Health Insurance Options

SBA Co-op & Ep6ix MVP health plan (Small group 4-49 employees)

Base Monthly Billable Rates for start MVP Plan Summary Plan of Benefits	Bronze Plus	Silver	MVP GOLD
PPO Network	First Health	First Health	First Health
Deductible	None *Deductible may apply to Brand Rx	None *Deductible may apply to Brand Rx	None *Deductible may apply to Brand Rx
Annual Out-of-Pocket Maximum	$8,000 / $16,000	$7,000 / $14,000	$6,000 / $12,000
ACA Preventive & Wellness	Covered 100%	Covered 100%	Covered 100%
Telemedicine	$0 Copay	$0 Copay	$0 Copay
Primary Care (Wellness)	$0 Copay	$0 Copay	$0 Copay
Primary Care (Sick Visit)	$50 Copay 4 visits per year	$35 Copay 6 visits per year	$25 Copay 8 visits per year
Specialist (Includes Outpatient Behavior Health)	$75 Copay 4 visits per year	$50 Copay 6 visits per year	$35 Copay 8 visits per year
Urgent Care	$75 Copay 2 visits per year	$50 Copay 3 visits per year	$35 Copay 4 visits per year
Physical & Occupational Therapy	$75 Copay 4 visits per year	$50 Copay 6 visits per year	$35 Copay 8 visits per year
Lab & X-Ray (Non-Hospital Based)	$75 Copay 3 visits per year	$50 Copay 4 visits per year	$35 Copay 5 visits per year
Complex Medical Imaging (MRI/CT Scan)	$750 Copay 1 visit per year	$500 Copay 2 visits per year	$375 Copay 3 visits per year
Surgery - Outpatient	$750 Copay 1 per year	$500 Copay 2 per year	$375 Copay 3 per year
Surgery - Inpatient	$750 Copay 2 per year	$500 Copay 2 per year	$375 Copay 3 per year
Emergency Room	$750 Copay 1 visit per year	$500 Copay 1 visit per year	$375 Copay 2 visits per year
Inpatient - Hospitalization & ICU	$1,500 Copay per Admission 5 Days Maximum per year	$1,000 Copay per Admission 7 Days Maximum per year	$750 Copay per Admission 10 Days Maximum per year
Maternity Global Services Facility and Professional Fees	$3,400 Copay Childlbirth / Delivery	$2,300 Copay Childlbirth / Delivery	$1,700 Copay Childlbirth / Delivery
Generic Rx - Tier 1 (Preventive)	$0 Copay	$0 Copay	$0 Copay
Generic RX - Tier 2 (Non-Preventative)	40% Coinsurance	30% Coinsurance	20% Coinsurance
Brand RX: Tier 3 (Preferred)	$500 Deductible	$250 Deductible	No Deductible
Brand RX - Tier 4 (Non-Pref)	40% Coinsurance $500 Benefit Cap on Eligible Prescription per Month	30% Coinsurance $500 Benefit Cap on Eligible Prescription per Month	20% Coinsurance $500 Benefit Cap on Eligible Prescription per Month
Specialty Rx:	Not Covered	Not Covered	Not Covered
Employee Only	$598.82	$686.97	$788.08
Employee + Spouse	$876.37	$1,034.83	$1,218.18
Employee + Child(ren)	$837.24	$984.33	$1,154.96
Employee + Family	$1,089.19	$1,293.66	$1,516.60

*The rates are illustrative and still require the standard underwriting process to determine final eligibility.