



Paramount Care, Inc.—Ohio 2009

The following is our Annual Statement to members, a yearly update that describes our services, provider networks, complaint and appeal procedures, and member rights and responsibilities of Paramount Care, Inc.

Paramount Care, Inc., was licensed in Ohio in 1988. To serve customers in Michigan, a separate corporation, Paramount Care of Michigan, Inc., was established and received Michigan licensure in July 1996. Paramount is a for-profit entity and is wholly owned by ProMedica Health System, a nonprofit entity. ProMedica serves its communities through five divisions—ProMedica Ambulatory and Acute Care; ProMedica Physician Group; ProMedica Health, Education and Research Corporation; ProMedica Continuing Care Services Corporation; and ProMedica Insurance Corporation.

Paramount is a health maintenance organization (HMO) that is accredited by the National Committee for Quality Assurance (NCQA). In December 2008, the Commercial member enrollment was approximately 83,440 in Ohio and 5,807 in Michigan.

Paramount offers a variety of comprehensive health benefit plans for our members. Paramount's participating Primary Care and Specialist Physicians treat Paramount members in their own private offices conveniently located throughout the area. A current directory of Participating Physicians and Facilities lists the Primary Care Physicians (Family Practice, Internal Medicine, or Pediatrics) and participating specialists and hospitals. If you would like to receive a current version of the Participating Physicians and Facilities directory, call Member Services at **1-419-887-2525** or outside the area at **1-800-462-3589**. Or you can visit the Paramount Web site at **www.paramounthealthcare.com** to find a list of participating providers.





The Paramount Health Care service area includes all of Ashland, Crawford, Defiance, Erie, Fulton, Hancock, Henry, Huron, Lucas, Marion, Morrow, Ottawa, Putnam, Richland, Sandusky, Seneca, Williams, Wood, and Wyandot and portions of Allen, Delaware, Hardin, Knox, Lorain, and Paulding counties in Ohio. In Michigan, the service area includes Lenawee and Monroe counties.

The Paramount Health Care administrative office is located at:

1901 Indian Wood Circle
Maumee, OH 43537
Telephone: 1-419-887-2525
Toll-free: 1-800-462-3589
TTY: 1-419-887-2526 (toll-free 1-888-740-5670)
Fax: 1-419-887-2018
Member Services hours: 8 a.m. to 5 p.m.,
Monday through Friday

Paramount Health Care contracts with providers for health care services on an economically competitive basis, while taking steps to ensure that all our members receive appropriate and timely access to qualified providers. Through contracts with participating providers, Paramount obtains discounts. These discounts help Paramount offer affordable premiums. When copayments are charged as a percentage of eligible expenses, the amount you pay is determined as a percentage of the allowed amount between Paramount and the participating provider, rather than a percentage of the provider's billed charge. Paramount's allowed amount is ordinarily lower than the participating provider's billed charge. Therefore, the benefit of the discount is passed on to you.

Express Scripts provides Pharmacy Benefit Management (PBM) services for Paramount. Part of this service is to obtain discounts at pharmacies that contract with Express Scripts. These discounts are passed on to you. If your drug copayment is a percentage, the amount you pay is determined as a percentage of the discounted cost, rather than a percentage of the retail

cost. Therefore, the benefit of the discount is passed on to you. If the drug costs less than your copayment, you will pay the lesser of your copayment or the cost of the drug plus the pharmacist's dispensing fee. Under our agreement with Express Scripts, there are also certain administrative costs and rebates. Neither the administrative costs nor the rebates are included in your drug benefit. Paramount pays the administrative costs and retains the rebates to help offset administrative expenses. Not all benefit plans, however, include coverage for outpatient prescription drugs. Contact the Member Service Department if you have questions. Physicians who apply to participate must meet high standards established by their peers and must be approved by the Board of Directors. Paramount physicians actively participate in our managed care programs. Except for deductibles, copayments, coinsurance, and noncovered services, participating providers may not bill members for covered services.

