SUMMARY OF MEC BENEFITS- MEC 3 PLUS PLAN

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 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 855-798-2538. **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	$20 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	$50 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. Urgent Care Physician visits from an out-of-network provider will be considered at the in-network rate.
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 Visit/Service Limit per Enrolled Plan Member	Additional Limitations and Explanations
ACA* Preventive Prescriptions -Generic Only -Retail Only 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 855-798-2538.	$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.

*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/

Benefit Description	You Pay, When Using a Participating Pharmacy	Benefit Year Visit/Service Limit per Enrolled Plan Member	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 855-798-2538. Plan Members will have access to Diabetic Supply, International Pharmacy and Prescription Assistance Programs. Mail Order is available.	$0 for Acute Formulary $1 Co-pay for Chronic Formulary	Acute Formulary: Unlimited 30-day supply. Chronic Formulary: Employee only coverage: 12 retail and 4 mail order prescriptions per Benefit Year. Employee + 1 coverage: 18 retail and 7 mail order prescriptions per Benefit Year for all Plan Members combined. Family coverage: 24 retail and 10 mail order prescriptions per Benefit Year for all Plan Members combined.	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 to 72 generic Viagra 50/100mg pills or 48 generic Cialis 5/20mg pills per Benefit Year.