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 heath 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 1-866-452-6128 or 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.paramounthealthcare.com or call 1-866-452-6128 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$5200** Single (In-Network) **$10400** Family (In-Network) **$10400** Single (Out-of-Network) **$20800** Family (Out-of-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 deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes, preventive care	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No (In-Network) No (Out-of-Network)	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**$9500** Single (In-Network) **$19000** Family (In-Network) **$19000** Single (Out-of-Network) **$38000** Family (Out-of-Network)	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, Out-of-Network 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 out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.paramountinsurancecompany.com/FindAProvider or call 1-866-452-6128 for a list of POS providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (a balance bill). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No	You can see the specialist 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) In-Network Provider	Your Cost If You Use A(n) Out-of-Network Provider	
If you visit a health care provider's office or clinic	Primary Care visit to treat an injury or illness	$50.00 Co-pay/visit.	50% Co-Insurance.	Deductible does not apply to tier 1.
	Specialist visit	$80.00 Co-pay/visit.	50% Co-Insurance.	Deductible does not apply to tier 1..
	Preventive care/screening /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 plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% Co-Insurance.	50% Co-Insurance.	——————none——————
	Imaging (CT/PET scans, MRIs)	20% Co-Insurance.	50% Co-Insurance.	Pre-Notification Required if using an Out-of-Network Provider. Penalty for non-compliance is a decrease in Covered Expenses.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.paramounthealthcare.com/Employers-PharmacyResources-CommercialDrugBenefits	Preferred Generics	$15.00 copay / prescription (retail) $30.00 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 - $0.00.Growth Hormone Drugs - .CVS Maintenance Choice - .Oral Chemotherapy Drugs - 20% Coinsurance with a maximum of $250.00. Drug Formulary - Michigan ACA/Alliance
	Non-Preferred Generics	$40.00 copay / prescription (retail) $80.00 copay / prescription (mail order)	Not Covered	Same as Generic Drugs
	Preferred Brands	$75.00 copay / prescription (retail) $225.00 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.paramounthealthcare.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Your Cost If You Use A(n) In-Network Provider	Your Cost If You Use A(n) Out-of-Network Provider	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.paramounthealthcare.com/Employers-PharmacyResources-CommercialDrugBenefits	Non-Preferred Brands	$150.00 copay / prescription (retail) $450.00 copay / prescription (mail order)	Not Covered	Same as Generic Drugs
	Preferred Specialty	20% Co-insurance / prescription (retail) $450.00 maximum.	Not Covered	Same as Specialty Drugs
	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, tobacco 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.
	Non-Preferred Specialty	20% Co-insurance / prescription (retail) $600.00 maximum.	Not Covered	Same as Specialty Drugs
	Oral Chemotherapy Drugs	20% Coinsurance with a maximum of $250.00	Not Covered	Specialty network may apply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Co-Insurance.	50% 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	20% Co-Insurance.	50% Co-Insurance.	——————none——————
If you need immediate medical attention	Emergency room care	$400.00 Co-pay/visit.	$400.00 Co-pay/visit.	Deductible does apply. To prevent balance billing, use First Health Network providers.
	Emergency medical transportation	20% Co-Insurance.	20% Co-Insurance.	To prevent balance billing, use First Health Network providers.
	Urgent care	$65.00 Co-pay/visit.	$65.00 Co-pay/visit.	Deductible does not apply. To prevent balance billing, use First Health Network providers.

*For more information about limitations and exceptions, see the plan or policy document at www.paramounthealthcare.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Your Cost If You Use A(n) In-Network Provider	Your Cost If You Use A(n) Out-of-Network Provider	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Co-Insurance.	50% 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	20% Co-Insurance.	50% Co-Insurance.	————————none————————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$35.00 Co-pay/visit.	50% Co-Insurance.	Deductible does not apply.
	Inpatient services	20% Co-Insurance.	50% Co-Insurance.	————————none————————
If you are pregnant	Office visits	No charge.	Not covered.	Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	20% Co-Insurance.	50% Co-Insurance.	————————none————————
	Childbirth/delivery facility services	20% Co-Insurance.	50% Co-Insurance.	————————none————————
If you need help recovering or have other special health needs	Home health care	20% Co-Insurance.	50% Co-Insurance.	————————none————————
	Rehabilitation services	20% Co-Insurance.	Not covered.	Outpatient rehabilitation includes 30 combined sessions per Calendar year for Physical therapy, Occupational therapy and Spinal Treatment, and 30 sessions per Calendar year for Speech therapy.
	Habilitation services	20% Co-Insurance.	Not covered.	Outpatient habilitation includes 30 combined sessions per Calendar year for Physical therapy, Occupational therapy and Spinal Treatment, and 30 sessions per Calendar year for Speech therapy. Autism Spectrum Disorder is limited to children up to age nineteen (19).
	Skilled nursing care	20% Co-Insurance.	50% Co-Insurance.	Limited to 45 days per calendar year.
	Durable medical equipment	20% Co-Insurance.	50% Co-Insurance.	Subject to Medicare Part B Guidelines.
	Hospice services	No charge.	50% Co-Insurance.	Facility charges are limited to 45 days per calendar year. Non-facility care no calendar year limit.
If your child needs dental or eye care	Children's eye exam	No charge.	Not covered.	Limited to one (1) routine vision exam every twelve (12) months.

