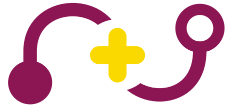

carepath BENEFITS

MINIMUM ESSENTIAL COVERAGE PLANS

Affordable coverage options designed to promote the health of your employees & their families.

- MEC
- MEC+
- MEC CARE
- MEC PRIME

Carepath Benefits is pleased to offer four affordable Minimum Essential Coverage (MEC) plans that cover all the bases for preventive and wellness services but also go a step further, offering limited outpatient and inpatient medical benefits to give employers maximum flexibility in addressing costs and plan benefits while still prioritizing employee health. These value-based MEC plans offer an additional layer of tangible medical-related benefits for employees - in categories that they will appreciate!

Affordable, Flexible, and ACA-Compliant

MINIMUM ESSENTIAL COVERAGE & MORE!

Since provisions of the Affordable Care Act (ACA) were implemented in 2016, employers with 50 or more full-time (or equivalent) employees are required to provide at least a Minimum Essential Coverage group health benefit plan to avoid the $2,000 per employee penalty (indexed for inflation) for non-compliance.

Carepath Benefits offers four MEC plan designs to meet the minimum essential coverage required services for employers in search of an affordable, ACA-compliant solution. Our MEC plans provide employers with an expanded set of options with regards to ACA-compliance.

If you offer our MEC plans alongside a major medical plan that meets the requirements for Minimum Value, you can also eliminate the possibility of the $3,000 penalty (indexed for inflation) in the event that an eligible employee purchases insurance through the Marketplace.

FEATURED PLAN DESIGNS

	MEC	MEC+	MEC CARE	MEC PRIME
64 Preventive & Wellness Services	✓	✓	✓	✓
Telemedicine Services	✓	✓	✓	✓
Primary Care Office Visit Copay		✓	✓	✓
Specialist Office Visit Copay		✓	✓	✓
Outpatient Services		✓	✓	✓
Emergency Services		✓	✓	✓
Inpatient Services		✓	✓	✓
Rx Drug Benefits			✓	✓

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COVERED SERVICES

Carepath's MEC Plans meet the criteria for preventive and wellness services as designated by the Centers for Medicare and Medicaid Services (CMS) by offering the following covered benefits:

15 COVERED PREVENTIVE SERVICES FOR ADULTS (AGES 18 AND OLDER)

1. Abdominal Aortic Aneurysm
2. Alcohol Misuse
3. Aspirin for CVD
4. Blood Pressure
5. Cholesterol
6. Colorectal Cancer
7. Depression Screening
8. Type 2 Diabetes Screening
9. Diet Counseling
10. HIV Screening
11. Immunizations
12. Obesity Screening
13. Sexually Transmitted Infection (STI) Prevention Counseling
14. Tobacco Use Screening
15. Syphilis Screening

23 COVERED PREVENTIVE SERVICES FOR WOMEN (INCLUDING PREGNANT WOMEN)

1. Anemia Screening
2. Bacteriuria urinary tract Infection screening
3. BRCA Counseling
4. Breast Cancer Mammography
5. Breast Cancer Chemoprevention Counseling
6. Breastfeeding Support/Counseling
7. Cervical Cancer Screening
8. Chlamydia Infection Screening
9. Contraception (FDA Approved)
10. Domestic and Interpersonal Violence Screening
11. Folic Acid Supplements
12. Gestational diabetes screening
13. Gonorrhea Screening
14. Hepatitis B Screening
15. Human Immunodeficiency Virus (HIV) Screening
16. Human Papillomavirus (HPV) DNA Test
17. Osteoporosis Screening
18. Routine prenatal visits
19. Rh Incompatibility Screening
20. Tobacco Use Screening
21. Sexually Transmitted Infections (STI) Counseling
22. Syphilis Screening
23. Well-woman visits

26 COVERED SERVICES FOR CHILDREN (UNDER 26 YEARS OLD ON PARENT'S PLAN)

1. Alcohol and Drug Use Assessments
2. Autism Screening
3. Behavioral Assessments
4. Blood Pressure Screening
5. Cervical Dysplasia Screening
6. Congenital Hypothyroidism Screening
7. Depression screening
8. Developmental Screening / Surveillance
9. Dyslipidemia Screening
10. Fluoride Chemoprevention Supplements
11. Gonorrhea Preventative Medication
12. Hearing Screening for Newborns
13. Height, Weight and Body Mass Index Measurments
14. Hematocrit or Hemoglobin Screening
15. Hemoglobinopathies or Sickle-Cell Screening
16. HIV Screening
17. Immunizations
18. Iron supplements
19. Lead Screening
20. Medical History throughout Developmental Ages
21. Obesity screening and Counseling
22. Oral Health Risk Assessment
23. Phenylketonuria (PKU) Screening
24. Sexually Transmitted Infection (STI) prevention counseling
25. Tuberculin Testing
26. Vision Screening

IMPORTANT NOTE:

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

PLAN BENEFITS

In addition to the Preventive & Wellness covered services, our plans offer the following covered benefits

