

MEC ESSENTIALS^{2.5}



Find A Provider



Go to www.multiplan.com

Sample ID Card

MEC ESSENTIALSSM 

Employer Name: United Benefits GP **Plan ID:** WPL333

Member Name: First Last **Member ID #:** 123456789

Each Person is a Cardholder: Replace Last 2 Digits with Applicable Suffix

Dependents:


 www.WellDyneRX.com **Pharmacy Help Desk**
555-555-5555

Member Services: 555-555-5555 **Processor:** NetCard
BIN:123456 **RXGROUP:** HMATPA

This card does not guarantee coverage.

To Verify benefits, eligibility, or obtain precertification/ authorization, visit the websites or call:
555-555-5555

For Members: www.hma-az.com/members
For Providers: www.hma-az.com/provider-portal
Claims: HMA 123 Easy St Tempe AZ 85285

Administered by
 **To find a PHCS, or if not available, a Multiplan provider, visit**
www.multiplan.com or call 888-826-5317

MEC ESSENTIALS 2.5

MEC Essentials™ provides coverage for the preventive health and wellness services required by the Affordable Care Act’s PHSA § 2713 (a). This health plan provides Minimum Essential Coverage and satisfies the “A Tax” penalty and Individual Mandate. MEC Essentials™ provides coverage for a broad range of medical services, as outlined in the table below.

Medical Service Deductible Information		
	Deductible	Out-of-Pocket Maximum
Individual	\$2,500	\$7,350
Family	\$5,000	\$14,700
Medical services		
Medical Service	Member Pays	Limitations & Exceptions
Telemedicine	\$0 Copay	None
Preventive & Wellness Coverage	\$0 Copay	Some Services are subject to age and other limitations. See Summary of Benefits.
Primary Doctor Visit	\$50 Copay	New Patient Visit \$150 copay
Specialist Visit	\$100 Copay	New Patient Visit \$200 copay
Urgent Care	\$150 Copay	Subject to the deductible.
Outpatient Laboratory	\$50 Copay	Outpatient only, not covered if services provided at hospital. Copay is per test/panel/image.
X-Rays	\$75 Copay	
CT/MRI/PET	\$500 Copay	
Emergency Room	\$400 Copay plus deductible and 50% coinsurance	1 Visit per plan year. See Summary of Benefits.
Hospital Room & Board	\$500 Copay per admission, then deductible & 50% coinsurance.	Limit of 8 Days per plan year. See Summary of Benefits. <small>Inpatient and outpatient Surgery not covered.</small>
Generic Drugs <small>(Retail)</small>	\$20 Copay	Covers up to a 30- day supply (retail); 31-90 day supply (mail order prescription). Subject to formulary. No coverage for brand drugs or specialty drugs.
Generic Drugs <small>(Mail Order)</small>	\$60 Copay	

NOTE: Please refer to the Schedule of Benefits for a more in-depth list of Benefits Coverage, Limitations, and Exclusions before enrolling in this plan.
 This plan is not Major Medical Insurance as defined by the Affordable Care Act.
 This plan is a Health Plan that provides only benefits listed above.

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Exclusions

The following exclusions apply to the benefits offered under this Plan:

1. Office visits, physical examinations, immunizations, and tests when required solely for the following:
 - a. Sports,
 - b. Camp,
 - c. Employment,
 - d. Travel,
 - e. Insurance,
 - f. Marriage,
 - g. Legal proceedings
2. Routine foot care for treatment of the following:
 - a. Flat feet,
 - b. Corns,
 - c. Bunions,
 - d. Calluses,
 - e. Toenails,
 - f. Fallen arches
 - g. Weak feet,
 - h. Chronic foot strain
3. Rehabilitative therapies
4. Dental procedures
5. Any other medical service, treatment, or procedure not covered under this Plan
6. Any other expense, bill, charge, or monetary obligation not covered under this Plan, including but not limited to all non-medical service expenses, bills, charges, and monetary obligations. Unless the medical service is explicitly provided by this Schedule of Benefits or otherwise explicitly provided in this *Plan Document*, this Plan does not cover the medical service or any related expense, bill, charge, or monetary obligation to the medical service
7. Claims unrelated to treatment of medical care or treatment
8. Cosmetic surgery unless authorized as medically necessary. Such authorization is based on the following causes for cosmetic surgery: accidental injury, correction of congenital deformity within six (6) years of birth, or as a treatment of a diseased condition
9. Any treatment with respect to treatment of teeth or periodontium, any treatment of periodontal or periapical disease involving teeth surrounding tissue, or structure. Exceptions to this exclusion include only malignant tumors or benefits specifically noted in the schedule of benefits to the Plan Document
10. Any claim related to an injury arising out of or in the course of any employment for wage or profit
11. Claims which would otherwise be covered by a Worker's Compensation policy for which a participant is entitled to benefit
12. Any claim arising from service received outside of the United States, except for the reasonable cost of claims billed by the Veterans Administration or Department of Defense for benefits covered under this Plan and not incurred during or from service in the Armed Forces of the United States
13. Claims for which a participant is not legally required to pay or claims which would not have been made if this Plan had not existed
14. Claims for services which are not medically necessary as determined by this Plan or the excess of any claim above reasonable and customary rates when a PPO network has not been contracted
15. Charges which are or could be reimbursed by any public health program irrespective of whether such coverage has been elected by a participant

