2017 Health Insurance Plan Options - Goodwill Industries of NW Ohio

2017 Medical	$500 GOLD Paramount	$5,000 MVP Paramount	MEC KeySolution
Plan	031058	031509	MEC
Network	Paramount HMO	Paramount HMO	MultiPlan PPO Network
Deductible In Network/Non-Network:			
Single	$500 / n/a	$5,000 / n/a	$0 / $0
Family	$1,000 / n/a	$10,000 / n/a	$0 / $0
Coinsurance In Network/Non-Network :	80% / n/a	60% / n/a	100% / 40%
Maximum Out-Of-Pocket In Network/Non-Network:			
Single (includes deductible)	$2,500 / n/a	$6,500 / n/a	$0 / $0
Family (includes deductible)	$5,000 / n/a	$13,000 / n/a	$0 / $0
Copayment: OV / Specialty / UC	$15 / $25 / $45	$35 / ded. & coins. / ded. & coins.	not covered
Prescription Retail / Mail Order:	Paramount Select Formulary	Paramount Select Formulary	not covered
Generic	$10 / $20	$10 / $20	
Preferred Brand	$30 / $60	$30 / $60	
Non-Preferred Brand	$50 / $150	$50 / $150	
Specialty/Injectable	20% coins. to $100max/ n/a	20% coins. to $100max / n/a	
Preventive Care Services	covered in full IN Network (refer to list of covered preventive services)	covered in full IN Network (refer to list of covered preventive services)	covered in full IN Network (refer to list of covered preventive services by CMS)
Inpatient Hospital Services	coinsurance after deductible	coinsurance after deductible	not covered
Maternity	coinsurance after deductible	coinsurance after deductible	not covered
Outpatient Services:			
Surgery	coinsurance after deductible	coinsurance after deductible	not covered
Lab Pathology, X-Ray and Diagnostic Services	coinsurance after deductible	coinsurance after deductible	not covered
Emergency Room	$150 copay, waived if admitted	coinsurance after deductible	not covered
Durable Medical Equipment	coinsurance after deductible	coinsurance after deductible	not covered
Chiropractic	$30 copay (40 visit/yr)	not covered	not covered
Therapy - Physical / Occupational	coinsurance after deductible (30 visit/yr combined)	coinsurance after deductible (20 visit/yr combined)	not covered
Therapy - Speech		coins. after ded. (20 visit/yr)	
Mental Health - Biological	covered same as illness	covered same as illness	not covered
Mental Health/Substance Abuse - Non-Biological:			
Inpatient	covered services are subject to same deductible, copayments and/or coinsurance as any other physical disease or condition	covered services are subject to same deductible, copayments and/or coinsurance as any other physical disease or condition	not covered
Outpatient			
Dependent Age Limit	26	26	26
Lifetime Max	unlimited	unlimited	unlimited

The above is a summary. Please refer to the Plan Summary Booklet for specific coverage.