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, [insert contact information]. 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?	**$100** Single or **$200** Family**; $500** Single or **$1,000** Family (Paramount Out-of-Network.)	Generally, you must pay all the costs 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	Yes such as preventive services. This plan covers some items and services even if you haven't met the deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit (OOPL) for this plan?	**For network providers $2,100** Single/ **$4,200** Family; for out-of-network providers **$4,500** Single/**$9,000 Family**.	The out-of-pocket limit is the most you could pay during a 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 meet.
What is not included in the out-of-pocket limit?	Premiums contribution	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.paramounthealthcare.com or call 1-800-4662-3589. For retail prescription drugs go to www.rxbenefits.com or call 800-334-8134.	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 providers, and you might receive a bill from a providers for the difference between the providers' charge and what your plan pay (balance billing). 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 permission from this plan.

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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	**$20** copay/office visit	Not covered	None
	Specialist visit	**$40** copay/office visit	Deductible then 40% coinsurance	Preauthorization is required. If you don't get Preauthorization benefits could be reduced by 50% of the total cost of the service.
	Preventive care/screening/ immunization	No cost share	Deductible then 40% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Deductible then 20% coinsurance	Deductible then 40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	Deductible then 20% coinsurance	Deductible then 40% coinsurance	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.[in.com	Generic drugs (Tier 1)	10% coinsurance (retail or mail order)	10% coinsurance (retail or mail order)	All tiers cover up to a 30-day supply retail pharmacy; 31-90 day supply mail order pharmacy; Effective 9/1/2020 the RX out-of-pocket limit Single: $4,000 and Family $8,000
	Preferred brand drugs	20% coinsurance (retail or mail order)	20% coinsurance (retail or mail order)	
	Non-preferred brand drugs	30% coinsurance (retail or mail order)	30% coinsurance (retail or mail order)	
	Specialty drugs	20% coinsurance (retail or mail order)	20% coinsurance (retail or mail order)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible then 20% coinsurance	Deductible then 40% coinsurance	Preauthorization may be required.
	Physician/surgeon fees	Deductible then 20% coinsurance	Deductible then 40% coinsurance	None
If you need immediate medical attention	Emergency room care	**$125** copay/visit	**$125** copay/visit	None
	Emergency medical transportation	Deductible then 20% coinsurance	Deductible then 40% coinsurance	None
	Urgent care	**$50** copay/office visit	**$50** copay/office visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible then 20% coinsurance	Deductible then 40% coinsurance	Preauthorization may be required.

[* For more information about limitations and exceptions, see the summary plan description which has been provided to you.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	Deductible then 20% coinsurance	Deductible then 40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Covered services subject to the same deductible, coinsurance & copay as other physical disease or condition	Deductible then 40% coinsurance	None
	Inpatient services	Same as above	Deductible then 40% coinsurance	
If you are pregnant	Office visits	Copay per visit	Deductible then 40% coinsurance	
	Childbirth/delivery professional services	Deductible then 20% coinsurance	Deductible then 40% coinsurance	
	Childbirth/delivery facility services	Deductible then 20% coinsurance	Deductible then 40% coinsurance	
If you need help recovering or have other special health needs	Home health care	Deductible then 20% coinsurance	Deductible then 40% coinsurance	60 visits/calendar year
	Rehabilitation services	Deductible then 20% coinsurance	Deductible then 40% coinsurance	60 visits/year, includes physical, speech and occupational therapies
	Habilitation services	Deductible then 20% coinsurance	Deductible then 40% coinsurance	
	Skilled nursing care	Deductible then 20% coinsurance	Deductible then 40% coinsurance	100 visits/calendar year
	Durable medical equipment	Deductible then 20% coinsurance	Deductible then 40% coinsurance	Subject to Medicare Part B guidelines
	Hospice services	Deductible then 20% coinsurance	Deductible then 40% coinsurance	
If your child needs dental or eye care	Children's eye exam	**$20** copay/office visit	Not covered	Coverage limited to one/year
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered. There is a separate dental plan.	Not covered	None

[* For more information about limitations and exceptions, see the summary plan description which has been provided to you.

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)**
- **Non-emergency care when traveling outside the U.S.**
- **Weight loss programs**
- **Bariatric Surgery**
- **Hearing Aids**
- **Private-duty nursing**
- **Cosmetic surgery**
- **Long-term care**
- **Routine foot care**

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

- **Chiropractic care**
- **Infertility treatment** (if medically necessary; excludes Assisted Reproductive Technology; (ART) and infertility drugs)
- **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: [insert State, HHS, DOL, and/or other applicable agency contact information]. Other coverage options may be 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: [insert applicable contact information from instructions].

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 Standards? **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.

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al [insert telephone number].]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [insert telephone number].]

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 [insert telephone number].]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [insert telephone number].]

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 summary plan description which has been provided to you.

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.

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

The plan's overall deductible	$500
Specialist *[cost sharing]*	$50
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$8,000**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$100
Copayments	$240
Coinsurance	$1,580
What isn't covered	
Limits or exclusions	
The total Peg would pay is	**$1,920**

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

The plan's overall deductible	$100
Specialist *[cost sharing]*	$40
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$100
Copayments	$80
Coinsurance	$1,060
What isn't covered	
Limits or exclusions	
The total Joe would pay is	**$1,240**

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

The plan's overall deductible	$100
Specialist *[cost sharing]*	$40
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$3,000**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$100
Copayments	$165
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$565**

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