# MEC 1 – ALL 50 STATES

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

Coverage Period: 01/01/2022-12/31/2022
**Plan Type:** PPO

**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 (855) 422-8527.

| 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 do not 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 is 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 since there is 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. PHCS, Multiplan, Star Healthcare Network. Visit www.multiplan.com<br>Select PHCS > Healthy Directions<br>Or<br>Select Multiplan > Practitioner & Ancillary to search the network. | If you use an in-network doctor or other health care provider, this plan will pay some or all the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. 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?** | No. | You can see the Specialist you choose that is within the network. |
| **Are there services this plan does not cover?** | Yes. | Some of the services this plan does not 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, $35) you pay for covered health care, usually when you receive the service.

| 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, Specialized Wellness, or Immunization Office Visit | Limited Coverage | Not Covered | Use in-network providers only. Does not include non-wellness & non-preventive care services. Please see page 6 for more information regarding Specialized Wellness. |
| | Primary care visit to treat injury or illness | $35.00 Copay | Not Covered | Use in-network providers only. Limited to one visit per year, per participant. |
| | Specialist visit | $40.00 Copay | Not Covered | Use in-network providers only. Limited to one visit per year, per participant. |
| | Other practitioner office visits | Telemedicine only | Telemedicine only | Services provided by MyTelemedicine are included in this plan but must be added upon request. Contact 1(855)422-8527 for more information. |

| 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 per year, adolescents, and adults at increased risk for HIV infection. |
| | Blood pressure screening in adults and children | No Charge | Not Covered | Once per year. |
| | Autism screening: children | No Charge | Not Covered | Once per year from 18-24 months. |
| | For Preventive Care, Routine Screening, or Immunization | No Charge | Not Covered | See the attached Wellness & Preventive Services Summary Addendum. |
| | Diagnostic Test (x-ray, blood work) & Imaging (CT/PET Scans/MRI) | Limited Coverage | Not Covered | Limited to two diagnostic services per year, per participant. $75 max for each service. |
| **If you need drugs to treat your illness or condition** More information about prescription drug coverage is available at www.Atlashealthcare.org Or call (855) 422-8527 | Prescriptions | 0-80% of Savings | Not Applicable | Prescription card only. Please check with your local pharmacy to see what discounts are offered for you, or see https://www.goodrx.com/ for more information. |

| 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 | Limited to one visit per year, per participant. $100 max. |
| | Emergency medical transportation (ground only) | Limited Coverage | Not Covered | Limited to one use per year, per participant. $100 max. |
| | Urgent care | Limited Coverage | Not Covered | Limited to one visit per year, per participant. $75 max. |
| **If you have a hospital stay** | Facility fee (e.g. ambulatory surgery center) | Not Covered | Not Covered | None |
| | Emergency Room with admission | Not Covered | Not Covered | None |
| | Physician/surgeon fee | Not Covered | Not Covered | None |
| **If you have mental health, behavioral health, or substance abuse needs** | Depression screening: adolescents and adults | Telemedicine Only | Not Covered | Service(s) may be covered at no additional cost through MyTelemedicine. |
| | Mental/Behavioral health out-patient services | Telemedicine Only | Not Covered | Service(s) may be covered at no additional cost through MyTelemedicine. Ages 18 and older. |
| | Tobacco use screening counseling and interventions | Telemedicine Only | Not Covered | Service(s) may be covered at no additional cost through MyTelemedicine. Ages 18 and older. |
| | Behavior assessment: children | Telemedicine Only | Not Covered | Service(s) may be covered at no additional cost through MyTelemedicine. |
| | Alcohol misuse counseling | Telemedicine Only | Not Covered | Service(s) may be covered at no additional cost through MyTelemedicine. Ages 21 and older. |

| 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 | Not Covered | Not Covered | None |
| | Gestational diabetes screening | No Charge (Preventative Only) | Not Covered | Once a year, women who are after 24-weeks pregnant and those at high risk of developing gestational diabetes. |
| | Hypothyroidism screening: newborns | No Charge (Preventative Only) | Not Covered | Once a year. |
| | Anemia screening pregnant women | No Charge (Preventative Only) | Not Covered | Once a year symptomatic pregnant woman. |
| | Breastfeeding counseling | Not Covered | Not Covered | None |
| | Bacteriuria screening: pregnant women | No Charge (Preventative Only) | Not Covered | Once a year, pregnant women at 12-16 weeks of gestation or at the first prenatal visit. |
| | Contraception | No Charge (Preventative Only) | Not Covered | As prescribed, FDA approved methods and sterilization procedures, not including abortifacient drugs. |
| | Well women visit | Apply to Office Visit | Not Covered | One time per year, women only. |
| | Delivery and all inpatient services | Not Covered | Not Covered | None |
| **If you need help recovering or have other special health needs** | Critical Care & Illness | Not Covered | Not Covered | None |
| | Home health care | Not Covered | Not Covered | None |
| | 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. For dependent children 18 years and younger. |
| | Glasses | Not Covered | Not Covered | None |
| | Dental check-up | Not Covered | Not Covered | None |

## Excluded Services:

**Services Your Plan Does NOT Cover** (This is not 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.Atlashealthcare.org for more information.

- Chiropractic care
- Bariatric surgery
- Cosmetic surgery
- Dental care
- Hearing aids
- Infertility treatment
- Long-term care
- Out-of-network services are NOT covered.
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

**Restrictions/Limitations & Other Covered Services** (This is not a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- **Specialized Wellness includes the following: Colonoscopy, Shingles, Low-dose CT Scans, Mammography, and Osteoporosis. Each item has a maximum coverage of $200.**
- Service provided through MyTelemedicine (call for activation).

## 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 (855) 422-8527.

## 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 in writing. For questions about your rights, this notice, or assistance, contact us:

ATTN: Grievances and Appeals
Atlas Health Care
P.O. Box 3257
Clovis, CA 93613

## 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 (855) 422-8527.

## 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.

### Routine (Colonoscopy)

- **Amount owed to providers**: $3,700
- **Plan pays:** $200
- **Patient pays:** $3,500

### This is NOT a cost estimator

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.

**Sample care costs:**

| | |
|---|---|
| Facility Fee | $1,000 |
| Anesthesia Fee | $700 |
| Laboratory Fee | $300 |
| Surgeon's Fee | $1,700 |
| | |
| **Total** | **$3,700** |

**Patient pays:**

| | |
|---|---|
| Copays | $0 |
| Deductibles | $0 |
| Services not covered | $3,500 |
| **Total** | **$3,500** |

## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs assume individual only coverage.
- Costs do not include monthly contributions.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services and are not specific to a 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 is not 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 cannot 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 will 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.