

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

Coverage for: Single/Family | Plan Type: CDHP



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.paramounthealthcare.com/member-handbooks or by calling **1-866-452-6128**

| Important Questions | Answers | Why this Matters: |
|----------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall deductible? | \$5000 Single (In-Network) \$10000 Family (In-Network) \$6000 Single (Out-of-Network) \$12000 Family (Out-of-Network) Does not apply to preventive care or covered services requiring a copayment. | You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u> . |
| Are there other deductibles for specific services? | No (In-Network) No (Out-of-Network) | You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers. |
| Is there an out-of-pocket limit on my expenses? | \$6550 Single (In-Network) \$13100 Family (In-Network) \$7150 Single (Out-of-Network) \$14300 Family (Out-of-Network) | The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. |
| What is not included in the out-of-pocket limit? | Premiums, 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 <u>out-of-pocket limit</u> . |
| Is there an overall annual limit on what the plan pays? | No | The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits. |
| Does this plan use a network of providers? | Yes. See www.paramountinsurancecompany.com/FindAProvider or call 1-866-452-6128 for a list of CDHP providers, including Curanet and Encore networks. | If you use an in-network doctor or other health care <u>provider</u> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers in their network</u> . See the chart starting on page 2 for how this plan pays different kinds of providers. |
| Do I need a referral to see a specialist? | No | You can see the <u>specialist</u> you choose without permission from this plan. |
| Are there services this plan doesn't cover? | Yes. | Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about <u>excluded services</u> . |

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- **Co-Payments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **co-insurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use In-Network **providers** by charging you lower **deductibles**, **co-payments**, and **co-insurance** amounts.

| Common Medical Event | Services You May Need | Your Cost If You Use A(n) In-Network Provider | Your Cost If You Use A(n) Out-of-Network Provider | Limitations & Exclusions |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|---------------------------------------------------------------------------------------|---------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | 30% Co-Insurance. | 50% Co-Insurance. | —————none————— |
| | Specialist visit | 30% Co-Insurance. | 50% Co-Insurance. | —————none————— |
| | Other practitioner office visit | 30% coinsurance for chiropractic services | 50% coinsurance for chiropractic services | Limited to Spinal Manipulations 12 times a year per calendar year. |
| | Preventive/care/screening/immunization | Covered in full. | 50% Co-Insurance. | —————none————— |
| If you have a test | Diagnostic test (x-ray, blood work) | 30% Co-Insurance. | 50% Co-Insurance. | —————none————— |
| | Imaging (CT/PET scans, MRIs) | 30% 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 <u>prescription drug coverage</u> is available at www.paramountinsurancecompany.com | Preferred Generics | 30% co-insurance / prescription (retail) 30% co-insurance / prescription (mail order) | 50% of allowed amount | Covers up to a 30 day supply (retail prescription); 90 day supply (mail order prescription) PPACA Mandated Preventive Drugs - \$0 copayment. Paramount Value-Added Preventive Medications - \$0 copayment. Oral Chemotherapy Drugs - \$100 copayment. |
| | Non-Preferred Generics | 30% co-insurance / prescription (retail) 30% co-insurance / prescription (mail order) | 50% of allowed amount | Same as Generic Drugs |

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| Common Medical Event | Services You May Need | Your Cost If You Use A(n) In-Network Provider | Your Cost If You Use A(n) Out-of-Network Provider | Limitations & Exclusions |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|---------------------------------------------------------------------------------------|---------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.paramountinsurancecompany.com | Preferred Brands | 35% co-insurance / prescription (retail) 35% co-insurance / prescription (mail order) | 50% of allowed amount | Same as Generic Drugs |
| | Non-Preferred Brands | 35% co-insurance / prescription (retail) 35% co-insurance / prescription (mail order) | 50% of allowed amount | Same as Generic Drugs |
| | Specialty and Injectables | 35% co-insurance / prescription (retail) | 50% of allowed amount | Specialty drugs available through a limited specialty network and not available through standard mail-order benefits. |
| | Oral Chemotherapy Drugs | \$100.00 copayment Copay per fill | 50% of allowed amount | Subject to deductible. Subject to prior authorization, quantity limits and dispensing limits. Up to one month supply may be dispensed per fill. |
| | PPACA Mandated Preventive Drugs | \$0.00 copayment Copay | 50% of allowed amount | Preventive Drugs covered in accordance with PPACA mandates. This includes products from the following categories: aspirin, vitamins, smoking cessation medications, women's contraceptive medications and devices, vaccines and bowel preparations. These drugs are not subject to the deductible. This list is subject to change. |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 30% 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 | 30% Co-Insurance. | 50% Co-Insurance. | —————none————— |
| If you need immediate medical attention | Emergency room services | 30% Co-Insurance. | 30% Co-Insurance. | You may be balanced billed for non-network services. To prevent this, use PHCS Healthy Directions network providers when out of the service area. |

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|-------------------------------------------------------------------------------|----------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|
| If you need immediate medical attention | Emergency medical transportation | 30% Co-Insurance. | 50% Co-Insurance. | You may be balanced billed for non-network services. To prevent this, use PHCS Healthy Directions network providers when out of the service area. |
| | Urgent care | 30% Co-Insurance. | 50% Co-Insurance. | You may be balanced billed for non-network services. To prevent this, use PHCS Healthy Directions network providers when out of the service area. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 30% 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 fee | 30% Co-Insurance. | 50% Co-Insurance. | _____none_____ |
| If you have mental health, behavioral health, or substance abuse needs | Mental/Behavioral health outpatient services | Covered Services are subject to the same deductible, copayments and/or coinsurance as any other physical disease or condition. | Covered Services are subject to the same deductible, copayments and/or coinsurance as any other physical disease or condition. | _____none_____ |
| | Mental/Behavioral health inpatient services | Covered Services are subject to the same deductible, copayments and/or coinsurance as any other physical disease or condition. | Covered Services are subject to the same deductible, copayments and/or coinsurance as any other physical disease or condition. | _____none_____ |
| | Substance use disorder outpatient services | Covered Services are subject to the same deductible, copayments and/or coinsurance as any other physical disease or condition. | Covered Services are subject to the same deductible, copayments and/or coinsurance as any other physical disease or condition. | _____none_____ |

