

## 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](http://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
<b>Preventive Care Services</b>	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
<b>Preventive Prescriptions</b> -Generic Only -Retail Only	\$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 filled by a participating pharmacy. 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/](http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/)
- [www.healthcare.gov/coverage/preventive-care-benefits/](http://www.healthcare.gov/coverage/preventive-care-benefits/)