SUMMARY OF MINIMUM ESSENTIAL COVERAGE 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.**

The services that are eligible under the Plan are limited to the following:

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
Primary Care Physician Office Visits **Included Physicians** -General Pediatrics -Internal Medicine -OB/Gynecology -Family Practice -General Medicine	No	$25 Co-pay per visit	Limited to 5 visits per Benefit Year per Plan Member. Discounts will continue to apply after the 5-visit limit is exhausted.	Applies to the Primary Care Physician office visit charge only and does not include lab, x-ray, or other testing or services performed. All other services will be the Plan Members responsibility.
Specialist Physician Office Visits	No	$50 Co-pay per visit	Limited to 3 visits per Benefit Year per Plan Member. Discounts will continue to apply after the 3-visit limit is exhausted.	Applies to the Specialist Physician office visit charge only and does not include lab, x-ray, or other testing or services performed. All other services will be the Plan Members responsibility.
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**
Urgent Care Physician Office Visits	No	$75 Co-pay per visit	Limited to 3 visits per Benefit Year per Plan Member. Discounts will continue to apply after the 3-visit limit is exhausted.	Applies to the Urgent Care Physician office visit charge only and does not include lab, x-ray, or other testing or services performed. All other services will be the Plan Members responsibility. Urgent Care Physician visits from an out-of-network provider will be considered at the in-network rate.

Chiropractic Visits (Manipulation Only)	No	$0	Limited to 10 visits per Benefit Year per Plan Member and $50 payment limit per visit.	Applies to Chiropractic Manipulation only and does not include any other services performed.
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. * If a Plan Member receives covered Preventive Care Services at an in-network Hospital or in-network ambulatory surgical center and some of the covered services are performed by out-of-network providers (such as professional readings of covered testing, anesthesia, etc.) those out-of-network services will be considered at the in-network rate.

Benefit Description	You Pay, When Using a Participating Pharmacy	Benefit Year Prescription Limit	Additional Limitations and Explanations
ACA Preventive Care Prescriptions View the list of participating pharmacies, formularies, and available medications by downloading the "The Health Wallet" app from the Apple App Store or Google Play Store or call 800-838-0007.	$0	None	Limited to specific prescriptions required by the Patient Protection and Affordable Care Act. * Must be included on the formulary of approved drugs and filled by a participating pharmacy. Mail Order is available.
Benefit Description	**You Pay, When Using a Participating Pharmacy**	**Benefit Year Prescription Limit**	**Additional Limitations and Explanations**
Non-ACA Prescriptions See the Prescription Section of this Plan Document for more information. View the list of participating pharmacies, formularies, and available medications by downloading the "The Health Wallet" app from the Apple App Store or Google Play Store or call 800-838-0007.	$0 for Acute Formulary $1 Co-pay for Chronic Formulary	Acute Formulary: Unlimited 30-day supply. Chronic Formulary: Limited to 12 retail and 4 mail order prescriptions per Benefit Year per Plan Member.	All prescriptions must be included on the formulary of approved drugs and filled by a participating pharmacy for this benefit. Plan Members may use the Prescription Discount Program for non-formulary prescriptions filled at a participating pharmacy (discount only). Chronic Formulary: After the first retail purchase, all chronic prescriptions must be filled through the mail-order service. Generic Viagra and Cialis can only be purchased through mail order and are limited

Plan Members will have access to Diabetic Supply, International Pharmacy and Prescription Assistance Programs. Mail Order is available.			to 72 generic Viagra 50/100mg pills or 48 generic Cialis 5/20mg pills per Benefit Year.

*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/

SUMMARY OF MEDICAL INDEMNITY BENEFITS

This summary is intended to provide an outline of the benefits provided in the Indemnity portion of the Plan. Indemnity Benefits are considered an excepted benefit and therefore, HIPAA Portability Rules and ACA requirements are not required. See the specific benefit under the Covered Medical Indemnity Benefits and Prescription Drug sections as well as the Medical and Prescription Exclusions and Limitations sections for complete benefit details.

The Plan will pay the maximum amounts shown for the specific Eligible Expenses for in network or out of network providers for the benefits listed below. Although it is not required to use a First Health, Limited Benefit Plan, PPO participating provider for the following Indemnity benefits, the Plan Member may receive discounts on their services by using a First Health, Limited Benefit Plan, PPO provider. You can visit the Network website at www.firsthealthlbp.com or call 1-800-226-5116 for a list of in network providers.
The Plan will pay the providers for the charges incurred up to the visit limit maximum amount. If the providers allowable charge is less than the maximum visit amount, the remaining benefit amount will be paid to the Plan Member. If the provider allowable charge is more than the maximum visit amount, the remaining charges will be the Plan Members responsibility. Any services not specifically stated in this document as an Eligible Expense or any service where the Benefit Year maximum visit limit/monthly prescription limit has been met, will also be the Plan Members responsibility.

DIAGNOSTIC TESTING (OUTPATIENT)

Benefit Description	Plan Pays	Benefit Year Visit/Service Limit per Plan Member	Additional Limitations and Explanations
Diagnostic Outpatient Lab Tests	$30 per day	2 days	Benefit does not include the professional reading of the test. Lab must be performed to diagnose or treat an accident or illness.
Select Diagnostic Outpatient Tests Includes: – Simple X-rays – Ultrasound – Diagnostic Mammogram – Sonogram – Angiogram	$100 per day	2 days	Benefit does not include the professional reading of the test. Testing must be performed to diagnose or treat an accident or illness.

Advanced Studies Diagnostic Outpatient Tests Includes: – CT Scan – MRI – PET Scan	$100 per day	1 day	Benefit does not include the professional reading of the test. Testing must be performed to diagnose or treat an accident or illness.

ACCIDENT BENEFIT (OUTPATIENT)

Benefit Description	Plan Pays	Benefit Year Visit/Service Limit per Plan Member	Additional Limitations and Explanations
Accident Benefit for outpatient services.	100%	Plan pays up to $1,000 per Benefit Year.	This is a per Plan Member per Benefit Year benefit and is not a per Accident benefit.

SURGERY BENEFITS (OUTPATIENT)

Benefit Description	Plan Pays	Benefit Year Visit/Service Limit per Plan Member	Additional Limitations and Explanations
Surgery Benefits	$750 per day	1 day	Surgery must be Medically Necessary.

ANESTHESIA BENEFIT (OUTPATIENT)

Benefit Description	Plan Pays	Benefit Year Visit/Service Limit per Plan Member	Additional Limitations and Explanations
Outpatient Anesthesia Benefits	$187.50 per day	1 day	Surgery must be Medically Necessary.

HOSPITAL CONFINEMENT BENEFITS (Includes maternity and excludes mental health and substance)

Benefit Description	Plan Pays	Benefit Year Visit/Service Limit per Plan Member	Additional Limitations and Explanations
Hospital Confinement- Day 1	$750 per day	1 day	Plan Member must be confined to a Hospital for over 23 hours per day as a result of a covered accident or sickness. This benefit does not include emergency room, outpatient stay or an observation unit stay.
Hospital Confinement- Day 2+	$375 per day	29 days	