Paramount Hospitality Management, Inc.

Health Insurance Options

January 1, 2021

	Florida Blue - Medical Benefits			2021
	Low Option	Mid Option 1	Mid Option 2	High Option
Benefits	Blue Options PPO Plan 5903	Blue Care HMO Plan 47	Blue Care HMO 59	Blue Options PPO Plan 05771
In-Network Benefits				
Deductible (Individual/Family)	$5,500 / $11,000	$1,500 / $4,500	$500 / $1,000	$1,500 / $4,500
Coinsurance	30%	20%	10%	20%
Physician Visit	$50 Copay (Preventive Care Services covered 100%)	$30 Copay (Preventive Care Services covered 100%)	$15 Copay (Preventive Care Services covered 100%)	$30 Copay (Preventive Care Services covered 100%)
Specialist Visit	$75 Copay	$55 Copay	$35 Copay	$55 Copay
Emergency Room	$500 Copay/Admission (Waived if admitted)	$250 Copay/Admission (Waived if admitted)	$100 Copay/Admission (Waived if admitted)	$250 Copay/Admission (Waived if admitted)
Urgent Care	$80 Copay	$60 Copay	$35 Copay	$60 Copay
Hospital	Deductible and Coinsurance	Deductible and Coinsurance	$500 Copay/Admission	Deductible and Coinsurance
Out-Patient Surgery	Deductible and Coinsurance	$200 Copay at Ambulatory Surgical Center; Deductible and Coinsurance at Hospital Outpatient Facility	$250 Copay/Admission at Ambulatory Surgical Center; $350 Copay/Admission at Outpatient Hospital Facility	Deductible and Coinsurance
Diagnostic Services (Lab, X-ray) at a participating	$0 Copay Lab Deductible & Coinsurance X-ray	$0 Copay Lab $50 Copay X-ray	$0 Copay Lab $35 Copay X-ray	$0 Copay Lab $50 Copay X-ray
Major Diagnostic (MRI, MRA, PET, CT, etc.)	Deductible and Coinsurance	$250 Copay at an Independent Diagnostic Facility; Deductible and Coinsurance at Outpatient Hospital Facility	$175 Copay at an Independent Diagnostic Facility; $350 Copay at Outpatient Hospital Facility	$250 Copay at an Independent Diagnostic Facility; Deductible and Coinsurance at Outpatient Hospital Facility
Rx	$800 Rx Deductible; then $10/$60/Not Covered	$10/$50/$80 Specialty: 20% up to $200	$10/$50/$80 Specialty: 20% up to $200	$10/$30/$50 Specialty: 20% up to $200
Out of Pocket Max (Individual/Family)	$6,850 / $13,700	$4,500 / $9,000	$3,500 / $7,000	$4,500 / $9,000
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Network Referral Needed	**No**	**No**	**No**	**No**
Out-of-Network Benefits				
Deductible (Individual/Family)	$11,000 / $22,000	N/A	N/A	$4,500 / $13,500
Coinsurance	50%	N/A	N/A	50%
Physician Office Visit	Deductible and Coinsurance	N/A	N/A	Deductible and Coinsurance
Emergency Room	Emergency - $500 Copay/Admission (Waived if admitted)	Emergency - $250 Copay/Admission (Waived if admitted)	Emergency Only - $100 Copay/Admission (Waived if admitted)	Emergency - $250 Copay/Admission (Waived if admitted)
Hospital	Deductible and Coinsurance	Emergency Only	Emergency Only	Deductible and Coinsurance
Out of Pocket Max (Individual/Family)	$20,000 / $40,000	N/A	N/A	$9,000/$18,000
Lifetime Maximum	Unlimited	N/A	N/A	Unlimited
PER PAYCHECK DEDUCTION				
Plan	Blue Options PPO Plan 5903	Blue Care HMO Plan 47	Blue Care HMO 59	Blue Options PPO Plan 05771
Employee	**$46.85**	**$53.18**	**$113.27**	**$145.86**
Employee & Spouse	**$212.81**	**$241.58**	**$306.96**	**$353.52**
Employee & Child(ren)	**$140.53**	**$159.54**	**$213.43**	**$249.43**
Employee & Family	**$311.85**	**$354.02**	**$435.12**	**$496.15**

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Paramount Hospitality Management, Inc.
Dental Benefit Options
January 1, 2021

DENTAL	METLIFE		
Dental Benefits	**DHMO SGX245**	**DPPO**	
Annual Deductible	No Annual Deductible	$50/$150 (Applies to Types B, C)	
Annual Max: (Individual/Family)	Unlimited	$1,500 Per Individual	
Ortho Lifetime Max: (Individual/Family)	N/A	Not Covered	
Waiting Period	None	None	
Coinsurance:	**In-Network**	**In-Network**	**Out-of-Network**
Type A: Preventive	All Benefits are Determined According to Fee Schedule	100%	100%
Type B: Basic		100%	80%
Type C: Major		60%	50%
Type D: Orthodontia		Not Covered	Not Covered
Endodontics & Periodontal		Basic	Basic
Dependent Child	Covered to Age 26		
Website	www.metlife.com		
	IF ENROLLING IN MEDICAL BEENFEITS PER PAYCHECK DEDUCTION		
Employee	**$0.00**	**$18.00**	
Employee & Spouse	**$4.86**	**$36.02**	
Employee & Child(ren)	**$7.13**	**$34.18**	
Employee & Family	**$12.65**	**$55.20**	
	IF NOT ENROLLING IN MEDICAL BEENFEITS PER PAYCHECK DEDUCTION		
Employee	**$6.50**	**$18.00**	
Employee & Spouse	**$11.36**	**$36.02**	
Employee & Child(ren)	**$13.63**	**$34.18**	
Employee & Family	**$19.15**	**$55.20**	

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Paramount Hospitality Management, Inc.
Vision Benefit Options
January 1, 2021

Vision	**MetLife**	
Network	**VSP**	
BENEFITS	**In Network**	**Out of Network**
Eye Exam	$10 Copay	Reimbursed up to $45
Eye Exam Frequency	*Once every 12 months*	
Lenses	$15 Copay	Reimbursed Single - up to $30 Bifocal - up to $50 Trifocal - up to $65 Lenticular - up to $100
Lenses Frequency	*Once every 12 months*	
Frames	Members receive a $150 retail allowance and 20% off balance above allowance. Costco: $85 Allowance	Reimbursed up to $70 (less copay)
Frames Frequency	*Once every 24 months*	
Contact Lenses Conventional/Disposable	In lieu of Lenses & Frames, plan covers elective contact lenses - $150 allowance and 20% off balance above allowance	Reimbursed up to $105 (less copay)
Contact Lenses Medically Necessary	In lieu of Lenses & Frames, plan covers medically necessary contact lenses - 100% (after Copay)	Reimbursed up to $210 (less copay)
Contact Lenses Frequency	*Once every 12 months*	
Laser Vision Correction	Savings averaging 15% off the regular price or 5% off a promotional offer for laser surgery	Not Covered
Depdent Child	Covered up to Age 26	
Website	www.metlife.com	
	IF ENROLLING IN MEDICAL BENEFITS PER PAYCHECK DEDUCTION	
Employee	$0.00	
Employee & Spouse	$2.99	
Employee & Children	$2.07	
Employee & Family	$5.35	
	IF NOT ENROLLING IN MEDICAL BENEFITS PER PAYCHECK DEDUCTION	
Employee	$2.98	
Employee & Spouse	$5.97	
Employee & Children	$5.05	
Employee & Family	$8.33	