



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE:** Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.mvphealthcare.com. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-888-687-6277 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$0.	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible ?	Yes. Preventive care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	In-Network -\$7,150 individual /\$14,300 family	The out-of-pocket limit is the most you could pay in a year for covered services.If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit ?	Copayments for certain services, premiums, balance-billing charges, and healthcare this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider ?	Yes. See www.mvphealthcare.com or call 1-888-687-6277 for a list of network providers.	You pay the least if you use a provider in the Preferred Provider tier. You pay more if you use a provider in the In-Network tier. You will pay the most if you use an Out-of-Network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing).Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist ?	No.	You can see the specialist you choose without a referral.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Network Provider (You will pay the least)	In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$20 copay/office visit	\$20 copay/office visit	Not covered	None
	<u>Specialist</u> visit	\$20 copay/visit	\$20 copay/visit	Not covered	None
	<u>Preventive care/screening/immunization</u>	No charge	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	Lab Office - No charge; Lab Facility - No charge; Radiology Office - \$20/visit; Radiology Facility - No charge	Lab Office - No charge; Lab Facility - No charge; Radiology Office - \$20/visit; Radiology Facility - \$20/visit	Not covered	Lab Office - None; Lab Facility - None; Radiology Office - None; Radiology Facility - None
	Imaging (CT/PET scans, MRIs)	Office - \$20 copay/procedure; Facility - No charge	Office - \$20 copay/procedure; Facility - \$20 copay/procedure	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Network Provider (You will pay the least)	In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at	Tier 1 (Generic drugs)	Retail \$10/prescription; Mail order \$25/prescription	Retail \$10/prescription; Mail order \$25/prescription	Not covered	30 day retail/90 day mail order
	Tier 2 (Preferred brand drugs)	Retail \$30/prescription; Mail order \$75/prescription	Retail \$30/prescription; Mail order \$75/prescription	Not covered	30 day retail/90 day mail order
	Tier 3 (Non-preferred brand drugs)	Retail \$50/prescription; Mail order \$125/prescription	Retail \$50/prescription; Mail order \$125/prescription	Not covered	30 day retail/90 day mail order
	Tier 4 Specialty drugs	Retail Covered as noted in Tier 1, Tier 2, and Tier 3 classes	Retail Covered as noted in Tier 1, Tier 2, and Tier 3 classes	Not covered	30 day retail/90 day mail order
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	\$75 copay/day	Not covered	None
	Physician/surgeon fees	No charge	No charge	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Network Provider (You will pay the least)	In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	\$50 copay/visit	\$50 copay/visit	\$50 copay/visit	None
	Emergency medical transportation	No charge	No charge	No charge	None
	Urgent care	\$20 copay/visit	\$20 copay/visit	\$20 copay/visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$240 copay/continuous confinement	\$240 copay/continuous confinement	Not covered	one copay per member per year, limited to 3 copays per family
	Physician/surgeon fees	No charge	No charge	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 copay/visit	\$20 copay/visit	Not covered	None
	Inpatient services	\$240 copay/stay	\$240 copay/stay	Not covered	1 copay per member per year, limited to 3 copays per family

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Network Provider (You will pay the least)	In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	No charge	No charge	Not covered	Cost sharing does not apply to certain preventive services. Depending on the type of services, a copay, coinsurance, and/or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No charge	No charge	Not covered	
	Childbirth/delivery facility services	\$240 copay/stay	\$240 copay/stay	Not covered	
If you need help recovering or have other special health needs	Home health care	\$20 copay/visit	\$20 copay/visit	Not covered	60 visits per Calendar Year
	Rehabilitation services/ Habilitation services	OP ReHab: \$20 copay/visit IP ReHab: \$240 copay/visit	OP ReHab: \$20 copay/visit IP ReHab: \$240 copay/visit	OP ReHab: Not covered IP ReHab: Not covered	OP ReHab: 30 combined PT/OT/ST visits per year IP ReHab: 60 days per Calendar Year, 1 copay per member per year, limited to 3 copays per family
	Skilled nursing care	\$240 copay/stay	\$240 copay/stay	Not covered	60 days per Calendar Year
	Durable medical equipment	20% coinsurance	20% coinsurance	Not covered	None
	Hospice services	No charge	No charge	Not covered	210 days per Calendar year; unlimited visits for family bereavement counseling

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Network Provider (You will pay the least)	In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not covered	Subject to appropriate cost share	Not covered	One routine eye exam once per Plan Year
	Children's glasses	Not covered	50% coinsurance	Not covered	Standard prescription lenses or contact lenses through Participating Providers one time per Plan Year. Deductible may apply
	Children's dental check-up	\$25 copay/visit	\$25 copay/visit	\$25 copay/visit	See benefit for description

Excluded Services & Other Covered Services:

Services Your [Plan](#) Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other [excluded services](#).)

