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. 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/member-handbooks or call 1-800-462-3589 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$6,500** Single (Paramount Ohio HMO Network) **$13,000** 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 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 annual 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 (Paramount OH HMO Network)	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Deductible and Coinsurance not to exceed **$8,000** Single (Paramount Ohio HMO Network) **$16,000** Family (Paramount Ohio HMO 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 and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why this Matters:
Will you pay less if you use a network provider?	Yes. See www.paramounthealthcare.com or call 1-800-462-3589 for a list of network 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) Paramount Ohio HMO 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	$30 Copayment/visit, Deductible does not apply	Not Covered	————none————
	Specialist visit	$75 Copayment/visit, Deductible does not apply	Not Covered	————none————
	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)	40% Coinsurance, Subject to Deductible	Not Covered	————none————
	Imaging (CT/PET scans, MRIs)	40% Coinsurance, Subject to Deductible	Not Covered	————none————
If you need drugs to treat your illness or condition More information about prescription drug coverage	Preferred Generics	$15 Copayment/ prescription (retail), Deductible does not apply $37.50 Copayment/	Not Covered (retail) Not Covered (mail order)	Covers up to a 1-30 day supply (retail prescription); 31-90 day supply (mail order prescription)

*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) Paramount Ohio HMO Network Provider	Your Cost If You Use A(n) Out-of-Network Provider	
www.paramounthealthcare.com/thinking-about-enrolling-843		prescription (mail order), Deductible does not apply		Drug Formulary - Individual Exchange
	Non-Preferred Generics	$25 Copayment/ prescription (retail), Deductible does not apply $62.50 Copayment/ prescription (mail order), Deductible does not apply	Not Covered (retail) Not Covered (mail order)	Same as Generic Drugs
	Preferred Brands	$50 Copayment/ prescription (retail), Deductible does not apply $125 Copayment/ prescription (mail order), Deductible does not apply	Not Covered (retail) Not Covered (mail order)	Same as Generic Drugs
	Non-Preferred Brands	$250 Copayment/ prescription (retail), Deductible does not apply $750 Copayment/ prescription (mail order), Deductible does not apply	Not Covered (retail) Not Covered (mail order)	Same as Generic Drugs
	Preferred Specialty	40% Coinsurance/ prescription (retail), Subject to Deductible Not Applicable (mail order)	Not Covered (retail) Not Applicable (mail order)	Specialty drugs are available through a limited specialty network and not available through standard mail-order benefits.
	Non-Preferred Specialty	50% Coinsurance/ prescription (retail), Subject to Deductible Not Applicable (mail order)	Not Covered (retail) 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 Deductible	Not Covered	Preventive Drugs covered in accordance with PPACA mandates. This includes

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	
				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% Coinsurance, Not Subject to Deductible, 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% Coinsurance, Subject to Deductible	Not Covered	————none————
	Physician/surgeon fees	40% Coinsurance, Subject to Deductible	Not Covered	————none————
If you need immediate medical attention	Emergency room care	40% Coinsurance, Subject to Deductible	40% Coinsurance, Subject to Deductible	————none————
	Emergency medical transportation	40% Coinsurance, Subject to Deductible	40% Coinsurance, Subject to Deductible	————none————
	Urgent care	$100 Copayment/visit, Deductible does not apply	$100 Copayment/visit, Deductible does not apply	————none————
If you have a hospital stay	Facility fee (e.g., hospital room)	40% Coinsurance, Subject to Deductible	Not Covered	————none————
	Physician/surgeon fees	40% Coinsurance, Subject to Deductible	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	$30 Copayment/visit, Deductible does not apply	Not Covered	————none————
	Inpatient services	40% Coinsurance, Subject	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	
		to Deductible		
If you are pregnant	Office visits	No Charge	Not Covered	Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	40% Coinsurance, Subject to Deductible	Not Covered	————none————
	Childbirth/delivery facility services	40% Coinsurance, Subject to Deductible	Not Covered	————none————
If you need help recovering or have other special health needs	Home health care	40% Coinsurance, Subject to Deductible	Not Covered	Limited to 100 visits per calendar year
	Rehabilitation services	Inpatient: 40% Coinsurance, Subject to Deductible Outpatient: 40% Coinsurance, Subject to Deductible	Inpatient: Not Covered Outpatient: Not Covered	Inpatient: covered up to 60 days per calendar year. Outpatient: PT covered up to 20 visits per calendar year. Outpatient: OT covered up to 20 visits per calendar year. Outpatient: ST covered up to 20 visits per calendar year. Outpatient: Pulmonary covered up to 20 visits per calendar year. Outpatient: Cardiac covered up to 36 visits per calendar year.
	Habilitation services	Inpatient: 40% Coinsurance, Subject to Deductible Outpatient: 40% Coinsurance, Subject to Deductible	Inpatient: Not Covered Outpatient: Not Covered	Inpatient: covered up to 60 days per calendar year. Outpatient: PT covered up to 20 visits per calendar year. Outpatient: OT covered up to 20 visits per calendar year. Outpatient: ST covered up to 20 visits per calendar year. Outpatient: Pulmonary covered up to 20 visits per calendar

