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 and primary 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 -$4,600 individual /$9,200 family Pharm -$2,000 individual /$4,000 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 1-888-687-6277 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 see a specialist?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

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	$15 copay/office visit	Not covered	None
	Specialist visit	$15 copay/visit	Not covered	None
	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 - No charge; Lab Facility - No charge; Radiology Office - $15 copay/visit; Radiology Facility - $15 copay	Not covered	Lab Office - None; Lab Facility - None; Radiology Office - None; Radiology Facility - None
	Imaging (CT/PET scans, MRIs)	Office - $15 copay/procedure; Facility - $15 copay/procedure	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay: In-Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
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 Copayment; Mail order $10. Mail order Copay is 2 x retail copay.	Retail Not covered; Mail order Not covered	None
	Tier 2 (Preferred brand drugs)	Retail $20 Copayment; Mail order $40. Mail order Copay is 2 x retail copay.	Retail Not covered; Mail order Not covered	None
	Tier 3 (Non-preferred brand drugs)	Retail $40 Copayment; Mail order $80. Mail order Copay is 2 x retail copay.	Retail Not covered; Mail order Not covered	None
	Tier 4 Specialty drugs	Retail Covered as noted in Tier 1, Tier 2, and Tier 3 classes;	Not covered	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$15 copay/day	Not covered	None
	Physician/surgeon fees	No charge	Not covered	None
If you need immediate medical attention	Emergency room care	$50 copay/visit	$50 copay/visit	None
	Emergency medical transportation	No charge	No charge	None
	Urgent care	$15 copay/visit	$15 copay/visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Not covered	None
	Physician/surgeon fees	No charge	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)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 copay/visit	Not covered	None
	Inpatient services	No charge	Not covered	None
If you are pregnant	Office visits	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	Not covered	
	Childbirth/delivery facility services	No charge	Not covered	
If you need help recovering or have other special health needs	Home health care	$15 copay/visit	Not covered	60 visits per year
	Rehabilitation services	$15 copay/visit	Not covered	30 combined PT/OT/ST visits per year
	Habilitation services	$15 copay/visit	Not covered	30 combined PT/OT/ST visits per year
	Skilled nursing care	No charge	Not covered	60 days per year
	Durable medical equipment	20% Coinsurance	Not covered	No
	Hospice services	No charge	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
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	$15 copay/exam	Not covered	one exam every two years
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	$25 copay/visit	Not covered	preventive dental services to age 19

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
- Children's Glasses
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Long-Term Care
- Non-Emergency care when traveling outside the US
- Private-Duty Nursing
- Routine Foot Care
- Weight Loss Programs

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

- Bariatric Surgery
- Chiropractic Care
- Durable Medical Equipment
- Generic drugs
- Infertility Treatment
- Non-preferred brand drugs
- Preferred brand drugs
- Routine Eye Care (Adult)
- Specialty drugs

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 $15
- Hospital (facility) Copay $0
- 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	$13,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$30
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$90**

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 $15
- Hospital (facility) Copay $0
- Other Copay $15

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	$1,100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$300
The total Joe would pay is	**$1,400**

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

- The plan's overall deductible $0
- Specialist Copay $15
- Hospital (facility) Copay $0
- Other Copay $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	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$100**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: www.mvphealthcare.com.
*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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

Non-Discrimination Notice

MVP Health Care complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. MVP Health Care does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. MVP Health Care:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Jane Strange. If you believe that MVP Health Care has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Jane Strange, Civil Rights Coordinator, 625 State Street, Schenectady, NY 12305, 1-844-946-8009 (phone), 1-800-662-1220 (TTY), CivilRightsCoordinator@mvphealthcare.com. You can file a grievance in person or by mail or email. If you need help filing a grievance, Jane Strange, Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services. 200 Independence Avenue, SW. Room 509F, HHH Building. Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

Getting Help in a Language Other than English.

This is an important document. If you need help to understand it, please call **1-844-946-8010**. We can give you an interpreter for free in the language you speak.

Español *(Spanish)*

Este es un documento importante. Si necesita ayuda para entenderlo, llame al **1-844-946-8010**. Le proporcionaremos un intérprete sin ningún costo.

