health options plus

health options 3500

Schedule of Benefits

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MEDICAL BENEFITS	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
MAXIMUM LIFETIME BENEFIT AMOUNT	Unlimited	

DEDUCTIBLE, PER CALENDAR YEAR		
Per Covered Person	$3,500	$7,000
Per Family Unit	$7,000	$14,000

The Calendar Year Deductible is waived for the following Covered Charges:

- Preventative Care
- Telemedicine Services
- Sterilization for Women
- Selected Medical Second Opinions
- Services to which a Copayment Apply
- Supplementary Accident Coverage

Network and Non-Network Deductible amounts are considered to be totally separate and will not contribute to or offset each other. A covered person may be required to satisfy both Network and Non-Network Deductible amounts.

COINSURANCE, PER CALENDAR YEAR		
Per Covered Person	$2,500	$5,000
Per Family Unit	$5,000	$10,000
Coinsurance Percentage Paid by Plan	70%	50%
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR, INCLUDING THE CALENDAR YEAR DEDUCTIBLE		
Per Covered Person	$6,000	$12,000
Per Family Unit	$12,000	$24,000

The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise.

Network and Non-Network out-of-pocket amounts are considered to be totally separate and will not contribute to or offset each other. A covered person may be required to satisfy both Network and Non-Network out-of-pocket amounts.

The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%.

- Cost containment penalties

Charges for benefits paid at 100% do not apply to the maximum out-of-pocket.

COPAYMENTS		
Physician Visits	$50	N/A
Specialist Visits	$75	N/A
Per Inpatient Admission	$250 per day (5 day max); Deductible and Coinsurance apply	N/A
Skilled Nursing Facility	$50 per day; Deductible and Coinsurance apply	N/A
Advanced Imaging (CT/PET Scans, MRI, etc)	$250; Deductible and Coinsurance apply	N/A
Emergency Room	$500; waived if admitted	$500; waived if admitted

The Physician and Specialist visit copayment is for the office visit, basic laboratory (including diagnostic and laboratory services ordered by the network physician at an outside facility), received in the physician's office for each day of service. Office visit copayment excludes surgical procedures, cardiovascular procedures, chemotherapy/radiation therapy, infusion therapy, and advanced imaging.

COVERED CHARGES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Hospital Services		
Room and Board	70% after Copayment and Deductible; Private Room Rate	50% after Copayment and Deductible; Private Room Rate
Intensive Care Unit	70% after Copayment and Deductible; Private Room Rate	50% after Copayment and Deductible; Private Room Rate
Physician Services		
Inpatient visits	70% after Deductible	50% after Deductible
Office visits	100% after Copayment	50% after Deductible
Surgery	70% after Deductible	50% after Deductible
Skilled Nursing Facility	70% after Deductible; Private Room Rate	50% after Deductible
Home Health Care	70% Deductible	50% after Deductible
Hospice Care	70% Deductible	50% after Deductible
Skilled Nursing Facility, Home Health Care and Hospice are each paid for a maximum of 120 days per calendar year.		
Ambulance Service	70% after Deductible	50% after Deductible
Emergency Room	70% after Copayment and Deductible	50% after Copayment and Deductible
Urgent Care Facility	70% after Deductible	50% after Deductible
Advanced Imaging (CT/PET Scans, MRI, etc)	70% after Copayment and Deductible	50% after Deductible
Occupational Therapy	70% after Deductible	50% after Deductible
Speech Therapy	70% after Deductible	50% after Deductible
Physical Therapy	70% after Deductible	50% after Deductible
Durable Medical Equipment	70% after Deductible	50% after Deductible
Prosthetics & Orthotics	70% after Deductible	50% after Deductible
Spinal Manipulation Chiropractic	Not Covered	Not Covered
Mental Disorders	Not Covered	Not Covered
Substance Abuse	Not Covered	Not Covered
Sterilization	100%	100%
For women, as required by law.		
Organ Transplants	50% after Deductible*	50% after Deductible*
Bariatric Procedures	50% after Deductible*	50% after Deductible*
Dialysis	50% after Deductible*	50% after Deductible*
*For Bariatric Procedures, Organ Transplants and Dialysis, all providers, including PPO Network Providers, are considered to be Non-Network unless there is a rate contracted with or charges are approved by an IMA approved repricing source.		
Preventative Care		
Routine Well Care	100%	Not Covered
Includes, but is not limited to, immunizations/flu shots and routine well child care. Also covered under this benefit is preventative care as required by law.		
Preventive Services and Procedures	100%	Not Covered
Include only services/procedures that have a rating of A or B from the U.S. Preventive Services Task Force (USPSTF). Services are covered based upon age and gender and at the intervals as recommended by the USPSTF. Services/procedures include but are not limited to adult and child routine annual physical exam, mammogram, pap smear, cholesterol testing, prostate screening, colonoscopy, immunizations.		
Maternity		
Pregnancy	70% after Deductible	50% after Deductible
Global Billing services are not subject to copayment. Dependent daughters not covered.		
Routine Well Newborn Care	70% after Deductible	50% after Deductible
Subject to Plan enrollment. Preventive Services are covered at 100% for Network Providers under the Preventive Care section.		

