30-day supply: No coinsurance	35
• Mail order	90-day supply:	35

	\$20 copay for generic drugs; \$50 copay for preferred name brand drugs; \$135 copay for non-preferred name brand drugs	
Dental care:	Nothing	37
Special features: College Student Coverage		38

Summary of benefits for the HDHP of the - 2009

Do not rely on this chart alone. All benefits 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.

In 2009 for each month you are eligible for the HSA, will deposit \$41.67 per month for Self Only enrollment or \$83.33 per month for Self and Family enrollment to your HSA. For the Health Savings Account (HSA), you must satisfy your calendar year deductible of \$1,500 for Self Only and \$3,000 for Self and Family before using your HSA. Once you satisfy your calendar year deductible, Traditional medical coverage begins.

For the Health Reimbursement Arrangement (HRA), your health charges are applied to your annual HRA Fund of \$500 for Self Only and \$1,000 for Self and Family. Once your HRA is exhausted, you must satisfy your calendar year deductible. Once your calendar year deductible is satisfied, Traditional medical coverage begins.

Below, an asterisk (*) means the item is subject to the \$1,500 for Self Only and \$3,000 for Self and Family calendar year deductible. And, after we pay, you generally pay any difference between our allowance and the billed amount if you use a Non-PPO physician or other health care professional.

Benefits	You pay	Page
In-network medical preventive care	Covered in full	47
Medical services provided by physicians:	Subject to deductible then covered in full.	50
Diagnostic and treatment services provided in the office	Subject to deductible then covered in full.	50
Services provided by a hospital:		63
• Inpatient	Subject to deductible then covered in full.	63
• Outpatient	Subject to deductible then covered in full.	63
Emergency benefits:		66
• In-area	Subject to deductible then covered in full.	67
• Out-of-area	Subject to deductible then covered in full.	67
Mental health and substance abuse treatment:	Subject to deductible then covered in full.	68
Prescription drugs:	Subject to deductible then covered in full.	71
• Preventive drugs:	Covered in full	71
• Retail pharmacy	Subject to deductible then covered in full.	71
• Mail order	Subject to deductible then covered in full.	71
Protection against catastrophic costs (out-of-pocket maximum):	\$1,500 for Self Only enrollment and \$3,000 for Self and Family enrollment	9

2009 Rate Information for Paramount Health Care - 2009

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

Postal rates apply to career Postal Service employees. Most employees should refer to the Guide to Benefits for Career United States Postal Service Employees, RI 70-2, and to the rates shown below.

The rates shown below do not apply to Postal Service Inspectors, Office of Inspector General (OIG) employees and Postal Service Nurses. Rates for members of these groups are published in special Guides. Postal Service Inspectors and OIG employees should refer to the *Guide to Benefits for United States Postal Inspectors and Office of Inspector General Employees* (RI 70-2IN). Postal Service Nurses should refer to the *Guide to Benefits for United States Postal Nurses* (RI 70-2NU).

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

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
High Option Self Only	U21	155.66	89.34	337.26	193.57	179.45	65.55
High Option Self and Family	U22	352.56	235.41	763.88	510.05	406.42	181.55
HDHP Option Self Only	U24	134.75	44.91	291.96	97.30	155.41	24.25
HDHP Option Self and Family	U25	314.30	104.77	680.98	227.00	362.50	56.57