Paramount Insurance Co. : ALLC HMO OH 100 (6450) HSA

Coverage Period: 01/01/2016 - 12/31/2016

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

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

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** or by calling **1-800-462-3589**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$6450** Single (Paramount Ohio HMO Network.) **$12900** Family (Paramount Ohio HMO Network.) Does not apply to preventive care or covered services requiring a copayment.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible 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 deductible.
Are there other deductibles for specific services?	No (Paramount Ohio HMO Network.)	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	**$6450** Single (Paramount Ohio HMO Network.) **$12900** Family (Paramount Ohio HMO Network.)	The out-of-pocket limit 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.
What is not included in the out–of–pocket limit?	Premiums, penalties and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.paramountinsurancecompany.com/FindAProvider or call 1-800-462-3589 for a list of Paramount Ohio HMO Network Providers.	If you use an in-network doctor or other health care provider, 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 provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a specialist?	No	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	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 excluded services.

- **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) Paramount Ohio HMO Network. Provider	Your Cost If You Use A(n) Out-of-Network Provider	Limitations & Exclusions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Covered in full.	Not covered.	——————none——————
	Specialist visit	Covered in full.	Not covered.	——————none——————
	Other practitioner office visit	Covered in Full for Chiropractic Services.	Not covered.	Limited to Spinal Manipulations 12 Visits per Calendar year.
	Preventive/care/screening/immunization	Covered in full.	Not covered.	——————none——————
If you have a test	Diagnostic test (x-ray, blood work)	Covered in full.	Not covered.	——————none——————
	Imaging (CT/PET scans, MRIs)	Covered in full.	Not covered.	——————none——————
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.paramountinsurancecompany.com	Preferred Generics	$0.00 copay / prescription (retail) $0.00 copay / prescription (mail order)	Not Covered	Covers up to a 30 day supply (retail prescription); 90 day supply (mail order prescription) PPACA Mandated Preventive Drugs - $0 copayment. Oral Chemotherapy Drugs - 0% Coinsurance.
	Non-Preferred Generics	$0.00 copay / prescription (retail) $0.00 copay / prescription (mail order)	Not Covered	Same as Generic Drugs

Common Medical Event	Services You May Need	Your Cost If You Use A(n) Paramount Ohio HMO Network. Provider	Your Cost If You Use A(n) Out-of-Network Provider	Limitations & Exclusions
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.paramountinsurancecompany.com	Preferred Brands	$0.00 copay / prescription (retail) $0.00 copay / prescription (mail order)	Not Covered	Same as Generic Drugs
	Non-Preferred Brands	$0.00 copay / prescription (retail) $0.00 copay / prescription (mail order)	Not Covered	Same as Generic Drugs
	Specialty and Injectables	$0.00 copay / prescription (retail)	Not Covered	Specialty drugs available through a limited specialty network and not available through standard mail-order benefits.
	Oral Chemotherapy Drugs	0% Coinsurance	Not Covered	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	Not Covered	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.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Covered in full.	Not covered.	——————none——————
	Physician/surgeon fees	Covered in full.	Not covered.	——————none——————
If you need immediate medical attention	Emergency room services	Covered in full.	Payable under HMO network of benefits.	——————none——————
	Emergency medical transportation	Covered in full.	Payable under HMO network of benefits.	——————none——————
	Urgent care	Covered in full.	Payable under HMO network of benefits.	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use A(n) Paramount Ohio HMO Network. Provider	Your Cost If You Use A(n) Out-of-Network Provider	Limitations & Exclusions
If you have a hospital stay	Facility fee (e.g., hospital room)	Covered in full.	Not covered.	——————none——————
	Physician/surgeon fee	Covered in full.	Not covered.	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Covered the same as any physical disease or condition. Office visits subject to Primary Care Physician Copayment / Coinsurance.	Not covered.	——————none——————
	Mental/Behavioral health inpatient services	Covered the same as any physical disease or condition.	Not covered.	——————none——————
	Substance use disorder outpatient services	Covered the same as any physical disease or condition. Office visits subject to Primary Care Physician Copayment / Coinsurance.	Not covered.	——————none——————
	Substance use disorder inpatient services	Covered the same as any physical disease or condition.	Not covered.	——————none——————
If you are pregnant	Prenatal and postnatal care	Covered in full.	Not covered.	——————none——————
	Delivery and all inpatient services	Covered in full.	Not covered.	——————none——————
If you need help recovering or have other special health needs	Home health care	Covered in full.	Not covered.	Limited to 100 visits per calendar year.
	Rehabilitation services	Covered in full.	Not covered.	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.

Common Medical Event	Services You May Need	Your Cost If You Use A(n) Paramount Ohio HMO Network. Provider	Your Cost If You Use A(n) Out-of-Network Provider	Limitations & Exclusions
If you need help recovering or have other special health needs	Habilitation services	Covered in full.	Not covered.	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	Covered in full.	Not covered.	Limited to 90 days per calendar year.
	Durable medical equipment	Covered in full.	Not covered.	——————none——————
	Hospice service	Covered in full.	Not covered.	——————none——————
If your child needs dental or eye care	Eye exam	Covered in full.	Not covered.	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——————

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.)		
• **Acupuncture** • **Dental care (Adult)** • **Non-emergency care when traveling outside the U.S.**	• **Bariatric Surgery** • **Hearing Aids** • **Routine foot care**	• **Cosmetic surgery** • **Long-term care** • **Weight loss programs**

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.)		
• **Chiropractic care** • **Routine eye care (Adult)**	• **Infertility treatment** (if medically necessary, excludes Assisted Reproductive Technology (ART) and infertility drugs)	• **Private-duty nursing**

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 1-800-462-3589. 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, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or 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 contactParamount 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

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.**

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)	
• **Amount owed to providers:**	$7,540
• **Plan pays:**	$940
• **Patient pays:**	$6,600
Sample care costs:	
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
Total	**$7,540**
Patient Pays:	
Deductibles	$6,450
Co-pays	$0
Co-insurance	$0
Limits or exclusions	$150
Total	**$6,600**

Managing type 2 diabetes (routine maintenance of a well-controlled condition)	
• **Amount owed to providers:**	$5,400
• **Plan pays:**	$2,900
• **Patient pays:**	$2,500
Sample care costs:	
Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory Tests	$100
Vaccines, other preventive	$100
Total	**$5,400**
Patient Pays:	
Deductibles	$2,420
Co-pays	$0
Co-insurance	$0
Limits or exclusions	$80
Total	**$2,500**

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?

✘ **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?

✘ **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.