CONCIERGE
Third Party Administrator

MEC SELECT SUMMARY OF BENEFITS

This Summary of Benefits is only intended to provide an outline of the benefits provided in the Plan. See the specific benefit under the Covered Medical Benefits and Prescription Drug sections as well as the Medical and Prescription Exclusions and Limitations sections in this document for complete details.

Plan Members can visit the First Health, Limited Benefit Plan, PPO Network website at www.firsthealthlbp.com or call 1-800-226-5116 for a list of in network participating providers for the Plan. **Out of Network Providers are not covered by the Plan**.

All prescriptions must be filled by a participating pharmacy. Plan Members may view the back of their ID Card for the pharmacy network designated to their Plan. **Out of Network Pharmacies are not covered by the Plan.**

Benefit Description	Subject to Benefit Year Deductible	You Pay, When Using a Participating Provider	Benefit Year Visit/Service Limit per Enrolled Plan Member	Additional Limitations and Explanations
Physician Office Visits	No	$25 Co-pay per visit	Limited to 3 visits per Benefit Year per Plan Member.	This benefit applies to the Physician office visit charge only and does not include lab, x-ray, or other testing or services performed.
Specialist Physician Office Visits	No	$50 Co-pay per visit	Limited to 3 visits per Benefit Year per Plan Member.	This benefit applies to the Specialist Physician office visit charge only and does not include lab, x-ray, or other testing or services performed.
Urgent Care Physician Office Visits	No	$75 Co-pay per visit	Limited to 1 visit per Benefit Year per Plan Member.	This benefit applies to the Urgent Care Physician office visit charge only and does not include lab, x-ray, or other testing or services performed.
Diagnostic Lab & X-Ray	No	$50 Co-pay per test	1 lab or x-ray test per day and 5 tests combined per Benefit Year per Plan Member.	Diagnostic services only. Includes simple x-rays and lab. Benefit does not include the professional reading of the testing.
CT Scan & MRI	No	$200 Co-pay per test	Pays up to $1,000 for 1 CT Scan or MRI per Benefit Year per Plan Member.	Benefit includes one test per Benefit Year for CT Scan or MRI and does not include one of each test.
Preventive Care Services	No	$0	None	Limited to specific services noted in the Covered Medical Benefits section of this document and required by the Patient Protection and Affordable Care Act. *

Benefit Description	Subject to Benefit Year Deductible	You Pay, When Using a Participating Pharmacy	Benefit Year Visit/Service Limit per Enrolled Plan Member	Additional Limitations and Explanations
ACA* Preventive Prescriptions -Generic Only -Retail Only	No	$0	None	Limited to specific prescriptions noted in the Prescription section of this document and required by the Patient Protection and Affordable Care Act *. Must be included on the formulary of approved drugs. 30-day supply only.
Prescriptions Generic Only	No	10% Co-pay per script for Generic only	Plan pays a maximum of $150 per prescription.	Must be included on the formulary of approved drugs. 30-day supply only.
Prescriptions Brand Name Tier 1	No	30% Co-pay per script for Brand Name Tier 1	Plan pays a maximum of $150 per prescription.	Must be included on the formulary of approved drugs. 30-day supply only.
Prescriptions Brand Name Tier 2	No	40% Co-pay per script for Brand Name Tier 2	Plan pays a maximum of $150 per prescription.	Must be included on the formulary of approved drugs. 30-day supply only.

*Copies of the preventive care recommendations and guidelines may be reviewed at:

- www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/
- www.healthcare.gov/coverage/preventive-care-benefits/