

MotivHealth Insurance Company Outline of Coverage

Read Your Policy Carefully - This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

Major medical expense coverage is designed to provide, to persons insured, comprehensive coverage for major hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, and out-of-hospital care, subject to any deductibles, copayment provisions, or other limitations that may be set forth in the policy.

HSA Eligible plans

This plan has been designed to meet the IRS requirements to be compatible with Health Savings Accounts (HSA). An HSA is a tax favored savings account used in conjunction with High Deductible Health Plans (HDHPs) as defined by the IRS. You can use HSA dollars to pay for qualified health expenses such as your deductible, dental services, vision services, medications including some over the counter medications, and other expenses that may not be covered by your health plan. Dollars used from your HSA for health expenses are tax free.

Some basic rules regarding HSAs include:

- HSA funds belong to you and carry over from year to year even if you no longer have a High Deductible Health Plan (HDHP).
- For 2022, an individual can contribute up to \$3,650 into their HSA per year.
- For 2022 a family plan allows you to contribute up to \$7,300 into their HSA per year.
- For those age 55 and over, an extra “catch up” provision allows you to contribute an extra \$1,000 per year.
- Money contributed to your HSA may be a tax deduction when contributed on your behalf.
- Any earnings in your HSA are tax free.
- After age 65, the funds can be used for any purpose and you only pay income tax on the amount taken out of the account when the funds are not used for medical expenses.

See IRS publication 502 and Publication 969 for more information about HSAs.

Deductible

The deductible is the amount in a calendar year that you are responsible before MotivHealth Insurance Company begins to pay benefits. The deductible does not apply for benefits shown as not applicable to the deductible below such as for preventive services.

The deductible amount on this policy is:

\$2,800 for individual policies and \$5,600 for family policies for In Network
\$5,000 for individual policies and \$10,000 for family policies for Out of Network

For individual policies, once the deductible is met, benefits will become payable. For family policies, benefits become payable for any individual that has met the individual deductible amount. Benefits become payable for all covered family members once the family deductible has been met.

Coinsurance

Coinsurance is the amount, represented as a percentage, which **you** are responsible for after the deductible is met. The remaining amount is paid by MotivHealth Insurance Company.

The In Network Coinsurance amount for this policy is: 20%
The Out of Network Coinsurance amount for this policy is: 50%

Maximum Out of Pocket (MOOP)

The Maximum Out of Pocket is the limit for which you are responsible for. This limit doesn't include any services that are not eligible, such as dental services or any amount above the Maximum Allowable Fee. Once you reach the MOOP, eligible benefits will be paid at 100% for the remainder of the calendar year.

The Maximum Out of Pocket for this policy is:

\$3,000 for individual policies and \$6,000 for family policies for In Network
\$10,000 for individual policies and \$20,000 for family policies for Out of Network

For individual policies, once the Maximum Out of Pocket is met, eligible benefits will be paid at 100% for the remainder of the calendar year. For family policies, eligible benefits will be paid at 100% for the remainder of the calendar year for any individual that has met the individual Maximum Out of Pocket amount, even if it is less than the family deductible, eligible benefits will be paid at 100% for the remainder of the benefit year for that individual. Eligible benefits will be paid at 100% for the remainder of the calendar year once all amounts met towards Maximum Out of Pocket for all family members combined equals the family Maximum Out of Pocket amount.

The following chart gives information about cost sharing for your plan. However, please see the Policy for more details including limitation, exclusions, and prior authorization requirements that may not be listed here.

Services			
Inpatient Service	In Network	Out of Network	Benefit Notes/Limitations
Inpatient Hospital Services (e.g., Hospital Stay)			Daily hospital room and board, and other misc. costs. Facility benefits must be preauthorized.
Inpatient Physician and Surgical Services	20% After Deductible	50% After Deductible	
Skilled Nursing Facility			Skilled Nursing Facility limited to 30 days per Policy year. Facility benefits must be preauthorized.
Transplant			
Outpatient Service	In Network	Out of Network	Benefit Notes/Limitations
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)			Facility benefits must be preauthorized.
Outpatient Surgery Physician/Surgical Services	20% After Deductible		
Dialysis	in hospital 10% After Deductible	50% After Deductible	
Hospice Services	in ambulatory surgical center		Hospice services are limited to 6 months per every 3 years.
Home Health Care Services			Home Health Care Services are limited to 30 visits per Policy year. A visit is defined as up to 4 hours.
Professional Services	In Network	Out of Network	Benefit Notes/Limitations
Primary Care Visit to Treat an Injury or Illness	20% After Deductible		
Specialist Visit	20% After Deductible	50% After Deductible	Services must be rendered by a professional working within the scope of their license to be eligible.
Other Practitioner Office Visit (Nurse, Physician Assistant)	20% After Deductible		
Preventive Care	In Network	Out of Network	Benefit Notes/Limitations
Preventive Care/Screening/Immunization	No Cost	No Cost Up to Allowed Amount	Preventive Care and screenings are covered as required by the Affordable Care Act and may change from time to time.
Contraceptives			Contraceptives must be FDA approved to be eligible for coverage.

