Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services
Paramount Care, Inc. : UT OBA/FrontPath (Non-Grandfathered Plan)

Coverage Period: 1/1/2021 - 12/31/2021
Coverage for: Single/Family | **Plan Type:** PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered heath care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, contact Paramount at 1-800-462-3589 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 or call 1-800-462-3589 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Single **$150** (UTMC & Tier 1 Facilities**) **$300** Single +1(UTMC & Tier 1 Facilities**) Family **$600** (UTMC & Tier 1 Facilities**) **$300** Single (Front Path & First Health Networks) **$600** Single +1 (Front Path & First Health Networks) **$300** Family (Front Path & First Health Networks) **$300** Single (Out-of- Network Level) **$600** Single +1 (Out-of- Network Level) **$1000** Family (Out-of-Network Level) Does not apply to preventive care or covered services requiring a copayment.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes, preventive care	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No (UTMC & Tier 1 Facilities**) No (Front Path & First Health Networks) No (Out-of-Network Level)	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**$1,250** Single (UTMC & Tier 1 Facilities**) **$2,500** Single +1 (UTMC & Tier 1 Facilities**) **$2,500** Family (UTMC & Tier 1 Facilities**) **$2,500** Single (Front Path & First Health Networks) **$5,000** Single +1 (Front Path & First Health Networks) **$5,000** Family (Front Path & First Health Networks) **$5,000** Single (Out-of- Network Level) **$10,000** Single +1 (Out-of- Network Level) **$10,000** Family (Out-of-Network Level)	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, out-of-network charges in excess of UCR 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/FindAProvider for a list of UTMC & ProMedica owned and operated Hospitals for Inpatient Services and Outpatient Surgeries - Tier 1 Providers. Front Path, and First Health Networks. - Tier 2 Providers.	You pay the least if you use a provider in UTMC & Tier 1 Facilities**. You pay more if you use a provider in Front Path & First Health Networks. 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. However, if you use an Out-of-Network physician or facility, you must prenotify with Paramount at: 866-452-6128.	You can see the specialist you choose without a referral.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions & Other Important Information
		Your Cost If You Use A(n) UTMC & Tier 1 Facilities** Provider	Your Cost If You Use A(n) Front Path & First Health Networks Provider	Your Cost If You Use A(n) Out-of-Network Level Provider	
If you visit a health care provider's office or clinic	Primary Care visit to treat an injury or illness	$15.00 Co-pay/visit.	$25.00 Co-pay/visit.	30% Co-Insurance.	Deductible does not apply to office visit copay.
	Specialist visit	$30.00 Co-pay/visit.	$40.00 Co-pay/visit.	30% Co-Insurance.	Podiatry Services: $25 copay Tier 1; $30 copay Tier 2; 30% coinsurance Tier 3.
	Preventive care/screening /immunization	No charge.	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)	5% Co-Insurance.	15% Co-Insurance.	30% Co-Insurance.	
	Imaging (CT/PET scans, MRIs)	5% Co-Insurance	15% Co-Insurance.	30% Co-Insurance.	Prior Authorization Required.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.paramounthealthcare.com/Employers-PharmacyResources-CommercialDrugBenefits	Prescription Drug Coverage	Not Covered By Paramount.	Not Covered By Paramount.	Not Covered By Paramount.	Not Covered By Paramount.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	5% Co-Insurance.	15% Co-Insurance.	30% Co-Insurance.	Prior Authorization Required.

*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) UTMC & Tier 1 Facilities** Provider	Your Cost If You Use A(n) Front Path & First Health Networks Provider	Your Cost If You Use A(n) Out-of-Network Level Provider	
If you have outpatient surgery	Physician/surgeon fees	5% Co-Insurance.	15% Co-Insurance.	30% Co-Insurance.	——————none——————
If you need immediate medical attention	Emergency room care	$200 Facility Copay	$200 Facility Copay	$200 Facility Copay	Deductible does not apply Waived if admitted.
	Emergency medical transportation	5% Co-Insurance.	15% Co-Insurance.	15% Co-Insurance.	——————none——————
	Urgent care	N/A	$50 Copay	$50 Copay	Deductible does not apply to copay.
If you have a hospital stay	Facility fee (e.g., hospital room)	5% Co-Insurance.	15% Co-Insurance.	30% Co-Insurance.	Prior Authorization Required.
	Physician/surgeon fees	5% Co-Insurance	15% Co-Insurance.	30% Co-Insurance.	——————none——————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15.00 Co-pay/visit.	$25.00 Co-pay/visit.	30% Co-Insurance.	Deductible does not apply to office visit copay.
	Inpatient services	5% Co-Insurance.	15% Co-Insurance.	30% Co-Insurance.	Prior Authorization Required.
If you are pregnant	Office visits	$15.00 Co-pay/visit.	$25.00 Co-pay/visit.	30% Co-Insurance.	Deductible does not apply to office visit copay. Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	5% Co-Insurance	15% Co-Insurance.	30% Co-Insurance.	——————none——————
	Childbirth/delivery facility services	5% Co-Insurance	15% Co-Insurance.	30% Co-Insurance.	Prior Authorization Required.
If you need help recovering or have other special health needs	Home health care	5% Co-Insurance	15% Co-Insurance.	30% Co-Insurance.	Prior Authorization Required.

