



**HIPAA  
9V  
\$10/\$20 90/10**

**Dependent Child Care Limit**  
 Dependent children are covered until the end of the month they turn age 19. Full time students are covered until the end of the month they turn age 23.

<b>Deductible</b> (applies to any services with coinsurance) <b>\$100 Single/\$200 Family</b>  <b>Out-of-pocket Maximum</b> <b>\$2000 Single/\$4000 Family</b>	Co-payments and Coinsurance for Supplemental Health Services such as Mental Health, Substance Abuse, Home Health Care, Durable Medical Equipment, Prosthetic Devices, Prescription Drugs and any penalties do not count toward the Out-of-Pocket Maximum.
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SERVICES	MEMBER COPAY
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PHYSICIAN OFFICE SERVICES	
<b>Primary Care Physician</b> <ul style="list-style-type: none"> <li>▪ Office Visits</li> <li>▪ Outpatient and Home Visits</li> <li>▪ Office Consultation</li> </ul>	\$10.00 Copay per office visit.
<b>Specialist Physician Services</b> (Including annual vision exam) <ul style="list-style-type: none"> <li>▪ Office Visits</li> <li>▪ Outpatient and Home Visits</li> <li>▪ Office Consultations</li> <li>▪ Urgent Care Visits</li> </ul>	\$20.00 Copay per office visit.
<b>Contraceptive/Sterilization</b> <ul style="list-style-type: none"> <li>▪ Physician Office</li> <li>▪ Outpatient</li> </ul>	Applicable office visit copay 10% Coinsurance (subject to plan deductible)

EMERGENCY MEDICAL CARE	
Hospital Emergency Care Service	Facility- 20% Coinsurance (subject to plan deductible) Physician- 20% Coinsurance (subject to plan deductible)
Urgent Care Facility Visits	Facility- 20% Coinsurance (subject to plan deductible) Physician - 20% Coinsurance (subject to plan deductible)
Emergency Ambulance Services	10% Coinsurance (subject to plan deductible)

DIAGNOSTIC SERVICES	
<b>Laboratory &amp; Pathology</b> <ul style="list-style-type: none"> <li>▪ PCP Office</li> <li>▪ Specialist Office</li> <li>▪ Facility</li> </ul>	\$10.00 Copay \$20.00 Copay 10% Coinsurance (subject to plan deductible)
<b>Diagnostic Tests, X-rays &amp; Radiation Therapy</b> <ul style="list-style-type: none"> <li>▪ PCP Office</li> <li>▪ Specialist Office</li> <li>▪ Facility</li> </ul>	\$10.00 Copay \$20.00 Copay 10% Coinsurance (subject to plan deductible)

MATERNITY SERVICES	
<ul style="list-style-type: none"> <li>▪ Pre-Natal and Post-Natal Care</li> <li>▪ Facility</li> <li>▪ Delivery and Nursery Care</li> </ul>	Covered In Full 10% Coinsurance (subject to plan deductible) 10% Coinsurance (subject to plan deductible)

SERVICES	MEMBER COPAY
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### HOSPITAL CARE

Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	10% Coinsurance(subject to plan deductible)
Inpatient Rehabilitation (Up to 60 days)	10% Coinsurance (subject to plan deductible)
Inpatient Consultation	10% Coinsurance (subject to plan deductible)
Chemotherapy	10% Coinsurance (subject to plan deductible)
Outpatient Hospital	10% Coinsurance (subject to plan deductible)

### ALTERNATIVES TO HOSPITAL CARE

Hospice Services	10% Coinsurance (subject to plan deductible)
Skilled Nursing Facility (Up to 100 Days)	10% Coinsurance (subject to plan deductible)
Home Health Service	10% Coinsurance (subject to plan deductible)

### HUMAN ORGAN TRANSPLANTS

Specified Organ or Bone marrow Transplants-in designated facilities only, when coordinated through Paramount Utilization Management Department	10% Coinsurance-in designated facilities only (subject to plan deductible)
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### MENTAL HEALTH CARE & SUBSTANCE ABUSE TREATMENT

