

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.**

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
Physician Office Visits Specialist Physician Office Visits Urgent Care Physician Office Visits	No	\$25 Co-pay per visit	Limited to 5 visits per Benefit Year per Plan Member for Physician, Specialist Physician and Urgent Care Physician office visits combined.	<p>This benefit applies to the Physician, Specialist Physician or Urgent Care Physician office visit charge only and does not include lab, x-ray, or other testing or services performed.</p> <p>All other services will be the Plan Members responsibility for payment.</p> <p>Urgent Care Physician visits from an out-of-network provider will be considered at the in-network rate.</p>
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
Preventive Care Services	No	\$0	None	<p>Limited to specific services noted in the Covered Medical Benefits section of this document and required by the Patient Protection and Affordable Care Act. *</p> <p>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.</p>

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.

*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 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. 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: 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 to 72 generic Viagra 50/100mg pills or 48 generic Cialis 5/20mg pills per Benefit Year.