MEC PLAN BENEFITS

Bridgewell Health

PLAN BENEFITS	SIMPLE	BASIC	EDGE
Preventive & Wellness Services	100% Coverage * **	100% Coverage * **	100% Coverage * **
Physician Office Visits			*Lab services not included, must utilize preferred lab vendor*
• Primary Care Office Visit	Not Covered	$20 Copay, Max 6 visits per person per year	$30 Copay, then 100% to $300 per visit
• Specialist Office Visit	Not Covered	Not Covered	$50 Copay, then 100% to $300 per visit
• Physician & Surgeon Professional Services	Not Covered	Not Covered	$150 Copay, then 100% to $500 per day
• Anesthesia Professional Services	Not Covered	Not Covered	$150 Copay, then 100% to $250 per day
Telemedicine Consultations	Included, $0 Copay	Included, $0 Copay	Included, $0 Copay
Outpatient Lab	Not Covered	Not Covered	100% if preferred vendor, otherwise $50 Copay, then 100%
Outpatient Radiology & Imaging			
• Physician Office/Freestanding Imaging Ctr.	Not Covered	Not Covered	$50 Copay, then 100% to $500 per visit
• Hospital Outpatient	Not Covered	Not Covered	$250 Copay, then 100% to $500 per visit
Outpatient Rehab & Therapy	Not Covered	Not Covered	Not Covered
Allergy Treatment	Not Covered	Not Covered	Not Covered
Emergency Services			
• Hospital ER (Facility Charge Only)	Not Covered	Not Covered	$250 Copay, then 100% to $1,000 per visit
• Urgent Care / ER Professional Services	Not Covered	Not Covered	$75 Copay, then 100% to $500 per visit
• Ambulance	Not Covered	Not Covered	Not Covered
• Air Ambulance	Not Covered	Not Covered	Not Covered
Outpatient Surgical Procedures			
• Physician Office / Freestanding Surgery Ctr.	Not Covered	Not Covered	$250 Copay, then 100% to $500 per day
• Outpatient Hospital	Not Covered	Not Covered	$500 Copay, then 100% to $500 per day
Inpatient Hospitalization			
• Medical Facility Services	Not Covered	Not Covered	$150 per day benefit, unlimited days
Prescription Drug Benefits	Not Covered	Rx Discount Card Available	Rx Discount Card Available
COBRA Administration	Not Covered	Not Covered	Included
PPO Network	PHCS *	PHCS *	PHCS *

* (Plan participants must see a doctor within the PHCS PPO Network in order to be covered for the benefits and services listed as part of the covered benefits summary.)
** (All Mammography and Colonoscopy Screening require pre-certification. For pre-certification, please call a Care Coordinator at: 1-844-643-5104.)

V082820

MEC PLAN BENEFITS

Bridgewell Health

PLAN BENEFITS	CARE 1	PLUS	PREMIER
Preventive & Wellness Services	100% Coverage * **	100% Coverage * **	100% Coverage * **
Physician Office Visits	*Lab services not included, must utilize preferred lab vendor*	*Lab services not included, must utilize preferred lab vendor*	*Lab services not included, must utilize preferred lab vendor*
• Primary Care Office Visit	$30 Copay, then 100% to $300 per visit	$30 Copay, then 100% to $300 per visit	$30 Copay, then 100% to $300 per visit
• Specialist Office Visit	$50 Copay, then 100% to $300 per visit	$50 Copay, then 100% to $300 per visit	$50 Copay, then 100% to $300 per visit
• Physician & Surgeon Professional Services	$150 Copay, then 100% to $500 per day	$150 Copay, then 100% to $750 per day	$150 Copay, then 100% to $1,000 per day
• Anesthesia Professional Services	$150 Copay, then 100% to $250 per day	$150 Copay, then 100% to $500 per day	$150 Copay, then 100% to $750 per day
Telemedicine Consultations	Included, $0 Copay	Included, $0 Copay	Included, $0 Copay
Outpatient Lab	100% if preferred vendor, otherwise $50 Copay, then 100%	100% if preferred vendor, otherwise $50 Copay, then 100%	100% if preferred vendor, otherwise $50 Copay, then 100%
Outpatient Radiology & Imaging			
• Physician Office/Freestanding Imaging Ctr.	$50 Copay, then 100% to $750 per visit	$50 Copay, then 100% to $1,000 per visit	$50 Copay, then 100% to $1,500 per visit
• Hospital Outpatient	$250 Copay, then 100% to $750 per visit	$250 Copay, then 100% to $1,000 per visit	$250 Copay, then 100% to $1,500 per visit
Outpatient Rehab & Therapy	$30 Copay then 100% to $100 per visit, 26 visit annual max	$30 Copay then 100% to $150 per visit, 26 visit annual max	$30 Copay then 100% to $250 per visit, 26 visit annual max
Allergy Treatment	$20 Copay, then 100% to $100 per visit, 6 visit annual max	$20 Copay, then 100% to $100 per visit, 12 visit annual max	$20 Copay, then 100% to $100 per visit, 24 visit annual max
Emergency Services			
• Hospital ER (Facility Charge Only)	$250 Copay, then 100% to $1,000 per visit	$250 Copay, then 100% to $1,000 per visit	$250 Copay, then 100% to $2,000 per visit
• Urgent Care / ER Professional Services	$75 Copay, then 100% to $500 per visit	$75 Copay, then 100% to $500 per visit	$75 Copay, then 100% to $1,000 per visit
• Ambulance	Not Covered	$500 Copay, then 100%to $1,000 per day	$500 Copay, then 100%to $2,000 per day
• Air Ambulance	Not Covered	Not Covered	Not Covered
Outpatient Surgical Procedures			
• Physician Office / Freestanding Surgery Ctr.	$250 Copay, then 100% to $750 per day	$250 Copay, then 100% to $1,000 per day	$250 Copay, then 100%to $2,000 per day
• Outpatient Hospital	$500 Copay, then 100% to $750 per day	$500 Copay, then 100% to $1,000 per day	$500 Copay, then 100% to $2,000 per day
Inpatient Hospitalization			
• Medical Facility Services	$1,000 Copay per admission then 100% to $500 per day benefit, unlimited days	$1,000 Copay per admission then 100% to $1,000 per day benefit, unlimited days	$1,000 Copay per admission then 100% to $1,500 per day benefit, unlimited days
Prescription Drug Benefits	$20 Copay, Generic Only to $250/script	$20 Copay, Generic Only to $250/script	$20 Copay, Generic Only to $250/script
COBRA Administration	Included	Included	Included
PPO Network	PHCS *	PHCS *	PHCS *

* (Plan participants must see a doctor within the PHCS PPO Network in order to be covered for the benefits and services listed as part of the covered benefits summary.)
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