Current quality improvement activities include promotion of preventive services and improved care for people with chronic illness. Examples include monitoring diabetes, asthma, pediatric immunizations, and stop-smoking programs. In addition, our member newsletter offers constructive information to encourage effective use of Paramount Health Care services. Direct member surveys also monitor member satisfaction.

What to Do When You Have Questions, Complaints, or Appeals

Paramount's Member Service Department is available to assist you from 8 a.m. to 5 p.m., Monday through Friday. If you call the Member Service Department after hours, you can leave a message, and we will return your call on the next working day. You can also contact us by e-mail at member.services@promedica.org.

The Member Service Department's goal is to help you with any questions about procedures, benefits, participating providers, payment for services, enrollment, and more. We encourage you to call us with any questions. If you have any suggestions for improving our service or if you wish to recommend changes in procedures or benefits, please write us, call us, or send us an e-mail. We also encourage you to develop a good relationship with your physician so that you fully understand the diagnosis and treatment prescribed.

Reconsideration of a Utilization Review Decision

Under ORC 1751.82, a provider has the right to request reconsideration on your behalf when Paramount has made an adverse determination (denial) on a prospective or concurrent utilization review of an admission,

availability of care, continued stay, or other health care service. The provider or health care facility may not request reconsideration without your prior written consent. Paramount will reconsider a nonurgent care pre-certification request **within two (2) working days** from receipt of the provider's written request for reconsideration. Reconsideration of a denial for care currently in process (previously authorized by Paramount) is conducted **within twenty-four (24) hours** from receipt of the request for reconsideration. Reconsideration of a denial for services that have already been received is conducted **within twenty-five (25) calendar days** from receipt of the request for reconsideration. The reconsideration will be conducted between the provider and the Paramount reviewer who made the adverse determination. If the reconsideration process does not resolve the difference of opinion, the member (you), your legal representative, an authorized person, or the provider or health care facility acting on your behalf can request an Internal Review under ORC 1751.83.

How to Handle a Complaint

A complaint is when you are dissatisfied with any aspect of Paramount's service. If you have a complaint, call the Member Service Department at **1-419-887-2525** or toll-free at **1-800-462-3589**. A Member Service Representative will try to resolve the complaint **within two (2) working days** for urgent clinical issues and **thirty (30) working days** for other complaints. You will be advised of the disposition of your complaint by telephone or in writing. If a complaint is not resolved to your satisfaction, you will be advised of your right to appeal.

Appeal to Paramount

As a member of Paramount, you have the right to appeal decisions that deny or limit your health care benefits. Your rights are explained below. (Appeal rights vary for members of self-insured and FEHB groups. Refer to your summary plan description or benefit booklet.)

Internal Review

If a service is denied, reduced, or terminated, you can ask Paramount to review the request for the service again. You can make this request in writing. This is called an internal review. You must request an internal review within one year from the denial, reduction, or termination. You (the member), your legal representative, an authorized person, the provider, or the health care facility can request the review. The provider and health care facility must have the member's authorization to request a review. You do not need the authorization of the provider. You will receive an acknowledgment from Paramount **within five (5) working days** from receipt of your request. You will

be given the opportunity to attend a hearing before an administrative review panel. If you cannot attend the hearing, you can attend by teleconference or submit a written statement. If the service is being denied, reduced, or terminated because of contract benefit limits, because the service is not covered under the contract, or the case involves a membership or enrollment issue, the review will be conducted by administrative staff. Paramount will use a clinical peer for this review if it involves a clinical issue. A clinical peer is a physician or provider who has the same license as the provider who will perform the service or provide treatment. The clinical peer will review your medical records and determine if the service is medically necessary. If the clinical peer determines that the service is medically necessary, Paramount must pay for the service; if the clinical peer determines that the service is not medically necessary, Paramount can continue to deny payment for the services. If payment for the services is denied, you have the right to ask for another review.

