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/vermont. 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 -$1,500 individual /$3,000 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 Primary Care, Mental Health and Substance Abuse Office Visits, 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?	Prescription -$500 individual /$1,000 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 -$6,700 individual /$13,400 family.Includes Diabetic Supplies and Equipment. Pharm -$1,400 individual /$2,800 family Medical and Pharmacy Out of Pocket Limits are separate.	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 www.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 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
		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	$30 copay/office visit Deductible applies	Not covered	First 3 visits no Deductible
	Specialist visit	$60 copay/visit Deductible applies	Not covered	None
	Other practitioner office visit	$45 copay/visit Deductible applies for Chiropractic Care, Physical and Occupational Therapy	Not covered	No visit limit for Chiropractic Care
	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 - $30/visit Deductible applies; Lab Facility - $60/visit Deductible applies; Radiology Office - PCP: $30/visit Deductible applies & Spec: $60/visit Deductible applies; Radiology Facility - $150/visit Deductible applies	Not covered	Lab Office - First 3 visits no Deductible; Lab Facility - None; Radiology Office - PCP: First 3 visits no Deductible & Spec: None; Radiology Facility - None
	Imaging (CT/PET scans, MRIs)	Office - $1,400 copay/procedure Deductible applies; Facility - $1,400 copay/procedure 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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.mvphealthcare.com **www.mvphealthcare.com/vermont**	Tier 1 (Generic drugs)	Retail $5/prescription Deductible applies; Mail order $12.50/prescription Deductible applies	Not covered	30 day retail/90 day mail order; VBID retail copay is $1/mail order $2.50
	Tier 2 (Preferred brand drugs)	50% coinsurance Deductible applies	Not covered	30 day retail/90 day mail order; VBID retail copay is $1/mail order $2.50. Prior authorization required for some prescriptions
	Tier 3 (Non-preferred brand drugs)	50% coinsurance Deductible applies	Not covered	30 day retail/90 day mail order; VBID retail copay is $1/mail order $2.50. Prior authorization required for some prescriptions. Includes Diabetic Supplies and Equipment
	Tier 4 Specialty drugs	50% coinsurance Deductible applies	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)	$1,400 copay/day Deductible applies	Not covered	Prior authorization is required for some services
	Physician/surgeon fees	$300 copay Deductible applies	Not covered	Prior authorization is required for some services
If you need immediate medical attention	Emergency room care	$400 copay/visit Deductible applies	$400 copay/visit Deductible applies	None
	Emergency medical transportation	$100 copay/trip Deductible applies	$100 copay/trip Deductible applies	None
	Urgent care	$60 copay/visit Deductible applies	$60 copay/visit Deductible applies	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 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	$30 copay/visit Deductible applies	Not covered	First 3 visits no Deductible
	Inpatient services	50% coinsurance Deductible applies	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	50% coinsurance Deductible applies	Not covered	
	Childbirth/delivery facility services	50% coinsurance Deductible applies	Not covered	

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 help recovering or have other special health needs	Home health care	$60 copay/visit Deductible applies	Not covered	None
	Rehabilitation services/ Habilitation services	OP ReHab: $60 copay/visit Deductible applies IP ReHab: 50% coinsurance Deductible applies	OP ReHab: Not covered IP ReHab: Not covered	OP ReHab: 30 combined PT/OT/ST visits per year 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	$60 copay/exam Deductible applies	Not covered	One eye exam per year to age 21
	Children's glasses	50% coinsurance Deductible applies	Not covered	One pair per year to age 21
	Children's dental check-up	Class 1: No charge Class 2: 30% coinsurance Deductible applies Class 3 and Orthodontic: 50% coinsurance Deductible applies	Class 1: Not covered Class 2: Not covered Class 3 and Orthodontic: 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.)