*For more information about limitations and exceptions, see the plan or policy document at www.paramounthealthcare.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Your Cost If You Use A(n) In-Network Provider	Your Cost If You Use A(n) Out-of-Network Provider	
If your child needs dental or eye care	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.paramounthealthcare.com.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Acupuncture • Hearing Aids • Private-duty nursing	• Cosmetic surgery • Long-term care • Routine foot care	• Dental care (Adult) • Non-emergency care when traveling outside the U.S. • Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please check your plan document.		
• Bariatric Surgery • Routine eye care (Adult)	• Chiropractic care	• Infertility treatment

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

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 Care of Michigan, Member Service Department at: (734) 529-7800, Toll-Free 1-888-241-5604, or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or 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.

*For more information about limitations and exceptions, see the plan or policy document at www.paramounthealthcare.com.

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	$5200
Specialist copayment	$80
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*)

Total Example Cost	**$12,731**

In this example, you would pay:

Cost Sharing	
Deductibles	$5,200
Co-pays	$140
Co-insurance	$2,480
What isn't covered	
Limits or exclusions	$60
The total you would pay is	**$7,880**

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

The Plan's overall deductible	$5200
Specialist copayment	$80
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*)

Total Example Cost	**$7,389**

In this example, you would pay:

Cost Sharing	
Deductibles	$4,520
Co-pays	$1,550
Co-insurance	$370
What isn't covered	
Limits or exclusions	$60
The total you would pay is	**$6,500**

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

The Plan's overall deductible	$5200
Specialist copayment	$80
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*)

Total Example Cost	**$1,925**

In this example, you would pay:

Cost Sharing	
Deductibles	$1,020
Co-pays	$640
Co-insurance	$210
What isn't covered	
Limits or exclusions	$0
The total you would pay is	**$1,870**

*For more information about limitations and exceptions, see the plan or policy document at www.paramounthealthcare.com.

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: .(0765-047-888-1 :ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 9853-264-008-1 (رقم هاتف الصم والبكم

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 করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১-800-462-3589 (TTY: ১-888-740-5670)।

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 निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-800-462-3589 (टिटिवाइ: 1-888-740-5670) ।

Wann du **[Deitsch (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).

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-462-3589 (TTY: 1-888-740-5670).

Romanian: ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-462-3589 (TTY: 1-888-740-5670).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-462-3589 (телетайп: 1-888-740-5670).

Serbo-Croatian: OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-462-3589 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1-888-740-5670).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-462-3589 (TTY: 1-888-740-5670).

Syriac: ܙܘܗܪܐ: ܐܢ ܐܢܬܘܢ ܟܡܣܘܪܝܬܘܢ ܠܫܢܐ ܐܬܘܪܝܐ، ܟܐ ܡܨܝܬܘܢ ܕܡܩܒܠܝܬܘܢ ܚܠܡܬܐ ܕܗܝܪܬܐ ܒܠܫܢܐ ܡܓܢܢܐܝܬ. ܩܪܘ ܥܠ ܡܢܝܢܐ 1-800-462-3589- (TTY: 1-888-740-5670)

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-462-3589 (TTY: 1-888-740-5670).

Ukrainian: УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800 -462-3589 (телетайп: 1-888-740-5670).

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 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
300 Madison Ave, 3rd Floor, Toledo OH 43604
Phone: 419-887-2525
Toll Free: 1-800-462-3589
TTY: 1-888-740-5670
Fax: 419-887-2047
Email: Paramount.MemberServices@MedMutual.com

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.

*For more information about limitations and exceptions, see the plan or policy document at www.paramounthealthcare.com.