MotivHealth Insurance Company: HSA 2000

Coverage Period: 09/01/2020-08/31/2021

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

Coverage for: Individual + Family | Plan Type: PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-844-234-4472. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$2,000 person/$4,000 family. Doesn't apply to preventative care. For non-participating providers $4,000 person/ $8,000 family.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. For your policy, the deductible starts over January 1st. See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Are there services covered before you meet your deductible?	Yes.	Some covered services may be paid prior to meeting the **deductible**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Are there other deductibles for specific services?	There are no specific deductibles.	
What is the out-of-pocket limit for this plan?	For participating providers $6,000 person/ $6,850 family For non-particpating providers $12,000 person/$24,000family	The **out-of-pocket limit**, sometimes referred to as the **Maximum Out Of Pocket (MOOP)** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, difference between billed and allowed amounts, health care this plan doesn't cover, and ineligible expenses.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Will you pay less if you use a network provider?	Yes. See **www.MotivHealth.com** or call **1-844-234-4472** for a list of participating providers.	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. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do you need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.

MotivHealth Insurance Company: HSA 2000

Coverage Period: 09/01/2020-08/31/2021

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

Coverage for: Individual + Family **| Plan Type:** PPO

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% After Deductible	40% After Deductible	
	Specialist visit	20% After Deductible	40% After Deductible	
	Preventive care/ screening/immunization	No charge	No charge up to allowed amount	
If you have a test	Diagnostic test (x-ray, blood work)	20% After Deductible	40% After Deductible	
	Imaging (CT/PET scans, MRIs)	20% After Deductible	40% After Deductible	Prior authorization applies
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.motivhealth.com	Generic drugs	20% After Deductible	40% After Deductible	
	Preferred brand drugs	20% After Deductible	40% After Deductible	
	Non-preferred brand drugs	20% After Deductible	40% After Deductible	
	Specialty drugs	20% After Deductible	40% After Deductible	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% After Deductible	40% After Deductible	
	Physician/surgeon fees	20% After Deductible	40% After Deductible	
If you need immediate medical attention	Emergency room care	20% After Deductible	20% After Deductible	Out-of-network utilization of these benefits will apply to in network benefits up to allowed amount
	Emergency medical transportation	20% After Deductible	20% After Deductible	Out-of-network utilization of these benefits will apply to in network benefits up to allowed amount
	Urgent care	20% After Deductible	40% After Deductible	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% After Deductible	40% After Deductible	Pre-cert is required except for maternity care.
	Physician/surgeon fees	20% After Deductible	40% After Deductible	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% After Deductible	40% After Deductible	Facility charges require prior authorization.
	Inpatient services	20% After Deductible	40% After Deductible	
If you are pregnant	Office visits	20% After Deductible	40% After Deductible	
	Childbirth/delivery professional services	20% After Deductible	40% After Deductible	Home births are not covered.

MotivHealth Insurance Company: HSA 2000

Coverage Period: 09/01/2020-08/31/2021

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

Coverage for: Individual + Family **| Plan Type:** PPO

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Childbirth/delivery facility services	20% After Deductible	40% After Deductible	Home births are not covered.
If you need help recovering or have other special health needs	Home health care	20% After Deductible	40% After Deductible	
	Rehabilitation services	20% After Deductible	40% After Deductible	Services have quantity limitations of 20 of each type of service per policy year.
	Chiropractic services	20% After Deductible	40% After Deductible	Limited to 20 visits per year
	Habilitation services	20% After Deductible	40% After Deductible	
	Skilled nursing care	20% After Deductible	40% After Deductible	Limited to 30 days per year
	Durable medical equipment	20% After Deductible	40% After Deductible	
	Hospice services	No charge	40% After Deductible	
If you need eye care	Eye exam	20% After Deductible	40% After Deductible	Limited to one exam per year.
	Children's glasses	20% After Deductible	40% After Deductible	Limited to one pair of glasses per year. Benefit not to exceed $150.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic Surgery
- Dental Care
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Private-duty nursing

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Nutrition Counseling
- Smoking Cessation

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. Please contact MotivHealth at 1-844-234-4472 to understand your rights. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-801-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact MotivHealth at 1-844-234-4472.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al 1-844-234-4472.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-234-4472.]

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-844-234-4472.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-844-234-4472.]

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

MotivHealth Insurance Company: HSA 2000

Coverage Period: 09/01/2020-08/31/2021

Coverage Examples

Coverage for: Individual + Family **| Plan Type:** PPO

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$2,000
Specialist	20%
Hospital (facility)	20%
Other	20%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$7,540**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$0
Coinsurance	$1,108
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$3,108**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$2,000
Specialist	20%
Hospital (facility)	20%
Other	20%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$5,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$2
Coinsurance	$680
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2,682**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$2,000
Specialist	20%
Hospital (facility)	20%
Other	20%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$2,000**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,000**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Questions: Call **1-844-234-4472** or visit us at **www.MotivHealth.com**.
If you aren't clear about any of the underlined terms used in this form, see the Glossary.
You can view the Glossary at https://www.healthcare.gov/sbc-glossary.