PREVENTIVE PLUS PLAN (MINIMUM ESSENTIAL COVERAGE)

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 the Plan Document for complete details.

Plan Members can visit the First Health, Limited Benefit Plan, PPO network website at www.firsthealthlbp.com or call customer service at 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.**

Out-of-Pocket Maximum: The Plan is a limited benefit Plan. The Plan Members will not be out-of-pocket more than the determined Department of Health and Human Services maximum out-of-pocket limit for the applicable Benefit Year for all eligible Essential Health Benefits.

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 3 visits per Benefit Year per Plan Member. Discounts will continue to apply after the 3-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 and Urgent Care Physician office visits are not covered.
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**
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 -Retail Only	No	20% Co-pay per script	12 prescriptions per Benefit Year per Plan Member.	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/