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.
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 -$2,450 individual /$4,900 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 provider's office or clinic	Primary care visit to treat an injury or illness	$5 copay/office visit	$5 copay/office visit	Not covered	$0 copay first 3 visits
	Specialist visit	$45 copay/visit	$45 copay/visit	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 - $5/visit; Lab Facility - No charge; Radiology Office - PCP: $5/visit & Spec: $45/visit; Radiology Facility - No charge	Lab Office - $5/visit; Lab Facility - $45/visit; Radiology Office - PCP: $5/visit & Spec: $45/visit; Radiology Facility - $45/visit	Not covered	Lab Office - $0 copay first 3 visits; Lab Facility - None; Radiology Office - PCP: $0 copay first 3 visits & Spec: None; Radiology Facility - None
	Imaging (CT/PET scans, MRIs)	Office - $100 copay/procedure; Facility - No charge	Office - $100 copay/procedure; Facility - $100 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 www.mvphealthcare.com	Tier 1 (Generic drugs)	Retail $5/prescription; Mail order $12.50/prescription	Retail $5/prescription; Mail order $12.50/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 $50/prescription; Mail order $125/prescription	Retail $50/prescription; Mail order $125/prescription	Not covered	30 day supply retail available through Specialty Pharmacy
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	$100 copay/day	Not covered	None
	Physician/surgeon fees	$100 copay/procedure	$100 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 immediate medical attention	Emergency room care	$100 copay/visit	$100 copay/visit	$100 copay/visit	None
	Emergency medical transportation	$100 copay/trip	$100 copay/trip	$100 copay/trip	None
	Urgent care	$45 copay/visit	$45 copay/visit	$45 copay/visit Deductible does not apply	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$300 copay/continuous confinement	$300 copay/continuous confinement	Not covered	Per continuous confinement
	Physician/surgeon fees	$100 copay/procedure	$100 copay/procedure	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$5 copay/visit	$5 copay/visit	Not covered	$0 copay first 3 visits
	Inpatient services	$300 copay/stay	$300 copay/stay	Not covered	Including residential treatment

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	$100 copay/delivery	$100 copay/delivery	Not covered	
	Childbirth/delivery facility services	$300 copay/stay	$300 copay/stay	Not covered	
If you need help recovering or have other special health needs	Home health care	$45 copay/visit	$45 copay/visit	Not covered	60 visits per plan year
	Rehabilitation services/ Habilitation services	$45 copay/visit	OP ReHab: $45 copay/visit IP ReHab: $300 copay/visit	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	$300 copay/stay	$300 copay/stay	Not covered	200 days per plan year
	Durable medical equipment	50% coinsurance	50% coinsurance	Not covered	Standard equipment covered
	Hospice services	$300 copay/stay	$300 copay/stay	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	$45 copay/exam	$45 copay/exam	Not covered	One exam per 12-month period
	Children's glasses	50% coinsurance	50% coinsurance	Not covered	One Prescribed Standard Lenses and Frames in a 12-Month Period
	Children's dental check-up	$25 copay/visit	$25 copay/visit	$25 copay/visit	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 Foot Care

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

- Acupuncture
- Bariatric Surgery
- Chiropractic Care
- Hearing Aids
- Infertility Treatment
- 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 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.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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	$45
Hospital (facility) Copay	$300
Other Copay	$100

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	$13,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$460

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 Copay	$45
Hospital (facility) Copay	$300
Other Copay	$5

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	$7,800

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	$760

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist Copay	$45
Hospital (facility) Copay	$300
Other Copay	$100

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	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$400
Coinsurance	$20
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$420

The plan would be responsible for the other costs of these EXAMPLE covered services.