BENEFITS	MEC	MEC+	MEC CARE	MEC PRIME
Preventive & Wellness Services	100% Coverage *	100% Coverage *	100% Coverage *	100% Coverage *
Physician Office Visits				
• Primary Care Office Visit	Not Covered	$25 Copay, then 100% to $300 / visit	$25 Copay, then 100% to $300 / visit	$25 Copay, then 100% to $300 / visit
• Specialist Office Visit	Not Covered	$75 Copay, then 100% to $300 / visit	$75 Copay, then 100% to $300 / visit	$75 Copay, then 100% to $300 / visit
• Physician & Surgeon Professional Services	Not Covered	$200 Copay, then 100% to $500 / day	$200 Copay, then 100% to $500 / day	$150 Copay, then 100% to $750 / day
• Anesthesia Professional Services	Not Covered	$200 Copay, then 100% to $250 / day	$200 Copay, then 100% to $250 / day	$150 Copay, then 100% to $500 / day
Telemedicine Consultations	Included, $0 Copay	Included, $0 Copay	Included, $0 Copay	Included, $0 Copay
Outpatient Lab	Not Covered	$50 Copay, then 100%	$50 Copay, then 100%	$50 Copay, then 100%
Outpatient Radiology & Imaging				
• Physician Office/Freestanding Imaging Ctr.	Not Covered	$50 Copay, then 100% to $500 / visit	$50 Copay, then 100% to $750 / visit	$50 Copay, then 100% to $1,000 / visit
• Hospital Outpatient	Not Covered	$250 Copay, then 100% to $500 / visit	$250 Copay, then 100% to $750 / visit	$250 Copay, then 100% to $1,000 / visit
Outpatient Rehab & Therapy	Not Covered	Not Covered	$30 Copay then 100% to $100 / visit, 26 visit annual max	$30 Copay then 100% to $150 / visit, 26 visit annual max
Allergy Treatment	Not Covered	Not Covered	$20 Copay, then 100% to $100 / visit, 6 visit annual max	$20 Copay, then 100% to $100 / visit, 12 visit annual max
Emergency Services				
• Hospital ER (Facility Charge Only)	Not Covered	$250 Copay, then 100% to $1,000 / visit	$250 Copay, then 100% to $1,000 /	$250 Copay, then 100% to $1,000 /
• Urgent Care / ER Professional Services	Not Covered	$75 Copay, then 100% to $500 / visit	visit $75 Copay, then 100% to $500 /	visit $75 Copay, then 100% to $500 /
• Ambulance	Not Covered	Not Covered	visit Not Covered	visit $500 Copay, then 100%to $1,000 /
• Air Ambulance	Not Covered	Not Covered	Not Covered	day Not Covered
Outpatient Surgical Procedures				
• Physician Office / Freestanding Surgery Ctr. • Outpatient Hospital	Not Covered Not Covered	$200 Copay, then 100% to $500 / day $500 Copay, then 100% to $500 / day	$200 Copay, then 100% to $750 / day $500 Copay, then 100% to $750 / day	$150 Copay, then 100% to $1,000 / day $500 Copay, then 100% to $1,000 / day
Inpatient Hospitalization				
• Medical Facility Services	Not Covered	$150 per day benefit, unlimited days	$1,000 Copay per admission then 100% to $500 / day benefit, unlimited days	$1,000 Copay per admission then 100% to $1,000 / day benefit, unlimited days
Prescription Drug Benefits	Not Covered	Rx Discount Card	$20 Copay, Generic Only to $250 / script	$20 Copay, Generic Only to $250 / script
COBRA Administration	Not Covered	Available Included	Included	Included
PPO Network	PHCS *	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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Third Party Administration (TPA)

TPA SERVICES

EHS offers our clients a truly unique white-glove approach to health plan administration. We never stop innovating and strategically adjusting your plan to ensure it functions at its highest potential, making the most of every opportunity to optimize health, risk management and cost. Our goal is always to "do the right thing" to serve you best!

CARE NAVIGATION

Our highly experienced nurses are fierce advocates for your members' healthcare who passionately work with members, families, and physicians to coordinate the highest-quality, cost-conscious healthcare which results in the best possible outcomes for patients.

CENTERS OF EXCELLENCE

EHS has embedded **Edison Healthcare** which operates a proprietary network of America's top medical teams inside 21 award-winning medical centers. Each center and team are hand selected for their excellence in dealing with Edison's specific covered diagnosis types.

At Edison Health Solutions We Are:

Bringing back the CARE in HealthCARE.
Bringing back the BENEFITS in employee BENEFITS.
Bringing back the LOWER in healthcare COSTS!

