EBenefits Copay MEC Summary of Benefits

PPO Network: Multiplan/PHCS Pracanc multiplan.com/phcspracanc - Prior authorization is not required for services.

Description of Benefits	*Member Pays at Participating Providers*
Annual Deductible	None
Annual Medical Out-of-pocket maximum	None
Services from participating providers	*For Participating Providers, the contract generally prohibits the provider from charging more than the amounts established in their Participating Provider agreement for covered services.*
Services from non-participating providers	*Eligible expenses, as defined in Plan Benefits Document, will be covered out-of-network when a network provider is not available within 50 mile radius. The Maximum Allowable Charge for services from non-network providers will be limited to 150% of the equivalent Medicare Allowed amount.*
Maximum Lifetime Benefit	*Unlimited*
Maximum Annual Benefit	*Unlimited*
Dependent Coverage	*Children up to age 26*

Physician Services	Participating providers member pays
Virtual Primary & Urgent Care	$0, Download the Recuro Health app for access
Primary Care Office Visits	*$20 copay, unlimited visits, $200 maximum per visit.*
Specialist Visit	*$50 copay, unlimited visits, $300 maximum per visit.*
Urgent Care	*$50 copay, limit 3 visits per calendar year*
Preventive Care	Participating providers member pays *Not covered if performed at a hospital*
Newborn circumcision	*No copayment*
Well Child Care Office Visits ***7 visits birth to 12 months*** ***3 visits during age 1*** ***2 visits during age 2*** ***1 visit from age 3 through 21***	*No Copayment*
Well Child Care Immunizations ***(as recommended by Bright Futures project)***	*No Copayment*
Well Child Care Lab Tests ***(as recommended by Bright Futures project)***	*No Copayment*
Adult Preventive Screening/Testing	Participating providers member pays *Not covered if performed in a hospital*
Adults, one physical exam per benefit year to obtain recommended and diagnostic services	*No Copayment*
Immunizations- doses, recommended ages, and recommended populations vary per the recommendations of the Advisory Committee for Immunization Practices (ACIP)	*No Copayment*
Prostate-specific antigen (Men, one per CY, age > 49	*No Copayment*

Screenings such as; obesity, blood pressure, cholesterol, colorectal cancer, HIV, and alcohol misuse. ***Colorectal Cancer Screening (i.e.. Colonoscopy) Limited to Ambulatory Surgical Center locations only. Not covered if performed in a Hospital.)***	*No Copayment*
Counseling such as alcohol misuse, sexually transmitted infection (STI) prevention, nutritional counseling, and tobacco use	*No Copayment*
Women's Preventive Care Services	Participating providers member pays *Not covered if performed at a hospital*
Prescribed contraceptive methods, sterilization procedures, and patient education. ***(Supply and admin of contraceptives IUDs, implants and injectables); (Pharmacy- birth control pills, diaphragms, emergency contraceptive pill through your pharmacy benefit)***	*No Copayment*
Well-woman exam to obtain recommended preventive and diagnostic services	*No Copayment*
Screenings such as pap smears, mammography, domestic and interpersonal violence screening, osteoporosis screening,	*No Copayment*
Counseling such as contraception, BRCA, breast cancer chemoprevention, folic acid supplements	*No copayment*
Services for pregnant women including but not limited to anemia screening, rh incompatibility screening, breastfeeding, and hepatitis B screening; Breastfeeding: comprehensive support, and counseling from trained providers as well as access to breastfeeding supplies for pregnant and nursing women. ***(Participating breastfeeding supplies up to the amount of $200)***	*No copayment*
Hospital & Facility Services	Member pays
Inpatient room & care- semi private room rate; unlimited number of days in acute or skilled nursing	*Not covered*

facility	
Inpatient room & care (mental/behavioral health/substance abuse) Semi private room rate	*Not covered*
Outpatient/Ambulatory surgery services & birthing centers	*Not covered*
Other outpatient hospital services (such as cardiac, pulmonary, PT/OT/ST)	*Not covered*
Emergency room services	*Not covered*
Diagnostic & Imaging Services	Member Pays
Laboratory Work	$10 copay, $100 max benefit paid per date of service
Diagnostic X-ray	$50 copay, $250 max benefit per x-ray
Radiation Oncology services	Not covered
Advanced diagnostic imaging, MRI/CT/MRA/PET/Ultra Sound	*$200 copay, maximum 2 tests per calendar year*
Mental Health/Behavioral Health/Substance Abuse Disorder (Inpatient)	Member pays
Hospital & facility services; semi private room rate	Not covered
Psyciatrist & psychologist service	Not covered
Outpatient	Member pays
Psychiatrist & psychologist services	Not covered
Psycholigical testing	Not covered
Other Services	Member pays
Allergy testing (including serums, injections, and administration)	Not covered

Ground ambulance	Not covered
Air ambulance	Not covered
Chemotherapy	Not covered
Dialysis and supplies	Not covered
Durable medical equipment (including orthotics/prosthetics)	Not covered
Enteral nutritional therapy	Not covered
Hearing aids	Not covered
Evaluations for the use of hearing aids	Not covered
Home health services	Not covered
Home infusion services	Not covered
Hospice services	Not covered
Human growth hormone, genetic testing/counseling, other	Not covered
Physical/occupational/ speech therapy (non hospital based)	Not covered
Mental health visits (Including therapy, psychiatry, and counseling)	Not covered
Alternative care services	Member pays
Acupuncture	Not covered
Chiropractic care	Not covered
Naturopathy	Not covered

Massage Therapy	Not covered
Pharmacy Benefits ***(refer to ID card for pharmacy benefits)***	Member pays The outline below applies to the copay portion of the plan. Eligible costs beyond the copay amount exceeding the Unshared Amount are eligible for sharing with ShareWELL. International and Prescription Assistance programs available.
132 common acute medications & ACA preventive medications	$0 copay
Tier 1- Generics	$15 in-store or $30 mail order 90-day supply
Tier 2- Preferred brands	$40 in store or $80 mail order 90 day supply
Tier 3- Non-preferred brand	$65 in-store or $130 mail order 90 day supply
Brand specialty	Member pays discounted price
Monthly maximum allowance	$200 in store and $600 mail order
Presription Assistance Program	Member pays a $60 processing fee if approved by the manufacturer

Consider other benefits you may have in conjunction with this plan and use when appropriate.

Network Providers

Your PPO Network is:

Private Healthcare Systems – PHCS Practitioner and Ancillary To locate a provider: https://www.multiplan.com/webcenter/portal/ProviderSearch

Be sure to select “PHCS” then “Practitioner and Ancillary” on the left side

Your Pharmacy Benefit Manager (Prescription Drug PPO) is:

Rx Valet https://www.myrxvalet.com 1-855-798-2538

Your Telemedicine Provider is:

Recuro https://recurohealth.com