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|-------------------------------------------------------------------------------|-----------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| If you have mental health, behavioral health, or substance abuse needs | Substance use disorder inpatient services | Covered Services are subject to the same deductible, copayments and/or coinsurance as any other physical disease or condition. | Covered Services are subject to the same deductible, copayments and/or coinsurance as any other physical disease or condition. | —————none————— |
| If you are pregnant | Prenatal and postnatal care | Covered in full. | 50% Co-Insurance. | —————none————— |
| | Delivery and all inpatient services | 30% Co-Insurance. | 50% Co-Insurance. | —————none————— |
| If you need help recovering or have other special health needs | Home health care | 30% Co-Insurance. | 50% Co-Insurance. | Limited to 100 visits per calendar year. |
| | Rehabilitation services | 30% Co-Insurance. | 50% Co-Insurance. | Inpatient Rehabilitation is limited to 60 days per calendar year. Outpatient Physical, Occupational, Speech Therapy and Pulmonary Rehabilitation limited to 20 visits. Cardiac Rehabilitation limited to 36 visits. |
| | Habilitation services | 30% Co-Insurance. | 50% Co-Insurance. | Outpatient physical Habilitation is limited to 20 visits. Visits are combined with Rehabilitation services. Medically diagnosed Autism Spectrum disorders are limited to children up to age twenty-one (21) if medically necessary. |
| | Skilled nursing care | 30% Co-Insurance. | 50% Co-Insurance. | Limited to 90 days per calendar year. |
| | Durable medical equipment | 30% Co-Insurance. | 50% Co-Insurance. | Subject to Medicare Part B Guidelines and deductible. |
| | Hospice service | Covered in full. | Covered in full. | —————none————— |
| | If your child needs dental or eye care | Eye exam | Covered in full. | 50% Co-Insurance. |
| Glasses | | No charge for Pediatric Vision | Not covered. | Limited to lenses/contacts in lieu of glasses one (1) every twelve (12) months. Frames one (1) every twelve (12) months. From Collection |
| Dental check-up | | Not covered. | Not covered. | —————none————— |

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Excluded Services & Other Covered Services:

Services Your Plan Does NOT cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

| | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> • Acupuncture • Cosmetic surgery • Long-term care • Weight loss programs | <ul style="list-style-type: none"> • Bariatric Surgery • Dental care (Adult) • Non-emergency care when traveling outside the U.S. | <ul style="list-style-type: none"> • Chiropractic care • Hearing Aids • Routine foot care |
|-------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

| | | |
|---------------------------------------------------------------------------|--------------------------------------------------------------------------|------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> • Infertility treatment | <ul style="list-style-type: none"> • Private-duty nursing | <ul style="list-style-type: none"> • Routine eye care (Adult) |
|---------------------------------------------------------------------------|--------------------------------------------------------------------------|------------------------------------------------------------------------------|

Your Rights to Continue Coverage

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-866-452-6128. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact Paramount Insurance Co. Member Service Department at (419) 887-2525 or Toll Free at 1(800) 462-3589, or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

| Having a baby (normal delivery) | |
|------------------------------------|----------------|
| • Amount owed to providers: | \$7,540 |
| • Plan pays: | \$1,710 |
| • Patient pays: | \$5,830 |
| Sample care costs: | |
| Hospital charges (mother) | \$2,700 |
| Routine obstetric care | \$2,100 |
| Hospital charges (baby) | \$900 |
| Anesthesia | \$900 |
| Laboratory tests | \$500 |
| Prescriptions | \$200 |
| Radiology | \$200 |
| Vaccines, other preventive | \$40 |
| Total | \$7,540 |
| Patient Pays: | |
| Deductibles | \$5,000 |
| Co-pays | \$0 |
| Co-insurance | \$680 |
| Limits or exclusions | \$150 |
| Total | \$5,830 |

| Managing type 2 diabetes (routine maintenance of a well-controlled condition) | |
|----------------------------------------------------------------------------------|----------------|
| • Amount owed to providers: | \$5,400 |
| • Plan pays: | \$240 |
| • Patient pays: | \$5,160 |
| Sample care costs: | |
| Prescriptions | \$2,900 |
| Medical Equipment and Supplies | \$1,300 |
| Office Visits and Procedures | \$700 |
| Education | \$300 |
| Laboratory Tests | \$100 |
| Vaccines, other preventive | \$100 |
| Total | \$5,400 |
| Patient Pays: | |
| Deductibles | \$5,000 |
| Co-pays | \$0 |
| Co-insurance | \$80 |
| Limits or exclusions | \$80 |
| Total | \$5,160 |

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**
- Sample care costs are based on national averages supplied by the US Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

x No. Treatments shown are just examples. The care you would receive for this condition would be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

x No. Coverage examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare Plans?

✓ Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ Yes. An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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

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

Arabic:

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم [1-800-462-3589] [(TTY: 1-888-740-5670)].

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

Bengali: লক্ষ্য করুন: যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন [1-800-462-3589] [(TTY: 1-888-740-5670)]।

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)].



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

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

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>.