



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 1-800-348-8515..

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In network - \$0 person/\$0 family	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> 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 <u>deductible</u> .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	No.	There's no limit on how much you could pay during a coverage period for your share of the cost of covered services.
What is not included in the <u>out-of-pocket limit</u>?	This plan has no Out-of-Pocket Limit.	Not applicable because there's no <u>out-of-pocket limit</u> on your expenses.
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 <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u>?	Yes. For a list of participating providers see www.mvphealthcare.com .	If you use an in-network doctor or other health care <u>provider</u> , 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 <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a <u>specialist</u>?	No.	You can see the <u>specialist</u> 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 <u>excluded services</u> .

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary

at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.



- **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		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you visit a health care provider’s office or clinic	Primary care visit to treat an injury or illness	\$0 copay	Not covered.	—————none—————
	Specialist visit	\$0 copay	Not covered.	—————none—————
	Other practitioner office visit	\$0 copay	Not covered.	—————none—————
	Preventive care/ screening/immunization	\$0 copay	Not covered.	—————none—————
If you have a test	Diagnostic test (x-ray, blood work)	\$0 copay	Not covered.	—————none—————
	Imaging (CT/PET scans, MRIs)	\$0 copay	Not covered.	—————none—————

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren’t clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.mvphealthcare.com .	Generic drugs	\$0 copay	Not covered.	30 day retail/90 day mail order.
	Preferred brand drugs	\$0 copay	Not covered.	30 day retail/90 day mail order.
	Non-preferred brand drugs	\$0 copay	Not covered.	30 day retail/90 day mail order.
	Specialty drugs	Retail Covered at Specialty Pharmacy as noted in generic, preferred, and non-preferred classes.	Not covered.	30 day supply available through Specialty Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery)	\$0 copay	Not covered.	—————none—————
	Physician/surgeon fees	\$0 copay	Not covered.	—————none—————
If you need immediate medical attention	Emergency room services	\$0 copay	\$0 copay	—————none—————
	Emergency medical transportation	\$0 copay	\$0 copay	—————none—————
	Urgent care	\$0 copay	\$0 copay	—————none—————
If you have a hospital stay	Facility fee (e.g., hospital room)	\$0 copay	Not covered.	—————none—————
	Physician/surgeon fee	\$0 copay	Not covered.	—————none—————

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary

at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient	\$0 copay	Not covered.	—————none—————
	Mental/Behavioral health inpatient services	\$0 copay	Not covered.	—————none—————
	Substance use disorder outpatient services	\$0 copay	Not covered.	—————none—————
	Substance use disorder inpatient services	\$0 copay	Not covered.	—————none—————
If you are pregnant	Prenatal and postnatal	\$0 copay	Not covered.	—————none—————
	Delivery and all inpatient services	\$0 copay	Not covered.	—————none—————
If you need help recovering or have other special health needs	Home health care	\$0 copay	Not covered.	—————none—————
	Rehabilitation services	\$0 copay	Not covered.	30 combined PT/OT/ST visits/yr.
	Habilitation services	\$0 copay	Not covered.	30 combined PT/OT/ST visits/yr.
	Skilled nursing care	\$0 copay	Not covered.	—————none—————
	Durable medical equipment	\$0 copay	Not covered.	—————none—————
	Hospice service	\$0 copay	Not covered.	—————none—————
If your child needs dental or eye care	Eye exam	\$0 copay	Not covered.	One eye exam per year to age 21.
	Glasses	\$150 allowance per year to age 21.	Same as Par Provider.	—————none—————
	Dental check-up	\$0 copay	Same as Par Provider.	Two dental exams per year to age 21.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary

at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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.)

- Acupuncture
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Infertility Treatment
- Long-Term Care
- Non-Emergency care when traveling outside the US
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight Loss Programs
- MVP Wellness Program

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.)

- Bariatric Surgery
- Chiropractic Care
- Private-Duty Nursing

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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 1-800-637-7788 or <http://www.dfr.vermont.gov/insurance/insurance-consumer/consumer-information>

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 1-800-637-7788 or <http://www.dfr.vermont.gov/insurance/insurance-consumer/consumer-information>

The following is the Vermont State Department of Insurance contact information:

External Appeals Program, Vermont Department of Financial Regulation

89 Main Street, Montpelier, VT 05602, 1-800-631-7788 or 1-802-282-2900, 1-888-236-5966 (Emergency request for external appeal)

Additionally, a consumer assistance program can help you file your appeal. Contact:

Vermont Legal Aid, Office of Health Care Ombudsman, 264 North Winooski Avenue, Burlington, VT 05402

1-800-917-7787 or 1-802-863-2316; TTY: 1-888-884-1955 or 1-802-863-2473, www.vtlegalaid.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.*—————

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary

at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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** \$7,316
- **Patient pays** \$150

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	\$0
Co-pays	\$0
Co-insurance	\$0
Limits or exclusions	\$150
Total	\$150

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

- **Amount owed to providers: \$5,490**
- **Plan pays** \$5,490
- **Patient pays** \$0

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	\$0
Co-pays	\$0
Co-insurance	\$0
Limits or exclusions	\$0
Total	\$0

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.