Paramount must provide you with a written response indicating its decision **within thirty (30) calendar days** for pre-service issues and **within sixty (60) calendar days** for post-service issues of the date we receive your written request for an internal review. If your medical condition requires a faster review (called an expedited review), Paramount must provide you with a response **within seventy-two (72) hours**. If Paramount does not respond to your request for an internal review **within sixty (60) calendar days** or **within seven (7) calendar days** for expedited reviews, it is considered a denial, and you have the right to appeal further.

Additional Appeals

If Paramount continues to deny payment for the service, you will be informed of your right to ask for another review. You can appeal denials for any of the reasons listed below:

- A. They are not covered services.
- B. They are not medically necessary.
- C. They are experimental and you have a terminal illness.

Denial Because Services Are Not Covered

If Paramount denies the service because it is not a covered service under the terms of your Paramount contract, you can request a review from the Department of Insurance. You should write promptly to the Department of Insurance at 50 W. Town St., Columbus, OH 43215, or call the Department at **1-800-686-1526**.

The Department will review your contract and the type of service requested. If the Department determines

that the service is not a covered benefit, Paramount does not have to pay for the service. If the Department determines that the service is a covered benefit, Paramount must either pay for the service or give you an opportunity for a review by an independent review organization (IRO).

Denial Because the Services Are Not Medically Necessary

If Paramount denies, reduces, or terminates the service because it is not medically necessary and the service and the related expenses will cost you more than \$500 if it is not covered by Paramount (the \$500 does not apply in cases of expedited reviews), you can request an external review from an IRO. The IRO is not affiliated with Paramount.

You must request this review **within sixty (60) calendar days** of receiving notice that your claim was denied by the clinical peer. Your request must be in writing and include a certification from the provider that the services will **cost you more than \$500**. You (the member), your legal representative, an authorized person, the provider, or the health care facility can request the review. The provider and health care facility must have the member's authorization to request a review. You do not need the authorization of the provider. You will receive an acknowledgment from Paramount **within five (5) working days** from receipt of your request.

The IRO will review your medical records and determine if the recommended service is medically necessary. If the IRO determines that the service is medically necessary, Paramount must pay for the service according to the terms of the contract. If the IRO determines that the service is not medically necessary, Paramount does not have to pay for the service.

Denial Because the Services Are Experimental

If you have a terminal illness, you can also request an external review when the services are denied because they are experimental or investigative. To qualify for this review, you must meet all of the following criteria:

1. You have a terminal condition that according to the current diagnosis has a high probability of causing death within two years.
2. You request an external review **no later than sixty (60) calendar days** after receipt of notice of the result of your internal review.
3. Your physician certifies that one of the following situations applies to your condition:
 - ▶ Standard therapies have not been effective in improving your condition.
 - ▶ Standard therapies are not medically appropriate for you.

- ▶ There is no standard therapy covered by Paramount that will benefit you more than the therapy requested by either you or your physician.

4. Your physician has recommended a drug, device, procedure, or other therapy that he or she certifies in writing is likely to benefit you more than standard therapies or you have requested a therapy that has been found in a preponderance of peer-reviewed published studies to be associated with effective clinical outcomes for the same condition.
5. You have exhausted the internal review process.
6. The drug, device, procedure, or other therapy would be covered if it were not considered to be experimental or investigative.

Instructions for Requesting an External Independent Review

You must request an external independent review in writing **within sixty (60) calendar days** of receiving notice of the denial from Paramount's internal review. You (the member), your legal representative, an authorized person, the provider, or the health care facility can request the review. The provider and health care facility must have the member's authorization to request a review. You do not need the authorization of the provider. You will receive an acknowledgment from Paramount **within five (5) working days** from receipt of your request. You cannot be required to pay for the review. The review is paid for by Paramount.

