This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.mvphealthcare.com or by calling 1-888-687-6277..

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In network -$950 person/$1,900 family	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Are there other deductibles for specific services?	RX Brand -$100 person \$200 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.
Is there an out–of–pocket limit on my expenses?	In network -$6,550 person/$13,100 family.	The out–of–pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges and excluded benefits.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes, for a list of participating providers see www.mvphealthcare.com.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a specialist?	No.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about excluded services.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating providers by charging you lower deductibles, copayments and coinsurance amounts.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copay	Not covered	Deductible waived, $0 copay first 3 visits
	Specialist visit	$50 copay	Not covered	Deductible applies
	Other practitioner office visit	$50 copay	Not covered	Deductible applies
	Preventive care/ screening/immunization	Covered in Full	Not covered	——————none——————
If you have a test	Diagnostic test (x-ray, blood work)	Lab Office - $15 copay Lab Facility - $50 copay Radiology Office - PCP: $15 copay/Spec: $60 copay Radiology Facility - $60 copay	Not covered	Lab Office - Deductible waived, $0 copay first 3 visits Lab Facility - Deductible waived Radiology Office - Deductible waived, $0 copay first 3 visits
	Imaging (CT/PET scans, MRIs)	$160 copay	Not covered	Deductible applies, per day, per provider Hi-Tech Facility - Deductible applies, per day per provider

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www. mvphealthcare.com.	Generic drugs	Retail $10 copay Mail order Not covered	Not covered	Deductible waived, 30 day supply retail
	Preferred brand drugs	Retail $40 copay Mail order Not covered	Not covered	Deductible applies, 30 day supply retail
	Non-preferred brand drugs	Retail $60 copay Mail order Not covered	Not covered	Deductible applies, 30 day supply retail
	Specialty drugs	Retail $60 copay Mail order Not covered	Not covered	Deductible applies, 30 day supply retail available through Specialty Pharmacy
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery)	$200 copay	Not covered	Deductible applies, interruption of pregnancy is covered
	Physician/surgeon fees	$100 copay	Not covered	Deductible applies, interruption of pregnancy is covered
If you need immediate medical attention	Emergency room services	$350 copay	$350 copay	Deductible waived, waived if admitted to hospital
	Emergency medical transportation	$350 copay	$350 copay	Deductible waived
	Urgent care	$50 copay	$50 copay	Deductible waived
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copay	Not covered	Deductible applies, per continuous confinement
	Physician/surgeon fee	$100 copay	Not covered	Deductible applies

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient	$15 copay	Not covered	Deductible waived, $0 copay first 3 visits
	Mental/Behavioral health inpatient services	$500 copay	Not covered	Deductible applies, including residential treatment
	Substance use disorder outpatient services	$15 copay	Not covered	Deductible waived, $0 copay first 3 visits, 20 visits for family counseling
	Substance use disorder inpatient services	$500 copay	Not covered	Deductible applies, including residential treatment
If you are pregnant	Prenatal and postnatal	Office Visit: Covered in Full	Not covered	Deductible waived, postnatal care visits
	Delivery and all inpatient services	$500 copay for admission and $100 copay for delivery	Not covered	Deductible applies, plus $100 physician copay
If you need help recovering or have other special health needs	Home health care	$50 copay	Not covered	Deductible applies, 60 visits per year
	Rehabilitation services	$50 copay	Not covered	Deductible applies, 54 combined PT/OT/ST visits per year
	Habilitation services	$50 copay	Not covered	Deductible applies, 54 combined PT/OT/ST visits per year
	Skilled nursing care	$500 copay	Not covered	Deductible applies, 200 days per plan year
	Durable medical equipment	50% coinsurance	Not covered	Deductible applies, standard equipment covered
	Hospice service	$500 copay	Not covered	Deductible applies, 210 days per plan year
If your child needs dental or eye care	Eye exam	$50 copay	Not covered	Deductible applies, one exam per 12-month period
	Glasses	50% coinsurance	Not covered	Deductible applies, one pair per 12-
	Dental check-up	Not covered	Not covered	benefits are available

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

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

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture
- Bariatric Surgery
- Chiropractic Care
- Hearing Aids
- Infertility Treatment
- Weight Loss Programs
- MVP Wellness Program

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-888-687-6277. You may also contact your state insurance department at 1-800-342-3736 or http://www.dfs.ny.gov/insurance/consindx.htm

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: MVP Health Care at 1-888-687-6277 or your state insurance department at 1-800-342-3736 or http://www.dfs.ny.gov/insurance/consindx.htm

The following is the New York State Department of Insurance contact information:
New York State Department of Financial Services, One Commerce Plaza, Albany, NY 12257, 1-800-342-3736 or 1-518-474-6600
Or, 25 Beaver Street, New York, NY 10004, 1-800-342-3736 or 1-212-480-6400
New York State External Appeals, P.O. Box 7209, Albany, NY 12224-0209
1-800-400-8882, 1-888-990-3991 (Expedited appeals on weekend & holidays), Email: externalappealquesions@dfs.ny.gov
Additionally, a consumer assistance program can help you file your appeal. Contact:
Community Service Society of New York, Community Health Advocates, 105 East 22nd Street, 8th floor, New York, NY 10010, 1-888-614-5400
www.communityhealthadvocates.org, Email: cha@cssny.org

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage."
This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value).
This health coverage does meet the minimum value standard for the benefits it provides.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers: $7,466**
- **Plan pays** $5,598
- **Patient pays** $1,868

Sample care costs:

Hospital charges (mother)	$2,714
Routine obstetric care	$2,084
Hospital charges (baby)	$852
Anesthesia	$905
Laboratory tests	$527
Prescriptions	$173
Radiology	$176
Vaccines, other preventive	$35
Total	**$7,466**

Patient pays:

Deductibles	$950
Co-pays	$768
Co-insurance	$0
Limits or exclusions	$150
Total	$1,868

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers: $5,490**
- **Plan pays** $3,897
- **Patient pays** $1,593

Sample care costs:

Prescriptions	$2,889
Medical Equipment and Supplies	$1,311
Office Visits and Procedures	$725
Education	$288
Laboratory tests	$137
Vaccines, other preventive	$140
Total	**$5,490**

Patient pays:

Deductibles	$315
Co-pays	$1278
Co-insurance	$0
Limits or exclusions	$0
Total	$1,593

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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** پر 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.