



AN AFFORDABLE ERISA COMPLIANT EMPLOYER SPONSORED HEALTH PLAN

USA HEALTH PLANS

MVP PLANS
Bronze, Silver, Gold
with Cancer Rider & HI Extension
for Groups of 4-49
Includes Minimum Essential Coverage
plus additional Health Care Services

*Maximizing savings and providing
cutting-edge solutions to help you
effectively manage your health care costs*

SERVICE

FLEXIBILITY

INTEGRITY

Facilitated by:
SB/A Cooperative



Reinsured by:
Magna Insurance Company



Administered by:
The Loomis Company

Pharmacy Benefits by:
Serve You Rx

SERVE YOU

70% Participation Eligible Full-Time Employees,
Less Qualified Waivers. Minimum of 4 EE Enrolled

MVP Plan - Bronze

Summary Plan of Benefits

MVP Bronze:
No Maternity

Bronze No Maternity

PPO Network	First Health
Deductible	None *Deductible may apply to Brand Rx
Annual Out-of-Pocket Maximum	\$8,000 / \$16,000
ACA Preventive & Wellness	Covered 100%
Telemedicine	\$0 Copay
Primary Care (Wellness)	\$0 Copay
Primary Care (Sick Visit)	\$50 Copay 4 visits per year
Specialist (Includes Outpatient Behavior Health)	\$75 Copay 4 visits per year
Urgent Care	\$75 Copay 2 visits per year
Physical & Occupational Therapy	\$75 Copay 4 visits per year
Lab & X-Ray (Non-Hospital Based)	\$75 Copay 3 visits per year
Complex Medical Imaging (MRI / CT Scan)	\$750 Copay 1 visit per year
Surgery - Outpatient	\$750 Copay 1 per year
Surgery - Inpatient	\$750 Copay 2 per year
Emergency room	\$750 Copay 1 visit per year
Inpatient - Hospitalization & ICU	\$1,500 Copay per Admission 5 Days Maximum per year
Inpatient Hospitalization & ICU *Additional Benefit - <i>See HI Extension Program on Page 4</i>	Plan pays \$2,000 per day, up to 365 days Day 6 through Discharge Date
Maternity Global Services Facility and Professional Fees	N/A
Generic Rx - Tier 1 (Preventative)	\$0 Copay
Generic Rx - Tier 2 (Non-Preventative)	40% Coinsurance
Brand Rx - Tier 3 (Preferred)	\$500 Deductible
Brand Rx - Tier 4 (Non-Preferred)	40% Coinsurance \$500 Benefit Cap on Eligible Prescription per Month
Specialty Rx	Not Covered

70% Participation Eligible Full-Time Employees,
Less Qualified Waivers. Minimum of 4 EE Enrolled