*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) UTMC & Tier 1 Facilities** Provider	Your Cost If You Use A(n) Front Path & First Health Networks Provider	Your Cost If You Use A(n) Out-of-Network Level Provider	
If you need help recovering or have other special health needs	Rehabilitation services	5% Co-Insurance	15% Co-Insurance.	30% Co-Insurance.	Inpatient Rehabilitation covered up to 60 days per calendar year. Outpatient occupational, physical therapy up to 15 visits per Calendar Year additional visits with Prior Authorization Required. Speech therapy up to 15 visits per Calendar Year for restorative/rehabilitate due to an illness or injury, additional visits with Prior Authorization Required.
	Habilitation services	5% Co-Insurance	15% Co-Insurance.	30% Co-Insurance.	Inpatient Habilitation covered up to 60 days per calendar year. Outpatient occupational, physical therapy up to 15 visits per Calendar Year additional visits with Prior Authorization Required. Speech therapy up to 15 visits per Calendar Year for restorative/rehabilitate due to an illness or injury, additional visits with Prior Authorization Required.
	Skilled nursing care	5% Co-Insurance	15% Co-Insurance.	30% Co-Insurance.	Limited to 120 days per member per calendar year. Prior Authorization Required.
	Durable medical equipment	5% Co-Insurance.	15% Co-Insurance.	30% Co-Insurance.	Orthotic Foot Devices, Subject to Medicare Part B Guidelines.
	Hospice services	5% Co-Insurance	15% Co-Insurance.	30% Co-Insurance.	Prior Authorization Required.
If your child needs dental or eye care	Children's eye exam	Not covered.	Not covered.	Not covered.	——————none——————

*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) UTMC & Tier 1 Facilities** Provider	Your Cost If You Use A(n) Front Path & First Health Networks Provider	Your Cost If You Use A(n) Out-of-Network Level Provider	
If your child needs dental or eye care	Children's glasses	Not covered.	Not covered.	Not covered.	——————none——————
	Children's dental check-up	Not covered.	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.)		
• **Acupuncture** • **Dental care (Adult)** • **Long-term care** • **Routine eye care (Adult)**	• **Bariatric Surgery** • **Hearing Aids** • **Non-emergency care when traveling outside the U.S.** • **Routine foot care**	• **Cosmetic surgery** • **Infertility treatment** • **Private-duty nursing** • **Weight loss programs**

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please check your plan document.		
		• **Chiropractic care**, Prior Authorization Required.

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

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Paramount Care, Inc., Member Service Department at: (419) 887-2525, Toll Free: 1-800-462-3589, or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform

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

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

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

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

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

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

About these Coverage Examples:

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

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

The Plan's overall deductible	$150
Specialist copayment	$30
Hospital (facility) coinsurance	5%
Other coinsurance	5%

This EXAMPLE event includes services like:

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

Total Example Cost	**$12,731**

In this example, you would pay:

Cost Sharing	
Deductibles	$150
Co-pays	$30
Co-insurance	$620
What isn't covered	
Limits or exclusions	$100
The total you would pay is	**$900**

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

The Plan's overall deductible	$0
Specialist copayment	$25
Hospital (facility) coinsurance	5%
Other coinsurance	5%

This EXAMPLE event includes services like:

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

Total Example Cost	**$7,389**

In this example, you would pay:

Cost Sharing	
Deductibles	$150
Co-pays	$180
Co-insurance	$10
What isn't covered	
Limits or exclusions	$6,040
The total you would pay is	**$6,380**

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

The Plan's overall deductible	$150
Specialist copayment	$30
Hospital (facility) coinsurance	5%
Other coinsurance	5%

