DESCRIPTION OF BENEFITS	PRECIS MEC STANDARD PLAN	
All plan benefits shown as a percentage of Eligible Charge.		
PLAN PROVISIONS	**Member Pays**	
Annual Medical Deductible	None	$500 Per Person
Annual Medical Out of Pocket Maximum *The Member's Deductible, Copayments, and Coinsurance apply to the Annual Out-of-Pocket Maximum.*	None	$10,000 Per Person
Amounts in Excess of Negotiated Rates/Reasonable and Allowed Amounts	For Participating Providers, the contract generally prohibits the provider from charging more than the Reasonable and Allowed amount for covered services. However, the Member will be responsible for the Deductible, Copayments, and Coinsurance.	For Non-Participating Providers, the Member will be responsible for the Deductible, Copayments, and Coinsurance, as well as any amounts exceeding the Reasonable and Allowed amounts. Any amounts in excess of the Reasonable and Allowed amount payable to Non-Participating Providers **DO NOT** apply to the Annual Deductible **NOR** the Annual Out-of-Pocket
Lifetime Maximum	None	
Dependent Coverage	To age 26	
MEDICAL SERVICES		
PHYSICIAN SERVICES	**Member Pays**	
	Participating Providers	**Non-Participating Providers**
Preventive Care Office Visit	0% Coinsurance	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable and Allowed Amount
Immunizations - doses, recommended ages, and recommended populations vary per the recommendations of the Advisory Committee for Immunization Practices (ACIP)	0% Coinsurance	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable and Allowed Amount
PREVENTIVE CARE		
BENEFITS FOR CHILDREN		
Covered Preventive Services for Children per PPACA	0% Coinsurance	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable and Allowed Amount
Newborn Circumcision	0% Coinsurance	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable and Allowed Amount
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")	0% Coinsurance	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable and Allowed Amount
Well Child Care Immunization (as recommended by Bright Futures Project)	0% Coinsurance	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable and Allowed Amount
Well Child Care Lab Tests (as recommended by Bright Futures Project)	0% Coinsurance	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable and Allowed Amount
ADULT PREVENTIVE SCREENING/TESTING		
Covered Preventive Services for Adults (ages 18 and older), per PPACA	0% Coinsurance	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable and Allowed Amount
Adults, one (1) physical exam per benefit year to obtain recommended preventive and diagnostic services	0% Coinsurance	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable and Allowed Amount
Prostate Specific Antigen (Men, one per CY, age ≥ 50)	0% Coinsurance	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable and Allowed Amount
Screenings such as; Obesity, Blood Pressure, Cholesterol, Colorectal Cancer, HIV, Alcohol Misuse	0% Coinsurance	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable and Allowed Amount
Counseling such as; Alcohol Misuse, Sexually Transmitted Infection (STI) Prevention, Nutritional Counseling, Tobacco Use	0% Coinsurance	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable and Allowed Amount
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)	0% Coinsurance	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable and Allowed Amount
Well Woman exam per benefit year to obtain recommended preventive and diagnostic services (Subject to all Limitations as described under Covered Medical Benefits)	0% Coinsurance	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable and Allowed Amount
Screenings such as Pap Smears, Mammography, Domestic and interpersonal violence screening, Osteoporosis screening (Subject to all Limitations as described under Covered Medical Benefits)	0% Coinsurance	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable and Allowed Amount
Counseling such as Contraception, BRCA, Breast Cancer Chemoprevention, Folic Acid Supplements	0% Coinsurance	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable and Allowed Amount
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. (Reimbursement of Non-Participating breastfeeding supplies up to the amount of $200)	0% Coinsurance	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable and Allowed Amount
Coinsurance amount is based on an approved negotiated rate for Participating Providers or Reasonable and Allowed reimbursement level for Non-Participating Providers as established by the Plan.		

PHARMACY PROVISIONS ***(Please refer to ID Card for Pharmacy Benefit Information)***	**Member Pays**	
PHARMACY BENEFITS	**Participating Pharmacies**	**Non-Participating Pharmacies**
Annual Pharmacy Deductible	None	None
Annual Pharmacy Out of Pocket Maximum	None	None
Lifetime Maximum	None	None
Preventive Prescription Services		
Mandatory Generic Only - Preventive Prescription Services, as defined by PPACA. All generic HCR Drugs are covered under PPACA. In order for preventive medications to be covered at 100%, a Prescription is required from the member's physician, including over-the-counter (OTC) drugs. Preventive Medications will **only** be covered in the Generic form. Brand Name Medications are excluded.		
Prescription Drugs **Pharmacy Retail - up to a 31 day supply**	Generic - $0 Copayment Applies to HCR Generic Drugs Only	Not Covered
Prescription Drugs **Pharmacy Retail - 90 Day Supply**	Generic - $0 Copayment Applies to HCR Generic Drugs Only	Not Covered
Prescription Drugs **Pharmacy Mail Order - 31 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.