Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

NWOBA MEWA HMO 8020 1500

Coverage Period: 5/1/2022 - 4/30/2023

Coverage for: Single/Family | **Plan Type:** HMO

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?	**$1500** Single (Paramount Ohio HMO Network.) **$3000** 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 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 Ohio HMO Network.)	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**$4500** Single (Paramount Ohio HMO Network.) **$9000** 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.
Will you pay less if you use a network provider?	Yes. See www.paramounthealthcare.com/FindAProvider or call 1-800-462-3589 for a list of Paramount Ohio HMO 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	$15.00 Co-pay/visit.	Not covered.	Deductible does not apply.
	Specialist visit	$45.00 Co-pay/visit.	Not covered.	Deductible does not apply.
	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)	20% Co-Insurance.	Not covered.	——————none——————
	Imaging (CT/PET scans, MRIs)	20% Co-Insurance.	Not covered.	——————none——————
If you need drugs to treat your illness or condition	Value Generics	$5.00 copay / prescription (retail) $10.00 copay / prescription (mail order)	Not Covered	Covers up to a 1-30 day supply (retail prescription); 31-90 day supply (mailorder prescription) ACA Mandated Preventive Drugs - $0.00.Oral Chemotherapy Drugs - 35% Coinsurance with a maximum of $100.00.
	Generics	$10.00 copay / prescription (retail) $20.00 copay / prescription (mail order)	Not Covered	Same as Generic Drugs
	Preferred Brands	$45.00 copay / prescription (retail) $135.00 copay / prescription (mail order)	Not Covered	Same as Generic Drugs

*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	
If you need drugs to treat your illness or condition	Non-Preferred Brands	$75.00 copay / prescription (retail) $225.00 copay / prescription (mail order)	Not Covered	Same as Generic Drugs
	ACA Mandated Preventive Drugs	$0.00 Copay	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.
	Tier 1 Specialty Drugs	35% Coinsurance with a maximum of $350.00	Not Covered	Specialty drugs are available through a limited specialty network and not available through standard mail-order program.
	Tier 2 Specialty Drugs	35% Coinsurance with a maximum of $450.00	Not Covered	Specialty drugs are available through a limited specialty network and not available through standard mail-order program.
	Tier 3 Specialty Drugs	50% Coinsurance	Not Covered	Specialty drugs are available through a limited specialty network and not available through standard mail-order program.
	Oral Chemotherapy Drugs	35% Coinsurance with a maximum of $100.00	Not Covered	Not subject to deductible. Subject to prior authorization, quantity limits and dispensing limits. One month supply dispensing maximum.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Co-Insurance.	Not covered.	————————none————————
	Physician/surgeon fees	20% Co-Insurance.	Not covered.	————————none————————
If you need immediate medical attention	Emergency room care	$400.00 Co-pay/visit.	Payable under HMO network of benefits.	Deductible does not apply. Waived if admitted.
	Emergency medical transportation	20% Co-Insurance.	Payable under HMO network of benefits.	————————none————————

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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 need immediate medical attention	Urgent care	$60.00 Co-pay/visit.	Payable under HMO network of benefits.	Deductible does not apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Co-Insurance.	Not covered.	——————none——————
	Physician/surgeon fees	20% Co-Insurance.	Not covered.	——————none——————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15.00 Co-pay/visit.	Not covered.	Deductible does not apply.
	Inpatient services	20% Co-Insurance.	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	20% Co-Insurance.	Not covered.	——————none——————
	Childbirth/delivery facility services	20% Co-Insurance.	Not covered.	——————none——————
If you need help recovering or have other special health needs	Home health care	20% Co-Insurance.	Not covered.	——————none——————
	Rehabilitation services	Inpatient Rehabilitation 20% Coinsurance Outpatient Rehabilitation $45 Copay per Visit	Not covered.	Inpatient Rehabilitation limited to 60 days per calendar year. Outpatient physical and occupational therapy limited to 30 visits combined. Speech therapy limited to 30 visits.
	Habilitation services	Inpatient Habilitation 20% Coinsurance Outpatient Habilitation $45 Copay per Visit	Not covered.	Inpatient Habilitation limited to 60 days per calendar year. Outpatient physical and occupational therapy limited to 30 visits combined. Speech therapy limited to 30 visits. Coverage provided for screening, diagnosis, and treatment of Autism Spectrum Disorder (ASD) for Covered Persons under the age of twenty-one (21). Subject to applicable cost sharing and benefit limits per type of service.
	Skilled nursing care	20% Co-Insurance.	Not covered.	Limited to 100 days per calendar year.
	Durable medical equipment	20% Co-Insurance.	Not covered.	Subject to Medicare Part B Guidelines.
	Hospice services	20% Co-Insurance.	Not covered.	——————none——————
If your child needs dental or eye care	Children's eye exam	No charge.	Not covered.	Limited to one (1) routine vision exam every twelve (12) months.

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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 your child needs dental or eye care	Children's glasses	Not covered.	Not covered.	——————none——————
	Children's dental check-up	Not covered.	Not covered.	——————none——————

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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 check 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: 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: the Department of Labor 's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or your plan.

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	$1500
Specialist copayment	$45
Hospital (facility) coinsurance	20%
Other coinsurance	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	**$12,731**

In this example, you would pay:

Cost Sharing	
Deductibles	$1,500
Co-pays	$50
Co-insurance	$2,480
What isn't covered	
Limits or exclusions	$60
The total you would pay is	**$4,090**

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

The Plan's overall deductible	$1500
Specialist copayment	$45
Hospital (facility) coinsurance	20%
Other coinsurance	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	**$7,389**

In this example, you would pay:

Cost Sharing	
Deductibles	$1,500
Co-pays	$500
Co-insurance	$370
What isn't covered	
Limits or exclusions	$60
The total you would pay is	**$2,430**

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

The Plan's overall deductible	$1500
Specialist copayment	$45
Hospital (facility) coinsurance	20%
Other coinsurance	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	**$1,925**

In this example, you would pay:

Cost Sharing	
Deductibles	$690
Co-pays	$540
Co-insurance	$170
What isn't covered	
Limits or exclusions	$0
The total you would pay is	**$1,400**

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Notice of Nondiscrimination and Accessibility: Discrimination is Against the Law

The Northwest Ohio Business Alliance MEWA and Paramount Insurance Company comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. The Northwest Ohio Business Alliance MEWA and Paramount Insurance Company do 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 Ave Suite 270, Toledo OH 43604
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.

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