

Brightspring Health Services
Employee Benefit Summary –MEC Enhanced Plan
Network: National PPO (BlueCard PPO) Network
Effective Date: 1/1/2025

Benefit	In-Network	Out-Of-Network
Plan Deductible	\$0 Individual \$0 Family	N/A
Any Other Deductible	N/A	N/A
Deductible – Accumulation	N/A	N/A
Deductible – INN and OON integration	N/A	
Member Coinsurance	None	N/A
Out of Pocket Maximum	\$9,450 Individual \$18,900 Family	N/A
Out of Pocket – Accumulation	Embedded	N/A
Out of Pocket – INN and OON integration	N/A	
Annual Benefit Maximum	Unlimited	Unlimited
Lifetime Benefit Maximum	Unlimited	Unlimited
Benefit Period	Calendar Year	1/1 -12/31
Prescription Drug Benefits Carelon Rx 1-833-271-2374 www.carelonrx.com		
Benefit	In-Network	Out-Of-Network
Generic (Tier 1)	\$0 for Preventive Medicine \$10 per prescription	Not Covered
Brand (Tier 2)	Not Covered	Not Covered
Non-Preferred (Tier 3)	Not Covered	Not Covered
Specialty (Tier 4)	Not Covered	Not Covered
Preventive Medical Services		
Hospital based services are excluded. PPACA benefits are covered 100% when performed in an office setting.		
Primary Care Physician: Adult Routine Physical - 1 visit per Plan year.	No Charge	Not Covered
Pediatrician - Well Child Care: Up to age 2 - 9 visits per Plan year Age 2 – 2 visits per Plan year Age 3 and more – 1 visit per Plan year	No Charge	Not Covered
Children Eye Exam	No Charge	Not Covered
Gynecological - Adult Routine Physical - 1 visit per Plan year.	No Charge	Not Covered
Maternity (ACA Required Prenatal /Postnatal Testing/Services only)	No Charge	Not Covered
Routine Immunizations (Child & Adult)	No Charge	Not Covered
Flu Shot (Routine)	No Charge	Not Covered
X-Rays and Lab tests (Routine)	No Charge	Not Covered
Mammography (Routine) – 1 per Plan year; Age 40 and more	No Charge	Not Covered
Pap-smear (Routine) – 1 per Plan year	No Charge	Not Covered

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Prostate Cancer Screening PSA (Routine) - 1 per Plan year	No Charge	Not Covered	
Colon Cancer Screening (Routine) - age 45-75 Colonoscopy – 1 in 10 years Sigmoidoscopy – 1 in 3 years	No Charge	Not Covered	
Non-Preventive Medical Services			
Benefit	In-Network		Out-Of-Network
Primary Care Physician Visits: <i>PCP and Specialist visits are limited to a combined maximum of 5 visits per calendar year.</i>	Professional Non-Facility based Services: \$25 Copay / per visit	Facility based Services: Not Covered	Not Covered
Specialist Physician Visits <i>PCP and Specialist visits are limited to a combined maximum of 5 visits per calendar year.</i>	Professional Non-Facility based Services: \$50 Copay / per visit	Facility based Services: Not Covered	Not Covered
Maternity Visits: PPACA mandated maternity covered at no cost. <i>PCP and Specialist visits are limited to a combined maximum of 5 visits per calendar year. Home delivery charges or services are excluded. Maternity care for dependent daughters is not covered.</i>	Professional Non-Facility based Services: \$25 Copay / per visit	Facility based Services: Not Covered	Not Covered
Mental / Behavioral Health / Substance Use Visits.	Not Covered		Not Covered
Allergy Services <i>PCP and Specialist visits are limited to a combined maximum of 5 visits per calendar year.</i>	Professional Non-Facility based Services: Non-Specialist: \$25 Copay / per visit Specialist: \$50 Copay / per visit	Facility based Services: Not Covered	Not Covered
Online Visits – Telehealth	\$10 Copay / per visit		Not Covered
Online Visits – Telemedicine Vendor Live Health Online.	\$10 Copay / per visit		Not Covered
Non-Preventive Lab and Radiology			
Lab and Pathology	Office Setting: \$0 Copay during covered Physician or Specialist visits. Covered only when an visit is billed. Not covered at freestanding facilities. Independent Lab or Out Patient Facility: Not Covered		Not Covered
X-Rays / Radiology	Office Setting: \$0 Copay during covered Physician or Specialist visits. Covered only when an visit is billed. Not covered at freestanding facilities. Independent Lab or Out Patient Facility: Not Covered		Not Covered
MRI / MRA; CT / CTA / PET Scan	Not Covered		Not Covered
Sleep Studies	Not Covered		Not Covered

