



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.paramounthealthcare.com/member-handbooks](http://www.paramounthealthcare.com/member-handbooks) or by calling **1-866-452-6128**

Important Questions	Answers	Why this Matters:
<b>What is the overall deductible?</b>	<b>\$1500</b> Single (In-Network) <b>\$3000</b> Family (In-Network) <b>\$1500</b> Single (Out-of-Network) <b>\$3000</b> Family (Out-of-Network) Does not apply to preventive care or covered services requiring a copayment.	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u> .
<b>Are there other deductibles for specific services?</b>	No (In-Network) No (Out-of-Network)	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
<b>Is there an out-of-pocket limit on my expenses?</b>	<b>\$2200</b> Single (In-Network) <b>\$4400</b> Family (In-Network) <b>\$6500</b> Single (Out-of-Network) <b>\$13000</b> Family (Out-of-Network)	The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
<b>What is not included in the out-of-pocket limit?</b>	Premiums, financial penalties imposed for failure to obtain required pre-authorization balanced-billed charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<b>Is there an overall annual limit on what the plan pays?</b>	No	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
<b>Does this plan use a network of providers?</b>	Yes. See <a href="http://www.paramountinsurancecompany.com/FindAProvider">www.paramountinsurancecompany.com/FindAProvider</a> or call 1-866-452-6128 for a list of CDHP providers, including Curanet and Encore networks.	If you use an in-network doctor or other health care <u>provider</u> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers in their network</u> . See the chart starting on page 2 for how this plan pays different kinds of providers.
<b>Do I need a referral to see a specialist?</b>	No	You can see the <u>specialist</u> you choose without permission from this plan.
<b>Are there services this plan doesn't cover?</b>	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about <u>excluded services</u> .

**Questions:** Call 1-866-452-6128 or visit us at [www.paramountinsurancecompany.com](http://www.paramountinsurancecompany.com)

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary online at [www.paramountinsurancecompany.com](http://www.paramountinsurancecompany.com), or call 1-866-452-6128 to request a copy.

**Summary of Benefits and Coverage: What this Plan Covers & What it Costs**

**Coverage for: Single/Family | Plan Type: CDHP**



- **Co-Payments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **co-insurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use In-Network **providers** by charging you lower **deductibles**, **co-payments**, and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use A(n) In-Network Provider	Your Cost If You Use A(n) Out-of-Network Provider	Limitations & Exclusions
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	10% Co-Insurance.	30% Co-Insurance.	—————none—————
	Specialist visit	10% Co-Insurance.	30% Co-Insurance.	—————none—————
	Other practitioner office visit	10% coinsurance for chiropractic services	30% coinsurance for chiropractic services	Limited to Spinal Manipulations 12 times a year per calendar year.
	Preventive/care/screening/immunization	Covered in full.	30% Co-Insurance.	—————none—————
<b>If you have a test</b>	Diagnostic test (x-ray, blood work)	10% Co-Insurance.	30% Co-Insurance.	—————none—————
	Imaging (CT/PET scans, MRIs)	10% Co-Insurance.	30% Co-Insurance.	Pre-Notification Required if using an Out-of-Network Provider. Penalty for non-compliance is a decrease in Covered Expenses.
<b>If you need drugs to treat your illness or condition</b> More information about <u>prescription drug coverage</u> is available at <a href="http://www.paramountinsurancecompany.com">www.paramountinsurancecompany.com</a>	Preferred Generics	20% co-insurance / prescription (retail) 20% co-insurance / prescription (mail order)	50% of allowed amount	Covers up to a 30 day supply (retail prescription); 90 day supply (mail order prescription) PPACA Mandated Preventive Drugs - \$0 copayment. Paramount Value-Added Preventive Medications - \$0 copayment. Oral Chemotherapy Drugs - \$100 copayment.
	Non-Preferred Generics	20% co-insurance / prescription (retail) 20% co-insurance / prescription (mail order)	50% of allowed amount	Same as Generic Drugs

**Questions:** Call 1-866-452-6128 or visit us at [www.paramountinsurancecompany.com](http://www.paramountinsurancecompany.com)

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary online at [www.paramountinsurancecompany.com](http://www.paramountinsurancecompany.com), or call 1-866-452-6128 to request a copy.

