INZURIA HEALTH
POWERED BY GoAskJay

LBP Gold 3 – ALL 50 STATES

Coverage Period: 01/01/2019-12/31/2019
Coverage for: All Tiers | **Plan Type:** PPO
Summary of Benefits and Coverage: What this Plan Covers & What it Costs

This is only a summary

If you want more detail about your coverage and costs, you can get the complete terms in the Summary Plan Description (SPD) or by calling (844) 450-8111.

Important Questions	Answers	Why This Matters
What is the overall deductible?	$0	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific benefits?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	No.	There's no limit on how much you could pay during a coverage period for your share of the costs of covered services.
What is not included in the out-of-pocket limit?	This plan has no out-of-pocket limit.	Not applicable because there's no out-of-pocket limit on your expenses.
Is there an overall annual limit on what the plan pays?	No Annual Limit	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of preferred providers, see www.firsthealthlbp.com or call (844) 450-8111.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Limited coverage is available for out-of-network providers. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a specialist?	Yes. You do need a referral to see a specialist.	You can see the specialist you choose with Prior Authorization. Call (844) 450-8111
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about excluded services.

- Copayments are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- Co-pay After Deductible or % After Deductible (Responsibility Share) is *your* share of the costs of a covered service, calculated as a percentage of the allowed amount for the service. For example, if the plan's allowed amount for an overnight hospital stay is $1,000, your responsibility share payment of 40% would be $400. This may change if you haven't met your deductible.
- The amount the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the allowed amount is $1,000, you may have to pay the $500 difference. (This is called balance billing.)
- This plan may encourage you to use in-network providers, by charging you lower deductibles, copayments and responsibility share amounts. Out-of-network providers may be nominated to be invited to integrate the plans' Provider network.
- Maximum-Out-of-Pocket is the same as out-of-pocket limit. The out-of-pocket limit is the *most* you could pay for your share of the cost of covered services during a coverage period that ends 365 days after your effective date. Therefore, the out-of-pocket limit starts over every 365 days.

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Preventive care / screening / immunization	No Charge Lab-Office	Not Covered	Services are limited to those mandated by the Patient Protection Affordable Care Act. See the attached Wellness & Preventive Services Summary Addendum.
	Primary care visit to treat injury or illness	$15.00 Copay	Not Covered	Use in-network providers only. Six visits a year per participant.
	Specialist visit	$35.00 Copay	Not Covered	Limited to Six visits a year per participant. Prior Authorization Call (844) 450-8111
	Other practitioner office visit	N/A	Not Covered	Not Covered

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
If you have a test	HIV screening	No Charge	Not Covered	Once a year, adolescents and adults at increased risk for HIV infection.
	Blood pressure screening in adults and children	No Charge	Not Covered	Once a year for ages 0-18+
	Autism screening: children	No Charge	Not Covered	Once a year from 18-24 months.
	For Preventive Care / Screening or Immunization	No Charge	Not Covered	See the attached Wellness & Preventive Services Summary Addendum.
	Diagnostic Test (x-ray, blood work)	No Charge	Not Covered	Preventive Care Only at no cost. Copay applies to additional exams.
	Imaging (CT/PET Scans/MRI)	No Charge	Not Covered	Preventive Care Only. Breast & Cervical exam. Preauthorization required. Copay applies.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.themedaccessnetwork.com Or call (844) 450-8111	Generics and Tier 1	No Cost	No Cost	Limited to prescribed covered medication
	Tier 2 – Preferred Brands and Non- Preferred Generics	$35 Copay	$35 Copay	Limited to prescribed covered medication.
	Tier 3 – Non-Preferred Brands	$35 Copay	$35 Copay	Limited to prescribed covered medication.
	Tier 4 – Specialty Brand Generic	Not Covered	Not Covered	Not Covered
	Tier 5 – Specialty Brand Non-Generic	Not Covered	Not Covered	Not Covered

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not Covered	Not Covered	None
	Physician/surgeon fees	Not Covered	Not Covered	None
If you need immediate medical attention	Emergency room services	Limited Coverage	Not Covered	Hospital admission will be covered up to $2,000 once per year.
	Emergency medical transportation	Not Covered	Not Covered	None
	Urgent care	Not Covered	Not Covered	Covered under specialty visit
If you have a hospital stay	Facility fee (e.g. ambulatory surgery center)	Limited Coverage	Not Covered	Plan will pay $300 towards stay. After 24 hours (maximum 14 days).
	Emergency Room for Injuries	Limited Coverage	Not Covered	$500 Per injury.
	Physician/surgeon fee	Not Covered	Not Covered	None
If you have mental health, behavioral health, or substance abuse needs	Depression screening: adolescents and adults	$45.00 Copay	Not Covered	Limited to 1 screening annually. Additional care covered under Telemedicine
	Mental/Behavioral health in-patient services	$45.00 Copay	$70.00	Limited to 8 visits annually. Additional care covered under Telemedicine
	Tobacco use screening counseling and interventions	No Charge	Not Covered	Once a year, adults and pregnant women who uses tobacco. Additional care covered under Telemedicine
	Behavior assessment: children	No Charge	Not Covered	Once a year, 0-17 years. Additional care covered under Telemedicine
	Alcohol misuse counseling	No Charge	Not Covered	Once a year. Additional care covered under Telemedicine
If you are pregnant	Prenatal and postnatal care	Minimal Coverage	Not Covered	None. Covered as a primary or specialty visit.

