1250MVP-85OV

Minimum Value Plan Series

The Health Options MVP series (Minimum Value Plan) provide Minimum Essential Coverage but do not contain all 10 Minimum Essential Benefits under the Affordable Care Act. These "Bronze" level plans are fully ACA compliant and meet the Minimum Value testing requirements.

Health Options 1250MVP-85OV does not provide coverage for Inpatient Hospital Services, Skilled Nursing Services, Mental Health or Substance Abuse Services.

MEDICAL BENEFITS	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
MAXIMUM LIFETIME BENEFIT AMOUNT	Unlimited	

DEDUCTIBLE, PER CALENDAR YEAR		
Per Covered Person	$1,250	$3,750
Per Family Unit	$2,500	$7,500
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.		
COPAYMENTS		
Physician Visits	$40	N/A
Specialist Visits	$50	N/A
The Physician and Specialist visit copayment is for the office visit, basic laboratory (including diagnostic and laboratory services ordered by the network physician at an outside facility), received in the physician's office for each day of service. Office visit copayment excludes surgical procedures, cardiovascular procedures, chemotherapy/radiation therapy, infusion therapy, and advanced imaging.		
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR, INCLUDING THE CALENDAR YEAR DEDUCTIBLE		
Per Covered Person	$6,350	$19,050
Per Family Unit	$12,700	$38,100
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. **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	Not Covered	Not Covered
Intensive Care Unit	Not Covered	Not Covered
Inpatient	Not Covered	Not Covered
Emergency Room	85% after deductible	50% after deductible
Skilled Nursing Facility	Not Covered	Not Covered
Urgent Care Facility	85% after deductible	50% after deductible
Advanced Imaging MRA, MRI, CT, SPECT & PET Imaging	85% after deductible	50% after deductible

COVERED CHARGES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Physician Services		
Inpatient visits	85% after deductible	50% after deductible
Office visits	100% after copayment	50% after deductible
Surgery	85% after deductible	50% after deductible
Home Health Care	85% after deductible	50% after deductible
Hospice Care	85% after deductible	50% after deductible
Ambulance Service	85% after deductible	85% after network deductible
Occupational Therapy	85% after deductible	50% after deductible
Speech Therapy	85% after deductible	50% after deductible
Physical Therapy	85% after deductible	50% after deductible
Durable Medical Equipment	85% after deductible	50% after deductible
Prosthetics	85% after deductible	50% after deductible
Orthotics	85% after deductible	50% after deductible
Spinal Manipulation Chiropractic	85% after deductible	50% after deductible
Mental Disorders	Not Covered	Not Covered
Substance Abuse	Not Covered	Not Covered
Sterilization	100%	100%
For women, as required by law.		
Preventative Care		
Routine Well Care	100%	100%
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.		
Dialysis	85% after deductible	50% after deductible
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.		
Pregnancy & Newborn Care	85% after deductible	50% after deductible
Global Billing services are not subject to copayment. Dependent daughters not covered.		
Prescription Drugs – Major Medical Drug Card		
Contraceptives	100%	
Generic Drugs	85% after network deductible	
Brand Drugs	85% after network deductible	
OTHER BENEFITS		
The Prevention Plan™ —Wellness, Prevention, Biometric Testing and Health Coach through US Preventive Medicine, Inc.		
AmeriDoc™ Telemedicine Benefit — First 3 calls per member at No Charge; additional calls at $30 per call		

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 applicable Copay, Deductible and/or Coinsurance applies to every physician office visit.
- The Declining Deductible feature is NOT available under this plan.
- This plan does not provide coverage for Inpatient Hospital Services, Skilled Nursing Services, Mental Health or Substance Abuse Services.