



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, contact Paramount at 1-800-462-3589 or [www.paramounthealthcare.com/member-handbooks](http://www.paramounthealthcare.com/member-handbooks). For general definitions of common terms such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at [www.paramountinsurancecompany.com](http://www.paramountinsurancecompany.com) or call 1-800-462-3589 to request a copy.

Important Questions	Answers	Why this Matters:
<b>What is the overall deductible?</b>	<b>\$2000</b> Single (Paramount Ohio HMO Network.) <b>\$4000</b> Family (Paramount Ohio HMO Network.) Does not apply to preventive care or covered services requiring a copayment.	Generally, you must pay all of the costs from providers up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
<b>Are there services covered before you meet your deductible?</b>	Yes, <u>preventive care</u>	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain preventive services without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other deductibles for specific services?</b>	No (Paramount Ohio HMO Network.)	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the out-of-pocket limit for this plan?</b>	<b>\$6000</b> Single (Paramount Ohio HMO Network.) <b>\$12000</b> Family (Paramount Ohio HMO Network.)	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
<b>What is not included in the out-of-pocket limit?</b>	Premiums and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<b>Will you pay less if you use a network provider?</b>	Yes. See <a href="http://www.paramountinsurancecompany.com/FindAProvider">www.paramountinsurancecompany.com/FindAProvider</a> or call 1-800-462-3589 for a list of Paramount Ohio HMO Network Providers.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (a <u>balance bill</u> ). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
<b>Do you need a referral to see a specialist?</b>	No	You can see the <u>specialist</u> you choose without a referral.



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Your Cost If You Use A(n) Paramount Ohio HMO Network Provider	Your Cost If You Use A(n) Out-of-Network Provider	
If you visit a health care <b>provider's</b> office or clinic	Primary Care visit to treat an injury or illness	\$15.00 <u>Co-pay</u> /visit.	Not covered.	<u>Deductible</u> does not apply.
	<u>Specialist</u> visit	\$55.00 <u>Co-pay</u> /visit.	Not covered.	<u>Deductible</u> does not apply.
	<u>Preventive care/screening</u> /immunization	No charge.	Not covered.	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>Co-Insurance</u> .	Not covered.	—————none—————
	Imaging (CT/PET scans, MRIs)	20% <u>Co-Insurance</u> .	Not covered.	—————none—————
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at <a href="http://www.paramounthealthcare.com/Employers-PharmacyResources-CommercialDrugBenefits">www.paramounthealthcare.com/Employers-PharmacyResources-CommercialDrugBenefits</a>	Preferred Generics	\$5.00 copay / prescription (retail) \$12.50 copay / prescription (mail order)	Not Covered	Covers up to a 1-30 day supply (retail prescription); 31-90 day supply (mail order prescription) ACA Mandated Preventive Drugs - \$0. Oral Chemotherapy Drugs - 20% Coinsuran with a maximum of \$100. Drug Formulary - ACA/Alliance
	Non-Preferred Generics	\$15.00 copay / prescription (retail) \$37.50 copay / prescription (mail order)	Not Covered	Same as Generic Drugs
	Preferred Brands	\$40.00 copay / prescription (retail) \$100.00 copay / prescription (mail order)	Not Covered	Same as Generic Drugs
	Non-Preferred Brands	\$90.00 copay / prescription (retail) \$270.00 copay / prescription (mail order)	Not Covered	Same as Generic Drugs

