Summary of Benefits Paramount Choice HRA 1-1-2017 At Enrollment Member Chooses Paramount PCP		
Service	**Member uses PROMEDICA Facilities Including University of Toledo Medical Center & St. Luke's Hospital Mercy Providers Are Not Covered**	**Member Uses Any other PHC Ohio HMO Contracted Providers Mercy Providers Are Not Covered**
Dependent Age Limit	Age 26 End of the Month	
Deductible	$1500 Single/$3000 Family **Does not apply to preventive services**	
Deductible Credit	Yes	
Coinsurance	10% Coinsurance after deductible	30% Coinsurance after deductible
Maximum Out-of-Pocket Limit (includes Deductible + Coinsurance + Medical Copays, includes Rx Copays)	$ 4,000 Single/$ 8,000 Family	$5,500 Single/$11,000 Family
Benefit Renewal	Calendar Year	
PROFESSIONAL SERVICES		
Preventive Services	Covered in Full to PPACA levels of benefits	
Allergy Testing & Treatment	Covered in Full as Preventive	
Routine Vision Exam every 365 Days	Covered in Full as Preventive	
Pre & Post Natal Care	Covered in Full as Preventive	
Pap Smears & Mammograms Physician's Office Annual GYN Visits Independent Diagnostic Site	 Covered in Full as Preventive Covered in Full as Preventive Covered in Full as Preventive	
Preventive Colonoscopies	Covered in Full as Preventive	
Primary Care Services	$15 Copay per Visit	
ProMedica on Demand/Virtual Visit	$15 Copay per encounter	
Specialist Services: Office Visits	 $25 Copay per Visit	
GYN Visits (non-preventive)	$25 Copay per Visit	
Maternity Care ▪ Hospital Charge ▪ Physician Delivery	 10% Coinsurance after deductible 10% Coinsurance after deductible	 30% Coinsurance after deductible 10% Coinsurance after deductible
Inpatient/Outpatient Professional Hospital Based Physician Services (Hospital visits, consultations, Radiology, Surgeons Fees)	10% Coinsurance after deductible	
Therapy Services: ▪ Inpatient Rehabilitation ▪ Up to 60 Days ▪ Outpatient Therapy Physical/Occupational/Speech ▪ Up to 60 Visits Combined	 10% Coinsurance after deductible $15 Copay per Visit	 30% Coinsurance after deductible $25 Copay per Visit
Prosthetic Devices Includes Repair & Replacement Subject to Medicare Part B Guidelines	20% Coinsurance after deductible	
Durable Medical Equipment Subject to Medicare Part B Guidelines ▪ Orthotic Foot Devices	20% Coinsurance after deductible 20% Coinsurance after deductible, to a maximum of $500/person/per year, NOT subject to Medicare Part B Guidelines	
Infertility Services ▪ Up to $10,000 Lifetime Max., Medical & Drug Therapy Combined Not Subject to Out-of-Pocket Limit	All Services Subject to 30% Coinsurance after deductible	

Service	Member uses PROMEDICA Facilities Including University of Toledo Medical Center & St. Luke's Hospital Mercy Providers Are Not Covered	Member Uses Any other PHC Ohio HMO Contracted Providers Mercy Providers Are Not Covered
Mental Health/Substance Abuse ▪ Inpatient ▪ Outpatient	10% Coinsurance after deductible $15 Copay per Visit	30% Coinsurance after deductible [Penalty does not apply to children under the age of 12] $15 Copay per Visit
Outpatient Diagnostic Services: (Such As: Lab, ECG, EKG, EMG, EEG, Stress test) ▪ At Physician's Office ▪ At Independent Diagnostic Facility or Hospital	 Office Visit Copay 10% Coinsurance after deductible	 Office Visit Copay 30% Coinsurance after deductible
Outpatient Radiology (Such As: X-ray, MRI, CT Scan, Ultrasound) ▪ At Physician's Office ▪ At Independent Diagnostic Facility or Hospital	 Office Visit Copay 10% Coinsurance after deductible	 Office Visit Copay 30% Coinsurance after deductible
Inpatient Hospital Services	10% Coinsurance after deductible	30% Coinsurance after deductible [Emergency and Urgent Admissions will be paid under ProMedica Facility benefits]
Morbid Obesity Surgery $50,000 Lifetime Maximum ▪ Facility ▪ Professional Services Not Subject to Out-of-Pocket Limit	 20% Coinsurance after deductible 20% Coinsurance after deductible	 30% Coinsurance after deductible 20% Coinsurance after deductible
Outpatient Hospital Services & Ambulatory Surgical Center(s)	10% Coinsurance after deductible	30% Coinsurance after deductible
Outpatient Surgery Facility (Includes Endoscopic Procedures & Pain Management Injections)	10% Coinsurance after deductible	30% Coinsurance after deductible
Skilled Nursing Facility (Up to 100 Days)	10% Coinsurance after deductible	30% Coinsurance after deductible
Hospice (with participating provider and Health Plan Approval)	10% Coinsurance after deductible	
Home Health Care	10% Coinsurance after deductible	30% Coinsurance after deductible
Emergency Room Facility	$250 Copay Per visit (Waived if Admitted)	
Urgent Care Facility	$35 Copay per visit	$50 Copay per visit
Emergency Transportation	10% Coinsurance after deductible	
Non-Emergency Transportation	Not Covered	
TMJ	Medical Treatment Only, 10% Coinsurance after deductible	
Human Organ Transplant when Approved in advance by Health Plan	10% Coinsurance after deductible	
Other:	There is a higher Coinsurance for failure to use a PROMEDICA, SLH, or UTMC Facility for Inpatient & Outpatient Hospital, Inpatient Rehab, Inpatient Mental Health/Substance Abuse, Skilled Nursing Facility, Outpatient Surgery Facility, Morbid Obesity, Home Health, Outpatient PT/OT/ST therapy and Outpatient Radiology & Lab.	

Official Terms of Enrollment and Health Benefits
See ProMedica Summary Plan Description