Mental Health Care Inpatient: Up to 30 Days per calendar year Outpatient: Up to 20 Visits per calendar year (Combined with Substance Abuse)	10% Coinsurance (subject to plan deductible) \$25.00 Copay
Substance Abuse Inpatient: Up to 30 Days per calendar year Outpatient: Up to 20 Visits per calendar year (Combined benefit with Mental Health)	10% Coinsurance (subject to plan deductible) \$25.00 Copay

### OTHER SERVICES

<b>Allergy Treatment</b>	
<ul style="list-style-type: none"> <li>▪ PCP Office</li> <li>▪ Specialist Office</li> <li>▪ Facility</li> <li>▪ Allergy Testing</li> </ul>	\$10.00 Copay \$20.00 Copay 10% Coinsurance (subject to plan deductible) \$25.00 Copay
Outpatient Physical, Occupational and Speech Therapy (Combined benefit up to 30 visits per calendar year)	\$20.00 Copay
Durable Medical Equipment	20% Coinsurance. Subject to Medicare Part B guidelines (subject to plan deductible)
Prosthetics (Covers initial device, repairs and replacements up to an annual limit of \$7,500)	20% Coinsurance. Subject to Medicare Part B guidelines (subject to plan deductible)
Infertility Services	40% Coinsurance (subject to plan deductible)
Chiropractic Rider (Up to 40 visits or \$750 per member, whichever occurs first)	\$20.00 Copay

**Notice Concerning Coordination of Benefits**

If you or your family members are covered by more than one health care plan, you may not be able to collect benefits from both plans. Each plan may require you to follow its rules or use specific doctors and hospitals, and it may be impossible to comply with both plans at the same time. Read all the rules very carefully, including the Coordination of Benefits section, and compare them with the rules of any other plan that covers you or your family.

**Restrictions on Choice of Providers**

All services described in the Summary of Benefits must be provided, arranged or authorized by your Primary Care Physician. Exceptions are Emergency Medical Conditions and services from the following Participating Providers: OB/GYNs, vision providers, dermatologists, allergists, hematologists, oncologists and pediatric pulmonologists. In the event you are referred to a non-Participating Provider, prior authorization must be obtained from Paramount by your Primary Care Physician except for Emergency Medical Conditions. The services of chiropractors are not covered unless an optional rider has been purchased.

**Principal Exclusions and Limitations**

Exclusions include, but are not limited to: dental services, dental treatment of TMJ, growth hormones, custodial care, convenience care items, experimental/investigational services, routine foot care, cosmetic surgery (except to restore functioning), assisted reproductive technology including but not limited to: in vitro fertilization, GIFT, ZIFT, infertility drugs, surrogate pregnancy and other assisted reproductive technology unless specifically required by state regulation. The Summary of Benefits is an outline of Deductibles, Copayments, Coinsurance and limits. For complete details on Paramount's Benefits, refer to your Ohio Member Handbook, the Group Medical and Hospital Service Agreement or call our Member Service Department at (419) 887-2525 or toll-free at 1-800-462-3589. TTY services for the hearing impaired are available by calling 1-888-740-5670. You may also visit our web site at [www.paramounthealthcare.com](http://www.paramounthealthcare.com)

All Covered Services are subject to Medical Necessity. Refer to the Group Medical and Hospital Service Agreement, Sections I through V for further details.

**Deductible and Out-of-Pocket Copayment Limit**

A Deductible is the amount you must pay for Covered Services within each Contract or Calendar Year before benefits will be paid by Paramount. If your plan has a Deductible, it is stated above. Preventive Health Services and Covered Services requiring a Copayment are not subject to the Deductible. The Out-of-Pocket Copayment Limit is the maximum amount of Copayments and Coinsurance including the Deductible (if any) you pay every Contract or Calendar Year. Copayments and Coinsurance for Supplemental Health Services such as mental health, substance abuse, home health care, durable medical equipment, prosthetic devices, prescription drugs and any penalties do not count toward the Out-of-Pocket Copayment Limit.