

| DESCRIPTION OF BENEFITS <i>All plan benefits shown as a percentage of Eligible Charge.</i> | MEC SIMPLE PLAN | |
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| PLAN PROVISIONS | Member Pays | |
| Annual Medical Deductible | None | Not Applicable |
| Annual Medical Out of Pocket Maximum | None | Not Applicable |
| Amounts in Excess of Negotiated Rates/Maximum Allowable Charge | For Participating Providers, the contract generally prohibits the provider from charging more than the negotiated rate for covered services. However, the Member will be responsible for the Deductible, Copayments, and Coinsurance. | For Non-Participating Providers, the Member is responsible for the full amount billed by the provider. Amounts billed by Non-Participating Providers are not covered and DO NOT apply to the Annual Deductible NOR the Annual Out-of-Pocket Maximum. |
| Lifetime Maximum | None | |
| Dependent Coverage | To age 26 | |
| MEDICAL SERVICES | | |
| PHYSICIAN SERVICES | Member Pays | |
| | In-Network | Out-of-Network |
| Preventive Care Office Visits | Covered in Full | Not Covered |
| PREVENTIVE CARE | | |
| BENEFITS FOR CHILDREN | | |
| Covered Preventive Services for Children per PPACA | Covered in Full | Not Covered |
| Newborn Circumcision | Covered in Full | Not Covered |
| Well Child Care Office Visits 0 to 11 months (6 "well-baby visits"), 1 to 4 years (7 "well-child visits"), 5 to 17 years (1 per year, "well-child visit") | Covered in Full | Not Covered |
| Well Child Care Immunization (as recommended by Bright Futures Project) | Covered in Full | Not Covered |
| Well Child Care Lab Tests (as recommended by Bright Futures Project) | Covered in Full | Not Covered |
| ADULT PREVENTIVE SCREENING/TESTING | | |
| Covered Preventive Services for Adults (ages 18 and older), per PPACA | Covered in Full | Not Covered |
| Adults, one (1) physical exam per benefit year to obtain recommended preventive and diagnostic services | Covered in Full | Not Covered |
| Immunization Services for Adults Immunizations - doses, recommended ages, and recommended populations vary per the recommendations of the Advisory Committee for Immunization Practices (ACIP) | Covered in Full | Not Covered |
| Prostate Specific Antigen (Men, one per CY, age ≥ 50) | Covered in Full | Not Covered |
| Screenings such as; Obesity, Blood Pressure, Cholesterol, Colorectal Cancer, HIV, Alcohol Misuse | Covered in Full | Not Covered |
| Counseling such as; Alcohol Misuse, Sexually Transmitted Infection (STI) Prevention, Nutritional Counseling, Tobacco Use | Covered in Full | Not Covered |
| WOMEN'S PREVENTIVE CARE SERVICES | | |
| Prescribed contraceptive methods, sterilization procedures and patient education. (Supply and administration of Contraceptive IUDs, Implants and Injectables) (Pharmacy - birth control pills, diaphragms, emergency contraceptive pill through your Pharmacy Benefits) | Covered in Full | Not Covered |
| Well Woman exam per benefit year to obtain recommended preventive and diagnostic services (Subject to all Limitations as described under Covered Medical Benefits) | Covered in Full | Not Covered |
| Screenings such as Pap Smears, Mammography, Domestic and interpersonal violence screening, Osteoporosis screening (Subject to all Limitations as described under Covered Medical Benefits) | Covered in Full | Not Covered |
| Counseling such as Contraception, BRCA, Breast Cancer Chemoprevention, Folic Acid Supplements | Covered in Full | Not Covered |
| Services for Pregnant Women including but not limited to Anemia Screening, Rh Incompatibility Screening, Breastfeeding, Hepatitis B Screening. Breastfeeding: Comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women. | Covered in Full | Not Covered |
| Coinsurance amount is based on an approved negotiated rate for Participating Providers. | | |
| Benefits that are subject to the No Surprises Act will be reimbursed at the In-Network level of benefits. | | |

| <i>PHARMACY PROVISIONS</i> | Member Pays | |
|--|---------------------------|---------------------------|
| PHARMACY BENEFITS | In-Network Pharmacies | Out-of-Network Pharmacies |
| Annual Pharmacy Deductible | None | Not Applicable |
| Annual Pharmacy Out of Pocket Maximum | None | Not Applicable |
| Lifetime Maximum | None | Not Applicable |
| Preventive Prescription Services | | |
| Mandatory Generic Only - Preventive Prescription Services as defined by PPACA. In order for preventive medications to be covered at 100%, a prescription is required from your physician, including over-the-counter (OTC) drugs. | | |
| Prescription Drugs Pharmacy Retail - up to a 30 Day Supply | Generic - Covered in Full | Not Covered |
| Non-Preventive Prescription Services | | |
| Prescription Drugs Pharmacy Retail - up to a 30 Day Supply | Not Covered | Not Covered |
| Prescription Drugs Pharmacy Retail - 90 Day Supply | Not Covered | Not Covered |
| Prescription Drugs Pharmacy Mail Order - 30 or 90 Day Supply | Not Covered | Not Covered |
| Specialty Drugs | Not Covered | Not Covered |
| This summary provides a condensed explanation of plan benefits. Certain limitations, restrictions and exclusions may apply. Please refer to the Plan Document for complete information on benefits. In the case of discrepancy between this summary and the language contained in the Plan Document, the latter will take precedence. | | |

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