	Gestational diabetes screening	No Charge	Not Covered	Once a year, women 24-28 weeks pregnant and those at high risk of developing gestational diabetes.
	Hypothyroidism screening: newborns	No Charge	Not Covered	Once a year.
	Anemia screening pregnant women	No Charge	Not Covered	Once a year symptomatic pregnant woman.
	Breastfeeding counseling	No Charge	Not Covered	Twice a year; to assist parent(s) of the child once during the pregnancy and once postpartum.
	Bacteriuria screening: pregnant women	No Charge	Not Covered	Once a year, pregnant women at 12-16 weeks of gestation or at the first prenatal visit.
	Contraception	No Charge	Not Covered	As prescribed, FDA approved methods, sterilization procedures, not including abortifacient drugs.
	Well women visit	No Charge	Not Covered	1 time per year, women only.
	Delivery and all inpatient services	Not Covered	Not Covered	None
	Critical Care & Illness	Limited Coverage	Not Covered	Plan will pay $10,000 per critical Care & illness, once a year. Physician Medical Summary required.
	Home health care	Not Covered	Not Covered	None. Additional Telemedicine Coverage
If you need help recovering or have other special health needs	Rehabilitation services	Not Covered	Not Covered	None
	Habilitation services	Not Covered	Not Covered	None
	Skilled nursing care	Not Covered	Not Covered	None
	Medical equipment	Not Covered	Not Covered	None
	Hospice Service	Not Covered	Not Covered	None

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
If your child needs dental or eye care	Eye Exam	No Charge	Not Covered	Limited to one exam every 24 months.
	Glasses	Not Covered	Not Covered	None
	Dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services. Some of these may be purchased additionally as a rider. Please refer to **www.themedaccessnetwork.com** for more information.		
Chiropractic care	Infertility treatment	Routine eye care (Adult)
Bariatric surgery	Long-term care	Routine foot care
Cosmetic surgery	No non-network services covered outside of Network areas	Weight loss programs
Dental care	Non-emergency care when traveling outside the U.S.	
Hearing aids	Private-duty nursing	

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)
Eye Exam for dependent children 18 years and younger.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a monthly contribution, which may be significantly higher than the monthly contribution you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

Federal and State laws may provide protections that allow you to keep this health plan coverage if you pay your monthly contribution. There are exceptions, such as, if:

- You commit fraud
- The health plan carrier stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the health plan carrier at (844) 450-8111

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact:

ATTN: Grievances and Appeals
MEDA ACCESS NETWORK
4572 Executive Square, Suite 200
La Jolla, CA 92037

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Si necesita ayuda en Español, le suplicamos que se ponga en contacto con su Miembro Asociado Representante de membresía o con el administrador de su grupo. Si ya está inscrito, le rogamos que llame al número de servicio de atención al cliente que aparece en su tarjeta de identificación, o al (844) 450-8111.

About These Coverage Examples

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is NOT a Cost Estimator

THIS IS A MEC. Do **NOT** use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a Baby (normal delivery)

- **Amount owed to providers**: $7,540
- **Plan pays:** $4,915
- **Patient pays:** $2,625

Sample care costs	
Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays	
Copays	$200
Deductibles	$2,425
Total	**$2,625**

Managing Type 2 Diabetes (routine maintenance of well-controlled condition)

- **Amount owed to providers:** $5,300
- **Plan pays:** $2,350
- **Patient pays:** $2,950

Sample care costs	
Prescriptions (Tier 3, 4)	$2,900
Medical Equipment	$1,300
Office Visits (5)	$700
Education	$300
Laboratory Tests (diagnostic)	$100
Total	**$5,300**

Patient Pays	
Copays	$300
Responsibility Share	$1,050
Services not Included	$1,600
Total	**$2,950**

Questions and answers about the Coverage Examples

What are some of the assumptions behind the Coverage Examples?

- Costs assume individual only coverage.
- Costs don't include monthly contributions.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments and Responsibility Share can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered, or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the monthly contribution you pay. Generally, the lower your monthly contribution, the more you will pay in the out-of-pocket costs, such as copayments, deductibles, and Responsibility Share. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.