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Emergency Services		
Emergency Room: Facility	Not Covered	
Emergency Room: Professional	Not Covered	
Emergency Medical Transportation	Not Covered	
Urgent Care – Limited to 2 visits per plan year.	\$75 Co-pay/ per visit	Not Covered
Inpatient Services		
Benefit	In-Network	Out-Of-Network
Pre-Surgical / Pre-Admission Testing	Not Covered	Not Covered
Hospital Stay: Room and Board; Drugs and Medication; Anesthesia and ICU; Inpatient Lab, Maternity, delivery, and newborn services. Maternity care for dependent daughters is excluded.	Not Covered	Not Covered
Inpatient Physician/Delivery Services	Not Covered	Not Covered
Anesthesia – excluded with exception of PPACA covered benefit.	Not Covered	Not Covered
Inpatient Surgeon Professional	Not Covered	Not Covered
Inpatient Rehab	Not Covered	Not Covered
Skilled Nursing Facility	Not Covered	Not Covered
Inpatient Mental/ Behavioral Health / Inpatient Chemical Abuse Facility	Not Covered	Not Covered
Inpatient Mental/ Behavioral Health / Inpatient Chemical Abuse: Professional	Not Covered	Not Covered
Outpatient Services		
Abortion	Not Covered	Not Covered
Ambulatory Surgical Facility	Not Covered	Not Covered
Ambulatory Surgical Physician	Not Covered	Not Covered
Outpatient Surgery Facility	Not Covered	Not Covered
Outpatient Surgery Physician	Not Covered	Not Covered
Anesthesia – excluded with exception of PPACA covered benefit.	Not Covered	Not Covered
Home Health Care	Not Covered	Not Covered
Hospice	Not Covered	Not Covered
Second Opinion – Surgical	Not Covered	Not Covered
Therapy Services		
Cardiac Rehab	Not Covered	Not Covered
Chemotherapy	Not Covered	Not Covered
Chiropractic Care	Not Covered	Not Covered
Dialysis / Hemodialysis	Not Covered	Not Covered
Infusion Therapy	Not Covered	Not Covered
Occupational Therapy	Not Covered	Not Covered
Physical Therapy	Not Covered	Not Covered

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Radiation Therapy	Not Covered	Not Covered
Respiratory Therapy	Not Covered	Not Covered
Speech Therapy	Not Covered	Not Covered
Other Services		
Acupuncture	Not Covered	Not Covered
Bariatric Surgery	Not Covered	Not Covered
Diabetic Supplies	Not Covered	Not Covered
Durable Medical Equipment	Not Covered	Not Covered
Orthotics and Prosthetic Devices	Not Covered	Not Covered
Dialysis / Hemodialysis	Not Covered	Not Covered
Home Visits	Not Covered	Not Covered
Infertility Services	Not Covered	Not Covered
Injections	Not Covered	Not Covered
Nutritional Counseling - Diabetics	Not Covered	Not Covered
Nutritional Counseling – Non-Diabetics	Not Covered	Not Covered
Oral Surgery	Not Covered	Not Covered
Private Duty Nursing	Not Covered	Not Covered
Transgender Surgery	Not Covered	Not Covered
TMJ Treatment	Not Covered	Not Covered
Vision exams (non-routine)	Not Covered	Not Covered
Transplant Services		
Live Donor Health Services	Not Covered	Not Covered
Bone Marrow Donor Search	Not Covered	Not Covered
Organ Transplant	Not Covered	Not Covered
Travel and lodging for Organ	Not Covered	Not Covered
Preauthorization (Health Link: 1-877-284-0102)		
The following services require Preauthorization. If Preauthorization is not obtained benefit may be denied.		
Inpatient Services		Outpatient Services
N/A		Genetic Testing
Exclusions		
In addition to exclusions listed in the document, the following services are excluded from coverage under the Plan		
Abortion – Elective and Therapeutic	Hospital Inpatient services/surgery	
Acupuncture	Infertility Treatment/Services	
Ambulance Services	Long-term care	
Aquatic Therapy	Massage therapy	
Bariatric Surgery	Maternity care for dependent daughters	
Biofeedback	Non-emergency care when traveling outside the U.S.	
Chemotherapy	Nutritional Counseling Diabetic	
Childbirth: Delivery and Postnatal Care except as required by ACA	Nutritional Counseling Non-Diabetic	
Chiropractic Care	Outpatient Surgery	
Dental care (Adult and Child) except as required by ACA	Private-duty nursing	
Diabetes except as required by ACA.	Radiation therapy	

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Dialysis therapy	Rehabilitation Services
Durable medical equipment	Routine eye care (Adult)
Emergency Room Services	Sexual dysfunction
Facility and free standing physician and diagnostic services	Skilled nursing care
Foot care -routine	Surgical procedures in Office Setting
Gender Affirmation surgery and services	TMJ Treatment and Appliance
Genetic testing except as required by ACA	Transplants and Transplant services
Habilitative Services	Vision Exam and Hardware
Halfway house/home	Vision Exams(non-routine)
Hearing aids	Weight loss programs
Hospice service	