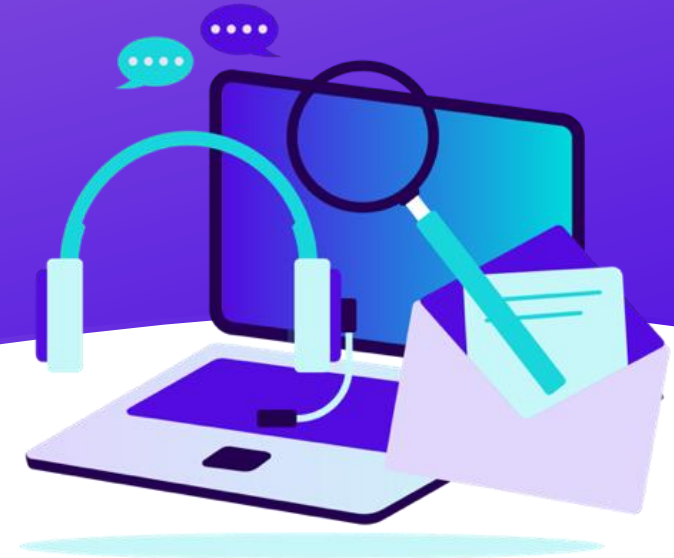


MEMBER ADVOCACY



888-341-5606

MedWatch Offers:

- ✓ Single point of contact
- ✓ Comprehensive support, from scheduling, to balance bills, health plan information and pre-certification
- ✓ Understand diagnoses
- ✓ Referrals

- ✓ Provide educational support & resources
- ✓ Answer medication questions
- ✓ Find service locations

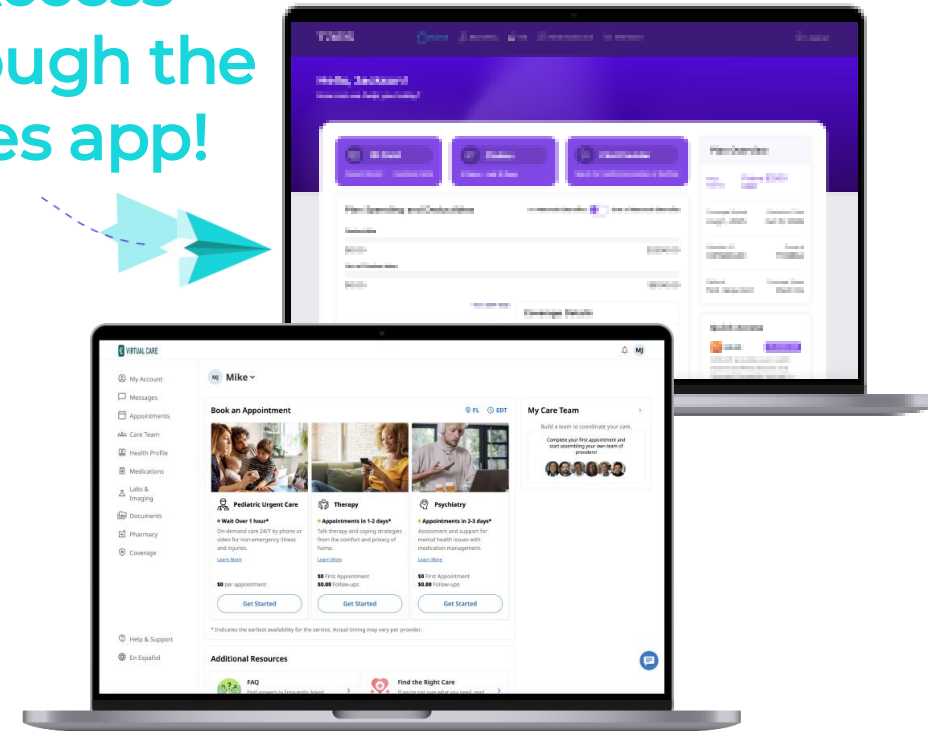
Seamless Health Management Experience

UNLIMITED TELEMEDICINE & TELEPSYCHOLOGY

MDLIVE Offers:

- ✓ Urgent Care - On-demand for illness and injuries, including Rx scripts
- ✓ Mental Health - Talk therapy and psychiatry from licensed therapists and board-certified psychiatrists
- ✓ Appointment Scheduling in as little as five days with after-hours and flexible sessions available
- ✓ Integrated digital and mobile access through the Tres Health portal and app

Access
through the
Tres app!



Board-Certified Doctors in Minutes

TRES HEALTH MEC Plus

MEC Plus Rates

Single	EE + Spouse	EE + Children	Family
\$125.34	\$195.04	\$171.36	\$241.06

CO-PAY : Per: visit / admission / test / trip / Supply **Refer to the plan documents for full details**
LIMIT : Per calendar year

PHYSICIAN SERVICES

Primary Care Office Visit

Includes In-Person & Virtual. This is the encounter fee only. This benefit includes Retail/Walk In Clinics.

