MEC PLUS SELECT 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 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 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**.

Benefit Description	You Pay, When Using First Health, Limited Benefit Plan, Participating Provider	Benefit Year Visit/Service Limit per Enrolled Plan Member	Additional Limitations and Explanations
Physician Office Visits Included Physicians: -General Pediatrics -Internal Medicine -OB/Gynecology -Family Practice -General Medicine	$25 Co-pay per visit **Out of network Physicians are not covered by the Plan.**	Limited to 3 visits per Benefit Year per Plan Member.	This benefit 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 performed in the office and visits that exceed the maximum will be the Plan Members responsibility for payment.
Specialist Physician Office Visits Includes all Physician's whose specialty is not one of the following: -General Pediatrics -Internal Medicine -OB/Gynecology -Family Practice -General Medicine	$50 Co-pay per visit **Out of network Physicians are not covered by the Plan.**	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. All other services performed in the office and visits that exceed the maximum will be the Plan Members responsibility for payment.
Urgent Care Physician Office Visits	$75 Co-pay per visit **Out of network Physicians are not covered by the Plan.**	Limited to 1 visit per enrolled Plan Member per Benefit Year.	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. All other services performed in the office and visits that exceed the maximum will be the Plan Members responsibility for payment.

Benefit Description	You Pay, When Using a Participating Pharmacy	Benefit Year Visit/Service Limit per Enrolled Plan Member	Additional Limitations and Explanations
Preventive Care* Services -All Adults -Women -Pregnant Women -Children	$0 **Out of network Providers are not covered by the Plan.**	None	Limited to specific services noted in the *Covered Medical* Benefits section of the Plan Document and required by the Patient Protection and Affordable Care Act. *
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	$0 **Out of network Pharmacies are not covered.**	None	Limited to in network participating pharmacies only for 30-day supply. Plan Members may view the back of their ID Card for the Participating Pharmacy Network; phone number; and website. Limited to specific services noted in the *Covered Medical Benefits-Minimum Essential Coverage* and *Prescription Drug* sections of this document and required by the Patient Protection and Affordable Care Act.

*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 BENEFITS-INDEMNITY

The following Summary of Benefits is only intended to provide an outline of the Indemnity benefits covered in the Plan. Please see the specific benefit under the *Covered Medical Benefits-Indemnity* section as well as the *Exclusions and Limitations* sections for medical and prescriptions of this document for more 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 PPO participating provider for the medical Indemnity benefits outlined below, the Plan Member may receive discounts on their services by using a First Health PPO provider. You can visit the First Health Network website at www.firsthealthlbp.com or call 1-800-226-5116 for a list of in network providers.

The Plan will pay the medical 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 has been met, will also be the Plan Members responsibility. Usual and Customary will be used to determine the allowable amount for out-of-network provider services.

HEALTH WALLET & TELEMEDICINE

Health Wallet allows Plan Members to look up participating providers and pharmacies and to review cost comparisons for their prescription drugs from different pharmacies. Health Wallet also includes Telemedicine. Plan Members can view their Health Wallet app to access information, seven days a week/365 days per year/24 hours a day and can speak to a Physician and receive treatment for acute illnesses at no cost to the Plan Member. This benefit is eligible for COBRA Continuation of Coverage.

DIAGNOSTIC LABORATORY SERVICES; SIMPLE X-RAYS; CAT-SCAN/MRI BENEFITS

Benefit Description	Plan Pays	Benefit Year Visit/Service Limit per Enrolled Plan Member
Diagnostic Laboratory Services & Simple X-Rays	After the Plan Member pays a Co-pay of $50, the Plan pays the remaining allowable charge for one lab or simple x-ray test per day.	Limited to 1 lab or x-ray test per Plan Member per day to a maximum of 5 tests for lab and x-ray combined per Benefit Year. If multiple tests are performed in one day, the lab or simple x-ray with the lower allowable charge will be considered by the Plan.
Cat-Scan & MRI	After the Plan Member pays a Co-pay of $200, the Plan pays $1,000 for one Cat-Scan or MRI per Plan Member per Benefit Year.	Limited to 1 Cat-Scan or MRI per Plan Member per Benefit Year.

PRESCRIPTIONS

All Prescriptions must be filled by a Participating Pharmacy. The Plan Member may view the back of their ID Card for the Participating Pharmacy Network name, phone number and website. **Out of network pharmacies are not covered by the Plan**. This benefit includes retail prescriptions, 30-day supply only. Mail order is not covered. Specialty Drugs are not covered by the Plan. Discounts for Prescriptions are available through the Health Wallet App.

Benefit Description	Plan Pays
Generic Prescriptions*	90%
Preferred Prescriptions*	70%
Non-Preferred Prescriptions*	60%
Specialty Prescriptions	Not Covered by The Plan

Plan pays up to a maximum of $150 per prescription on all non-ACA preventive medications.