中文 *(Simplified Chinese)*

这是一份重要的文件。如果您需要帮助理解此文件，请打电话至 **1-844-946-8010**。我们可以为您免费提供相应语种的口译服务。

中文 *(Traditional Chinese)*

這是重要的文件。 如果您需要獲得關於瞭解文件內容方面的協助，請致電 **1-844-946-8010**。我們可以為您免費提供您所使用語言的翻譯人員。

Русский *(Russian)*

Это важный документ. Если Вам нужна помощь для понимания этого документа, позвоните по телефону **1-844-946-8010**. Мы можем бесплатно предоставить Вам переводчика Вашего языка.

Français *(French Creole)*

Sa a se yon dokiman ki enpòtan. Si ou bezwen èd pou konprann li, tanpri rele nimewo **1-844-946-8010**. Nou kapab ba ou yon entèprèt gratis nan lang ou pale a.

한국어 *(Korean)*

중요한 서류입니다. 이해하는 데 도움이 필요하시면 **1-844-946-8010** 번으로 연락해 주십시오. 귀하의 언어에 대한 무료 통역 서비스가 제공됩니다.

Italiano *(Italian)*

Questo è un documento importante. Per qualsiasi chiarimento può chiamare il numero **1-844-946-8010**. Possiamo metterle a disposizione un interprete nella sua lingua.

אידיש *(Yiddish)*

טפור עטיב ,ןייטשראפ וצ סע ףליה טפראד ריא בויא .טנעמוקאד רעגיטכיוו א זיא סאד ךארפש יד ןיא לאצפא ןופ יירפ רעשטעמלאד א ןבעג ךייא ןענעק רימ .**1-844-946-8010** .טדער ריא סאוו

বাংলা *(Bengali)*

এটি এক গুরুত্বপূর্ণ নথি। এটি বুঝতে আপনার যদি সাহায্যের প্রয়োজন হয় তাহলে, অনুগ্রহ করে **1-844-946-8010** নম্বরে কল করুন। আপনি যে ভাষায় কথা বলেন বিনামূল্যে আমরা আপনাকে একজন দোভাষী দিতে পারি।

Polski *(Polish)*

To jest ważny dokument. W przypadku konieczności skorzystania z pomocy w celu zrozumienia jego treści należy zadzwonić pod numer **1-844-946-8010**. Istnieje możliwość uzyskania bezpłatnej usługi tłumacza języka, którym się posługujesz.

العربية *(Arabic)*

هذه وثيقة مهمة. إذا كنت بحاجة إلى مساعدة لفهم محتواها، يُرجى الاتصال بالرقم **1-844-946-8010**. يُمكننا توفير مترجم فوري لك باللغة التي تتحدثها مجانًا.

Français *(French)*

Ceci est un document important. Si vous avez besoin d'aide pour en comprendre le contenu, appelez le **1-844-946-8010**. Nous pouvons mettre gratuitement à votre disposition un interprète dans votre langue.

اردو *(Urdu)*

یہ ایک اہم دستاویز ہے۔ اگر آپ کو اسے سمجھنے کے لیے مدد کی ضرورت ہے تو براہ کرم **1-844-946-8010**۰پر کال کریں۔ ہم آپ کو آپ کی مادری زبان میں ایک مفت مترجم فراہم کر سکتے ہیں۔

Tagalog *(Tagalog)*

Ito ay isang mahalagang dokumento. Kung kailangan mo ng tulong para maintindihan ito, pakitawagan ang **1-844-946-8010**. Maaari ka naming bigyan ng libreng interpreter sa wikang iyong sinasalita.

Ελληνικά *(Greek)*

Αυτό το έγγραφο είναι σημαντικό. Αν χρειάζεστε βοήθεια για να το κατανοήσετε, καλέστε μας στο **1-844-946-8010**. Μπορούμε να σας προσφέρουμε δωρεάν διερμηνεία στη μητρική σας γλώσσα.

Shqip *(Albanian)*

Ky është një dokument i rëndësishëm. Nëse ju nevojitet ndihmë për ta kuptuar, ju lutemi të telefononi në numrin **1-844-946-8010**. Mund t'ju ofrojmë pa pagesë një interpret për gjuhën që flisni.