Additional Benefits
Supplementary Accident Charge Benefit — First $500 per Member payable at 100%.
The Prevention Plan™ —Wellness, Prevention, Biometric Testing and Health Coach through US Preventive Medicine, Inc.
AmeriDoc™ Telemedicine Benefit — First 3 calls per member at No Charge; additional calls at $30 per call.

PRESCRIPTION DRUG BENEFITS

	FIRST CHOICE PHARMACY NETWORK	NON-NETWORK PROVIDERS
Deductible	$350 per Family	$350 per Person; $1,050 Family Maximum
Tier 1 - Generic	$0-$5 Copayment	$10 Copayment
Tier 2 - Formulary	$35 Copayment	Greater of: $50 or 30% Copayment
Tier 3 – Non-Formulary	$55 Copayment	Greater of: $75 or 50% Copayment

- Deductible Waived for Tier 1 Generic prescriptions.
- Immunizations are covered under the Prescription Benefit.
- Deductible is separate from Medical Deductible.
- Deductible and Copayments apply toward Out-of-Pocket Maximum.
- 90 day supply available at Retail Pharmacy or Mail Order.

DECLINING DEDUCTIBLE

The Declining Deductible is a feature that is unique to Health Options Plus™ plans and is included at no additional charge. Employees and their families can earn Declining Deductible Credits each month that they have limited medical claims and do something positive for their health such as having a preventive screening or completing an online health risk assessment or work with a health coach. Credits that are not used by the end of the Plan Year will automatically carry over to the next Plan Year. Each family member can earn a maximum of $1,400 in Declining Deductible credits in the first year of plan participation.

For example, if a person has a $2,000 Deductible plan and has earned a $1,400 Declining Deductible Credit, they will then only be required to pay the first $600 of the Deductible and the credit will be used to offset the balance. Credits can be used to reduce Network or Non-Network charges but cannot be applied against Preferred Network charges. Declining Deductible Credits that are earned by an adult will also be applied to minor children. Adult children ages 18-26 are able to earn their own Declining Deductible Credits.

By earning Declining Deductible Credits employees and their dependents will have access to Network and Out-of-Network providers with lower out-of-pocket costs. Best of all, the Declining Deductible credit motivates employees to be proactive in improving their health and gives all employees the opportunity to have a Gold level health plan at Bronze plan pricing.

This Schedule of Benefits is part of the Summary Plan Description (SPD) but does not replace it. Many words are defined elsewhere in the SPD, and other limitations or exclusions may be listed in other sections of the SPD. Reading this Schedule by itself could give you an inaccurate impression of the terms of coverage. Prior authorization may be required for specific services.

- **Deductible Three Month Carryover.** Each January 1st, a new Deductible amount is required. However, covered Charges incurred in, and applied toward the participant's individual Deductible in October, November and December will be applied toward the participant's individual Deductible in the next Calendar Year.
- **Family Unit Limit.** When the maximum amount shown in the Schedule of Benefits has been incurred by members of a Family Unit toward their Calendar Year deductibles, the deductibles of all members of that Family Unit will be considered satisfied for that year.
- The applicable Copay, Deductible and/or Coinsurance applies to every physician office visit.