



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 <https://www.paramounthealthcare.com/Members/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 <https://www.paramounthealthcare.com/Members/Member-Handbooks> or call 1-800-462-3589 to request a copy.

| Important Questions                                                 | Answers                                                                                                                                                                             | Why this Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|---------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <u>deductible</u> ?                             | <b>\$6,000</b> Single (Paramount Ohio HMO Network) <b>\$12,000</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> .                                                                                                           |
| Are there services covered before you meet your <u>deductible</u> ? | Yes, <u>preventive care</u>                                                                                                                                                         | This <u>plan</u> covers some items and services even if you haven't yet met the annual <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 cost-sharing 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> |
| Are there other <u>deductibles</u> for specific services?           | No (Paramount OH HMO Network)                                                                                                                                                       | You don't have to meet <u>deductibles</u> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?       | <u>Deductible</u> and <u>Coinsurance</u> not to exceed <b>\$8,900</b> Single (Paramount Ohio HMO Network) <b>\$17,800</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.                                                                                                                                                                                                                          |
| What is not included in the <u>out-of-pocket limit</u> ?            | 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> .                                                                                                                                                                                                                                                                                                                                                                                                       |

| Important Questions                                        | Answers                                                                                                                                       | Why this Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Will you pay less if you use a <u>network provider</u> ?   | Yes. See <a href="http://www.paramounthealthcare.com">www.paramounthealthcare.com</a> or call 1-800-462-3589 for a list of 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</u> charge 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. |
| Do you need a <u>referral</u> to see a <u>specialist</u> ? | 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 <u>provider's</u> office or clinic | Primary care visit to treat an injury or illness | \$40 <u>Copayment</u> /visit, <u>Deductible</u> does not apply | Not Covered                                       | —————none—————                                                                                                                                            |
|                                                               | <u>Specialist</u> visit                          | \$80 <u>Copayment</u> /visit, <u>Deductible</u> does not apply | Not Covered                                       | —————none—————                                                                                                                                            |
|                                                               | <u>Preventive care/screening/immunization</u>    | 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                                            | <u>Diagnostic test</u> (x-ray, blood work)       | 40% <u>Coinsurance</u> , Subject to <u>Deductible</u>          | Not Covered                                       | —————none—————                                                                                                                                            |
|                                                               | Imaging (CT/PET scans, MRIs)                     | 40% <u>Coinsurance</u> , Subject to <u>Deductible</u>          | Not Covered                                       | —————none—————                                                                                                                                            |

| 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="https://www.paramounthealthcare.com/Individuals-and-Families/Thinking-About-Enrolling">prescription drug coverage</a><br><a href="https://www.paramounthealthcare.com/Individuals-and-Families/Thinking-About-Enrolling">https://www.paramounthealthcare.com/Individuals-and-Families/Thinking-About-Enrolling</a> | Preferred Generics     | \$20 <u>Copayment</u> /prescription (retail), <u>Deductible</u> does not apply<br>\$50 <u>Copayment</u> /prescription (mail order), <u>Deductible</u> does not apply  | Not Covered (retail)<br>Not Covered (mail order)    | Covers up to a 1-30 day supply (retail prescription); 31-90 day supply (mail order prescription)<br>Drug Formulary - Individual Exchange |
|                                                                                                                                                                                                                                                                                                                                                                                                                | Non-Preferred Generics | \$20 <u>Copayment</u> /prescription (retail), <u>Deductible</u> does not apply<br>\$50 <u>Copayment</u> /prescription (mail order), <u>Deductible</u> does not apply  | Not Covered (retail)<br>Not Covered (mail order)    | Same as Generic Drugs                                                                                                                    |
|                                                                                                                                                                                                                                                                                                                                                                                                                | Preferred Brands       | \$40 <u>Copayment</u> /prescription (retail), <u>Deductible</u> does not apply<br>\$100 <u>Copayment</u> /prescription (mail order), <u>Deductible</u> does not apply | Not Covered (retail)<br>Not Covered (mail order)    | Same as Generic Drugs                                                                                                                    |
|                                                                                                                                                                                                                                                                                                                                                                                                                | Non-Preferred Brands   | \$80 <u>Copayment</u> /prescription (retail), Subject to <u>Deductible</u><br>\$240 <u>Copayment</u> /prescription (mail order), Subject to <u>Deductible</u>         | Not Covered (retail)<br>Not Covered (mail order)    | Same as Generic Drugs                                                                                                                    |
|                                                                                                                                                                                                                                                                                                                                                                                                                | Preferred Specialty    | \$350 <u>Copayment</u> /prescription (retail), Subject to <u>Deductible</u>                                                                                           | Not Covered (retail)<br>Not Applicable (mail order) | Specialty drugs are available through a limited specialty network and not                                                                |