**Summary of Benefits and Coverage: What this Plan Covers & What it Costs**

**Coverage for: Single/Family | Plan Type: CDHP**

Common Medical Event	Services You May Need	Your Cost If You Use A(n) In-Network Provider	Your Cost If You Use A(n) Out-of-Network Provider	Limitations & Exclusions
<b>If you need drugs to treat your illness or condition</b> More information about <u>prescription drug coverage</u> is available at <a href="http://www.paramountinsurancecompany.com">www.paramountinsurancecompany.com</a>	Preferred Brands	20% co-insurance / prescription (retail) 20% co-insurance / prescription (mail order)	50% of allowed amount	Same as Generic Drugs
	Non-Preferred Brands	35% co-insurance / prescription (retail) 35% co-insurance / prescription (mail order)	50% of allowed amount	Same as Generic Drugs
	Specialty and Injectables	35% co-insurance / prescription (retail) \$200.00 maximum.	50% of allowed amount	Specialty drugs available through a limited specialty network and not available through standard mail-order benefits.
	Oral Chemotherapy Drugs	\$100.00 copayment Copay per fill	50% of allowed amount	Not subject to deductible. Subject to prior authorization, quantity limits and dispensing limits. Up to one month supply may be dispensed per fill.
	PPACA Mandated Preventive Drugs	\$0.00 copayment Copay	50% of allowed amount	Preventive Drugs covered in accordance with PPACA mandates. This includes products from the following categories: aspirin, vitamins, smoking cessation medications, women's contraceptive medications and devices, vaccines and bowel preparations. These drugs are not subject to the deductible. This list is subject to change.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	10% Co-Insurance.	30% Co-Insurance.	Pre-Notification Required if using an Out-of-Network Provider. Penalty for non-compliance is a decrease in Covered Expenses.
	Physician/surgeon fees	10% Co-Insurance.	30% Co-Insurance.	—————none—————
<b>If you need immediate medical attention</b>	Emergency room services	10% Co-Insurance.	10% Co-Insurance.	You may be balanced billed for non-network services. To prevent this, use PHCS Healthy Directions network providers when out of the service area.

**Questions:** Call 1-866-452-6128 or visit us at [www.paramountinsurancecompany.com](http://www.paramountinsurancecompany.com)

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary online at [www.paramountinsurancecompany.com](http://www.paramountinsurancecompany.com), or call 1-866-452-6128 to request a copy.

**Summary of Benefits and Coverage: What this Plan Covers & What it Costs**

**Coverage for: Single/Family | Plan Type: CDHP**

Common Medical Event	Services You May Need	Your Cost If You Use A(n) In-Network Provider	Your Cost If You Use A(n) Out-of-Network Provider	Limitations & Exclusions
<b>If you need immediate medical attention</b>	Emergency medical transportation	10% Co-Insurance.	30% Co-Insurance.	You may be balanced billed for non-network services. To prevent this, use PHCS Healthy Directions network providers when out of the service area.
	Urgent care	10% Co-Insurance.	30% Co-Insurance.	You may be balanced billed for non-network services. To prevent this, use PHCS Healthy Directions network providers when out of the service area.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	10% Co-Insurance.	30% Co-Insurance.	Pre-Notification Required if using an Out-of-Network Provider. Penalty for non-compliance is a decrease in Covered Expenses.
	Physician/surgeon fee	10% Co-Insurance.	30% Co-Insurance.	_____none_____
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	Covered Services are subject to the same deductible, copayments and/or coinsurance as any other physical disease or condition.	Covered Services are subject to the same deductible, copayments and/or coinsurance as any other physical disease or condition.	_____none_____
	Mental/Behavioral health inpatient services	Covered Services are subject to the same deductible, copayments and/or coinsurance as any other physical disease or condition.	Covered Services are subject to the same deductible, copayments and/or coinsurance as any other physical disease or condition.	_____none_____
	Substance use disorder outpatient services	Covered Services are subject to the same deductible, copayments and/or coinsurance as any other physical disease or condition.	Covered Services are subject to the same deductible, copayments and/or coinsurance as any other physical disease or condition.	_____none_____

**Questions:** Call 1-866-452-6128 or visit us at [www.paramountinsurancecompany.com](http://www.paramountinsurancecompany.com)

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary online at [www.paramountinsurancecompany.com](http://www.paramountinsurancecompany.com), or call 1-866-452-6128 to request a copy.

**Summary of Benefits and Coverage: What this Plan Covers & What it Costs**

**Coverage for: Single/Family | Plan Type: CDHP**

Common Medical Event	Services You May Need	Your Cost If You Use A(n) In-Network Provider	Your Cost If You Use A(n) Out-of-Network Provider	Limitations & Exclusions
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Substance use disorder inpatient services	Covered Services are subject to the same deductible, copayments and/or coinsurance as any other physical disease or condition.	Covered Services are subject to the same deductible, copayments and/or coinsurance as any other physical disease or condition.	—————none—————
<b>If you are pregnant</b>	Prenatal and postnatal care	Covered in full.	30% Co-Insurance.	—————none—————
	Delivery and all inpatient services	10% Co-Insurance.	30% Co-Insurance.	—————none—————
<b>If you need help recovering or have other special health needs</b>	Home health care	10% Co-Insurance.	30% Co-Insurance.	Limited to 100 visits per calendar year.
	Rehabilitation services	10% Co-Insurance.	30% Co-Insurance.	Inpatient Rehabilitation is limited to 60 days per calendar year. Outpatient Physical, Occupational, Speech Therapy and Pulmonary Rehabilitation limited to 20 visits. Cardiac Rehabilitation limited to 36 visits.
	Habilitation services	10% Co-Insurance.	30% Co-Insurance.	Outpatient physical Habilitation is limited to 20 visits. Visits are combined with Rehabilitation services. Medically diagnosed Autism Spectrum disorders are limited to children up to age twenty-one (21) if medically necessary.
	Skilled nursing care	10% Co-Insurance.	30% Co-Insurance.	Limited to 90 days per calendar year.
	Durable medical equipment	10% Co-Insurance.	30% Co-Insurance.	Subject to Medicare Part B Guidelines.
	Hospice service	Covered in full.	Covered in full.	—————none—————
<b>If your child needs dental or eye care</b>	Eye exam	Covered in full.	30% Co-Insurance.	Limited to one (1) routine vision exam every twelve (12) months.
	Glasses	No charge for Pediatric Vision	Not covered.	Limited to lenses/contacts in lieu of glasses one (1) every twelve (12) months. Frames one (1) every twelve (12) months. From Collection
	Dental check-up	Not covered.	Not covered.	—————none—————

