**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, visit mvphealthcare.com/vermont or by calling 1-800-348-8515 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 **1-800-348-8515** to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | In-Network - $7,250 individual / $14,500 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, First 3 PCP or MH/SA Office Visits, Generic Prescription Drugs, Pediatric Vision, Urgent Care, Dental Class 1 | 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?** | Yes. Rx Brand Prescription drugs – $900 individual / $1,800 family | You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. |
| **What is the out-of-pocket limit for this plan?** | In-Network - $10,000 individual / $20,000 family. Includes Diabetic Supplies and Equipment. Medical and Pharmacy Out of Pocket Limits are combined. | 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 mvphealthcare.com or call 1-800-348-8515 for a list of network providers | This plan uses a provider network. You will pay less if you use a provider in the plan's network. 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** | No. | You can see the specialist you choose without a referral. |

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **see a specialist?** | | |

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 |
|---|---|---|---|---|
| | | In-Network Provider (You will pay the least) | 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 copay/office visit Deductible applies | Not covered | First 3 PCP or MH/SA Visits Covered in Full |
| | Specialist visit | $100 copay/visit Deductible applies | Not covered | None |
| | Other practitioner office visit | $50 copay/visit Deductible applies for Chiropractic Care and Physical Therapy | Not covered | No visit limit for Chiropractic Care. Applies to all outpatient settings |
| | Preventive care/screening/immunization | 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 – PCP: $40 copay/visit Deductible applies & Spec: $100 copay/visit Deductible applies; Lab Facility – 50% coinsurance Deductible applies; Radiology Office – PCP: $40 copay/visit Deductible applies & Spec: $100 copay/visit Deductible applies; Radiology Facility – 50% coinsurance Deductible applies | Not covered | Lab Office – PCP: None & Spec: None; Lab Facility – None; Radiology Office – PCP: None & Spec: None; Radiology Facility – None |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | Imaging (CT/PET scans, MRIs) | Office – 50% coinsurance Deductible applies;<br>Facility – 50% coinsurance Deductible applies | Office – Not covered;<br>Facility – Not covered | Office – Prior authorization is required for some services;<br>Facility – Prior authorization is required for some services . |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at **mvphealthcare.com/vermont** | Tier 1<br>(Generic drugs) | 30 day supply $15 copay/prescription Deductible does not apply;<br>90 day supply $37.50 copay/prescription Deductible does not apply | 30 day supply Not covered;<br>90 day supply Not covered | VBID 30 day supply $3/90 day supply $7.50. $0 generics to age 10 |
| | Tier 2<br>(Preferred brand drugs) | 30 day supply $50 copay/prescription Deductible applies;<br>90 day supply $125 copay/prescription Deductible applies | 30 day supply Not covered;<br>90 day supply Not covered | VBID 30 day supply $3/90 day supply $7.50. Prior authorization is required for some prescriptions |
| | Tier 3<br>(Non-preferred brand drugs) | 30 day supply $80 copay/prescription Deductible applies;<br>90 day supply $200 copay/prescription Deductible applies | 30 day Not covered;<br>90 day supply Not covered | VBID 30 day supply $3/90 day supply $7.50. Prior authorization is required for some prescriptions. Includes Diabetic Supplies and Equipment |
| | Tier 4<br>(Specialty drugs) | 30 day supply<br>$80 copay/prescription Deductible applies<br>90 day supply Not covered. | 30 day supply Not covered;<br>90 day supply Not covered | Prior authorization is required for some prescriptions. 30 day supply available through Specialty Pharmacy |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 50% coinsurance Deductible applies | Not covered | Prior authorization is required for some services. |
| | Physician/surgeon fees | 50% coinsurance Deductible applies | Not covered | Prior authorization is required for some services |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you need immediate medical attention** | Emergency room care | 50% coinsurance Deductible applies | 50% coinsurance Deductible applies | None |
| | Emergency medical transportation | $100 copay/trip Deductible applies | $100 copay/trip Deductible applies | None |
| | Urgent care | $100 copay/visit Deductible does not apply | $100 copay/visit Deductible does not apply | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 50% coinsurance Deductible applies | Not covered | Prior authorization is required for some services |
| | Physician/surgeon fees | 50% coinsurance Deductible applies | Not covered | Prior authorization is required for some services |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $40 copay/visit Deductible applies | Not covered | First 3 PCP or MH/SA Visits Covered in Full |
| | Inpatient services | 50% coinsurance Deductible applies | Not covered | None |
| **If you are pregnant** | Office visits | $40 copay/visit Deductible applies | 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 | 50% coinsurance Deductible applies | Not covered | |
| | Childbirth/delivery facility services | 50% coinsurance Deductible applies | Not covered | |
| **If you need help recovering or have other** | Home health care | 50% coinsurance Deductible applies | Not covered | None |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **special health needs** | Rehabilitation services/Habilitation services | OP ReHab: $100 copay/visit Deductible applies<br>IP ReHab: 50% coinsurance Deductible applies | OP ReHab: Not covered<br>IP ReHab: Not covered | OP ReHab: 30 combined PT/OT/ST visits per year. OP PT applies Other practitioner office visit cost share in all OP settings<br>IP ReHab: None |
| | Skilled nursing care | 50% coinsurance Deductible applies | Not covered | None |
| | Durable medical equipment | 50% coinsurance Deductible applies | Not covered | Prior authorization is required for some items |
| | Hospice services | 50% coinsurance Deductible applies | Not covered | None |
| **If your child needs dental or eye care** | Children's eye exam | $20 copay/exam Deductible does not apply | Not covered | One eye exam per year to age 21 |
| | Children's glasses | $20 copay/pair Deductible does not apply | $20 copay/pair Deductible does not apply | One pair per year to age 21. Eyewear can be purchased from any provider |
| | Children's dental check-up | Class 1: No charge Deductible does not apply<br>Class 2: 30% coinsurance Deductible applies<br>Class 3 and Orthodontic: 50% coinsurance Deductible applies | Not covered | Two dental exams per year to age 21. Adult Dental not covered |