| 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     |                                                                                                                                                                                                                                                                                                                                    |
|                                         |                                                | Not Applicable (mail order)                                                                                |                                                       | available through standard mail-order benefits.                                                                                                                                                                                                                                                                                    |
|                                         | Non-Preferred Specialty                        | \$350 <u>Copayment</u> /prescription (retail), Subject to <u>Deductible</u><br>Not Applicable (mail order) | Not Covered (retail)<br>Not Applicable (mail order)   | Specialty drugs are available through a limited specialty network and not available through standard mail-order benefits.                                                                                                                                                                                                          |
|                                         | PPACA Preventive Drugs                         | No Charge, Not Subject to <u>Deductible</u>                                                                | 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. |
|                                         | Oral Chemotherapy Drugs                        | 40% <u>Coinsurance</u> , Not Subject to <u>Deductible</u> , up to a maximum of \$100 per fill.             | Not Covered                                           | Subject to prior authorization, quantity limits and dispensing limits. Up to one month supply may be dispensed per fill.                                                                                                                                                                                                           |
| If you have outpatient surgery          | Facility fee (e.g., ambulatory surgery center) | 40% <u>Coinsurance</u> , Subject to <u>Deductible</u>                                                      | Not Covered                                           | —————none—————                                                                                                                                                                                                                                                                                                                     |
|                                         | Physician/surgeon fees                         | 40% <u>Coinsurance</u> , Subject to <u>Deductible</u>                                                      | Not Covered                                           | —————none—————                                                                                                                                                                                                                                                                                                                     |
| If you need immediate medical attention | Emergency room care                            | 40% <u>Coinsurance</u> , Subject to <u>Deductible</u>                                                      | 40% <u>Coinsurance</u> , Subject to <u>Deductible</u> | —————none—————                                                                                                                                                                                                                                                                                                                     |

| 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              |                                                                                                                  |
|                                                                           | Emergency medical transportation          | 40% <u>Coinsurance</u> , Subject to <u>Deductible</u>                                                                                          | 40% <u>Coinsurance</u> , Subject to <u>Deductible</u>          | ————none————                                                                                                     |
|                                                                           | Urgent care                               | \$60 <u>Copayment</u> /visit, <u>Deductible</u> does not apply                                                                                 | \$60 <u>Copayment</u> /visit, <u>Deductible</u> does not apply | ————none————                                                                                                     |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)        | 40% <u>Coinsurance</u> , Subject to <u>Deductible</u>                                                                                          | Not Covered                                                    | ————none————                                                                                                     |
|                                                                           | Physician/surgeon fees                    | 40% <u>Coinsurance</u> , Subject to <u>Deductible</u>                                                                                          | Not Covered                                                    | Limited to 1 visits per day per physician or other professional provider                                         |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                       | \$40 <u>Copayment</u> /visit, <u>Deductible</u> does not apply                                                                                 | Not Covered                                                    | ————none————                                                                                                     |
|                                                                           | Inpatient services                        | 40% <u>Coinsurance</u> , Subject to <u>Deductible</u>                                                                                          | Not Covered                                                    | ————none————                                                                                                     |
| If you are pregnant                                                       | Office visits                             | No Charge                                                                                                                                      | Not Covered                                                    | Cost sharing does not apply for preventive services.                                                             |
|                                                                           | Childbirth/delivery professional services | 40% <u>Coinsurance</u> , Subject to <u>Deductible</u>                                                                                          | Not Covered                                                    | ————none————                                                                                                     |
|                                                                           | Childbirth/delivery facility services     | 40% <u>Coinsurance</u> , Subject to <u>Deductible</u>                                                                                          | Not Covered                                                    | ————none————                                                                                                     |
| If you need help recovering or have other special health needs            | Home health care                          | 40% <u>Coinsurance</u> , Subject to <u>Deductible</u>                                                                                          | Not Covered                                                    | Limited to 100 visits per calendar year                                                                          |
|                                                                           | Rehabilitation services                   | Inpatient: 40% <u>Coinsurance</u> , Subject to <u>Deductible</u><br>Outpatient: \$40 <u>Copayment</u> /visit, <u>Deductible</u> does not apply | Inpatient: Not Covered<br>Outpatient: Not Covered              | Inpatient: covered up to 60 days per calendar year.<br>Outpatient: PT covered up to 20 visits per calendar year. |