MVP Plan - Silver & Gold

Summary Plan of Benefits

	Silver	Gold
PPO Network	First Health	First Health
Deductible	None *Deductible may apply to Brand Rx	None *Deductible may apply to Brand Rx
Annual Out-of-Pocket Maximum	\$7,000 / \$14,000	\$6,000 / \$12,000
ACA Preventive & Wellness	Covered 100%	Covered 100%
Telemedicine	\$0 Copay	\$0 Copay
Primary Care (Wellness)	\$0 Copay	\$0 Copay
Primary Care (Sick Visit)	\$35 Copay 6 visits per year	\$25 Copay 8 visits per year
Specialist (Includes Outpatient Behavior Health)	\$50 Copay 6 visits per year	\$35 Copay 8 visits per year
Urgent Care	\$50 Copay 3 visits per year	\$35 Copay 4 visits per year
Physical & Occupational Therapy	\$50 Copay 6 visits per year	\$35 Copay 8 visits per year
Lab & X-Ray (Non-Hospital Based)	\$50 Copay 4 visits per year	\$35 Copay 5 visits per year
Complex Medical Imaging (MRI / CT Scan)	\$500 Copay 2 visits per year	\$375 Copay 3 visits per year
Surgery - Outpatient	\$500 Copay 2 per year	\$375 Copay 3 per year
Surgery - Inpatient	\$500 Copay 2 per year	\$375 Copay 3 per year
Emergency room	\$500 Copay 1 visit per year	\$375 Copay 2 visits per year
Inpatient - Hospitalization & ICU	\$1,000 Copay per Admission 7 Days Maximum per year	\$750 Copay per Admission 10 Days Maximum per year
Inpatient Hospitalization & ICU *Additional Benefit - <i>See HI Extension Program on page 6</i>	Plan pays \$2,000 per day, up to 365 days Day 8 through Discharge Date	Plan pays \$2,000 per day, up to 365 day Day 11 through Discharge Date
Maternity Global Services Facility and Professional Fees	\$2,300 Copay Childbirth / Delivery	\$1,700 Copay Childbirth / Delivery
Generic Rx - Tier 1 (Preventative)	\$0 Copay	\$0 Copay
Generic Rx - Tier 2 (Non-Preventative)	30% Coinsurance	20% Coinsurance
Brand Rx - Tier 3 (Preferred)	\$250 Deductible 30% Coinsurance	No Deductible 20% Coinsurance
Brand Rx - Tier 4 (Non-Preferred)	\$500 Benefit Cap on Eligible Prescription per Month	\$500 Benefit Cap on Eligible Prescription per Month
Specialty Rx	Not Covered	Not Covered



Cancer Coverage Rider **for MVP Bronze, Silver, and Gold Plans**

Cancer Rider is Included in the MVP Plan Rates

Rider Coverage - Radiotherapy, Chemotherapy, or Immunotherapy

Treatment can be inpatient or outpatient facilities. Rider covers up to 20 treatments at 80% - member pays 20% up to the MVP Plan stated out-of-pocket maximum limit. Rider covers up to \$100,000 of Radiotherapy, Chemotherapy, and Immunotherapy eligible expenses subject to member 20% coinsurance and out-of-pocket MVP Plan maximum. Payment will be made for immunotherapy only if the course of treatment is administered by or under the direction of a certified oncologist for malignant melanoma using mixed vaccines designed to stimulate the immune system.

Cancer Rider Qualifications:

- Requires 50 or more FTE eligible employees participating in SB/A MVP plans
- Subject to SB/A participation requirements
- Qualified waivers do not apply for some participation requirements – see specific requirements
- Rider is not voluntary and must be required on all offered SB/A MVP plans
- Rider is mandatory for a minimum of 24 months of coverage

Limitations and Exclusions:

- Chemotherapy, or Immunotherapy are subject to PRE-EXISTING CONDITION of being Diagnoses and Treatment all types of cancers for five (5) years prior to the Effective Date of this Benefit Coverage. This means the existence of symptoms that would cause an ordinarily prudent person to seek diagnosis, care or treatment within sixty (60) months period preceding the Effective Date of the coverage of the Insured or a condition for which medical advice or treatment was recommended by a Physician or received from a Physician within sixty (60) months period for any and all types of cancers preceding the Effective Date of coverage will not be eligible for coverage.
- A pre-existing condition can exist even though a diagnosis has not yet been made.

HI Extension Program for SB/A MVP Plan Designs

Guaranteed Acceptance



Hospital Indemnity Benefit

The following benefits are payable when a Participant has a qualified Hospital confinement. To receive benefits, each Participant must be enrolled in this program and complete the applicable Elimination / Waiting Period. Unless otherwise indicated below, any benefit amount, limitation, or benefit maximum applies to each Participant.

MVP Programs are affordable and comprehensive for both employers and

employees. However, recognizing these programs have some limitations, the HI Extension Program (elected at the employer level) was created with SB/A to provide a vital tax-free benefit to help offset potential out-of-pocket costs. Benefits are designed to provide protection when an MVP plan's hospital benefits are exhausted.

