Minimum Essential Coverage Options 3

DISCLAIMER: *Benefits listed on this proposal are intended to be a brief summary and are subject to change. Refer to the summary of benefits for full details of the benefits including description of coverage and a list of exclusions.*

PLAN	MEC 3	MEC 3 w HealthShare
Network	First Health (Aetna)	First Health (Aetna)
Deductible *(Individual/Family)*	$0/$0	$0/$0
Maximum Out-Of-Pocket *(Individual/Family)*	$7,500/$15,000	$7,500/$15,000
PREVENTATIVE CARE		
Routine Well Care *(Non-Hospital Services)*	Included	Included
Routine Well Care *(Hospital Services)*	Not Covered	Not Covered
PHYSICIAN SERVICES		
Telemedicine for Virtual Primary Care, Urgent Care and Dermatology	$0 Copay (Unlimited)	$0 Copay (Unlimited)
Primary Care Office Visit	$25 Copay (5 visits per Plan Year)	$25 Copay (5 visits per Plan Year)
Primary Care Office Visit (Mental & Behavioral Health: Balance For Life)	$0 Copay (10 visits per issue per Plan Year)	$0 Copay (10 visits per issue per Plan Year)
Primary Care Office Visit (Mental & Behavioral Health)	$25 Copay (5 visits per Plan Year)	$25 Copay (5 visits per Plan Year)
Specialist Office Visit	$50 Copay *(5 visits per Plan Year)*	$50 Copay *(5 visits per Plan Year)*
Allergy Services	Not Covered	IUA then 50% *(Immunotherapy for Inhalant Allergies only)*
Other Services Performed in Physician Office	Not Covered	IUA
Urgent Care	$75 Copay (4 visits per Plan Year)	$75 Copay (4 visits per Plan Year)

PLAN	MEC 3	MEC 3 w HealthShare
DIAGNOSTIC TESTING		
Radiology *(Non-Hospital Services)*	$50 Copay (4 visits combined per Plan Year for Lab & Radiology) Must Use CareGuide Advocates	$50 Copay *(4 visits combined per Plan Year for Lab & Radiology)* Must use CareGuide Advocates (IUA After)
Advanced Imaging *(Non-Hospital Services)*	$350 Copay *(3 tests combined per Plan Year for Advanced Imaging)* Must use CareGuide Advocates	$350 Copay *(3 tests combined per Plan Year for Advanced Imaging)* Must use CareGuide Advocates *(IUA after)*
Laboratory - QuestSelect Qualify Labs Only *(Non-Hospital Services)*	$0 Copay	$0 Copay
Laboratory *(Non-Hospital Services)*	Not Covered	IUA
Laboratory, Radiology, & Advanced Imaging *(Hospital Services)*	Not Covered	IUA
HOSPITAL, EMERGENCY, & FACILITY SERVICES		
Ambulance	Not Covered	IUA
Emergency	Not Covered	IUA
Hospital Services	Not Covered	IUA
Ambulatory Surgical or OP Surgical Facility	$500 Copay *(1 visit per Plan Year, $5,000 Max Benefit)* Must use CareGuide Advocates	$500 Copay *(1 visit per Plan Year, $5,000 Max Benefit)* Must use CareGuide Advocates (IUA after)
Second Surgical Opinion	Not Covered	$50 Copay (Must use CareGuide Advocates)

PLAN	MEC 3	MEC 3 w HealthShare
OTHER SERVICES		
Maternity	Not Covered	2 x IUA (Max $5,000) (Expected Delivery date 9 months after Plan Effective Date, normal delivery and Emergency Cesarean)
Mental or Nervous Disorders or Substance Abuse (Facilities)	Not Covered (BFL)	IUA (OutPatient - Max of $750 / InPatient - Max of $7,000 - Cognitive Injuries Only)
Chiropractic Care	Not Covered	IUA (18+ years old, Max of $3,000 for Injury or Illness, Maintenance not Covered)
Speech Therapy	Not Covered	IUA Out/Inpatient up to $3,000 (Illness/Injury/Accident Only)
Physical Therapy	Not Covered	IUA Out/Inpatient up to $3,000 (Illness/Injury/Accident Only)
Occupational Therapy	Not Covered	IUA Out/Inpatient up to $3,000 (Illness/Injury/Accident Only)
Home Health Care	Not Covered	IUA (Max of $200 per day and 90 days)
Hospice Care	Not Covered	IUA (Max of $200 per day and 90 days)
Skilled Nursing Facility	Not Covered	IUA (Earliest of $25,000 or 60 days)
Durable Medical Equipment (DME)	Not Covered	IUA then 75% Max of $25,000 (Sleep Apnea Max $2,500 - New Diagnosis Only)
Medical Supplies - Prosthetics, Orthotics, Supplies, & Surgical Dressings	Not Covered	IUA (Up to 120 days of treatment)
Dialysis	Not Covered	IUA
Transplant	Not Covered	IUA (Medication limited to 12 months)
PHARMACY BENEFITS RETAIL OPTION – 30 Day or 90 Day (when qualified) Supply		
95 ACA Prescriptions	$0 Copay	$0 Copay
37 Acute and 200 Chronic Prescriptions	$0/$1 Copay	$0/$1 Copay
1200 Generic Prescriptions	$15 Copy or Less	$15 Copy or Less
Preferred Brand, Non-Preferred Brand	Call RX Valet Concierge	IUA (Limited to 120 days of Medication after new diagnosis, cancer treatment excluded from limitation)
Specialty Drugs	Call RX Valet Concierge	IUA (Limited to 120 days of Medication after new diagnosis, cancer treatment excluded from limitation)

MEC 3 RATES (Non-HealthShare)

Employee Only (EE): **$242.95**
Employee Spouses (ES): **$360.82**
Employee Child (EC): **$320.04**
Family: **$438.58**

COMBINED HEALTH RATES (Final Rates)

*Tobacco adds $75

IUA $500

Tier	18-29	30-65
Employee Only (EE)	$467.95	$560.83
Employee Spouse (ES)	$894.56	$1,048.50
Employee Child (EC)	$784.12	$940.64
Family	$1,217.42	$1,422.96

IUA $1,000

Tier	18-29	30-65
Employee Only (EE)	$423.23	$466.23
Employee Spouse (ES)	$778.46	$832.64
Employee Child (EC)	$686.08	$749.72
Family	$1,047.14	$1,116.80

IUA $1,500

Tier	18-29	30-65
Employee Only (EE)	$403.45	$440.43
Employee Spouse (ES)	$729.44	$775.02
Employee Child (EC)	$644.80	$700.70
Family	$978.34	$1,035.9

IUA $2,500

Tier	18-29	30-65
Employee Only (EE)	$387.11	$423.23
Employee Spouse (ES)	$684.72	$736.32
Employee Child (EC)	$607.82	$664.58
Family	$911.26	$980.06

IUA $5,000

Tier	18-29	30-65
Employee Only (EE)	$375.93	$400.33
Employee Spouse (ES)	$654.62	$707.94
Employee Child (EC)	$582.88	$639.64
Family	$867.40	$939.64