| 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            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                      |                       |                                                                                                                                                         |                                                              | <p>Outpatient: OT covered up to 20 visits per calendar year.</p> <p>Outpatient: ST covered up to 20 visits per calendar year.</p> <p>Outpatient: Pulmonary covered up to 20 visits per calendar year.</p> <p>Outpatient: Cardiac covered up to 36 visits per calendar year.</p>                                                                                                                                                                                                                                                                                     |
|                      | Habilitation services | <p>Inpatient: 40% <u>Coinsurance</u>, Subject to <u>Deductible</u></p> <p>Outpatient: \$40 <u>Copayment</u>/visit, <u>Deductible</u> does not apply</p> | <p>Inpatient: Not Covered</p> <p>Outpatient: Not Covered</p> | <p>Inpatient: covered up to 60 days per calendar year.</p> <p>Outpatient: PT covered up to 20 visits per calendar year.</p> <p>Outpatient: OT covered up to 20 visits per calendar year.</p> <p>Outpatient: ST covered up to 20 visits per calendar year.</p> <p>Outpatient: Pulmonary covered up to 20 visits per calendar year.</p> <p>Outpatient: Cardiac covered up to 36 visits per calendar year.</p> <p>Coverage provided for screening, diagnosis, and treatment of Autism Spectrum Disorder (ASD) for Covered Persons under the age of twentyone (21).</p> |

| 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 |                                                                                                        |
|                                        |                            |                                                               |                                                   | Subject to applicable cost sharing and benefit limits per type of service.                             |
|                                        | Skilled nursing care       | 40% <u>Coinsurance</u> , Subject to <u>Deductible</u>         | Not Covered                                       | Limited to 90 days per calendar year                                                                   |
|                                        | Durable medical equipment  | 40% <u>Coinsurance</u> , Subject to <u>Deductible</u>         | Not Covered                                       | Subject to Medicare Part B Guidelines and deductible.                                                  |
|                                        | Hospice services           | 40% <u>Coinsurance</u> , Subject to <u>Deductible</u>         | Not Covered                                       | —————none—————                                                                                         |
| If your child needs dental or eye care | Children's eye exam        | No Charge                                                     | Not Covered                                       | Limited to 1 routine vision exam every 12 months                                                       |
|                                        | Children's glasses         | No Charge                                                     | Not Covered                                       | Limited to 1 frames every 12 months<br>Limited to 1 lenses/contacts in lieu of glasses every 12 months |
|                                        | Children's dental check-up | Not Covered                                                   | Not Covered                                       | —————none—————                                                                                         |

### 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.)

- |                                                                                                    |                              |                                                             |
|----------------------------------------------------------------------------------------------------|------------------------------|-------------------------------------------------------------|
| • <b>Abortion</b> (Except in cases of rape, incest, or when the life of the mother is endangered.) | • <b>Dental care (Adult)</b> | • <b>Non-emergency care when traveling outside the U.S.</b> |
| • <b>Bariatric surgery</b>                                                                         | • <b>Hearing Aids</b>        | • <b>Routine foot care</b>                                  |
| • <b>Cosmetic surgery</b>                                                                          | • <b>Long-term care</b>      | • <b>Weight loss programs</b>                               |

#### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- |                            |                                                                                                                                                   |                                   |
|----------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|
| • <b>Acupuncture</b>       | • <b>Infertility treatment</b> (Covered services are subject to applicable Member Deductible, Copayment or Coinsurance based on type of service.) | • <b>Routine eye care (Adult)</b> |
| • <b>Chiropractic care</b> | • <b>Private-duty nursing</b>                                                                                                                     |                                   |

**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 Insurance, 50 W. Town Street Third Floor—Suite 300, Columbus, OH 43215, Telephone: (614) 644-2673, Toll Free: 1-800-686-1526., Other options to continue coverage are available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**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: The Ohio Department of Insurance, 50 W. Town Street, Third Floor – Suite 300, Columbus, OH 43215, Telephone: (614) 644-2673, Toll Free: 1-800-868-1526

### Does this plan provide Minimum Essential Coverage? **Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

### 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 <u>plan's</u> overall <u>deductible</u> | \$6,000 |
| <u>Specialist copayment</u>                 | \$80    |
| Hospital (facility) <u>coinsurance</u>      | 40%     |
| Other <u>coinsurance</u>                    | 40%     |

**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>\$12,700</b> |
|---------------------------|-----------------|

**In this example, you would pay:**

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$6,000        |
| <u>Copayments</u>                 | \$10           |
| <u>Coinsurance</u>                | \$1,600        |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$60           |
| <b>The total you would pay is</b> | <b>\$7,670</b> |