HI Extension	Benefit / Reimbursement Amount	Elimination / Waiting Period	Limitation
Bronze HI Extension for MVP Bronze	\$2,000 per day (Day 6 through discharge date)	5 Days \$0 Benefit for days 1-5	up to 365 Days per condition (diagnosis)
Silver HI Extension for MVP Silver	\$2,000 per day (Day 8 through discharge date)	7 Days \$0 Benefit for days 1-7	up to 365 Days per condition (diagnosis)
Gold HI Extension for MVP Bronze	\$2,000 per day (Day 11 through discharge date)	10 Days \$0 Benefit for days 1-10	up to 365 Days per condition (diagnosis)

Plans shown have an initial benefit waiting period of 299 days for pregnancy. Benefits are available for most medically necessary treatment of an illness or injury that occur in a hospital facility. Benefits are not available for hospital confinement initiated during the Elimination Period. Please refer to the full Summary of Benefits for full plan Definition, Limitations, & Exclusions.

Please note: This is a generic representation of benefits and is only intended to serve as an initial proposal of benefits potentially available. Refer to the Schedule of Benefits for the official list of Benefits Coverage, Limitations, & Exclusions. If benefits outlined on this page differ from the Schedule of Benefits on Official Plan Documents, the Schedule of Benefits or Official Plan Documents will govern.

Minimum Essential Coverage ACA Annual Benefits

All Employer Plans – MEC Covered Services	Minimum Essential Coverage (MEC Plan) In-Network Provider (PPO) Only
Annual Deductible	None
Member Annual Out-of-Pocket Maximum	None
Co-Insurance Percentage covered (Plan Pays Based on Contracted Amounts)	100%
Pharmacy Benefit	100% of ACA mandated prescription, i.e. Birth Control
Annual Maximum of Covered Services	No Annual Maximum
Routine Well Care – As Provided Under the Affordable Care Act (ACA)	
Adult Preventative Services - Screenings and Services as Provided in the Affordable Care Act MEC	
1. Abdominal Aortic Aneurysm	9. Diet Counseling
2. Alcohol Misuse	10. Obesity
3. Aspirin	11. Sexually Transmitted Infection (STI)
4. Blood Pressure	12. Syphilis
5. Cholesterol	13. HIV
6. Colorectal Cancer	14. Tobacco Use
7. Depression	15. Immunization Vaccines
8. Type 2 Diabetes	
Women Preventative Services – Screenings and Services Listed Below are Eligible	
1. Anemia	12. Gestational Diabetes
2. Bacteriuria Urinary Tract	13. Gonorrhea
3. BRCA	14. Hepatitis B
4. Breast Cancer Mammography	15. Human Immunodeficiency Virus (HIV)
5. Breast Cancer Chemoprevention	16. Human Papillomavirus (HPV) DNA Test
6. Breastfeeding	17. Osteoporosis
7. Cervical Cancer	18. Rh Incompatibility
8. Chlamydia Infection	19. Tobacco Use
9. Contraception	20. Sexually Transmitted Infections (STI)
10. Domestic and Interpersonal Violence	21. Syphilis
11. Folic Acid Supplements	22. Well Woman Visits
Child Preventative Services – Screenings and Services Listed Below are Eligible	
1. Alcohol and Drug Use	14. Hematocrit or Hemoglobin
2. Autism	15. Hemoglobinopathies or Sickle Cell
3. Behavioral	16. HIV
4. Blood Pressure	17. Immunization Vaccines
5. Cervical Dysplasia	18. Iron Supplements
6. Congenital Hypothyroidism	19. Lead Exposure
7. Depression	20. Medical History
8. Developmental	21. Obesity
9. Dyslipidemia	22. Oral Health
10. Fluoride Supplements	23. Phenylketonuria (PKU)
11. Gonorrhea	24. Sexually Transmitted Infection
12. Hearing	25. Tuberculin Testing
13. Height, Weight and Body Mass Index	26. Vision