16. Claims due to the use of illegal drugs
17. Claims due to an act of war, declared or undeclared, not including acts of terrorism
18. Claims for eyeglasses, contacts, hearing aids (or examinations for the fitting thereof) or radial keratotomy
19. Elective, voluntary abortions, except in the case of rape, incest, or congenital deformities of the fetus as determined through pre-natal testing, or when the life of the mother would be threatened if the fetus were carried to term
20. Travel, unless specifically provided in the schedule of benefits
21. Custodial care for primarily personal, not medical, needs provided by persons with no special medical training or skill
22. Claims from any provider other than a healthcare provider as defined in the Plan Document unless explicitly permitted in the schedule of benefits
23. Investigatory or experimental treatment, services, or supplies unless specifically covered under Approved Clinical Trials
24. Services or supplies which are primarily educational
25. Claims due to attempted suicide or intentionally self-inflicted injury while sane or insane, unless the claim results from a medical condition such as depression
26. Claims resulting from, or which arise due to the attempt or commission of, an illegal act. Claims by victims of domestic violence will not be subject to this exclusion
27. Claims with respect to any treatment or procedure to change one's physical anatomy to those of the opposite sex and any other treatment or study related to sex change
28. Claims from a medical service provider who is related by blood, marriage, or legal adoption to a participant
29. Any claims for fertility or infertility treatment
30. Claims for weight control, weight reduction, or surgical treatment for obesity or morbid obesity, unless explicitly provided in the schedule of benefits
31. Claims for or disability resulting from reversal of sterilization
32. Claims for telephone consultations, the completion of forms, or failure to keep scheduled appointments
33. Recreational or diversional therapy
34. Personal hygiene or convenience items, including but not limited to air conditioning, humidifiers, hot tubs, whirlpools, or exercise equipment, irrespective of the recommendations or prescriptions of a medical service provider
35. Claims due to participation in a dangerous activity, including but not limited to sky-diving, motorcycle or automobile racing, bungee jumping, rock climbing, rappelling, or hang gliding
36. Claims that arise primarily due to medical tourism
37. Podiatry
38. Supportive devices of the foot
39. Treatments for sexual dysfunction
40. Aquatic or massage therapy
41. Claims arising while legally intoxicated under the influence of illegal drugs, irrespective whether a criminal charge arose, unless the claim arose due to a drug addiction
42. Biofeedback training
43. Ambulance services
44. Skilled nursing facilities
45. Durable medical equipment and prosthetics
46. Home health care or hospice care
47. Residential facility – for charges from a residential halfway house or home, or any facility which is not a health care institution licensed for the primary purpose of treatment of an illness or injury
48. Claims for temporomandibular joint syndrome
49. Claims for biotech or specialty prescriptions
50. Any claim which is not explicitly covered in the schedule of benefits
51. Genetic testing unless explicitly covered in the schedule of benefits
52. Outpatient hospital services unless explicitly covered in the schedule of benefits
53. Inpatient hospital services unless explicitly covered in the schedule of benefits

54. Organ transplants
55. Emergency Room visits in excess of twenty-four (24) hours
56. Claims for cosmetic surgery, not related to mastectomy reconstruction, to produce a symmetrical appearance or prosthesis or physical complications which result from such procedures
57. Chiropractic care
58. Radiation and chemotherapy
59. Dialysis
60. Acupuncture
61. Alternative medicine/homeopathy
62. Children dental and vision
63. Neonatal intensive care (NICU)