SUMMARY OF MEC 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 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	$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 3 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.
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	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
$0 ACA MEC Formulary-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 855-798-2538.	$0	None	Limited to specific prescriptions required by the Patient Protection and Affordable Care Act. * Must be included on the $0 ACA MEC 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	$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.	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).

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.		<u>Employee + 1 coverage:</u> 18 retail and 7 mail order prescriptions per Benefit Year for all Plan Members combined. <u>Family coverage:</u> 24 retail and 10 mail order prescriptions per Benefit Year for all Plan Members combined.	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.
Prescriptions Tier 1	10% Co-pay per script for Tier 1	Plan pays a maximum of $150 per prescription.	Must be included on the formulary of approved drugs. 30-day supply only.
Prescriptions Tier 2	30% 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.
Prescriptions Tier 3	40% Co-pay per script for Brand Name Tier 3	Plan pays a maximum of $150 per prescription.	Must be included on the formulary of approved drugs. 30-day supply only.

SUMMARY OF INDEMNITY BENEFITS

This summary of benefits is intended to provide an outline of the benefits provided in the Indemnity Plan. This Plan is considered an excepted benefit and therefore, HIPAA Portability Rules, Mental Health Parity, and ACA requirements are not required. See the specific benefit under the Covered Indemnity Benefits and Prescription Drug sections as well as the Medical and Prescription Exclusions and Limitations sections in the Plan Document 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. Although it is not required to use a First Health, Limited Benefit Plan, PPO participating provider for the Indemnity benefits outlined below, 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.

Benefit Description	Plan Pays	Benefit Year Visit/Service Limit per Enrolled Plan Member	Additional Limitations and Explanations
Diagnostic Lab & Simple X-Ray	$50 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	$1,000 per test	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.