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 1-866-942-7797 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network -$2,000 individual /$4,000 family Out-of-Network -$3,300 individual /$6,600 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 policy, the overall family deductible must be met before the plan begins to pay.
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 -$4,000 individual /$8,000 family Out-of-Network -$6,000 individual /$12,000 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, the overall family out-of-pocket limit must be 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 1-866-942-7797 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	20% coinsurance Deductible applies	20% coinsurance Deductible applies	40% coinsurance Deductible applies	None
	Specialist visit	20% coinsurance Deductible applies	20% coinsurance Deductible applies	40% coinsurance Deductible applies	None
	Preventive care/screening/ immunization	No charge	No charge	40% coinsurance Deductible applies	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 - 20% coinsurance Deductible applies; Lab Facility - 0% coinsurance Deductible applies; Radiology Office - 20% coinsurance Deductible applies; Radiology Facility - 0% coinsurance Deductible applies	Lab Office - 20% coinsurance Deductible applies; Lab Facility - 20% coinsurance Deductible applies; Radiology Office - 20% coinsurance Deductible applies; Radiology Facility - 20% coinsurance Deductible applies	40% coinsurance Deductible applies	Lab Office - None; Lab Facility - None; Radiology Office - None; Radiology Facility - None
	Imaging (CT/PET scans, MRIs)	Office - 20% coinsurance Deductible applies; Facility - 0% coinsurance Deductible applies	Office - 20% coinsurance Deductible applies; Facility - 20% coinsurance Deductible applies	40% coinsurance Deductible applies	Office - Prior authorization required for non-participating provider; Facility - 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 mvphealthcare.com	Tier 1 (Generic drugs)	Retail $5/prescription Deductible applies; Mail order $10/prescription Deductible applies	Retail $5/prescription Deductible applies; Mail order $10/prescription Deductible applies	Not covered	Preventive Rx Not Subject to Deductible
	Tier 2 (Preferred brand drugs)	Retail $35/prescription Deductible applies; Mail order $70/prescription Deductible applies	Retail $35/prescription Deductible applies; Mail order $70/prescription Deductible applies	Not covered	Preventive Rx Not Subject to Deductible
	Tier 3 (Non-preferred brand drugs)	Retail $70/prescription Deductible applies; Mail order $140/prescription Deductible applies	Retail $70/prescription Deductible applies; Mail order $140/prescription Deductible applies	Not covered	Preventive Rx Not Subject to Deductible
	Tier 4 Specialty drugs	Retail Covered as noted in Tier 1, Tier 2, and Tier 3 classes Deductible applies	Retail Covered as noted in Tier 1, Tier 2, and Tier 3 classes Deductible applies	Not covered	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance Deductible applies	20% coinsurance Deductible applies	40% coinsurance Deductible applies	None
	Physician/surgeon fees	20% coinsurance Deductible applies	20% coinsurance Deductible applies	40% coinsurance Deductible applies	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	20% coinsurance Deductible applies	20% coinsurance Deductible applies	20% coinsurance Deductible applies	None
	Emergency medical transportation	20% coinsurance Deductible applies	20% coinsurance Deductible applies	20% coinsurance Deductible applies	None
	Urgent care	20% coinsurance Deductible applies	20% coinsurance Deductible applies	40% coinsurance Deductible applies	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance Deductible applies	20% coinsurance Deductible applies	40% coinsurance Deductible applies	None
	Physician/surgeon fees	20% coinsurance Deductible applies	20% coinsurance Deductible applies	40% coinsurance Deductible applies	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance Deductible applies	20% coinsurance Deductible applies	40% coinsurance Deductible applies	None
	Inpatient services	20% coinsurance Deductible applies	20% coinsurance Deductible applies	40% coinsurance Deductible applies	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	40% coinsurance Deductible applies	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	20% coinsurance Deductible applies	20% coinsurance Deductible applies	40% coinsurance Deductible applies	
	Childbirth/delivery facility services	20% coinsurance Deductible applies	20% coinsurance Deductible applies	40% coinsurance Deductible applies	
If you need help recovering or have other special health needs	Home health care	20% coinsurance Deductible applies	20% coinsurance Deductible applies	40% coinsurance Deductible applies	None
	Rehabilitation services/ Habilitation services	OP ReHab: 20% coinsurance Deductible applies IP ReHab: 20% coinsurance Deductible applies	OP ReHab: 20% coinsurance Deductible applies IP ReHab: 20% coinsurance Deductible applies	OP ReHab: 40% coinsurance Deductible applies IP ReHab: 40% coinsurance Deductible applies	OP ReHab: 45 visits per Plan Year combined therapies IP ReHab: 60 days per Plan Year
	Skilled nursing care	20% coinsurance Deductible applies	20% coinsurance Deductible applies	40% coinsurance Deductible applies	45 days per Plan Year
	Durable medical equipment	20% coinsurance Deductible applies	20% coinsurance Deductible applies	40% coinsurance Deductible applies	None
	Hospice services	20% coinsurance Deductible applies	20% coinsurance Deductible applies	40% coinsurance Deductible applies	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	20% coinsurance Deductible applies	20% coinsurance Deductible applies	40% coinsurance Deductible applies	One (1) Exam per Plan Year
	Children's glasses	20% coinsurance Deductible applies	20% coinsurance Deductible applies	40% coinsurance Deductible applies	One (1) Prescribed Lenses & Frames per Plan Year
	Children's dental check-up	Not covered	Not covered	Not covered	None

