health options plus

health options 3500HSA-A

Schedule of Benefits

www.HealthOptionsPlus.com

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
- Sterilization for Women

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. For family coverage the entire family annual deductible must be met before coverage is provided for any individual family member.

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.

COVERED CHARGES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Hospital Services		
Room and Board	70% after Deductible; Private Room Rate	50% after Deductible; Private Room Rate
Intensive Care Unit	70% after Deductible; Private Room Rate	50% after Deductible; Private Room Rate
Physician Services		
Inpatient visits	70% after Deductible	50% after Deductible
Office visits	70% after Deductible	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.		

COVERED CHARGES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Ambulance Service	70% after Deductible	50% after Deductible
Emergency Room	70% after Deductible	50% after 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% (Deductible waived) for Network Providers under the Preventive Care section.		
Additional Benefits		
The Prevention Plan™ —Wellness, Prevention, Biometric Testing and Health Coach through US Preventive Medicine, Inc.		

PRESCRIPTION DRUG BENEFITS	
	FIRST CHOICE PHARMACY NETWORK
Deductible	$3,500 per Person $7,000 per Family Unit
Tier 1 - Generic	70% after Deductible
Tier 2 - Formulary	70% after Deductible
Tier 3 – Non-Formulary	70% after Deductible

- Immunizations are covered under the Prescription Benefit.
- Deductible is inclusive of the Medical Deductible.
- 90 day supply available at Retail Pharmacy or Mail Order.

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 Declining Deductible feature is not available with this plan.