MVP – Minimum Value Plan

Coverage Period: 01/01/2019-12/31/2019
Coverage for: All Group 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 Evidence of Coverage or by calling (844) 450-8111.

Important Questions	Answers	Why This Matters
What is the overall deductible?	$5,000 Individual coverage; $12,700 Family coverage for In-Network Providers. $10,000 Individual coverage; $25,400 Family coverage for Out-of-Network Providers. Does not apply to in-network Wellness and Preventive Care.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. The deductible starts over at your plan's annual anniversary from the effective date of enrollment. See the chart starting on page 3 for how much you pay for covered services after you meet the deductible.
Are there other deductibles for specific benefits?	No. There are no other specific deductibles.	You do not have to meet deductibles for specific services, but see the chart starting on page 3 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes; $6,350 Individual coverage; $12,700 Family coverage for In-Network Providers. $12,700 Individual coverage; $25,400 Family coverage for Out-of-Network Providers. (Includes Deductibles)	The out-of-pocket limit, also called the Maximum-Out-of-Pocket, is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services that ends 365 days after your effective date. This limit helps you plan for health care expenses for a certain time period.
What is not included in the out-of-pocket limit?	Monthly cost for the plan, balance-billed charges, benefit reductions, amounts greater than maximum benefits, amounts greater than reasonable and customary charges, prescription drug and healthcare this plan doesn't cover.	Even though you pay these expenses, they don't count toward your deductible or out-of-pocket limit.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 3 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, visit 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. Out-of-network providers can be nominated to be invited to integrate the plans network. See the chart starting on page 3 for how this plan pays different kinds of providers.
Do I need a referral to see a specialist?	Yes. You need to consult with your Primary Care Physician and get a written referral to see certain specialists. There may be some providers or services for which referrals are not required.	This plan will pay some or all of the costs to see a specialist for covered services, but only if referred by your Primary Care Physician; unless the visit result is part of routine or preventive care examinations, or the result of a consultation or service in an emergency situation. Please, refer to page 3 for required referrals for services.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 7. 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	50% after deductible	Coverage at 100% for In-Network Providers. Annual Wellness consultations starting on your plan's effective date.
	Primary care visit to treat injury or illness	$25 Copay	50% after deductible	Coverage for In-Network Providers only. Limited Coverage for out-of-network providers.
	Specialist visit	$45 Copay	50% after deductible	No referral required for Specialist providing Preventive Care/Screening or Immunization, or chronic care after first referral.
	Other practitioner office visit	$45 Copay	Not Covered	Pre-Authorization Required. Limited Services.

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	Diagnostic test (x-ray, blood work)	30% after deductible	50% after deductible	X-Ray – Office Visit for Reading Covered as Office Visit; Reading Fee as Diagnostic Test. Deductible applies.
	Imaging (CT/PET scans/MRI)	30% after deductible	50% after deductible	Deductible 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	$10 copay	50% after deductible	Covers up to 30-day supply
	Tier 2 – Generic / Non-Preferred / Non-Preferred Generic	$35 copay	50% after deductible	Covers up to 30-day supply
	Tier 3 – Non-Preferred Brands	$60 copay	50% after deductible	Covers up to 30 or 90-day supply
	Tier 4 – Specialty Brand Generic	Not Covered	Not Covered	Formulary does not carry Tier 4 Medicines. These may be covered on a case by case basis with Primary Care or Specialist recommendation and approval from Plan.
	Tier 5 – Specialty Brand Non-Generic	Not Covered	Not Covered	Formulary does not carry Tier 5 Medicines. These may be covered on a case by case basis with Primary Care or Specialist recommendation and approval from Plan.

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)	30% after deductible	50% after deductible	None
	Physician/surgeon fees	30% after deductible	50% after deductible	None
If you need immediate medical attention	Emergency room services	30% after deductible	50% after deductible	None
	Emergency medical transportation	30% after deductible	50% after deductible	None
	Urgent care	$75 copay and 30% after the deductible	50% after deductible	None
If you have a hospital stay	Facility fee (e.g. ambulatory surgery center)	30% after deductible	50% after deductible	Coverage for inpatient rehabilitation and skilled nursing services combined in-network providers is limited to 40 visits per benefit period. Deductible applies.
	Physician/surgeon fee	30% after deductible	50% after deductible	None
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	30% after deductible	50% after deductible	Coverage for Mental Health/Behavioral inpatient services are limited to 120 days per benefit period. Deductible applies.
	Mental/Behavioral health inpatient services	30% after deductible	50% after deductible	None
	Substance use disorder outpatient services	30% after deductible	50% after deductible	None
	Substance use disorder inpatient services	30% after deductible	50% after deductible	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 you are pregnant	Prenatal and postnatal care	No charge	50% after deductible	Deductible applies out-of-network
	Well baby visits	No charge	50% after deductible	Deductible applies out-of-network
	Delivery and all inpatient services	30% after deductible	50% after deductible	Other cost shares may apply depending on services provided.
If you need help recovering or have other special health needs	Home health care	30% after deductible	50% after deductible	Coverage for in-network providers is limited to 60 visits per benefit period. Deductible applies.
	Rehabilitation services	30% after deductible	50% after deductible	Coverage for physical therapy and occupational therapy combined is limited to 20 visits per benefit period and speech therapy is limited to 20 visits per benefit period. Deductible applies.
	Habilitation services	30% after deductible	50% after deductible	Coverage for physical therapy and occupational therapy combined is limited to 20 visits per benefit period and Speech Therapy is limited to 20 visits per benefit period. Deductible applies.
	Skilled nursing care	30% after deductible	50% after deductible	Coverage for inpatient rehabilitation and skilled nursing services combined in-network providers is limited to 60 visits per pay period. Deductible applies.
	Durable medical equipment	Not Covered	Not Covered	None
	Hospice Service	30% after deductible	50% after deductible	Deductible applies. Pre-authorization required.

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	50% after deductible	Deductible applies. 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.		
Acupuncture	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.	Wellness programs
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.)
Chiropractic care

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

Don't 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.