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.)

- Children's Dental Check-up
- 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:1-866-942-7797
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**	$2,000
■ **Specialist** Coinsuranc	20%
■ **Hospital (facility)** Coinsuranc	20%
■ **Other** Coinsurance	20%

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	$2,000
Copayments	$10
Coinsurance	$1,800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$3,870

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

■ **The plan's overall deductible**	$2,000
■ **Specialist**	20%
■ **Hospital (facility)**	20%
■ **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

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$0
Coinsurance	$700
What isn't covered	
Limits or exclusions	$30
The total Joe would pay is	$2,730

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

■ **The plan's overall deductible**	$2,000
■ **Specialist**	20%
■ **Hospital (facility)**	20%
■ **Other**	20%

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	$2,000
Copayments	$0
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$2,200

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

Language Assistance

ATTENTION: Language assistance services and other aids, free of charge, are available to you. Call **1-844-946-8010** (TTY 711).	**English**
ATENCIÓN: Dispone de servicios de asistencia lingüística y otras ayudas, gratis. Llame al **1-844-946-8010** (TTY 711).	**Español (Spanish)**
请注意 : 您可以免费获得语言协助服务和其他辅助服务。请致电 **1-844-946-8010** (TTY 711)。	繁體中文 **(Chinese)**
1-844-946-8010 (TTY 711) ملاحظة: خدمات المساعدة اللغوية والمساعدات الأخرى المجانية متاحة لك. اتصل بالرقم	**لعربية (Arabic)**
주의: 언어 지원 서비스 및 기타 지원을 무료로 이용하실 수 있습니다 **1-844-946-8010** (TTY 711). 번으로 연락해 주십시오.	한국어 **(Korean)**
ВНИМАНИЕ! Вам доступны бесплатные услуги переводчика и другие виды помощи. Звоните по номеру **1-844-946-8010** (TTY 711).	Русский **(Russian)**
ATTENZIONE: Sono disponibili servizi di assistenza linguistica e altri ausili gratuiti. Chiamare il **1-844-946-8010** (TTY 711).	**Italiano (Italian)**
ATTENTION : Des services d'assistance linguistique et d'autres ressources d'aide vous sont offerts gratuitement. Composez le **1-844-946-8010** (TTY 711).	**Français (French)**

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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 הילף סערוויסעס און אנדערע הילף, זענען אוועילעבל פאר אייך אומזיסט. רופ **1-844-946-8010** (TTY 711).	**אידיש (Yiddish)**
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 নামূল্যে 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 gjuhësore 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). کریں	اردو **(Urdu)**