### Managing Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

|                                             |         |
|---------------------------------------------|---------|
| The <u>plan's</u> overall <u>deductible</u> | \$6,000 |
| <u>Specialist copayment</u>                 | \$80    |
| Hospital (facility) <u>coinsurance</u>      | 40%     |
| Other <u>coinsurance</u>                    | 40%     |

**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>\$5,600</b> |
|---------------------------|----------------|

**In this example, you would pay:**

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$100          |
| <u>Copayments</u>                 | \$1,200        |
| <u>Coinsurance</u>                | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$20           |
| <b>The total you would pay is</b> | <b>\$1,320</b> |

### Simple Fracture

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

|                                             |         |
|---------------------------------------------|---------|
| The <u>plan's</u> overall <u>deductible</u> | \$6,000 |
| <u>Specialist copayment</u>                 | \$80    |
| Hospital (facility) <u>coinsurance</u>      | 40%     |
| Other <u>coinsurance</u>                    | 40%     |

**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>\$2,800</b> |
|---------------------------|----------------|

**In this example, you would pay:**

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$2,300        |
| <u>Copayments</u>                 | \$200          |
| <u>Coinsurance</u>                | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total you would pay is</b> | <b>\$2,500</b> |

Note: These numbers assume that the patient received care from an IHCP provider or with IHCP referral at a non-IHCP. If you receive care from a non-IHCP provider without a referral from an IHCP your costs may be higher.

## 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 ;liJ'9 ,oJ' eiLa ,ë,) 9853-264-008-1 ,Ë.I {Oï' .jLSAJLI "J .Ei9iï Ëi9AJJ' ÖTGLNAJ' ÜLATS ;EE IËAJJ' .LZ' UTTiï ÜIL ;Z! :Ëª9TJA

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

**Bengali:** VB7 #ªf% ç£f Wff£f §7°V7, #£7 §V\ u ff7ªf, u7X\V £f%7ªb7e u7B7 PX7eu7 ff£ªB§7 SffVB W\§I CN7f #ªf 5-800-462-3589 (TTY: 5-888-740-5670)I

**Chinese:** 矜シ: \$ë@\$\$橡\$)ëðfi屨縹手婆妨mm÷终fi 婁ㄇ囑 1-800-462-3589 (TTY:1-888-740-5670)ο

**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:** %oªf\$%o:BS T Ç±Çh@ ¢.↓\$ > T @Çsfi\$ª½fi£g1-800-462-3589 (TTY:1-888-740-5670)£½.¢叫± €s今ãCÇ

**Korean:** 揆@: 靚÷©≥ K 靚K÷ Q°, ©© K贅 kªp.m.≥ °ª™ © 靚¿ ; ®10日fi. 1-800-462-3589 (TTY: 1-888-740-5670) ¼ª™ ½靚揆gK°.

**Nepali:** éP7b h\ b ,\hfl. : JP7ª"U" b`P7U2 Bhub ,\,ª§ ¢b` JP7ª"§h hb£bJ ¢7B7 fl\7PJ7 fl'§7ª" hb:ª,u§ "PB7 7PUoff § I Æhb §b ,\hfl. 1-800-462- 3589 (h7h7§7\ : 1-888-740-5670) I

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).

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

**Russian:** BHNMAHNE: ECNN BΘ FOBOPNTE HA PYCCKOM ESΘKE, TO BAM GOCTYMHΘ 6ECMNATHΘE YCNYFN MEPEBOGA. 3BOHNTE 1-800-462-3589 (TENETANM: 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:** 1-800-462-3589- C,,2,,22£M 2..z .>za .B.ZC,,2,,Z..M C,,2,,2£2Z c,,bz..z..w¿ c,,b..m2£. .>B.22Z..A¿ .>b.z,,m rc,,z,,z.>b,,c C,,2,,2£2 .>B.2M£ÇM..W C,,2 .>b...c £c :c,,z,,w.>z- (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:** VBAFA! RKYO BN POSMOBNESTE YKPAÏHCAKOD MOBOD, BN MOMETE SBEPHYTNCE go 6ESKOMTOBHOÏ CNYM6N MOBHOÏ MIGTPNMKN. TENE\$OHYNTE sa HOMEPOM 1-800 -462-3589 (TENETANM: 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).

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  - 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.

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Member Services  
300 Madison Avenue, 3<sup>rd</sup> Floor  
Toledo, Ohio 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](mailto: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>.