Limit 2 Visits

Co-Pay \$25

Specialist Office Visit

Includes In-Person & Virtual
This is the encounter fee only.

Limit 2 Visits

Co-Pay \$50

Other Services Performed in the Physician's Office

This Copay is in addition to the office visit Copay. Collectively, these services and the office visit count as a single visit toward the office visit limits.

Limit see above

Co-Pay \$50

Telemedicine Services w/MDLive

Limit Unlimited

Co-Pay No Cost

OUTPATIENT SERVICES

Outpatient Services or Surgery

Non-Hospital Based.
Includes anesthesia when Medically Necessary.

Limit Not Covered

Co-Pay Not Covered

DIAGNOSTIC SERVICES AND SUPPLIES

Diagnostic Testing (Lab & Radiology)

Non-Hospital Based

Limit 1 tests

Co-Pay No Cost¹ / \$50

Diagnostic Testing (Advanced Imaging)

Non-Hospital Based

Limit Not Covered

Co-Pay Not Covered

¹No Cost Co-Pay only applies to radiology and imaging when accessed through our preferred imaging center partner, MedMo. All services outside MedMo are subject to the other copay listed respectively.

EMERGENCY SERVICES

Urgent Care

Limit 2 Visits

Co-Pay \$75

MEC PLUS PLAN

Prescription Drug Benefit Schedule

Refer to the Prescription Drug Benefits in this Plan for details on the Prescription Drug Program. Please note that not all drugs are covered. For additional information on Prescription Drugs, including a copy of the Plan's formulary, please call the phone number on the Plan ID card. **Specialty Drugs are not Covered.**

Co-Pay: Per drug, Retail Shown (30 Day Supply) Mail order available.

Preventive Drugs **Tier 1**

\$0 **\$10**

ACA Preventive & Wellness

NO COST

Deductibles (Ind/Fam)

\$0/\$0

Max Out-of-Pocket (Ind/Fam)

\$9,100 / \$18,200

Benefits listed are intended to be a brief summary and are subject to change. Refer to the plan documents for full details and exclusions .

MEC Plus Plan - MEDICAL PLAN EXCLUSIONS

The following charges are not covered under this Plan. All Exclusions related to Prescription Drugs are shown in the Prescription Drug benefits section.

Services not covered

Abortion.

Acupuncture.

Administrative Costs.

Ambulance Services.

Applied Behavioral Analysis Therapy.

Cardiac Rehabilitation.

Chemotherapy.

Chiropractic Care.

Complications of Non-Covered Expenses.

Cosmetic Components of Gender Dysphoria.

Cosmetic Surgery.

Custodial Care.

Dental Care.

Dialysis.

Diabetic Supplies.

Durable Medical Equipment.

Educational or Vocational Testing.

Emergency Room Services.

Excess Charges.

Exercise Programs.

Experimental and/or Investigational.

Eye Care.

Foreign Travel.

Gender Affirming Surgery Reversal.

Gene and Cell Therapy.

Genetic Counseling and Testing.

Government Coverage.

Hair Loss.

Hazardous Activities.

Hearing Aids and Exams.

Home Health Care.

Hospice Care.

Illegal Acts.

Illegal Drugs or Medications.

Imaging Services.

Immunizations.

Infertility.

Infusion Therapy.

Inpatient Services.

Long Term Care.

Mailing or Sales Tax.

Massage Therapy.

Medical Supplies.

Negligence.

No Charge.

Non-Compliance.

Non-Emergency Hospital Admissions.

Non-Emergency Use of Emergency Room.

Not Medically Necessary.

Not Specified as Covered.

Nutritional Supplements.

Occupational Injury.

Occupational Therapy.

Outpatient Rehabilitation Services.

Outpatient Services or Surgery.

Personal Convenience Items.

Physical Therapy.

Private Duty Nursing.

Professional (and Semi-Professional) Athletics.

Radiation Services.

Self-Inflicted.

Services Before or After Coverage.

Skilled Nursing Facility Care.

Sleep Studies.

Speech Therapy.

Sterilization Services.

Transplant Services.

Travel or Accommodations.

Travel or Accommodations.

War.

This is not a contract of insurance. The benefit summaries contained in this document are intended to be brief descriptions of the benefits. Full plan details will be documented in the Summary Plan Description ("SPD") issued to the group. In the event of conflict between this document and the SPD, the SPD shall supersede.

TRES

Important Information: Covered Expenses are limited to the Reasonable and Allowed Amount as defined in this Plan; Covered Expenses are also subject to Medical Necessity and all other provisions, conditions, limitations and exclusions listed in this Plan. This Plan does not use a participating provider organization (PPO) for facility services; therefore, claims for facility services, and non-network services (as indicated with an asterisk (*) in the Medical Benefits Schedule) are paid **at reference-based pricing**. See the definition of Reasonable and Allowed Amount in this Plan for additional information regarding reference-based pricing and other reimbursement methodologies.

