Paramount Insurance Company
Schedule of Benefits

Maximum Choice Plan

Whiteford Ag. Schools

Group Number:	MP02610001	**Effective Date:**	1/1/2020
Benefit Period:	Calendar Year		
Dependent Child Limiting Age:	Dependent children are covered until the end of the month they turn age 26. Your Employer is considered to be Large Group non-grandfathered health plan under the Patient Protection and Affordable Care Act.		

	Paramount PPO Network	Out-of-Network
Deductible (Embedded):	$500 single/$1,000 family	$1,000 single/$2,000 family
Annual Coinsurance Out-of-Pocket Limit:	$1,500 single/$3,000 family	$3,000 single/$6,000 family
Covered Services:	Covered in Full Biologically Based and Non-Biologically Based Mental Illness covered the same as any physical condition. Effective 10-1-2009: Inpatient & Outpatient Mental Illness and Substance Abuse is covered the same as any physical condition.	20% Coinsurance Biologically Based and Non-Biologically Based Mental Illness covered the same as any physical condition. Effective 10-1-2009: Inpatient & Outpatient Mental Illness and Substance Abuse is covered the same as any physical condition.
Hospice:	Covered in Full	Covered in Full
Physician Office Visit:	$20 Copayment	20% Coinsurance
Emergency Room Facility:	$150 Copay, Waived if Admitted	$150 Copay, Waived if Admitted
Urgent Care Facility:	$20 Copayment	$20 Copayment
Contraception/Sterilization:	Covered in Full	20% Coinsurance
Infertility Rider:	Not Covered	Not Covered
Preventive Health Services:	Covered in full.	20% Coinsurance
Durable Medical:	Covered in Full	20% Coinsurance
Prosthetic Devices:	Covered in Full	20% Coinsurance
Benefit Limits per Calendar Year/Optional Riders		
Skilled Nursing Facility Days:	120 Days per calendar year.	
Inpatient Rehabilitation Days:	60 Days per calendar year.	
Outpatient Physical/Occupational/Speech Therapy:	60 Visits combined per calendar year.	
Autism Spectrum Disorders:	For children up to age nineteen (19) for diagnosis and evidence based treatment of certain Autism Spectrum Disorders, are covered if prior authorized and care is determined to be Medically Necessary.	

Official Terms of Enrollment and Health Benefits

Michigan employer groups in 2017 see Maximum Choices Michigan Certificate of Coverage - Non Grandfathered/In 2018 see Maximum Choices Michigan Certificate of Coverage - Non Grandfathered

Prescription Drug Coverage Whiteford Ag. Schools		
Drug Formulary :	Commercial Select	
Copay Type :	3-Tier	
DAW Status :	Mandatory Generic Generic Drugs, when available, will be dispensed in place of Brand Drugs. These Brand Drugs that have Generic equivalents are called Multi-Source Brand Drugs. These Multi-Source Brand Drugs are not covered, unless medically necessary.	
Non-Participating Pharmacies :	50% of allowed amount	
Maximum Out of Pocket :	$1,500 per Calendar Year for Prescription Drugs and Medical Combined per Member $3,000 per Calendar Year for Prescription Drugs and Medical Combined per Family	
Maximum Out of Pocket (Out-of-Network) :	$3,000 per Calendar Year for Prescription Drugs and Medical Combined per Member $6,000 per Calendar Year for Prescription Drugs and Medical Combined per Family	
	Retail Pharmacy	**Mail Order Pharmacy**
Day Supply :	1-30	31-90
Generic Copay :	$10	$20
Preferred Brand Copay :	$40	$80
Non-Preferred Brand Copay :	$80	$240
	Additional Benefits and Programs	
Specialty Drugs :	20% Coinsurance up to a maximum of $250 . Specialty drugs are available through a limited specialty network and not available through standard mail-order benefits. Not subject to deductible.	
Limited Medical Supplies :	Applicable Copay Applies. Not subject to Deductible.	
ACA Mandated Preventive Drugs :	$0 Copay. 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.	