Nexus Health Management
Summary of Benefits – Plan E (MEC+)
Effective Date: 1/1/2027 – 12/31/2027

Benefit	All Providers – In-Network / Out-of-Network
Deductible	N/A
Member Co-Insurance	N/A
Out of Pocket Maximum (Inc. Deductible)	$1,850 Individual. / $3,700 Family
Deductible and Out-Of-Pocket Accumulation is on a Plan Year Basis	
Physician Based Services - Medical	
Primary Care Physician Visits – Limit 15 visits per Plan Year	$15 Co-Pay; Deductible does not apply
Specialist Office Visits - – Limit 15 visits per Plan Year	$15 Co-Pay; Deductible does not apply
Allergy Testing	Not Covered
Chiropractic Care	Not Covered
Dermatology	Not Covered
Maternity Physician Care Only (co-pay 1st visit only) ***NOTE:*** *Preventive care charges for pregnancy are covered under the Preventive Care benefit.*	$15 Co-Pay; Deductible does not apply
Telehealth / Virtual Office Visits	Subject to PCP/Specialist Co-Pay
Preventive Care – Adult, Infant, Pediatric	$0 Co-Pay; Deductible does not apply
Physician Based Outpatient Services	
Dialysis / Hemodialysis	Not Covered
Home Visits	Not Covered
Home Health Care Services	Not Covered
Mental Health	Not Covered
Substance Abuse	Not Covered
Second Opinion - Surgical	Not Covered
Urgent Care – Limit 2 visits per Plan Year	$50 Co-Pay; Deductible does not apply
Therapy Services	
All Therapy –	Not Covered
Other Services	
Prosthetic Devices and Durable Medical Equipment (includes Diabetic Supplies)	Not Covered
Facility Based Services	
Inpatient Services	
Pre-Surgical / Pre-Admission Testing	Not Covered
Inpatient Hospital Stay: Includes Room and Board; Drugs and Medication; Anesthesia and ICU; Maternity Stay, Inpatient Lab	
Inpatient Physician Services	
Inpatient Mental Health / Substance Abuse	
Skilled Nursing	Not Covered
Emergency Services	
Emergency Care	Not Covered
Emergency Medical Transportation	Not Covered
Outpatient Services	
Chemotherapy	Not Covered
Hospice	Not Covered
Outpatient Surgery	Not Covered

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Benefit	All Providers – In-Network / Out-of-Network	
Lab and Radiology		
Lab and Pathology – Limit 3 visits per Plan Year	$50 Co-Pay; Deductible does not apply	
X-Rays - Limit 3 visits per Plan Year	$50 Co-Pay; Deductible does not apply	
Advanced Radiology (MRI, CT, PET etc.)	Not Covered	
Prescription Drug		
	In-Network	**Out-Of-Network**
Generic	$15 Co-Pay; Deductible Does not apply	Not Covered
Brand	Not Covered	Not Covered
Non-Preferred	Not Covered	Not Covered
Specialty	Not Covered	Not Covered
90 day Mail Order is available for 2x co-pay		

PRESCRIPTION DRUG NOTES

1. **Coverage for Over-the-Counter (OTC) items are limited to items which require prescription as mandated by State or Federal law. Please check with MedTipster (877.226.2378) before ordering.**
2. **The Plan will cover charges for the first fill of injectables when filled at the facility providing treatment. All subsequent fills need to be Pre-Certified and will be provided under the Pharmacy Benefits.**

Network Utilization

Physician based services utilize the Prime Health Services network
Facility based services reimburse providers based on a Medicare Fee Schedule
Prescription Drug utilizes MedTipster participating pharmacies

Excluded Services

In addition to exclusions listed in the Plan Exclusions of the SPD, the following services are excluded from coverage under the Plan:

- Acupuncture
- Advanced Infertility Services including Artificial Insemination and InVitro Fertilization
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Routine)
- Foot Care (Routine)
- Genetic Testing unless medically necessary (except to the extent required by the Affordable Care Act)
- Hearing Aids
- Maternity Care Coverage for dependent daughters (except for Preventive Care services as required by the Affordable Care Act)
- Non-Emergency Services outside of United States
- Non-Emergency Services in Emergency Room setting
- Private Duty Nursing
- TMJ Treatment
- Vision Hardware (limited coverage on examination)
- Voluntary Sterilization (except for FDA-approved female sterilization procedures as required by Affordable Care Act)
- Weight Loss Programs