Diagnostic Lab and Imaging	In Network	Out of Network	Benefit Notes/Limitations
Imaging (CT/PET Scans, MRIs)	20% After Deductible	50% After Deductible	
Laboratory Outpatient and Professional Services	20% After Deductible		
X-rays and Diagnostic Imaging			
Urgent and Emergency Care	In Network	Out of Network	Benefit Notes/Limitations
Emergency Transportation/Ambulance	20% After Deductible up to a maximum of \$500	20% After Deductible up to a maximum of \$500	Emergency Transportation is limited to the nearest facility equipped to adequately care for needed emergency services. Emergency Services are covered only in case of emergency as determined by MotivHealth Insurance Company.
Emergency Room Services	20% After Deductible	20% After Deductible	
Urgent Care Centers or Facilities	20% After Deductible	50% After Deductible	
Maternity Services	In Network	Out of Network	Benefit Notes/Limitations
Prenatal and Postnatal Care	20% After Deductible	50% After Deductible	Home births are not covered
Delivery and All Inpatient Services for Maternity Care			
Mental Health/Substance Abuse Disorders	In Network	Out of Network	Benefit Notes/Limitations
Mental/Behavioral Health Outpatient Services	20% After Deductible	50% After Deductible	Facility charges require prior authorization.
Mental/Behavioral Health Inpatient Services	20% After Deductible		
Substance Abuse Disorder Outpatient Services	20% After Deductible		
Substance Abuse Disorder Inpatient Services	20% After Deductible		
Pharmacy	In Network	Out of Network	Benefit Notes/Limitations
Generic Drugs	1-30 days	Not covered	Some medications require quantity limitations. Some medications may require you to try other more effective medications before a medication will be eligible for coverage. Check the formulary for more details.
	31-90 days		
Preferred Brand Drugs	1-30 days	Not covered	
	31-90 days		
Non-Preferred Brand Drugs	1-30 days	Not covered	
	31-90 days		
Specialty Drugs	1-30 days	Not covered	
	31-90 days		

Habilitative and Rehabilitative Services	In Network	Out of Network	Benefit Notes/Limitations
Outpatient Rehabilitation Services Habilitative Services Rehabilitative Speech Therapy Rehabilitative Occupational and Rehabilitative Physical Therapy	20% After Deductible	50% After Deductible	Services have quantity limitations of 60 visits combined per policy year.
Chiropractic Services	20% After Deductible		Limited to 25 visits per policy year.
Vision Services	In Network	Out of Network	Benefit Notes/Limitations
Routine Eye Exam for children	No cost	50% After Deductible	One routine eye exam per year.
Other Services	In Network	Out of Network	Benefit Notes/Limitations
Allergy Testing	20% After Deductible	50% After Deductible	Treatment subject to review every 2 weeks. Limited to diagnostic services only. Limited per Women's Health and Cancer Rights Act.
Autism Spectrum Disorder	20% After Deductible	50% After Deductible	
Chemotherapy	20% After Deductible	50% After Deductible	
Diabetes Care Management	20% After Deductible	50% After Deductible	
Diabetes Education	20% After Deductible	50% After Deductible	
Durable Medical Equipment	20% After Deductible	50% After Deductible	
Infertility Treatment	20% After Deductible	50% After Deductible	
Infusion Therapy	20% After Deductible	50% After Deductible	
Inherited Metabolic Disorder - PKU	20% After Deductible	50% After Deductible	
Nutritional Counseling	20% After Deductible	50% After Deductible	
Prosthetic Devices	20% After Deductible	50% After Deductible	
Radiation	20% After Deductible	50% After Deductible	
Reconstructive surgery	20% After Deductible	50% After Deductible	

Refer to your Policy for more information. You can get more information by calling Customer Service at 844-234-4HSA (844-234-4472).

Many of these services require prior authorization as outlined in your Policy including, but not limited to Inpatient services, Outpatient services, Durable Medical Equipment, Prosthetic Devices, and some imaging services.

These benefits are subject to change to meet changes in state or federal law.