*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) Paramount Ohio HMO Network Provider	Your Cost If You Use A(n) Out-of-Network Provider	
				year. Outpatient: Cardiac covered up to 36 visits per calendar year. Coverage provided for screening, diagnosis, and treatment of Autism Spectrum Disorder (ASD) for Covered Persons under the age of twentyone (21). Subject to applicable cost sharing and benefit limits per type of service.
	Skilled nursing care	40% Coinsurance, Subject to Deductible	Not Covered	Limited to 90 days per calendar year
	Durable medical equipment	40% Coinsurance, Subject to Deductible	Not Covered	Subject to Medicare Part B Guidelines and deductible.
	Hospice services	40% Coinsurance, Subject to Deductible	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 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.)		
• **Abortion** (Except in cases of rape, incest, or when the life of the mother is endangered.)	• **Dental care (Adult)**	• **Routine foot care**
• **Acupuncture**	• **Hearing Aids**	• **Weight loss programs**
• **Bariatric surgery**	• **Long-term care**	
• **Cosmetic surgery**	• **Non-emergency care when traveling outside the U.S.**	

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)	
• **Chiropractic care**	• **Private-duty nursing**
• **Infertility treatment** (Covered services are subject to applicable Member Deductible, Copayment or Coinsurance based on type of service.)	• **Routine eye care (Adult)**

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 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 plan's overall deductible	$6,500
Specialist copayment	$75
Hospital (facility) coinsurance	40%
Other coinsurance	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)*

Total Example Cost	**$12,700**

In this example, you would pay:

Cost Sharing	
Deductibles	$6,500
Copayments	$10
Coinsurance	$1,400
What isn't covered	
Limits or exclusions	$60
The total you would pay is	$7,970

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

The plan's overall deductible	$6,500
Specialist copayment	$75
Hospital (facility) coinsurance	40%
Other coinsurance	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)*

Total Example Cost	**$5,600**

In this example, you would pay:

Cost Sharing	
Deductibles	$100
Copayments	$1,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total you would pay is	$1,120

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

The plan's overall deductible	$6,500
Specialist copayment	$75
Hospital (facility) coinsurance	40%
Other coinsurance	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)*

Total Example Cost	**$2,800**

In this example, you would pay:

Cost Sharing	
Deductibles	$2,700
Copayments	$80
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total you would pay is	$2,780

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.

*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 :,liJ¦9 ,oJ¦ eïLa ,ë,) 9853-264-008-1 ,Ë.I {OÏ¦ .¡LSAJLI "J .E¦9ÏÏ ËI9AJJ¦ ÖTGLNAJ¦ ÜLATS ¡EE IËAJJ¦ .LZ¦ UTTÏÏ 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% ¢£f Wff£f §7ºV7, #£7 §V\u ff7\ªf, u7X\V £f%7ªb7e u7B7 PX7eu7 ff£ª\B§7 SffVB W\§I CN7f #ªf 5-800-462-3589 (TTY: 5-888-74O-567O)I

Chinese: 玸シ: $ë®$亖椽$}›ë㔚fi㩳屣縹手婆妨mm÷柊fi○ 婳¤瞌 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: ‰$‰:B$ㄒÇ丰Çh@.↓§ ゝㄒ@Çsfi$"½flÆg1-800-462-3589 (TTY:1-888-740-5670)£½.¢岍丰□ €s亼ãCÇ"

Korean: 撩®: 覴÷©≥ K 覫K÷ Qº, ®© K謵 kªㅍ.≥ º"™ © 覫¿ ; ®10日flfl. 1-800-462-3589 (TTY: 1-888-740-5670) ¼º™ ½賜醱撩gKº.

Nepali: éP7b h\b¸\hfl˛: JP7\"U` b`P7U2 Bhub¸\¸¤§ åb` JP7\"§h hb£bJ å7B7 fl\7PJ7 fl`§7\" hb:ª¸u§ "PB7 7PUoff § I Æhb §b¸'\hfl˛ 1-800-462- 3589 (h7h7§7\: 1-888-740-5670) I

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: Jezeli mówisz po polsku, mozesz skorzystac z bezpłatnej pomocy jezykowej. Zadzwon pod numer 1-800-462-3589 (TTY: 1-888-740-5670).

Romanian: ATENŢIE: Dacă vorbili limba română, vă stau la dispozilie servicii de asistenlă lingvistică, gratuit. Sunali la 1-800-462-3589 (TTY: 1-888-740-5670).

Russian: BHNMAHNE: ECNN BƟ FOBOPNTE HA PYCCKOM ESƟKE, TO BAM GOCTYMHƟ 6ECMNATHƟE YCNYFN MEPEBOGA. 3BOHNTE 1-800-462-3589 (TENETANM: 1-888-740-5670).

Serbo-Croatian: OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezicke pomoci dostupne su vam besplatno. Nazovite 1-800-462-3589 (TTY-Telefon za osobe sa oštecenim 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: Neu ban nói Tieng Vi¾t, có các d%ch vn ho tro ngôn ngu mien phí dành cho ban. GQi so 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 Avenue, Suite 270
Toledo, Ohio 43604
Alternate in Person
Delivery Address: 650 Beaver Creek, Suite 100
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

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.