
 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](http://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/](http://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 <a href="#">deductible</a> ?	In-Network -\$5,900 individual /\$11,800 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 <a href="#">deductible</a> ?	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 <a href="#">deductibles</a> for specific services?	No.	You don't have to meet deductibles for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	In-Network -\$6,550 individual /\$13,100 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 <a href="#">out-of-pocket limit</a> ?	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 <a href="#">network provider</a> ?	Yes. See <a href="http://www.mvphealthcare.com">www.mvphealthcare.com</a> 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 <a href="#">referral</a> to see a <a href="#">specialist</a> ?	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
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$30 copay/office visit	Not covered	Deductible applies
	<a href="#">Specialist</a> visit	\$50 copay/visit	Not covered	Deductible applies
	<a href="#">Preventive care/screening/immunization</a>	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	<a href="#">Diagnostic test</a> (x-ray, blood work)	Lab Office - \$30 copay/visit; Lab Facility - \$50 copay/visit; Radiology Office - PCP: \$30 copay/visit & Spec: \$100 copay/visit; Radiology Facility - \$100 copay/visit	Not covered	Lab Office - Deductible applies; Lab Facility - Deductible applies; Radiology Office - Deductible applies; Radiology Facility - Deductible applies
	Imaging (CT/PET scans, MRIs)	Office - \$200 copay/procedure; Facility - \$200 copay/procedure	Not covered	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)	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.mvphealthcare.com">www.mvphealthcare.com</a>	Tier 1 (Generic drugs)	Retail \$10 copay/prescription; Mail order Not covered	Not covered	Deductible applies
	Tier 2 (Preferred brand drugs)	Retail \$45 copay/prescription; Mail order Not covered	Not covered	Deductible applies
	Tier 3 (Non-preferred brand drugs)	Retail \$90 copay/prescription; Mail order Not covered	Not covered	Deductible applies
	Tier 4 <a href="#">Specialty drugs</a>	Retail \$90 copay/prescription; Mail order Not covered	Not covered	Deductible applies, 30 day supply retail available through Specialty Pharmacy
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$100 copay/day	Not covered	Deductible applies
	Physician/surgeon fees	\$100 copay/procedure	Not covered	Deductible applies
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$500 copay/visit	\$500 copay/visit	Deductible applies, copay waived if admitted to hospital
	<a href="#">Emergency medical transportation</a>	\$500 copay/use	\$500 copay/use	Deductible applies
	<a href="#">Urgent care</a>	\$50 copay/visit	\$50 copay/visit	Deductible applies
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	30% coinsurance	Not covered	Deductible applies, per continuous confinement
	Physician/surgeon fees	30% coinsurance	Not covered	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 need mental health, behavioral health, or substance abuse services	Outpatient services	\$30 copay/visit	Not covered	Deductible applies
	Inpatient services	30% coinsurance	Not covered	Deductible applies, including residential treatment
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	30% coinsurance	Not covered	
	Childbirth/delivery facility services	30% coinsurance	Not covered	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	\$50 copay/visit	Not covered	Deductible applies, 60 visits per year
	<a href="#">Rehabilitation services</a>	\$50 copay/visit	Not covered	Deductible applies, 54 visits per Plan Year combined therapies
	<a href="#">Habilitation services</a>	\$50 copay/visit	Not covered	Deductible applies, 54 visits per Plan Year combined therapies
	<a href="#">Skilled nursing care</a>	30% coinsurance	Not covered	Deductible applies, 200 days per plan year
	<a href="#">Durable medical equipment</a>	50% coinsurance	Not covered	Deductible applies, standard equipment covered
	<a href="#">Hospice services</a>	30% coinsurance	Not covered	Deductible applies, 210 days per plan year

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	\$50 copay/exam	Not covered	Deductible applies, one exam per 12-month period
	Children's glasses	50% coinsurance	Not covered	Deductible applies, one pair per 12-month period
	Children's dental check-up	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 Eye Care (Adult)
- 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
- 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: 1-888-687-6277  
[www.mvphealthcare.com](http://www.mvphealthcare.com)  
[members@mvphealthcare.com](mailto:members@mvphealthcare.com)

You can also contact the NYS Department of Insurance at 1-800-342-3736 or [dfs.ny.gov](http://dfs.ny.gov), or the Community Health Advocates at 1-888-614-5400 or [communityhealthadvocates.org](http://communityhealthadvocates.org), or NY State of Health at 1-855-355- 5777 or [nystateofhealth.ny.gov](http://nystateofhealth.ny.gov). 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](http://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](http://www.mvphealthcare.com)  
[members@mvphealthcare.com](mailto:members@mvphealthcare.com)

You can also contact the NYS Department of Insurance at 1-800-342-3736 or [dfs.ny.gov](http://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](http://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](#) \$5,900
- [Specialist](#) Copay \$50
- Hospital (facility) Coinsurance 30%
- Other Coinsurance 30%

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*)

<b>Total Example Cost</b>	<b>\$13,800</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$5,900
Copayments	\$0
Coinsurance	\$700
<i>What isn't covered</i>	
Limits or exclusions	\$70
<b>The total Peg would pay is</b>	<b>\$6,670</b>

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

- The [plan's](#) overall [deductible](#) \$5,900
- [Specialist](#) Copay \$50
- Hospital (facility) Coinsurance 30%
- Other Copay \$30

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*)

<b>Total Example Cost</b>	<b>\$7,800</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$5,900
Copayments	\$400
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$200
<b>The total Joe would pay is</b>	<b>\$6,500</b>

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

- The [plan's](#) overall [deductible](#) \$5,900
- [Specialist](#) Copay \$50
- Hospital (facility) Coinsurance 30%
- Other Copay \$500

This EXAMPLE event includes services like:  
Emergency room care (*including medical supplies*)  
Diagnostic test (*x-ray*)  
Durable medical equipment (*crutches*)  
Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,900
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,900</b>