The IRO must provide a response **within thirty (30) calendar days**. The decision must include:

- ▶ A description of the patient's condition
- ▶ The principal reasons for the decision
- ▶ An explanation of the clinical rationale for the decision

Expedited Reviews

When the review must be completed quickly because of your medical condition, you can request an external review by phone, fax, or e-mail. However, you must follow up this request with a written request **within five (5) calendar days**. The IRO must provide you with a response to an expedited review of your initial request.

You can request an expedited review if delaying the review will do any of the following:

- ▶ Place the health of the patient or unborn child in serious jeopardy
- ▶ Cause serious impairment to bodily functions
- ▶ Cause serious dysfunction of any body organ or part

You may not bring action in court against Paramount until you have exhausted all the applicable procedures described above.

Members' Rights

As a member of Paramount, you have certain rights that you can expect from Paramount and Paramount providers. You have the right to:

- ▶ Receive information about Paramount, its services, providers, and your rights and responsibilities
- ▶ Participate with your physicians in making decisions regarding your health care
- ▶ Have a candid discussion of appropriate or medically necessary treatment options for the conditions regardless of cost or benefit coverage
- ▶ Voice complaints or appeals about the health plan or care provided
- ▶ Be treated with respect, recognition of your dignity, and the need for privacy
- ▶ Make recommendations regarding the organization's member rights and responsibilities policies

Members' Responsibilities

As a member of Paramount, you have certain responsibilities that Paramount and Paramount providers can expect from you. You have the responsibility to:

- ▶ Provide, to the extent possible, information that Paramount and participating practitioners need in order to care for you
- ▶ Engage in a healthy lifestyle, become involved in your health care, and follow the plans and instructions of care that you have agreed on with your Primary Care Physician or specialists
- ▶ Understand your health problems and participate in developing mutually agreed-upon treatment and goals to the degree possible

Insurance Fraud

Insurance fraud significantly increases the cost of health care. Paramount encourages you to let us know if you have any questions or concerns about Paramount providers and/or the services you receive. Please call the Paramount Member Service Department for confidential handling at **1-419-887-2525** or toll-free at **1-800-462-3589**. TTY services for the hearing-impaired are available at **1-419-887-2526** or toll-free at **1-888-740-5670**. You can also call the ProMedica Health System Compliance Hotline for confidential investigation. That hotline number is **1-419-824-1815** or toll-free **1-800-807-2693**.

Paramount Notice of Privacy Practices

I. THIS NOTICE DESCRIBES HOW YOUR NON-PUBLIC PERSONAL HEALTH INFORMATION ABOUT YOU MAY BE COLLECTED, USED, AND DISCLOSED BY US AND HOW YOU CAN GET ACCESS TO THE INFORMATION WE HAVE ABOUT YOU; PLEASE REVIEW IT CAREFULLY.

The terms of this Notice of Privacy Practices apply to the following affiliated covered entities: Paramount Health Care; Paramount Care of Michigan, Inc.; Paramount *Advantage*™; and Paramount Insurance Company (collectively Paramount) operating as health plans to carry out payment and health care operations as permitted by law.

II. WE HAVE A LEGAL DUTY TO PROTECT YOUR HEALTH INFORMATION.

We are required by law to protect the privacy of your health information. This includes all non-public personal information about you, such as whether you are enrolled in a Paramount health benefits plan, your premium information, and your claims information. We are required to provide you with this notice about our privacy practices. We are required to comply with all of the terms described in the current version of our Notice of Privacy Practices. You can request a copy of this notice from the contact office listed in Section X at any time and can view a copy of this notice on our Web site at **www.paramounthealthcare.com** or **www.paramountcareofmichigan.com**.

III. HOW WE COLLECT INFORMATION

We collect information about you that is related to your participation in a Paramount health benefits plan. We receive information from you on applications and other forms that you submit to us and from your transactions with us, our affiliates in the ProMedica Health System, or others.

