

**SUMMARY OF BENEFITS
SMALL GROUP HIGH POS PLAN**

At Enrollment Member Chooses Paramount PCP

Service	In-Network Benefits With Participating PCP Selection	Leak Yes or No	Leak Benefits With Participating PCP Selection
Child Age 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.		
Deductible	None		\$300 Single/\$600Family
Deductible Carryover	No		Does Not Apply
Coinsurance	Does Not Apply Except Where Indicated		30% Coinsurance
Maximum out of Pocket	\$1,500 Single/\$3,000 Family		\$3,000 Single/\$6,000 Family
Maximum Lifetime Benefit	Not Applicable		\$ 1 Million Overall (Substance Abuse Subject to The Lifetime Maximum Benefit of \$25,000)
Member Non-Notification Penalty	Not Applicable		\$500 Inpatient; 10% Up To \$100 On Other Services
Benefit Counters	Calendar Year		
Pre-Existing Conditions	Not Applicable		
PROFESSIONAL SERVICES			
Primary Care Services ▪ Wellness Visits ▪ Annual Physicals, ▪ Immunizations from Age 9	\$10 Copay	No	Not Covered
Sick Visits	\$10 Copay	No	Not Covered
▪ Wellness Visits ▪ Annual Physicals ▪ Immunizations Age 0 to 8	\$10 Copay	Yes	Not Subject to Deductible To Age 1: Covered in Full up To \$500 Limit Per Calendar Year Age 1 to 8: Covered in Full Up To \$150 Limit Per Calendar Year
Specialist Services: Office Visits	\$15 Copay	Yes*	30% Coinsurance; Subject to Deductible; With Prior Member Notification
Podiatry Services	\$15 Copay	Yes*	30% Coinsurance; Subject to Deductible; With Prior Member Notification
OB/GYN Visits	\$15 Copay	Yes*	30% Coinsurance; Subject to Deductible; With Prior Member Notification
Annual GYN Exam	\$15 Copay	Yes*	Covered in Full; Not Subject to Deductible; With Prior Member Notification
Maternity Care ▪ Pre & Post Natal ▪ Delivery	Covered in Full Covered in Full	Yes*	30% Coinsurance; Subject to Deductible; With Prior Member Notification
Diagnostic Services (Lab & X-Ray) • At Physician's Office	Applicable Copay	Yes*	30% Coinsurance; Subject to Deductible
• At Independent Diagnostic Facility	Covered in Full	Yes	30% Coinsurance; Subject to Deductible
• At Hospital	Covered in Full	Yes	30% Coinsurance; Subject to Deductible

PROFESSIONAL SERVICES (CONT.)			
Pap Smears and Screening Mammograms:			
• At Physician's Office	Applicable Copay	Yes*	Covered in Full; Not Subject to Deductible; Screening Mammograms are Covered up to \$85 Per Member Per Calendar Year
• At Independent Diagnostic Facility	Covered In Full	Yes	
• At Hospital	Covered in Full	Yes	
Infertility Services	All Services Subject to 70/30 Coinsurance Excluding Infertility Drugs	No	Not Covered
Sterilization/Contraception	Covered Subject to Office Visit Copay	No	Not Covered
Durable Medical Equipment	20% Coinsurance per member, Subject to Medicare Part B guidelines	Yes	30% Coinsurance; Subject to Deductible; Up to \$500 Per Member Per Calendar Year
▪ Orthotic Foot Devices	Not Covered; unless Medicare guidelines are met	No	Not Covered
Prosthetic Devices (Initial Device)	20% Coinsurance up to \$7500 per member; Subject to Medicare Part B Guidelines	Yes	30% Coinsurance; Subject to Deductible; Up to \$5,000 per Member Per Calendar Year
TMJ	Medical Treatment is Covered	No	Not Covered
Human Organ Transplant	Covered in Full with Prior Approval from Paramount	No	Not Covered
Allergy Testing	\$25 Copay	Yes*	30% Coinsurance; Subject to Deductible; With Prior Member Notification
Allergy Treatment	Office Visit Copay	Yes*	30% Coinsurance; Subject to Deductible; With Prior Member Notification
Routine Vision Exam	Applicable office visit Copay	No	Not Covered
Hearing Exam	Applicable office visit Copay	No	Not Covered
OUTPATIENT HOSPITAL SERVICES			
Facility Services	Covered in Full	Yes*	30% Coinsurance; Subject to Deductible; With Prior Member Notification
Professional Services	Covered in Full	Yes*	30% Coinsurance; Subject to Deductible; With Prior Member Notification
Outpatient Surgical Facility	Covered in Full	Yes*	30% Coinsurance Subject to Deductible with prior member notification
EMERGENCY SERVICES			
Emergency Conditions	\$75 Copayment (Waived If Admitted) For Emergency Medical Conditions	Yes	Covered under Network Benefits
Urgent Care Conditions	\$35 Copayment With PCP Prior Approval	Yes	30% Coinsurance
Emergency Transportation	Covered In Full	Yes	Covered under Network Benefits
INPATIENT HOSPITAL SERVICES			
Facility Services	Covered In Full	Yes*	30% Coinsurance; Subject to Deductible; With Prior Member Notification
Professional Services	Covered In Full	Yes*	30% Coinsurance; Subject to Deductible; With Prior Member Notification
Hospice/Home Health Care (In Lieu of Hospitalization)	Covered in Full With PCP and Health Plan Approval	Yes*	30% Coinsurance; Subject to Deductible; With Prior Member Notification

THERAPY SERVICES			
Inpatient Rehabilitation	Covered in Full up to 60 Days	No	Not Covered
Outpatient Physical/Occupational Therapy/Speech Therapy	30 combined visits; \$10 Copay per visit	No	Not Covered
MENTAL HEALTH/CHEMICAL DEPENDENCY			
Mental Health**	30 Units Maximum per Member: Inpatient Service 20% Coinsurance Outpatient Visit - \$25 Copay per Visit Inpatient: Up to 30 days per calendar year Outpatient: Up to 20 visits per calendar year (Combined Benefit with Substance Abuse)	No	Not Covered
Substance Abuse**	30 Units Maximum per Member: Inpatient Service – 20% Coinsurance Outpatient Visit - \$25 Copay per Visit Inpatient: Up to 30 days per calendar year Outpatient: Up to 20 visits per calendar year (Combined Benefit with Mental Health)	Yes	50% Coinsurance; Subject to Deductible; Not Subject to Out-of-Pocket Maximum; Annual Benefit of \$1,000 for Alcohol Abuse and \$1,000 for Drug Addiction per Member per Calendar Year
ADDITIONAL RIDERS			
Skilled Nursing Facility	Covered in Full; Up to 100 Days Limit Per calendar year.	Yes	30% Coinsurance; Up to 100 days per calendar year. Subject to deductible with prior member notification
Chiropractic Rider:	\$15 Copay per Visit up to 40 Visits or \$750 whichever occurs first.	No	Not Covered

- Denotes services that require prior member notification

** Mental Health and Substance Abuse is combined benefit for maximum days or visits