



1000MVP-80OVL

**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 1000MVP-80OVL does not provide coverage for Inpatient Hospital Services, Skilled Nursing Services, Mental Health or Substance Abuse Services.**

| MEDICAL BENEFITS                       | NETWORK PROVIDERS | NON-NETWORK PROVIDERS |
|--|-------------------|-----------------------|
| <b>MAXIMUM LIFETIME BENEFIT AMOUNT</b> | Unlimited         |                       |

| DEDUCTIBLE, PER CALENDAR YEAR |         |         |
|-------------------------------|---------|---------|
| Per Covered Person            | \$1,000 | \$3,000 |
| Per Family Unit               | \$2,000 | \$6,000 |

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.**

| 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 |
|--|----------------------|-----------------------|
| <b>Hospital Services</b>                                     |                      |                       |
| Room and Board   | Not Covered          | Not Covered           |
| Intensive Care Unit  | Not Covered          | Not Covered           |
| Inpatient  | Not Covered          | Not Covered           |
| <b>Emergency Room</b>  | 80% after deductible | 50% after deductible  |
| <b>Skilled Nursing Facility</b>                              | Not Covered          | Not Covered           |
| <b>Urgent Care Facility</b>                                  | 80% after deductible | 50% after deductible  |
| <b>Advanced Imaging</b><br>MRA, MRI, CT, SPECT & PET Imaging | 80% after deductible | 50% after deductible  |

| COVERED CHARGES  | NETWORK PROVIDERS            | NON-NETWORK PROVIDERS        |
|--|------------------------------|------------------------------|
| <b>Physician Services</b>  |                              |                              |
| Inpatient visits   | 80% after deductible         | 50% after deductible         |
| Office visits  | 100% after copayment         | 50% after deductible         |
| Surgery  | 80% after deductible         | 50% after deductible         |
| <b>Home Health Care</b>  | 80% after deductible         | 50% after deductible         |
| <b>Hospice Care</b>  | 80% after deductible         | 50% after deductible         |
| <b>Ambulance Service</b>   | 80% after deductible         | 80% after network deductible |
| <b>Occupational Therapy</b>  | 80% after deductible         | 50% after deductible         |
| <b>Speech Therapy</b>  | 80% after deductible         | 50% after deductible         |
| <b>Physical Therapy</b>  | 80% after deductible         | 50% after deductible         |
| <b>Durable Medical Equipment</b>   | 80% after deductible         | 50% after deductible         |
| <b>Prosthetics</b>   | 80% after deductible         | 50% after deductible         |
| <b>Orthotics</b>   | 80% after deductible         | 50% after deductible         |
| <b>Spinal Manipulation Chiropractic</b>  | 80% after deductible         | 50% after deductible         |
| <b>Mental Disorders</b>  | Not Covered                  | Not Covered                  |
| <b>Substance Abuse</b>   | Not Covered                  | Not Covered                  |
| <b>Sterilization</b>   | 100%                         | 100%                         |
| For women, as required by law.   |                              |                              |
| <b>Preventative Care</b>   |                              |                              |
| 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.                       |                              |                              |
| <b>Dialysis</b>  | 80% 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. |                              |                              |
| <b>Pregnancy &amp; Newborn Care</b>  | 80% after deductible         | 50% after deductible         |
| Global Billing services are not subject to copayment. Dependent daughters not covered.   |                              |                              |
| <b>Prescription Drugs – Major Medical Drug Card</b>  |                              |                              |
| Contraceptives   | 100%                         |                              |
| Generic Drugs  | 80% after network deductible |                              |
| Brand Drugs  | 80% after network deductible |                              |
| <b>OTHER BENEFITS</b>  |                              |                              |
| <b>The Prevention Plan™</b> —Wellness, Prevention, Biometric Testing and Health Coach through US Preventive Medicine, Inc.   |                              |                              |
| <b>AmeriDoc™ Telemedicine Benefit</b> — 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.

Administered by

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