## 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.
- Routine eye care (Adult)

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.) | | |
|---|---|---|
| • Abortion<br>• Acupuncture ($500 Allowance)<br>• Bariatric surgery (Requires Prior Authorization) | • Chiropractic care<br>• Hearing aids<br>• Infertility treatment | • Private-duty nursing<br>• Routine foot care<br>• 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: 1-800-348-8515
http://www.mvphealthcare.com/vermont
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 on how 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:1-800-348-8515
www.mvphealthcare.com
members@mvphealthcare.com

You can also contact the Vermont Department of Financial Regulation at 1-800-631-7788 or dfr.vermont.gov. Additionally, a consumer assistance program can help you file your appeal. Contact the Vermont Legal Aid at 1-800-889-2047 or vtlegalaid.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 prenatal care and a hospital delivery)

| | |
|---|---|
| ■ The plan's overall deductible | $7,250 |
| ■ Specialist copayment | $100 |
| ■ Hospital (facility) coinsurance | 50% |
| ■ Other coinsurance | 50% |

**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 | $7,250 |
| Copayments | $10 |
| Coinsurance | $2,700 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$10,020** |

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

| | |
|---|---|
| ■ The plan's overall deductible | $7,250 |
| ■ Specialist copayment | $100 |
| ■ Hospital (facility) coinsurance | 50% |
| ■ Other copayment | $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 | $1,900 |
| Copayments | $100 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$2,020** |

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

| | |
|---|---|
| ■ The plan's overall deductible | $7,250 |
| ■ Specialist copayment | $100 |
| ■ Hospital (facility) coinsurance | 50% |
| ■ Other coinsurance | 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** | **$2,810** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $2,400 |
| Copayments | $10 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $400 |
| **The total Mia would pay is** | **$2,810** |

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)** |
| ملاحظة: **1-844-946-8010** خدمات المساعدة اللغوية والمساعدات الأخرى المجانية متاحة لك. اتصل بالرقم (TTY 711). | 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)** |
| 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. רופט **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)** |

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