- Acupuncture
- Cosmetic Surgery
- Dental Care (Adult)
- Long-Term Care
- Non-Emergency care when traveling outside the U.S
- Routine Foot Care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Bariatric Surgery
- Chiropractic Care
- Hearing Aids
- Infertility Treatment
- Private-Duty Nursing
- Routine Eye Care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is:

MVP Health Care
P.O. Box 2207
Schenectady, NY 12301
Toll Free: 1-888-687-6277
www.mvphealthcare.com
members@mvphealthcare.com

You can also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or ccio.cms.gov. Church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact:

MVP Health Care
Attn: Member Appeals
P.O.Box 2207
Schenectady, NY 12301
Toll Free:1-888-687-6277
www.mvphealthcare.com
members@mvphealthcare.com

You can also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or dol.gov/ebsa/healthreform, or the NYS Department of Insurance at 1-800-342-3736 or dfs.ny.gov. Additionally, a consumer assistance program can help you file your appeal. Contact the Community Health Advocates at 1-888-614-5400 or communityhealthadvocates.org.

Pending

Does this plan provide Minimum Essential Coverage? Yes.

[Minimum Essential Coverage](#) generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes.

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall deductible	\$0
■ Specialist Copay	\$20
■ Hospital (facility) Copay	\$240
■ Other Copay	\$0

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$300
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$70
The total Peg would pay is	\$370

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$0
■ Specialist	\$20
■ Hospital (facility)	\$240
■ Other	\$20

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$800
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$200
The total Joe would pay is	\$1,000

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$0
■ Specialist	\$20
■ Hospital (facility)	\$240
■ Other	\$50

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
 Diagnostic test (*x-ray*)
 Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$200
Coinsurance	\$10
What isn't covered	
Limits or exclusions	\$10
The total Mia would pay is	\$220

Language Assistance



ATTENTION: Language assistance services and other English

aids, free of charge, are available to you. Call

1-844-946-8010 (TTY 711).

ATENCIÓN: Dispone de servicios de asistencia Español
lingüística y otras ayudas, gratis. (Spanish)

Llame al **1-844-946-8010** (TTY 711).

请注意：您可以免费获得语言协助服务和其他辅助服 繁體中文
务。请致电 **1-844-946-8010** (TTY 711)。 (Chinese)

1-844-946-8010 (TTY 711) العربية
ملاحظة: خدمات المساعدة اللغوية والمساعدات الأخرى المجانية متاحة (Arabic)

주의: 언어 지원 서비스 및 기타 지원을 무료로 한국어
이용하실 수 있습니다 **1-844-946-8010** (TTY 711). (Korean)

ВНИМАНИЕ! Вам доступны бесплатные услуги Русский
переводчика и другие виды помощи. Звоните по (Russian)
номеру **1-844-946-8010** (TTY 711).

ATTENZIONE: Sono disponibili servizi di assistenza Italiano
linguistica e altri ausili gratuiti. Chiamare il (Italian)
1-844-946-8010 (TTY 711).

ATTENTION: Des services d'assistance linguistique et Français
d'autres ressources d'aide vous sont (French)
offerts gratuitement. Composez le
1-844-946-8010 (TTY 711).

ATANSYON: Gen sèvis pou bay asistans nan lang
ak lòt èd ki disponib gratis pou ou. Rele
1-844-946-8010 (TTY 711).

Kreyòl
Ayisyen
(French
Creole)

אכטונג: שפראך גענויגע און אנדערע דיינגען, פאר אונזערע

איידיש
(Yiddish)

1-844-946-8010 (TTY 711).

UWAGA: Dostępne są bezpłatne usługi językowe
oraz inne formy pomocy. Zadzwoń:
1-844-946-8010 (TTY 711).

Polski
(Polish)

ATENSYON: Available ang mga serbisyong tulong sa
wika at iba pang tulong nang libre. Tumawag sa
1-844-946-8010 (TTY 711).

Tagalog
(Tagalog-
Filipino)

মনোযোগ ন্যামূল্যে ভাষা সহায়তা পরিষেবা এবং
অন্যান্য সাহায্য আপনার জন্য উপলব্ধ।
1-844-946-8010 (TTY 711).-এ ফোন করুন।

বাংলা
(Bengali)

VINI RE: Për ju disponohen shërbime asistence
gjjuhësore dhe ndihma të tjera falas.
Telefononi **1-844-946-8010** (TTY 711).

Shqip
(Albanian)

ΠΡΟΣΟΧΗ: Υπηρεσίες γλωσσικής βοήθειας και άλλα
βοηθήματα είναι στη διάθεσή σας, δωρεάν. Καλέστε
στο **1-844-946-8010** (TTY 711).

Ελληνικά
(Greek)

توجہ فرمائیں: زبان میں معاونت کی خدمات اور دیگر معاونتیں آپ
کے لیے بلا معاوضہ دستیاب ہیں۔ کال کریں
1-844-946-8010 (TTY 711).

اردو
(Urdu)