


MEC + Primary Care Benefit Plan

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual or Family | Plan Type: MECPC

 **This is only a summary** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.gohrx.com or call 877-884-4063

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	\$0	See the chart starting on page 2 for your costs for services this plan covers.
Are there other <u>deductibles</u> for specific services?	No.	Not applicable (plan has no deductibles).
Is there an <u>out-of-pocket limit</u> on my expenses?	No.	There's no limit on how much you could pay during a coverage period for your share of the cost of covered services.
What is not included in the <u>out-of-pocket limit</u> ?	This plan has no <u>out-of-pocket limit</u> .	Not applicable.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	No.	This plan is accepted by all providers who also accept Medicare.
Do I need a referral to see a <u>specialist</u> ?	No. You don't need a referral to see a <u>specialist</u> .	You can see the <u>specialist</u> you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan does not cover are listed on page 4. See your policy or plan document for additional information about <u>excluded services</u> .

Questions: Call 1-877.884-4063 or visit us at www.gohrx.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov/resources/files/Files2/02102012/uniform-glossary-final.pdf or call 877-479-3591 to request a copy.

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- **Copayments** are fixed dollar amounts (for example, \$20) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provide	Your Cost If You Use an Out-of-network Provide	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$20 co-pay	\$20 co-pay	-none-
	Specialist visit	\$40 co-pay	\$40 co-pay	-none-
	Other practitioner office visit	Not covered	Not covered	-none-
	Preventive care/screening/immunization	No charge	No charge	Services are limited to those mandated by the Patient Protection and Affordable Care Act
If you have a test	Diagnostic test (x-ray, blood work)	Preventative Only	Not covered	-none-
	Imaging (CT/PET scans, MRIs)	Preventative Only	Not covered	-none-
If you need drugs to treat your illness or condition	Generic drugs	Good RX	Not covered	-none-
	Preferred brand drugs	Good RX	Not covered	-none-
	Non-preferred brand drugs	Good RX	Not covered	-none-
More information about prescription drug coverage is available at www.specialinc.com .	Specialty drugs	Good RX	Not covered	-none-
	Facility fee (e.g., ambulatory surgery center)	Not covered	Not covered	-none-

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If you have outpatient surgery	Physician/surgeon fees	Not covered	Not covered	-none-
If you need immediate medical attention	Emergency room services	Not covered	Not covered	-none-
	Emergency medical transportation	Not covered	Not covered	-none-
	Urgent care	Co-pays apply	Co-pays apply	-non-hospital only-
If you have a hospital stay	Facility fee (e.g., hospital room)	Not covered	Not covered	-none-
	Physician/surgeon fee	Not covered	Not covered	-none-
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Not covered	Not covered	-none-
	Mental/Behavioral health inpatient services	Not covered	Not covered	-none-
	Substance use disorder outpatient services	Not covered	Not covered	-none-
	Substance use disorder inpatient services	Not covered	Not covered	-none-
If you are pregnant	Prenatal and postnatal care	No charge for routine prenatal office visits. All other services not covered.	No charge for routine prenatal office visits. All other services not covered.	Limited to routine prenatal office exams only.
	Delivery and all inpatient services	Not covered	Not covered	-none-
If you need help recovering or have other special health needs	Home health care	Not covered	Not covered	-none-
	Rehabilitation services	Not covered	Not covered	-none-
	Habilitation services	Not covered	Not covered	-none-
	Skilled nursing care	Not covered	Not covered	-none-
	Durable medical equipment	Not covered	Not covered	-none-
	Hospice service	Not covered	Not covered	-none-
If your child needs dental or eye care	Eye exam	Not covered	Not covered	-none-
	Glasses	Not covered	Not covered	-none-
	Dental check-up	Not covered	Not covered	-none-

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Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- | | | |
|-----------------------|--|----------------------------|
| • Acupuncture | • Hearing Aids | • Private-duty nursing |
| • Bariatric surgery | • Infertility | • Routine eye care (Adult) |
| • Chiropractic care | • Long-term care | • Routine foot care |
| • Cosmetic surgery | • Non-emergency care when traveling outside the U.S. | |
| • Dental care (Adult) | | |

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- | | | |
|--|--|---|
| • Weight loss programs (PPACA mandated only) | • Unlimited TeledocX for entire family | • COVID-19: Symptomatic patients screened & approved by a medical provider. * |
|--|--|---|

Your Rights to Continue Coverage:

If you lose coverage under the plan, then depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at **1-877.884-4063**. You may also contact your state insurance department, the US Department of Labor, Employee Benefits Security Administration at 866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 877-267-2323 x61565 or www.cciio.cms.gov.

* The test can be done by the approved testing facility which the patient will be directed to by one of our advocates. The policy aligns with new families first legislation and regulations requiring all health plans to provide coverage of COVID 19 testing without cost share.

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Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: WorXsiteHR Administration Services at 1-877-884-4063 or Employee Benefits Security Administration at 1-866-444-3272. www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does not meet the minimum value standard for the benefits it provides.**

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

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