IV. HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

A. USES AND DISCLOSURES THAT DO NOT REQUIRE YOUR AUTHORIZATION

Paramount collects health information from you and stores it in a paper file and on computer. Except as outlined below, we will not use or give out information about you for any purpose unless you have signed an authorization form.

1. **To carry out payment.** When you enroll with Paramount, we may disclose information about you to carry out payment functions. For example, we may use information about you for the purpose of:

- ▶ Claims payment
- ▶ Collection of premiums
- ▶ Coordination of benefits
- ▶ Subrogation of health benefit claims

2. For regular health plan operations. When you enroll with Paramount, we may disclose information about you to operate this health plan. For example, we may use information about you for the purpose of:

- ▶ Referrals, precertification, and case management
- ▶ Distribution of disease management educational notices and preventive care reminders
- ▶ Quality assessment and improvement activities
- ▶ Medical review and auditing functions, including fraud and abuse detection
- ▶ Underwriting and premium rating
- ▶ Customer service and requests for internal reviews
- ▶ Accreditation activities and program licensure

In addition, we give your information to our business associates, such as a pharmacy benefit manager and others, that process our claims. We may also provide information about you to our accountants, attorneys, consultants, and others in order to make sure that we are complying with the laws that affect us.

- 3. When required by federal, state, or local law; judicial or administrative proceedings; or law enforcement.** For example, we give out your information when the law requires that we report information to government agencies and law enforcement personnel in response to a subpoena, when ordered by the court, or in response to a discovery request.
- 4. For health oversight activities.** For example, we will provide information to assist the government when it conducts an investigation or audit to determine beneficiary eligibility and compliance with program standards.
- 5. To avoid harm.** In order to avoid a serious threat to the health or safety of a person or the public, we may give your information to law enforcement personnel or persons able to prevent or lessen such harm.
- 6. For specific government functions.** We may give out information on military personnel and veterans in certain situations. We may give your information to correctional institutions and law enforcement in custodial situations.

We may also give out your information for national security or intelligence activities.

- 7. For workers' compensation purposes.** We may give out your information in order to comply with workers' compensation laws.
- 8. To family and friends involved in your care.** If you are unavailable, incapacitated, or facing an emergency medical situation and we determine that a limited disclosure may be in your best interest, we may share limited personal health information with family, friends, or others who are involved in your care or in payment for your care.

B. DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Before we use or disclose your personal health information for any reason other than those reasons listed in Section IV.A, we will need to get your written authorization. If you authorize us to use or disclose your information, you can revoke your authorization by notifying the office listed in Section X in writing.

V. YOUR HEALTH INFORMATION RIGHTS

A. THE RIGHT TO REQUEST LIMITS ON HOW WE USE AND DISCLOSE YOUR HEALTH INFORMATION

You have the right to ask that we limit how we use and give out your information. We will carefully consider your request but are not required to accept it. If we accept your request, we will put it in writing and abide by it.

B. THE RIGHT TO CHOOSE HOW WE SEND YOUR INFORMATION TO YOU

You have the right to ask that we send information to you at an alternate address. For example, you may ask us to send information to your work address rather than your home address. You can also ask that it be sent by alternate means. For example, you can ask that we send information by fax instead of regular mail. We will agree to your request if we can easily provide it in the format you request.

C. THE RIGHT TO SEE AND GET COPIES OF YOUR HEALTH INFORMATION

Most of the time, you have the right to look at or get copies of your health information that we have. Your request must be on the appropriate form and signed by you or your legally authorized representative. In certain situations, we may deny your request. If we do, we will tell you, in writing, our reasons why and explain how you can have the denial reviewed.



D. THE RIGHT TO GET A LIST OF WHOM WE HAVE GIVEN YOUR INFORMATION TO

You have the right to get a list of certain instances in which we have given out your health information after April 14, 2003.