**Questions:** Call 1-866-452-6128 or visit us at [www.paramountinsurancecompany.com](http://www.paramountinsurancecompany.com)

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary online at [www.paramountinsurancecompany.com](http://www.paramountinsurancecompany.com), or call 1-866-452-6128 to request a copy.

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage for:** Single/Family | **Plan Type:** CDHP

**Excluded Services & Other Covered Services:**

**Services Your Plan Does NOT cover (This isn't a complete list. Check your policy or plan document for other excluded services.)**

<ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Cosmetic surgery</li> <li>• Long-term care</li> <li>• Weight loss programs</li> </ul>	<ul style="list-style-type: none"> <li>• Bariatric Surgery</li> <li>• Dental care (Adult)</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>• Chiropractic care</li> <li>• Hearing Aids</li> <li>• Routine foot care</li> </ul>
-------------------------------------------------------------------------------------------------------------------------------------------------------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------------------------------------

**Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

<ul style="list-style-type: none"> <li>• Infertility treatment</li> </ul>	<ul style="list-style-type: none"> <li>• Private-duty nursing</li> </ul>	<ul style="list-style-type: none"> <li>• Routine eye care (Adult)</li> </ul>
---------------------------------------------------------------------------	--------------------------------------------------------------------------	------------------------------------------------------------------------------

**Your Rights to Continue Coverage**

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-866-452-6128. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

**Your Grievance and Appeals Rights:**

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact Paramount Insurance Co. Member Service Department at (419) 887-2525 or Toll Free at 1(800) 462-3589, or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform)

**Does this Coverage Provide Minimum Essential Coverage?**

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

**Does this Coverage Meet the Minimum Value Standard?**

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

**Questions:** Call 1-866-452-6128 or visit us at [www.paramountinsurancecompany.com](http://www.paramountinsurancecompany.com)

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary online at [www.paramountinsurancecompany.com](http://www.paramountinsurancecompany.com), or call 1-866-452-6128 to request a copy.




**Summary of Benefits and Coverage: What this Plan Covers & What it Costs**

**Coverage for: Single/Family | Plan Type: CDHP**

**About these Coverage Examples:**

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)	
• <b>Amount owed to providers:</b>	\$7,540
• <b>Plan pays:</b>	\$5,310
• <b>Patient pays:</b>	\$2,230
<b>Sample care costs:</b>	
Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>
<b>Patient Pays:</b>	
Deductibles	\$1,500
Co-pays	\$0
Co-insurance	\$580
Limits or exclusions	\$150
<b>Total</b>	<b>\$2,230</b>

Managing type 2 diabetes (routine maintenance of a well-controlled condition)	
• <b>Amount owed to providers:</b>	\$5,400
• <b>Plan pays:</b>	\$3,210
• <b>Patient pays:</b>	\$2,190
<b>Sample care costs:</b>	
Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory Tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,400</b>
<b>Patient Pays:</b>	
Deductibles	\$1,500
Co-pays	\$0
Co-insurance	\$610
Limits or exclusions	\$80
<b>Total</b>	<b>\$2,190</b>

**Questions:** Call 1-866-452-6128 or visit us at [www.paramountinsurancecompany.com](http://www.paramountinsurancecompany.com)

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary online at [www.paramountinsurancecompany.com](http://www.paramountinsurancecompany.com), or call 1-866-452-6128 to request a copy.

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Single/Family | Plan Type: CDHP

## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**
- Sample care costs are based on national averages supplied by the US Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

**x No.** Treatments shown are just examples. The care you would receive for this condition would be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

**x No.** Coverage examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare Plans?

**✓ Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

**✓ Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

**Questions:** Call 1-866-452-6128 or visit us at [www.paramountinsurancecompany.com](http://www.paramountinsurancecompany.com)

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary online at [www.paramountinsurancecompany.com](http://www.paramountinsurancecompany.com), or call 1-866-452-6128 to request a copy.