Peoni
PLANS ADMINISTERED BY HMA

DESCRIPTION OF BENEFITS *All plan benefits shown as a percentage of Eligible Charge.*	**MEC CARE 1 HEALTH PLAN**	
PLAN PROVISIONS	**Member Pays**	
Annual Medical Deductible	None	Not Applicable
Annual Medical Out of Pocket Maximum	None	Not Applicable
Amounts in Excess of Negotiated Rates/Maximum Allowable Charge	For Participating Providers, the contract generally prohibits the provider from charging more than the negotiated rate for covered services. However, the Member will be responsible for the Deductible, Copayments, and Coinsurance.	For Non-Participating Providers, the Member is responsible for the full amount billed by the provider. Amounts billed by Non-Participating Providers are not covered and **DO NOT** apply to the Annual Deductible **NOR** the Annual Out-of-Pocket Maximum.
Lifetime Maximum	None	
Dependent Coverage	To age 26	
MEDICAL SERVICES		
PHYSICIAN SERVICES	**Member Pays**	
	In-Network	**Out-of-Network**
Primary Care Office Visits	$30 Copayment	Not Covered
Specialist Care Office Visits	$50 Copayment	Not Covered
Other Services performed in the office - including Office Surgery, Diagnostic Services such as Laboratory and Pathology services	$150 Copayment	Not Covered
Other Services performed in the office - including Radiology services	$50 Copayment	Not Covered
Physician Services in a Facility (Hospital, Outpatient Surgery) Limited to $500 per year	$150 Copayment, then 0% Coinsurance	Not Covered
Physician Services in a Facility (Emergency Room) Limited to $500 per year	$75 Copayment, then 0% Coinsurance	Not Covered
Anesthesia Professional Services Limited to $250 per year	$150 Copayment, then 0% Coinsurance	Not Covered
Urgent Care	$75 Copayment	Not Covered
PREVENTIVE CARE		
BENEFITS FOR CHILDREN		
Covered Preventive Services for Children per PPACA	Covered in Full	Not Covered
Newborn Circumcision	Covered in Full	Not Covered
Well Child Care Office Visits 0 to 11 months (6 “well-baby visits”), 1 to 4 years (7 “well-child visits”), 5 to 17 years (1 per year, “well-child visit”)	Covered in Full	Not Covered
Well Child Care Immunization (as recommended by Bright Futures Project)	Covered in Full	Not Covered
Well Child Care Lab Tests (as recommended by Bright Futures Project)	Covered in Full	Not Covered

PREVENTIVE CARE	Member Pays	
	In-Network	**Out-of-Network**
ADULT PREVENTIVE SCREENING/TESTING		
Covered Preventive Services for Adults (ages 18 and older), per PPACA	Covered in Full	Not Covered
Adults, one (1) physical exam per benefit year to obtain recommended preventive and diagnostic services	Covered in Full	Not Covered
Immunization Services for Adults Immunizations - doses, recommended ages, and recommended populations vary per the recommendations of the Advisory Committee for Immunization Practices (ACIP)	Covered in Full	Not Covered
Prostate Specific Antigen (Men, one per CY, age ≥ 50)	Covered in Full	Not Covered
Screenings such as; Obesity, Blood Pressure, Cholesterol, Colorectal Cancer, HIV, Alcohol Misuse	Covered in Full	Not Covered
Counseling such as; Alcohol Misuse, Sexually Transmitted Infection (STI) Prevention, Nutritional Counseling, Tobacco Use	Covered in Full	Not Covered
WOMEN'S PREVENTIVE CARE SERVICES		
Prescribed contraceptive methods, sterilization procedures and patient education. (Supply and administration of Contraceptive IUDs, Implants and Injectables) (Pharmacy - birth control pills, diaphragms, emergency contraceptive pill through your Pharmacy Benefits)	Covered in Full	Not Covered
Well Woman exam per benefit year to obtain recommended preventive and diagnostic services (Subject to all Limitations as described under Covered Medical Benefits)	Covered in Full	Not Covered
Screenings such as Pap Smears, Mammography, Domestic and interpersonal violence screening, Osteoporosis screening (Subject to all Limitations as described under Covered Medical Benefits)	Covered in Full	Not Covered
Counseling such as Contraception, BRCA, Breast Cancer Chemoprevention, Folic Acid Supplements	Covered in Full	Not Covered
Services for Pregnant Women including but not limited to Anemia Screening, Rh Incompatibility Screening, Breastfeeding, Hepatitis B Screening. Breastfeeding: Comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women.	Covered in Full	Not Covered
HOSPITAL/FACILITY SERVICES		
Inpatient Room & Care – semi-private room rate in an Acute setting Limited to $500 per day benefit, limited to 30 days per year	$1,000 Copayment per admission, then 0% Coinsurance	Not Covered
Outpatient Surgery in a Hospital Limited to $2,000 per year	$500 Copayment, then 0% Coinsurance	Not Covered
Outpatient Surgery in an Ambulatory Surgical Center Limited to $2,000 per year	$250 Copayment, then 0% Coinsurance	Not Covered
Emergency Room Services Limited to $1,500 per year	$250 Copayment, then 0% Coinsurance	Not Covered
DIAGNOSTIC SERVICES		
Laboratory Services		
Non Hospital Based	$50 Copayment	Not Covered
Hospital Based Limited to $750 per year	$250 Copayment, then 0% Coinsurance	Not Covered
Radiology Services		
Non Hospital Based	$50 Copayment	Not Covered
Hospital Based Limited to $750 per year	$250 Copayment, then 0% Coinsurance	Not Covered
CT/MRI/MRA/PET Scan		
Non Hospital Based Limited to $750 per year	$50 Copayment, then 0% Coinsurance	Not Covered
Hospital Based Limited to $750 per year	$250 Copayment, then 0% Coinsurance	Not Covered

