Paramount Insurance Company
Schedule of Benefits

STRS-STATE TEACH RET SYS

Group Number:	Paramount Commercial	**Effective Date:**	1/1/2023
Benefit Period:	Contract Year		
Dependent Child Limiting Age:	Dependent children are covered until the end of the month they turn age 26. Paramount believes this plan is a Large Group non-grandfathered health plan under the Patient Protection and Affordable Care Act.		

	Paramount HMO Network
Deductible:	$2,000 single/$ 4,000 family
Out-of-Pocket Copayment Limit:	$4,000 single/$8,000 family
Covered Services:	All Covered Services not listed below are subject to 20% coinsurance; Subject to Deductible.
Primary Care Physician Office Visits:	$10 Copay per Office Visit.
Specialist Physician Office Visits:	$20 Copayment per Office Visit.
Inpatient Hospital:	Inpatient hospital services are subject to a 20% Coinsurance per admission. Inpatient rehabilitation is covered up to 60 days.
Outpatient Surgical Facility:	Outpatient hospital or free-standing surgical facility services are subject to a 20% coinsurance.
Outpatient Physical/Occupational/Speech Therapy:	20% Coinsurance Subject to Deductible for physical, occupational, and speech language therapy visits. 20% Coinsurance Subject to Deductible for cardiac rehab/intensive cardiac rehab therapy visits. 20% Coinsurance Subject to Deductible for pulmonary rehab therapy visits.
Emergency Room Facility:	$150 Copay. Waived if admitted.
Urgent Care Facility:	$40 Copay
Ambulance:	Emergency - 20% coinsurance
Skilled Nursing Facility Days:	20% Coinsurance
Mental Illness/Substance Abuse:	Inpatient and Outpatient Mental Illness and Substance Abuse covered the same as any physical condition. Outpatient office visits subject to the Primary Care Physician Copayment/Coinsurance.
Durable Medical Equipment:	20% Coinsurance, subject to Medicare Part B guidelines.
Prosthetic Devices:	20% Coinsurance. Subject to Medicare Part B guidelines.
Infertility:	Covered, subject to Medicare criteria.
Contraception Services:	Covered, subject to applicable copayment.
Foot Orthotics Rider:	Not Covered unless meets Medicare Part B criteria.
Private Duty Nursing Rider:	Coverage not available.
Chiropractic Services Rider:	20% Coinsurance
Hearing Aid Rider:	Coverage not available.
Vision Hardware Rider:	Coverage not available.
Additional Rider A:	Coverage not available.
Additional Rider B:	Coverage not available.
Additional Rider C:	Coverage not available.
Preventive Health Services:	Covered in full.
Habilitative Services:	Coverage is provided for the screening, diagnosis, and treatment of Autism Spectrum Disorder (ASD) for Covered Persons under the age of twenty-one (21). Subject to applicable cost sharing and benefit limits per type of service. See Covered Expenses section of the Certificate for benefit limits and additional information.

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

When you enrolled in Paramount, you selected a Primary Care Provider (PCP) for yourself, and for each Member of your family. Your PCP will coordinate your medical care with other Participating Providers in the Paramount network. Female Members may receive OB/GYN care from a participating obstetrics/gynecology specialist without Prior Authorization from the Primary Care Provider. Prior Authorization is required for certain procedures or services. It is the responsibility of the Participating Provider to obtain Prior Authorization from Paramount in advance of these procedures or services. If a medically necessary covered service or procedure is not available from any Participating Providers, Paramount will make arrangements for an 'out-of-plan Prior Authorization'. Your Primary Care Provider must request an 'out of plan Prior Authorization' in advance. Consultations with Participating Specialists will be required before an 'out-of-plan Prior Authorization' can be considered.

Exclusions and Limitations

This Schedule of Benefits is an outline of Deductible, Copays, Coinsurance and Benefit Limits. For complete details please refer to Section IV of the Member Handbook which indicates items that are Covered Services, as well as items which are excluded from benefit consideration or Non-Covered Services. Excluded items will not be covered even if the service, supply, or equipment would otherwise be considered Medically Necessary.

Deductible and Out-of-Pocket Maximum

Your plan includes an Embedded Deductible which is the amount You and Your Dependents must pay for Covered Services within a calendar year, before any benefits will be paid by the Plan. The single Deductible is the amount each Covered Person must pay. If You have family coverage (two or more covered family members), the family Deductible is the total amount any two or more covered family members must pay. For a non-grandfathered plan, the Out-of-Pocket Maximum is the maximum amount of Copayments and Coinsurance including medical and prescription Deductibles (if any) you pay every Contract or Calendar Year. Once the Out-of-Pocket Maximum is met, there will be no additional cost sharing. The Out-of-Pocket Maximum is stated in your Schedule of Benefits. The single Out-of-Pocket Maximum is the amount each Member must pay, and the family Out-of-Pocket Maximum is the total amount any two or more covered family members must pay.

Signature_____George Hilfinger_____

Date_____6/17/2022_____