Plan Provisions and Exclusions

- MVP Bronze, Silver, and Gold Plans have provisions and exclusions that may impact eligibility for enrollee benefits.
- Participation Requirement for All SB/A Products – Subject to Stated Product Minimums and Additional Requirements provided by SB/A:
 - o **Option 1:** 70% of Eligible Full-Time Employees (30 Hours or More/Week) less Verifiable Qualified ACA Coverage Elsewhere - Part-Time Employees May be Eligible if Approved
 - o **Option 2:** 25% of Eligible Full-Time Employees (30 Hours or More/Week) less Verifiable Qualified ACA Coverage Elsewhere, if:
 1. Employers are offering another ACA Qualified Medical Benefit Program alongside SB/A or Employee waives and is covered by “Other Qualified Coverage” (Example: Spouse Plan, Exchange, Govt. Program, etc.) and Waiver Information is collected.
 2. Employer contributes the greater of 50% of the SB/A Cooperative Single Employee Funding Rate or the Same Dollar Amount as the other ACA Qualified Medical Benefit Program
 3. Employer utilizes approved Third-Party Enrollment Platform & Communication Approach (more below)
 4. Employer utilizes Written Comprehensive Benefits On-boarding Communication Program approved by SB/A
- Minimum 4+ enrollment is required.
- Prior-authorization is required for Major Diagnostic, In/Out Patient Surgery and Hospitalization.
- Employees must sign the appropriate employee application.
- Does not qualify as insurance
- Notice: All Non-Network Providers involved in the emergency services or the legally required Continuum of Care will be accepted, and Providers will be paid at Network contractual rates.

Benefit Exclusions:

- Outpatient Drugs, Kidney Dialysis, Chemotherapy, and all other Infusion Therapy is excluded from coverage under Outpatient Benefit Provisions, except as provided for under Cancer Coverage Rider;
- Surgery and treatment, procedures, products, or services that are experimental or investigative;
- Suicide;
- Surgery to correct vision or hearing, unless a result of a covered Injury, medically necessary surgery for glaucoma, cataracts or other sickness or injury;
- Dental care, dental x-rays, or dental treatment;
- Gastric or intestinal bypass services including lap banding, gastric stapling, and other similar procedures to facilitate weight loss; the reversal, or revision of such procedures; or services required for the treatment of complications from such procedures. This exclusion does not apply to completion of a weight reduction program that may be payable under the Health Screening benefit;
- Rest cures or custodial care, or treatment of sleep disorders;
- Cosmetic surgery (exceptions for some reconstructive or illness procedures):
- Workman’s Compensation injuries and illnesses
- Sex transformation/surgery
- Treatment relating to a covered person: taking part in any war or act of war (including service in the armed forces), commission of or attempt to commit a felony, an act of terrorism, or participating in an illegal occupation, riot or insurrection;
- Sickness or Injury sustained while on active duty in the armed forces of any country. This does not include Reserve or National Guard duty for training except if deployed on active duty;
- Services, treatment or loss rendered in any Veterans Administration or Federal Hospital, except if there is a legal obligation to pay;

For
Groups
4-49 EE

EMPLOYER GROUP MVP PLAN COST

includes the Cancer Rider and HI Extension Program

USAHP MVP PLAN **BRONZE:**

	Employee	Employee + Spouse	Employee + Child(ren)	Employee + Family
Bronze MVP	\$506.44	\$759.02	\$718.25	\$942.07
Bronze Extension	\$30.64	\$57.46	\$55.56	\$88.97
BRONZE TOTAL	\$537.08	\$816.48	\$773.81	\$1,031.04

USAHP MVP PLAN **SILVER:**

	Employee	Employee + Spouse	Employee + Child(ren)	Employee + Family
Silver MVP_	\$615.03	\$952.34	\$898.29	\$1,193.55
Silver Extension	\$25.44	\$47.05	\$45.51	\$72.38
SILVER TOTAL	\$640.47	\$999.39	\$943.80	\$1,265.93

USAHP MVP PLAN **GOLD:**

	Employee	Employee + Spouse	Employee + Child(ren)	Employee + Family
Gold MVP_	\$723.10	\$1,149.68	\$1,082.41	\$1,438.73
Gold Extension	\$18.13	\$32.33	\$31.33	\$49.03
GOLD TOTAL	\$741.23	\$1,182.01	\$1,113.74	\$1,487.76

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