Employee Health Application Form

Section 1: Employer Information

Employer Name: State Security Agency Hire Date: Location/Division:

Employer Address: 70-21 Austin St., 3rd Floor

City: Forest Hills State: NY Zip: 11375

Section 2: Employee Information

Employee Name: Social Sec #: Date of Birth:

Address: Job Title:

City: State: Zip:

Marital Status: ☐ Single ☐ Divorced ☐ Married ☐ Widowed

Home Phone: ( ) Cell Phone: ( ) E-mail Address:

Hours Worked per Week:

Spouse's Employer: Spouse's Business Phone: ( )

Section 3: Other Insurance Coverage

Do you or your spouse have other health insurance? ☐ YES ☐ NO If YES, name of Carrier:

Policy Holder's Name: Policy #: Effective Date:

Name of Covered Dependents:

Section 4: Subscriber / Dependents (Please complete for employee subscriber and all participating dependents.)

Name First Last	Relationship (Spouse, Child)	M / F	DOB	Social Sec. #	Height	Weight	Tobacco Use (Y/N)
	Employee						

Section 5: Health Plan Participation

☐ I elect to participate

☐ I decline participation

Coverage Level (Choose 1)

☐ Employee Only

☐ Employee / Spouse

☐ Employee / Child(ren)

☐ Family

Plan Selection (Please write-in below)

MEC

Reason for decline:

☐ Spouse's Employer's Plan ☐ Individual Plan ☐ Medicare ☐ Medicaid ☐ COBRA from Prior Employer

☐ VA Eligibility ☐ I (we) have no other coverage at this time ☐ Other: ______________________________

Section 6: Health Information

Please answer the following health questions regarding any medical conditions or medical treatment for you and your family.

1. Have you or any of your dependent(s) been diagnosed or treated for any of the following conditions in the past five (5) years?

A. Cardiac Disorder	☐ Yes ☐ No	I. Immune System Disorder	☐ Yes ☐ No
B. Cancer / Tumor (any form)	☐ Yes ☐ No	J. Alcohol / Drug Abuse	☐ Yes ☐ No
C. Diabetes	☐ Yes ☐ No	K. Mental / Nervous Disorder	☐ Yes ☐ No
D. Kidney Disorder	☐ Yes ☐ No	L. Neuromuscular Disorder	☐ Yes ☐ No
E. Respiratory Disorder	☐ Yes ☐ No	M. Stomach / Gastrointestinal	☐ Yes ☐ No
F. Liver Disorder	☐ Yes ☐ No	N. Arthritis, Back, Bone, Joint Disorder	☐ Yes ☐ No
G. High Blood Pressure	☐ Yes ☐ No	O. Seizures, Convulsions, Epilepsy	☐ Yes ☐ No
H. Reproductive Disorders	☐ Yes ☐ No	P. Any Other Medical Condition (not listed above)	☐ Yes ☐ No

2. Have you or any of your dependent(s) had any medical conditions in the past 24 months requiring medical care, surgery or hospitalization that exceeded $5000 in medical expenses? ☐ Yes ☐ No

   If Yes, please provide information on who and for what conditions in space provided below.

3. Are you or any of your dependent(s) anticipating hospitalization or surgery, or had surgery or hospitalization recommended that has not been performed? ☐ Yes ☐ No

   If Yes, please provide information below

4. Are you or any dependent(s) currently pregnant or suspect you / they may be pregnant? ☐ Yes ☐ No

   If Yes, please provide due date and detail in space provided below

5. Are you or any dependent(s) disabled ☐ YES ☐ NO   If YES, please indicate name(s):

If you answer "Yes" to any of the questions above, please provide detail in space provided below.
(If needed, please attach additional sheets, signed and dated by the employee subscriber.)

Question Number	Family Member	Disease / Diagnosis / Treatment	Date of Onset Month / Year	Date Last Seen By Physician	Remaining Symptoms or Problems

6. Prescriptions / Medications - List any medications, prescriptions, or injections taken in the last 12 months.

(Attach Additional Sheets as Necessary.)

Family Member	Medication / Rx / Injection	Dosage	Medical Condition

Agreements

The answers and statements on this Employee Health Application are true and complete. I agree that they shall form a part of the contract of insurance under which I am applying for coverage. I understand and agree that the insurance applied for shall not take effect until approved by the insurance carrier at its Home Office. I have read, or have had read to me, the completed application and I realize that any false statements or misrepresentation in the application may result in loss of coverage under the contract.

Medical Authorization

I authorize any of the following to disclose any data it has on me, my health or on the health of my family. (1) any physician or other medical practitioner; (2) any hospital, clinic or other medical or medically related facility; (3) any insurance company; (4) The Medical Information Bureau; (5) any other organization, institution, or person that has any data on me or my health or on the health of my family. A copy of this shall be as valid as the original.

Fraud Warning

Any person who knowingly and with intent to defraud an insurer files an application or statement of claim containing false, incomplete or misleading information may be guilty of insurance fraud which is a crime.

Section 7: Employee Signature

I hereby authorize my healthcare providers to disclose information from my medical records to respective carriers the extent necessary to for underwriting and benefit eligibility. In the event that I enroll, I hereby agree to abide by the terms and conditions of all benefit plan summary documents, which contain the benefits, limitations, and exclusions applicable to my health and other benefit coverage. Upon request, a customer service representative can explain my benefit coverage options. I have read and understand the above conditions and declarations.

Employee Signature: ____ **Date:** _________________________