\*For more information about limitations and exceptions, see the plan or policy document at [www.paramountinsurancecompany.com](http://www.paramountinsurancecompany.com).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Your Cost If You Use A(n) Paramount Ohio HMO Network Provider	Your Cost If You Use A(n) Out-of-Network Provider	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.paramounthealthcare.com/Employers-PharmacyResources-CommercialDrugBenefits">www.paramounthealthcare.com/Employers-PharmacyResources-CommercialDrugBenefits</a>	Preferred Specialty	20% <u>Co-insurance</u> / prescription (retail) \$350.00 maximum.	Not Covered	Same as Specialty Drugs
	Non-Preferred Specialty	20% <u>Co-insurance</u> / prescription (retail) \$500.00 maximum.	Not Covered	Same as Specialty Drugs
	Specialty Drugs	Applicable Copay Applies up to a maximum 30-day supply per fill	Not Covered	Specialty drugs are available through a limited specialty network and not available through standard mail-order benefits. Not subject to deductible.
	Oral Chemotherapy Drugs	20% Coinsurance with a maximum of \$100.00 per fill	Not Covered	Not subject to deductible. Subject to prior authorization, quantity limits and dispensing limits. Up to one month supply may be dispensed per fill.
	ACA Mandated Preventive Drugs	\$0.00 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.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <u>Co-Insurance</u> .	Not covered.	—————none—————
	Physician/surgeon fees	20% <u>Co-Insurance</u> .	Not covered.	—————none—————
<b>If you need immediate medical attention</b>	Emergency room care	20% <u>Co-Insurance</u> .	Payable under HMO network of benefits.	—————none—————
	<u>Emergency medical transportation</u>	20% <u>Co-Insurance</u> .	Payable under HMO network of benefits.	—————none—————
	<u>Urgent care</u>	20% <u>Co-Insurance</u> .	Payable under HMO network of benefits.	—————none—————
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% <u>Co-Insurance</u> .	Not covered.	—————none—————
	Physician/surgeon fees	20% <u>Co-Insurance</u> .	Not covered.	—————none—————

\*For more information about limitations and exceptions, see the [plan](#) or policy document at [www.paramountinsurancecompany.com](http://www.paramountinsurancecompany.com).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Your Cost If You Use A(n) Paramount Ohio HMO Network Provider	Your Cost If You Use A(n) Out-of-Network Provider	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$20.00 <u>Co-pay</u> /visit.	Not covered.	<u>Deductible</u> does not apply.
	Inpatient services	20% <u>Co-Insurance</u> .	Not covered.	—————none—————
<b>If you are pregnant</b>	Office visits	\$55.00 <u>Co-pay</u> /visit.	Not covered.	<u>Deductible</u> does not apply. Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	20% <u>Co-Insurance</u> .	Not covered.	—————none—————
	Childbirth/delivery facility services	20% <u>Co-Insurance</u> .	Not covered.	—————none—————
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	20% <u>Co-Insurance</u> .	Not covered.	Limited to 100 visits per calendar year.
	<u>Rehabilitation services</u>	20% <u>Co-Insurance</u> .	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.
	<u>Habilitation services</u>	20% <u>Co-Insurance</u> .	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.
	<u>Skilled nursing care</u>	20% <u>Co-Insurance</u> .	Not covered.	Limited to 90 days per calendar year.
	<u>Durable medical equipment</u>	20% <u>Co-Insurance</u> .	Not covered.	—————none—————
	<u>Hospice services</u>	20% <u>Co-Insurance</u> .	Not covered.	—————none—————
<b>If your child needs dental or eye care</b>	Children's eye exam	No charge.	Not covered.	Limited to one (1) routine vision exam every twelve (12) months.
	Children's 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
	Children's dental check-up	Not covered.	Not covered.	—————none—————

\*For more information about limitations and exceptions, see the [plan](#) or policy document at [www.paramountinsurancecompany.com](http://www.paramountinsurancecompany.com).

## Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)		
<ul style="list-style-type: none"><li>• Acupuncture</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>• Bariatric Surgery</li><li>• Hearing Aids</li><li>• Routine foot care</li></ul>	<ul style="list-style-type: none"><li>• Cosmetic surgery</li><li>• Long-term care</li><li>• Weight loss programs</li></ul>

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please check your <u>plan</u> document.		
<ul style="list-style-type: none"><li>• Chiropractic care</li><li>• Routine eye care (Adult)</li></ul>	<ul style="list-style-type: none"><li>• Infertility treatment (if medically necessary, excludes Assisted Reproductive Technology (ART) and infertility drugs)</li></ul>	<ul style="list-style-type: none"><li>• Private-duty nursing</li></ul>

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration, 1-866-444-EBSA (3272), [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform)

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Paramount Insurance Co., Member Service Department at: (419) 887-2525, Toll Free: 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 plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