TRES HEALTH

MEC Preventive

MEC Preventive Rates

Single	EE + Spouse	EE + Children	Family
\$73.95	\$119.54	\$106.77	\$144.46

CO-PAY : Per: visit / admission / test / trip / Supply **Refer to the plan documents for full details**
LIMIT : Per calendar year

PHYSICIAN SERVICES

Primary Care Office Visit

Includes In-Person & Virtual. This is the encounter fee only. This benefit includes Retail/Walk In Clinics.

Limit Not Covered

Co-Pay Not Covered

Specialist Office Visit

Includes In-Person & Virtual
This is the encounter fee only.

Limit Not Covered

Co-Pay Not Covered

Other Services Performed in the Physician's Office

This Copay is in addition to the office visit Copay. Collectively, these services and the office visit count as a single visit toward the office visit limits.

Limit Not Covered

Co-Pay Not Covered

Telemedicine Services w/MDLive

Limit Unlimited

Co-Pay No Cost

OUTPATIENT SERVICES

Outpatient Services or Surgery

Non-Hospital Based.
Includes anesthesia when Medically Necessary.

Limit Not Covered

Co-Pay Not Covered

DIAGNOSTIC SERVICES AND SUPPLIES

Diagnostic Testing (Lab & Radiology)

Non-Hospital Based

Limit Not Covered

Co-Pay Not Covered

Diagnostic Testing (Advanced Imaging)

Non-Hospital Based

Limit Not Covered

Co-Pay Not Covered

EMERGENCY SERVICES

Urgent Care

Limit Not Covered

Co-Pay Not Covered

MEC PREVENTIVE PLAN Prescription Drug Benefit Schedule

Refer to the Prescription Drug Benefits in this Plan for details on the Prescription Drug Program. Please note that not all drugs are covered. For additional information on Prescription Drugs, including a copy of the Plan's formulary, please call the phone number on the Plan ID card. **Specialty Drugs are not Covered.**

Co-Pay: Per drug, Retail Shown (30 Day Supply) Mail order available.

Preventive Drugs	Tier 1
\$0	Not covered

ACA Preventive & Wellness

NO COST

Deductibles (Ind/Fam)

\$0/\$0

Max Out-of-Pocket (Ind/Fam)

\$0/\$0

Benefits listed are intended to be a brief summary and are subject to change. Refer to the plan documents for full details and exclusions .

MEC Preventive Plan - MEDICAL PLAN EXCLUSIONS

The following charges are not covered under this Plan. All Exclusions related to Prescription Drugs are shown in the Prescription Drug benefits section.

Services not covered

Abortion.

Acupuncture.

Administrative Costs.

Allergy Testing and Injections.

Ambulance Services.

Applied Behavioral Analysis Therapy.

Cardiac Rehabilitation.

Chemotherapy.

Chiropractic Care.

Clinical Trials.

Complications of Non-Covered Expenses.

Cosmetic Components of Gender Dysphoria.

Cosmetic Surgery.

Custodial Care.

Dental Care.

Diagnostic Services and Supplies.

Dialysis.

Diabetic Supplies.

Durable Medical Equipment.

Educational or Vocational Testing.

Emergency Room Services.

Excess Charges.

Exercise Programs.

Experimental and/or Investigational.

Eye Care.

Foreign Travel.

Gender Affirming Surgery Reversal.

Gene and Cell Therapy.

Genetic Counseling and Testing.

Government Coverage.

Hair Loss.

Hazardous Activities.

Hearing Aids and Exams.

Home Health Care.

Hospice Care.

Illegal Acts.

Illegal Drugs or Medications.

Imaging Services.

Immunizations.

Infertility.

Infusion Therapy.

Inpatient Services.

Long Term Care.

Mailing or Sales Tax.

Massage Therapy.

Mastectomy.

Medical Supplies.

Mental or Nervous Disorders and Substance Use Disorder Treatment.

Negligence.

No Charge.

Non-Compliance.

Non-Emergency Hospital Admissions.

Non-Emergency Use of Emergency Room.

Not Medically Necessary.

Not Specified as Covered.

Nutritional Supplements.

Occupational Injury.

Occupational Therapy.

Outpatient Rehabilitation Services.

Outpatient Services or Surgery.

Personal Convenience Items.

Physical Therapy.

Physician Care.

Pregnancy.

Private Duty Nursing.

Professional (and Semi-Professional) Athletics.

Radiation Services.

Self-Inflicted.

Services Before or After Coverage.

Skilled Nursing Facility Care.

Sleep Studies.

Speech Therapy.

Sterilization Services.

Transplant Services.

Travel or Accommodations.

Urgent Care.

Travel or Accommodations.

War.

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TRES

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