

|   | Plan 1  |
|---|---|
|   | MEC PLUS PLAN   |
| Benefits  |   |
| Annual Deductible                                   |   |
| In – Network Per Person/Per Family                  | \$0/\$0   |
| Maximum Out of Pocket                               | \$5,000/\$10,000  |
| Percentage Payable                                  | 100%  |
| Professional Services                               | Services must be provided by Providers within the Healthsmart Network or benefit will not be covered. |
| Physician office visits                             | \$20 co-pay   |
| Procedures performed during an office visit         | Plan pays 100% of allowed   |
| Specialist office visit only                        | \$20 co-pay   |
| Procedures performed during Specialist office visit | Plan pays 100% of allowed   |
| Urgent Care   | \$40 co-pay   |
| Additional Services/Lab & X-ray in office           | Plan pays 100% of allowed   |
| Preventative Services - Child & Adult               | 100%  |
| Outpatient Lab & X-Ray                              | \$40 co-pay   |
| Imaging (CT, PET Scan, MRI)                         | \$20 co-pay   |
| Outpatient Services Facility                        | Not covered   |
| Outpatient Services Physician                       | Not covered   |
| Emergency Services                                  |   |
| Emergency Room                                      | Not covered   |
| Ambulance   | Not covered   |
| Hospital Benefits                                   |   |
| Inpatient   | Not covered   |
| Inpatient Professional Services                     | Not covered   |
| Additional Outpatient Services                      |   |
| Skilled Nursing                                     | Not covered   |
| Chiropractic  | Not covered   |
| Physical/Occupational                               | Not covered   |
| Mental Outpatient                                   | Not covered   |
| Durable Medical Equipment                           | Not covered   |
| Substance Abuse Outpatient                          | Not covered   |
| Additional Services                                 |   |
| Chemotherapy  | Not covered   |
| Sleep Study   | Not covered   |
| Pediatric Dental & Vision                           | ACA Required Benefits   |
| Prescriptions                                       |   |
| Generic   | \$5.00 co-pay   |
| Brand Formulary                                     | \$40.00 co-pay  |
| Brand Non-Formulary                                 | Not covered   |
| Specialty Medication                                | Not covered   |
| Mail Order (90 Days)                                |   |
| Generic   | Not covered   |
| Preferred   | Not covered   |
| Non-preferred                                       | Not covered   |
| Specialty Medication                                | Not covered   |