



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 ? | In-Network -\$6,350 individual /\$12,700 family | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. |
| 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 -\$7,100 individual /\$14,200 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. |



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

| 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 provider's office or clinic | Primary care visit to treat an injury or illness | 40% coinsurance Deductible applies | 40% coinsurance Deductible applies | Not covered | None |
| | Specialist visit | 40% coinsurance Deductible applies | 40% coinsurance Deductible applies | Not covered | None |
| | Preventive care/screening/immunization | 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 | Diagnostic test (x-ray, blood work) | Lab Office - 40% coinsurance Deductible applies; Lab Facility - 0% coinsurance Deductible applies; Radiology Office - 40% coinsurance Deductible applies; Radiology Facility - 0% coinsurance Deductible applies | Lab Office - 40% coinsurance Deductible applies; Lab Facility - 40% coinsurance Deductible applies; Radiology Office - 40% coinsurance Deductible applies; Radiology Facility - 40% coinsurance Deductible applies | Not covered | Lab Office - None; Lab Facility - None; Radiology Office - None; Radiology Facility - None |
| | Imaging (CT/PET scans, MRIs) | Office - 40% coinsurance Deductible applies; Facility - 0% coinsurance Deductible applies | Office - 40% coinsurance Deductible applies; Facility - 40% coinsurance Deductible applies | Not covered | None |

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|--|---|--|--|--|---|
| | | 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 Deductible applies; Mail order \$25/prescription Deductible applies | Retail \$10/prescription Deductible applies; Mail order \$25/prescription Deductible applies | Not covered | 30 day retail/90 day mail order; preventive drugs deductible waived |
| | Tier 2 (Preferred brand drugs) | Retail \$40/prescription Deductible applies; Mail order \$100/prescription Deductible applies | Retail \$40/prescription Deductible applies; Mail order \$100/prescription Deductible applies | Not covered | \$100 max out of pocket on 30 day supply of Insulin; preventive drugs deductible waived |
| | Tier 3 (Non-preferred brand drugs) | Retail \$60/prescription Deductible applies; Mail order \$150/prescription Deductible applies | Retail \$60/prescription Deductible applies; Mail order \$150/prescription Deductible applies | Not covered | 30 day retail/90 day mail order; preventive drugs deductible waived |
| | Tier 4 Specialty drugs | Retail \$60/prescription Deductible applies; Mail order \$150/prescription Deductible applies | Retail \$60/prescription Deductible applies; Mail order \$150/prescription Deductible applies | Not covered | 30 day supply retail available through Specialty Pharmacy |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 0% coinsurance Deductible applies | 40% coinsurance Deductible applies | Not covered | None |
| | Physician/surgeon fees | 40% coinsurance Deductible applies | 40% coinsurance Deductible applies | Not covered | None |

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|---|--|--|--|--|--|
| | | 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 | 40% coinsurance Deductible applies | 40% coinsurance Deductible applies | 40% coinsurance Deductible applies | None |
| | Emergency medical transportation | 40% coinsurance Deductible applies | 40% coinsurance Deductible applies | 40% coinsurance Deductible applies | None |
| | Urgent care | 40% coinsurance Deductible applies | 40% coinsurance Deductible applies | 40% coinsurance Deductible applies | None |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 40% coinsurance Deductible applies | 40% coinsurance Deductible applies | Not covered | Per continuous confinement |
| | Physician/surgeon fees | 40% coinsurance Deductible applies | 40% coinsurance Deductible applies | Not covered | None |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | 40% coinsurance Deductible applies | 40% coinsurance Deductible applies | Not covered | None |
| | Inpatient services | 40% coinsurance Deductible applies | 40% coinsurance Deductible applies | Not covered | Including residential treatment |

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|---|--|--|--|--|---|
| | | 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 | 40% coinsurance Deductible applies | 40% coinsurance Deductible applies | Not covered | |
| | Childbirth/delivery facility services | 40% coinsurance Deductible applies | 40% coinsurance Deductible applies | Not covered | |
| If you need help recovering or have other special health needs | Home health care | 40% coinsurance Deductible applies | 40% coinsurance Deductible applies | Not covered | 60 visits per plan year |
| | Rehabilitation services/ Habilitation services | OP ReHab: 40% coinsurance Deductible applies IP ReHab: 40% coinsurance Deductible applies | OP ReHab: 40% coinsurance Deductible applies IP ReHab: 40% coinsurance Deductible applies | OP ReHab: Not covered IP ReHab: Not covered | OP ReHab: 54 visits per condition/year combined therapies IP ReHab: 60 days per Plan Year Combined Therapies |
| | Skilled nursing care | 40% coinsurance Deductible applies | 40% coinsurance Deductible applies | Not covered | 200 days per plan year |
| | Durable medical equipment | 40% coinsurance Deductible applies | 40% coinsurance Deductible applies | Not covered | Standard equipment covered |
| | Hospice services | 40% coinsurance Deductible applies | 40% coinsurance Deductible applies | Not covered | 210 days per plan year, 5 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 | 40% coinsurance Deductible applies | 40% coinsurance Deductible applies | Not covered | One exam per 12-month period |
| | Children's glasses | 40% coinsurance Deductible applies | 40% coinsurance Deductible applies | Not covered | One Prescribed Standard Lenses and Frames in a 12-Month Period |
| | Children's dental check-up | \$25 copay/visit Deductible applies | \$25 copay/visit Deductible applies | \$25 copay/visit Deductible applies | One dental exam and cleaning per six month period |

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](#).)

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

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

- | | |
|---------------------|-------------------------|
| • Acupuncture | • Hearing Aids |
| • Bariatric Surgery | • Infertility Treatment |
| • Chiropractic Care | • Weight Loss Programs |

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 cciio.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.

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 | \$6,350 |
| ■ Specialist Coinsurance | 40% |
| ■ Hospital (facility) Coinsurance | 40% |
| ■ Other Coinsurance | 40% |

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 |
|---------------------------|----------|

In this example, Peg would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles | \$6,350 |
| Copayments | \$0 |
| Coinsurance | \$800 |
| What isn't covered | |
| Limits or exclusions | \$70 |
| The total Peg would pay is | \$7,220 |

Managing Joe's type 2 Diabetes

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

| | |
|---|---------|
| ■ The plan's overall deductible | \$6,350 |
| ■ Specialist Coinsurance | 40% |
| ■ Hospital (facility) Coinsurance | 40% |
| ■ Other Coinsurance | 40% |

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 |
|---------------------------|---------|

In this example, Joe would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles | \$5,400 |
| Copayments | \$0 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$5,420 |

Mia's Simple Fracture

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

| | |
|---|---------|
| ■ The plan's overall deductible | \$6,350 |
| ■ Specialist Coinsurance | 40% |
| ■ Hospital (facility) Coinsurance | 40% |
| ■ Other Coinsurance | 40% |

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 |
|---------------------------|---------|

In this example, Mia would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles | \$2,800 |
| Copayments | \$0 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$2,800 |