Medical

MotivHealth Insurance Company: Trad 3000
Sharp Transportation

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?	$3,000 person/$6,000 family. Doesn't apply to preventative care. For non-participating providers $6,000 person/ $12,000 family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services.
What is the out-of-pocket limit for this plan?	For participating providers $6,500 person/ $13,000 family. For non-particpating providers $13,000 person/$26,000 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, difference between billed and allowed amounts, healthcare 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.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the **specialist** you choose without a **referral**.

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	$25/visit	40% After Deductible	
	Specialist visit	$50/visit	40% After Deductible	
	Preventive care/ screening/immunization	No charge	No charge up to allowed amount	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Included in office copay	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	$10/prescription	40% After Deductible	$10 for 1-30 day supply/$25 for 31-90 day supply
	Preferred brand drugs	$35/prescription	40% After Deductible	$35 for 1-30 day supply/$87.5 for 31-90 day supply
	Non-preferred brand drugs	50%	40% After Deductible	
	Specialty drugs	25% (up to $250)	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	$250/visit	$250/visit	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	$$75./visit	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	

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 need mental health, behavioral health, or substance abuse services	Outpatient services	$25/visit	40% After Deductible	Facility charges require prior authorization.
	Inpatient services	20% After Deductible	40% After Deductible	
If you are pregnant	Office visits	$25/visit	40% After Deductible	
	Childbirth/delivery professional services	20% After Deductible	40% After Deductible	Home births are not covered.
	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	$50/visit	40% After Deductible	Limited to 20 visits per year
	Chiropractic services	$50/visit	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	20% After Deductible	40% After Deductible	
If you need eye care	Eye exam	No charge	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.)

- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care
- Hearing Aids
- Infertility Treatment
- Long-term Care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

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

- Chiropractic care limited to 20 visits per year

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for the Department of Labor's Employee Benefits Security Administration is 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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.

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	**$3,000**
Specialist	**$50**
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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,000
Copayments	$0
Coinsurance	$1,940
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$4,900**

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

The plan's overall deductible	**$3,000**
Specialist	**$50**
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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$3,000
Copayments	$0
Coinsurance	$520
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$3,500**

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

The plan's overall deductible	**$3,000**
Specialist	**$50**
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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,800
Copayments	$50
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,900**

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

MotivHealth Insurance Company: HSA 3000
Sharp Transportation

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?	$3,000 person/$6,000 family. Doesn't apply to preventative care. For non-participating providers $6,000 person/ $12,000 family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services.
What is the out-of-pocket limit for this plan?	For participating providers $5,000 person/ $10,000 family. For non-particpating providers $10,000 person/$20,000 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, difference between billed and allowed amounts, healthcare 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.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the **specialist** you choose without a **referral**.

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	Specialist visit	20% After Deductible	40% After Deductible	
	Preventive care/ screening/immunization	No charge	No charge up to allowed amount	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
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	$10/prescription After Deductible	40% After Deductible	$10 for 1-30 day supply/$25 for 31-90 day supply
	Preferred brand drugs	25% After Deductible	40% After Deductible	
	Non-preferred brand drugs	50% After Deductible	40% After Deductible	
	Specialty drugs	25% After Deductible (up to $250)	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.
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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
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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.
	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	Limited to 20 visits per 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	20% After Deductible	40% After Deductible	
If you need eye care	Eye exam	No charge	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:

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- Acupuncture
- Bariatric Surgery
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- Dental Care
- Hearing Aids
- Infertility Treatment
- Long-term Care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
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- Weight loss programs

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

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Does this plan provide Minimum Essential Coverage? Yes

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[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.

About these Coverage Examples:

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(9 months of in-network pre-natal care and a hospital delivery)

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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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,000
Copayments	$0
Coinsurance	$1,940
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$4,900**

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

The plan's overall deductible	**$3,000**
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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$3,000
Copayments	$0
Coinsurance	$520
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$3,500**

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

The plan's overall deductible	**$3,000**
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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

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

motivhealth®

DIABETES CARE PROGRAM

SAME INSULIN, LOWER COST

FREE TESTING SUPPLIES

We've partnered with a Utah-based manufacturer to provide type 1 and type 2 diabetics with **free** hospital-grade testing supplies, including:

- GLUCOSE METER
- TEST STRIPS
- LANCETS
- CONTROL SOLUTION
- LANCING DEVICE
- CARRYING CASE

How to Participate

Call **844-234-4472** and speak to a PHA to see if you qualify.

Treating and managing diabetes is expensive. On average, those with diabetes pay $16,750 a year for care. **We want to help!**

LEARN MORE

MotivHealth.com

844-234-4472

motivhealth™

Steps Incentive Program

Earn $1 for every day you and your covered spouse walk 8,000 or more steps, up to 20 days per month. Earnings are deposited into your HSA.

Earn Money
Earn up to $250 a year ($500 with enrolled spouse) in HSA contributions.

Free Stuff
Get a free MotivTrax device.

Be Healthier
Improved health and cardiovascular capacity.

HOW TO PARTICIPATE

1. **Create Member Account**
   Go to member.motivhealth.com.
2. **Choose a Steps Device**
   Fitbit/MotivTrax (free)/Apple Watch. Download app, create account, sync device.
3. **Connect With Member Account**
   Allow your app to sync with your member account.
4. **Start Earning by Walking**
   Earn cash for cardio.

Contact us at
844-234-4472

MOTIVHEALTH INSURANCE COMPANY

Learn More
motivhealth.com/steps-incentive

motivhealth™

SmartPay Discount Program

When our members choose to have certain planned medical procedures performed by our high-value providers, and pay in advance, we can reduce member out-of-pocket expenses between **$250-$3000**.

Pay Less
Lower your out-of-pocket expense.

Get Rewarded
Save extra for being a savvy healthcare consumer.

Get Excellent Care
Receive treatment from high value providers.

HOW TO PARTICIPATE

1. **Call Us**
   Call our Personal Health Assistants (844-234-4472) prior to scheduling a planned medical procedure.
2. **Choose Care**
   Choose a preferred high value provider.
3. **Pay Reduced Fee**
   Pay your reduced cost in advance.
4. **Get Care**
   Receive the medical care you need.

Contact us at
844-234-4472

MOTIVHEALTH INSURANCE COMPANY

Learn More
motivhealth.com