MENTAL HEALTH/BEHAVIORAL HEALTH/SUBSTANCE ABUSE DISORDER	Member Pays	
	In-Network	**Out-of-Network**
INPATIENT		
Hospital & Facility Services; semi-private room rate Limited to $500 per day benefit, limited to 30 days per year	$1,000 Copayment per admission, then 0% Coinsurance	Not Covered
Psychiatrist & Psychologist Services Limited to $500 per year	$150 Copayment, then 0% Coinsurance	Not Covered
OUTPATIENT		
Psychiatrist & Psychologist Services	$50 Copayment	Not Covered
OTHER SERVICES		
Allergy Testing (including serums, injections, and administration) Limited to 6 visits per benefit year	$20 Copayment	Not Covered
Physical/Occupational/Speech/Cardiac/Pulmonary Therapies Limited to 26 visits per benefit year	$30 Copayment	Not Covered
Coinsurance amount is based on an approved negotiated rate for Participating Providers.		
Benefits that are determined to be emergent services or services that are subject to the No Surprises Act will be reimbursed at the Participating Provider level of benefits.		

PHARMACY PROVISIONS	Member Pays	
PHARMACY BENEFITS	**In-Network Pharmacies**	**Out-of-Network Pharmacies**
Annual Pharmacy Deductible	None	Not Applicable
Annual Pharmacy Out of Pocket Maximum	None	Not Applicable
Lifetime Maximum	None	Not Applicable
Preventive Prescription Services		
Mandatory Generic Only - Preventive Prescription Services as defined by PPACA. In order for preventive medications to be covered at 100%, a prescription is required from your physician, including over-the-counter (OTC) drugs.		
Prescription Drugs Pharmacy Retail - up to a 30 Day Supply	Generic - Covered in Full	Not Covered
Non-Preventive Prescription Services (Mandatory Generic Only)		
Prescription Drugs Pharmacy Retail - up to a 30 Day Supply	$20 Copayment (Generic only up to $250 per prescription)	Not Covered
Prescription Drugs Pharmacy Retail - 90 Day Supply	Not Covered	Not Covered
Prescription Drugs Pharmacy Mail Order - 30 or 90 Day Supply	Not Covered	Not Covered
Specialty Drugs	Not Covered	Not Covered
This summary provides a condensed explanation of plan benefits. Certain limitations, restrictions and exclusions may apply. Please refer to the Plan Document for complete information on benefits. In the case of discrepancy between this summary and the language contained in the Plan Document, the latter will take precedence.		

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