This EXAMPLE event includes services like:

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

Total Example Cost	**$1,925**

In this example, you would pay:

Cost Sharing	
Deductibles	$150
Co-pays	$290
Co-insurance	$50
What isn't covered	
Limits or exclusions	$0
The total you would pay is	**$490**

*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 [illegible] 9853 264 008 1 [illegible]

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

Bengali: [illegible] 1-800-462-3589 (TTY: [illegible])

Chinese: [illegible] 1-800-462-3589 (TTY[illegible]1-888-740-5670[illegible]

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: [illegible]1-800-462-3589 [illegible]TTY:1-888-740-5670[illegible]

Korean: [illegible] 1 800 462 3589 (TTY: 1-888-740-5670) [illegible].

Nepali: [illegible] 1-800-462-3589 ([illegible] 1-888-740-5670) [illegible]

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).

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

Polish: 8:$*$: -HĪHOL PyZLV] SR SROVNX PRĪHV] VNRU]\VWDü] EH]SáDWQHM SRPRF\ MĊ]\NRZHM. =DG]ZRĚ SRG QXPHU 1 800 462 3589 (77<: 1 888 740 5670). **Romanian**:

$7(1Ʒ,(: 'DFă YRUELƫL OLPED URPkQă Yă VWDX OD GLVSR]LƫLH VHUYLFLL GH DVLVWHQƫă OLQJYLVWLFă JUDWXLW. 6XQDƫL OD 1-800-462-3589 (TTY: 1-888-740-5670). **Russian**:

ȼɇɂɆȺɇɂȿ: ȿɫɥɢ ɜɵ ɝɨɜɨɪɢɬɟ ɧɚ ɪɭɫɫɤɨɦ ɹɡɵɤɟ, ɬɨ ɜɚɦ ɞɨɫɬɭɩɧɵ ɛɟɫɩɥɚɬɧɵɟ ɭɫɥɭɝɢ ɩɟɪɟɜɨɞɚ. Ɂɜɨɧɢɬɟ 1 800 462 3589 (ɬɟɥɟɬɚɣɩ: 1 888 740 5670).

Serbo-Croatian: 2%$9-(â7(1-(: $NR JRYRULWH VUSVNR KUYDWVNL XVOXJH MH]LþNH SRPRüL GRVWXSQH VX YDP EHVSODWQR. 1D]RYLWH 1 800 462 3589 (77< Telefon za osobe VD RãWHüHQLP JRYRURP LOL VOXKRP: 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 ¾æÙæ£â áª§î ªû ÿ§Ø½æÅª§â ¾æý£àÁ ¿šûª§Øª§…ƒ ¿¤ÿª§ãà£Ï ª†ÿ§ÙàÂª§øƒ ª†ÿ§Ø÷âŤ¾Ø˜ª†š~ ¾æý£ß ª†ÿ§Ùâ£Îâª§… ¾¤Ü ª†ÿÏª§~ £~ À˜…§†‡- (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: ɍȼȺȽȺ! əɤɳɨ ɜɢ ɝɨɜɨɪɢɬɟ ɭɤɪɚʀɧɫɶɤɨɸ ɦɨɜɨɸ, ɜɢ ɦɨɠɟɬɟ ɡɜɟɪɧɭɬɢɫɹ ɞɨ ɛɟɡɤɨɲɬɨɜɧɨʀ ɫɥɭɠɛɢ ɦɨɜɧɨʀ ɩɿɞɬɪɢɦɤɢ. Ɍɟɥɟɮɨɧɭɣɬɟ ɡɚ ɧɨɦɟɪɨɦ 1 800 462 3589 (ɬɟɥɟɬɚɣɩ: 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:
  - 4XDOLILHG VLJQ ODQJXDJH LQWHUSUHWHUV
  - :ULWWHQ LQIRUPDWLRQ LQ RWKHU IRUPDWV (ODUJH SULQW DXGLR DFFHVVLEOH HOHFWURQLF IRUPDWV RWKHU IRUPDWV)
- Free language services to people whose primary language is not English, such as:
  - 4XDOLILHG LQWHUSUHWHUV
  - ,QIRUPDWLRQ ZULWWHQ LQ RWKHU ODQJXDJHV

If you need these services, contact Member Services at 1-800-462-3589.
If you believe that Paramount Insurance Company has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance. You can file a grievance in person or by mail, fax, or email.

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

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

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

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