### Does this plan meet the Minimum Value Standard? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*—————

## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Having a Baby (9 months of in-network pre-natal care and a hospital delivery)

The Plan's overall deductible	\$2000
Specialist copayment	\$55
Hospital (facility) coinsurance	20%
Other coinsurance	20%

#### This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
 Diagnostic tests (*ultrasounds and blood work*)  
 Specialist visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,731</b>
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#### In this example, you would pay:

Cost Sharing	
Deductibles	\$2,000
Co-pays	\$110
Co-insurance	\$2,000
What isn't covered	
Limits or exclusions	\$60
<b>The total you would pay is</b>	<b>\$4,170</b>

### Managing type 2 Diabetes (a year of routine in-network care of a well-controlled condition)

The Plan's overall deductible	\$2000
Specialist copayment	\$55
Hospital (facility) coinsurance	20%
Other coinsurance	20%

#### This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)  
 Diagnostic tests (*blood work*)  
 Prescription drugs  
 Durable medical equipment (*glucose meter*)

<b>Total Example Cost</b>	<b>\$7,389</b>
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#### In this example, you would pay:

Cost Sharing	
Deductibles	\$2,000
Co-pays	\$580
Co-insurance	\$370
What isn't covered	
Limits or exclusions	\$60
<b>The total you would pay is</b>	<b>\$3,010</b>

### Simple Fracture (in-network emergency room visit and follow up care)

The Plan's overall deductible	\$2000
Specialist copayment	\$55
Hospital (facility) coinsurance	20%
Other coinsurance	20%

#### This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$1,925</b>
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#### In this example, you would pay:

Cost Sharing	
Deductibles	\$1,310
Co-pays	\$170
Co-insurance	\$330
What isn't covered	
Limits or exclusions	\$0
<b>The total you would pay is</b>	<b>\$1,810</b>

## Language Access Services:

**English:** ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-462-3589 (TTY: 1-888-740-5670).

**Albanian:** KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-800-462-3589 (TTY: 1-888-740-5670).

**Arabic:** ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-462-3589 (رقم هاتف الصم والبكم: 1-888-740-5670).

**Bantu:** ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona 1-800-462-3589 (TTY: 1-888-740-5670).

**Bengali:** লক্ষ্য করুন: যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নি:খরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১-৮০০-৪৬২-৩৫৮৯ (TTY: ১-৮৮৮-৭৪০-৫৬৭০)।

**Chinese:** 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-462-3589 (TTY：1-888-740-5670)。

**Cushite:** XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-462-3589 (TTY: 1-888-740-5670).

**Dutch:** AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 1-800-462-3589 (TTY: 1-888-740-5670).

**French:** ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-462-3589 (ATS : 1-888-740-5670).

**German:** ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-462-3589 (TTY: 1-888-740-5670).

**Italian:** ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-462-3589 (TTY: 1-888-740-5670).

**Japanese:** 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-462-3589 (TTY:1-888-740-5670) まで、お電話にてご連絡ください。

**Korean:** 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-462-3589 (TTY: 1-888-740-5670) 번으로 전화해 주십시오.

**Nepali:** ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निमित्त भाषा सहायता सेवाहरू नि:शुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-800-462-3589 (टिटिवाइ: 1-888-740-5670) ।

**Wann du [Deutsch (Pennsylvania German / Dutch)]:** schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-462-3589 (TTY: 1-888-740-5670).





## Notice of Nondiscrimination and Accessibility: Discrimination is Against the Law

Paramount Insurance Company complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Paramount Insurance Company does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Paramount Insurance Company provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Member Services at 1-800-462-3589.

If you believe that Paramount Insurance Company has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance. You can file a grievance in person or by mail, fax, or email.

Member Services  
1901 Indian Wood Circle, Maumee OH 43537  
Phone: 419-887-2525  
Toll Free: 1-800-462-3589  
TTY: 1-888-740-5670  
Fax: 419-887-2047  
Email: [Paramount.MemberServices@ProMedica.org](mailto:Paramount.MemberServices@ProMedica.org)

If you need help filing a grievance, Member Services is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, D.C. 20201  
1-800-368-1019, 800-537-7697 (TDD)  
Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.