E. THE RIGHT TO CORRECT OR UPDATE YOUR HEALTH INFORMATION

If you believe that there is a mistake in your information or that a piece of important information is missing, you have the right to request that we correct the existing information or add the missing information. Your request and your reason for the request must be submitted on the appropriate form. Each request will be carefully considered. If we approve your request, we will make the change to your information, tell you that we have done it, and tell others who need to know about the change.

F. HOW TO MAKE REQUESTS

To make requests under Sections V.A through V.E, complete the appropriate form available from the contact office listed in Section X and send it to the address indicated.

G. THE RIGHT TO GET THIS NOTICE

You have the right to get a copy of this notice by e-mail. You also have the right to request a paper copy of this notice.

VI. PROCEDURES TO MAINTAIN CONFIDENTIALITY AND SECURITY

Paramount restricts access to health information about you to those employees who need to know that information to provide products or services to you. We maintain physical, electronic, and procedural safeguards that comply with applicable law.

VII. CHANGES TO THE POLICY

If our privacy policy should change at any time in the future, we will promptly change, post, and distribute the new notice. We will also distribute this Notice of Privacy Practices annually. We reserve the right to apply any changes to our privacy policy or this notice to all of the personal health information that we maintain, including information collected before the date of the change.

VIII. COMPLAINTS

If you think that we may have violated your privacy rights or you disagree with a decision we made about your health information, you may file a complaint with the office listed in Section X. You may also send a written complaint to the Secretary of the Department of Health and Human Services

in Washington, D.C. We will take no action against you if you file a complaint about our privacy practices.

IX. PROTECTIONS APPLY TO FORMER MEMBERS

Paramount does not destroy information about you when you terminate your coverage with us. However, the policies and procedures outlined in this notice continue to apply to protect the information of former members.

X. OFFICE TO CONTACT FOR INFORMATION ABOUT THIS NOTICE

If you have any questions about this notice or any complaints about our privacy practices, please contact:

Paramount Member Service Department
1901 Indian Wood Circle
Maumee, OH 43537
Mailing Address:
P.O. Box 928
Toledo, OH 43697-0928
Telephone: 1-419-887-2525
Toll-free: 1-800-462-3589

XI. EFFECTIVE DATE OF THIS NOTICE

This notice goes into effect on April 14, 2003.

To the extent state privacy laws apply, these state laws (rather than the terms of this notice) might impose the privacy standard under which Paramount is required to operate.

Paramount Web Site

Visit our Web site at www.paramounthealthcare.com. Through the Web site, you can access your health plan information, the Ohio Member Handbook, Provider Directory, Frequently Asked Questions (FAQs), health tips, news articles, Preferred Drug List, and more. You can also e-mail Paramount with your questions. Check us out!

Go to www.paramounthealthcare.com/myaccount to complete an interactive evaluation of your health. You need your Paramount ID number to register first. Visit Paramount's online health information resource today for access to 3,000 health topics!

Important Women's Health and Cancer Rights Act of 1998 Annual Notice for 2009

This notice is being sent to you in accordance with H.R. 4328, the Women's Health and Cancer Rights Act of 1998, passed by Congress and signed by President Clinton on October 21, 1998.

The act amends the Employee Retirement Income Security Act of 1974 to require group health insurers that provide "medical and surgical benefits with respect to a mastectomy" to also cover the following:

A member who will be receiving or has received a mastectomy and who elects breast reconstruction in consultation with her physician will have coverage for:

- ▶ Reconstruction of the breast on which the mastectomy has been performed,
- ▶ Surgery and reconstruction of the other breast to produce a symmetrical appearance and
- ▶ Prostheses and treatment for physical complications at all stages of the mastectomy, including lymphedemas.

Coverage will be subject to the same office visit copayments and/or coinsurance (if any) described in your Summary of Benefits as are applicable to other covered services.

Paramount is proud of the fact that we provided the above coverage to our members before it was required by legislation. However, this annual notice is required as part of the law. If you have any questions, please call the Member Service Department at **1-419-887-2525** or toll-free at **1-800-462-3589**.



www.paramounthealthcare.com