- Acupuncture
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Long-Term Care
- Non-Emergency care when traveling outside the U.S
- Routine Eye Care (Adult)
- Routine Foot Care(Routine Foot Care for Diabetes is covered)

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

- Abortion
- Bariatric Surgery(Requires Prior Authorization)
- Chiropractic Care
- Infertility Treatment
- Private-Duty Nursing
- 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/vermont
members@mvphealthcare.com

You can also contact the Vermont Department of Financial Regulation at 1-800-631-7788 or dfr.vermont.gov, or the Vermont Legal Aid at 1-800-889-2047 or vtlegalaid.org, or Vermont Health Connect at 1- 855-899-9600 or portal.healthconnect.vermont.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 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:1-800-348-8515
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? Not Applicable.

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** $1,500
- **Specialist** Copay $60
- **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	$1,500
Copayments	$200
Coinsurance	$4,300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$6,060

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

- **The plan's overall deductible** $1,500
- **Specialist** Copay $60
- **Hospital (facility)** Coinsurance 50%
- **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)*

Total Example Cost	$5,600

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,600
Copayments	$200
Coinsurance	$900
What isn't covered	
Limits or exclusions	$200
The total Joe would pay is	$2,900

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

- **The plan's overall deductible** $1,500
- **Specialist** Copay $60
- **Hospital (facility)** Coinsurance 50%
- **Other** Copay $400

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	$1,500
Copayments	$700
Coinsurance	$20
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$2,220

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

Non-Discrimination Notice

for MVP Commercial Plans

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.

What 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)

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

If you need these services, contact Jane Strange at **1-844-946-8009** (TTY: **1-800-662-1220**).

How to File a Grievance or Complaint

If you believe that MVP has not given you these services or has treated you differently because of race, color, national origin, age, disability, or sex, you can file a grievance with MVP by:

Mail: ATTN: JANE STRANGE
CIVIL RIGHTS COORDINATOR
MVP HEALTH CARE
625 STATE ST
SCHENECTADY NY 12305

Phone: **1-844-946-8009**
(TTY/TDD: **1-800-662-1220**)

In person: 625 State Street, Schenectady, NY

Email: **civilrightscoordinator@mvphealthcare.com**

You can also file a civil rights complaint with the U.S. Department of Health & Human Services Office for Civil Rights by:

Online: **ocrportal.hhs.gov**

Mail: US DEPT OF HEALTH & HUMAN SRVS
200 INDEPENDENCE AVE SW
HHH BLDG ROOM 509F
WASHINGTON DC 20201

Phone: **1-800-368-1019**
(TTY/TTD: **1-800-537-7697**)

Complaint forms are available by visiting **hhs.gov** and selecting *Laws & Regulations*, then *Complaints & Appeals*, then *Civil Rights: How to file a complaint*.

Multi-Language Interpreter Services

Español (Spanish)
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia linguística. Llame al **1-844-946-8010** (TTY: **1-800-662-1220**).

繁體中文 (Chinese)
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-844-946-8010**（TTY：**1-800-662-1220**）。

Русский (Russian)
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-844-946-8010** (телетайп: **1-800-662-1220**).

Kreyòl Ayisyen (French Creole)
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-844-946-8010** (TTY: **1-800-662-1220**).

한국어 (Korean)
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-844-946-8010** (TTY: **1-800-662-1220**) 번으로 전화해 주십시오.

Italiano (Italian)
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero **1-844-946-8010** (TTY: **1-800-662-1220**).

אידיש (Yiddish)
אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט (TTY: 1-800-662-1220) 1-844-946-8010.

বাংলা (Bengali) লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পিরেষবা উপলব্ধ আছে। ফোন করুন ১-844-946-8010 (TTY: ১-800-662-1220)।

Polski (Polish) UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer **1-844-946-8010** (TTY: **1-800-662-1220**).

العربية (Arabic) ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-844-946-8010 (رقم هاتف الصم والبكم: 1-800-662-0221).

Français (French)
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-844-946-8010** (ATS : **1-800-662-1220**).

اُردُو (Urdu) خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں ۔ **1-844-946-8010** (TTY: **1-800-662-1220**)

Tagalog (Tagalog-Filipino)
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-844-946-8010** (TTY: **1-800-662-1220**).

Ελληνικά (Greek)
ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε **1-844-946-8010** (TTY: **1-800-662-1220**).

Shqip (Albanian)
KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në **1-844-946-8010** (TTY: **1-800-662-1220**).