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 1-800-348-8515..

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In network -\$2,000 person/\$4,000 family	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> 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 <u>deductible</u> .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	In network -\$6,250 person/\$12,500 family Rx out-of-pocket -\$1,300 person /\$2,600 family	The <u>out-of-pocket limit</u> 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 and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
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 <i>specific</i> 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 <u>provider</u> , 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 <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a specialist?	No.	You can see the <u>specialist</u> 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 <u>excluded services</u> .

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary

at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.



- **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		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you visit a health care provider’s office or clinic	Primary care visit to treat an injury or illness	50% coinsurance*	Not covered.	Deductible applies.
	Specialist visit	50% coinsurance*	Not covered	Deductible applies.
	Other practitioner office visit	50% coinsurance*	Not covered	Deductible applies.
	Preventive care/ screening/immunization	\$0 copay	Not covered	Deductible waived.
If you have a test	Diagnostic test (x-ray, blood work)	50% coinsurance*	Not covered	Deductible applies.
	Imaging (CT/PET scans, MRIs)	50% coinsurance*	Not covered	Deductible applies.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren’t clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
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 \$12 copay* Mail order \$30 copay*	Not covered	Deductible applies. 30 day supply retail/90 day supply Mail order. Preventive drugs.
	Preferred brand drugs	40% coinsurance*	Not covered	Deductible applies. 30 day supply retail/90 day supply Mail order. Preventive drugs, Deductible waived.
	Non-preferred brand drugs	60% coinsurance*	Not covered	Deductible applies. 30 day supply retail/90 day supply Mail order. Preventive drugs, Deductible waived.
	Specialty drugs	Retail Covered at Specialty Pharmacy as noted in generic, preferred, and non-preferred classes.	Not covered	30 day supply available through Specialty Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery)	50% coinsurance*	Not covered	Deductible applies.
	Physician/surgeon fees	50% coinsurance*	Not covered	Deductible applies.
If you need immediate medical attention	Emergency room services	50% coinsurance*	50% coinsurance*	Deductible applies.
	Emergency medical transportation	50% coinsurance*	50% coinsurance*	Deductible applies.
	Urgent care	50% coinsurance*	50% coinsurance*	Deductible applies.
If you have a hospital stay	Facility fee (e.g., hospital room)	50% coinsurance*	Not covered	Deductible applies.
	Physician/surgeon fee	50% coinsurance*	Not covered	Deductible applies.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient	50% coinsurance*	Not covered	Deductible applies.
	Mental/Behavioral health inpatient services	50% coinsurance*	Not covered	Deductible applies.
	Substance use disorder outpatient services	50% coinsurance*	Not covered	Deductible applies.
	Substance use disorder inpatient services	50% coinsurance*	Not covered	Deductible applies.
If you are pregnant	Prenatal and postnatal	\$0 copay	Not covered	Deductible waived.
	Delivery and all inpatient services	50% coinsurance*	Not covered	Deductible applies.
If you need help recovering or have other special health needs	Home health care	50% coinsurance*	Not covered	Deductible applies.
	Rehabilitation services	50% coinsurance*	Not covered	Deductible applies. 30 combined PT/OT/ST visits/yr.
	Habilitation services	50% coinsurance*	Not covered	Deductible applies. 30 combined PT/OT/ST visits/yr.
	Skilled nursing care	50% coinsurance*	Not covered	Deductible applies.
	Durable medical equipment	50% coinsurance*	Not covered	Deductible applies.
	Hospice service	50% coinsurance*	Not covered	Deductible applies.
If your child needs dental or eye care	Eye exam	50% coinsurance*	Not covered	Deductible applies. One eye exam per year to age 21.
	Glasses	\$150 allowance* per year to age 21.	Not covered	Deductible applies.
	Dental check-up	\$0 copay*	Not covered	Deductible applies. Two dental exams per year to age 21.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary

at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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.)

- Acupuncture
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Infertility Treatment
- Long-Term Care
- Non-Emergency care when traveling outside the US
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight Loss Programs
- MVP Wellness Program

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.)

- Bariatric Surgery
- Chiropractic Care
- Private-Duty Nursing

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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 1-800-637-7788 or <http://www.dfr.vermont.gov/insurance/insurance-consumer/consumer-information>

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 1-800-637-7788 or <http://www.dfr.vermont.gov/insurance/insurance-consumer/consumer-information>

The following is the Vermont State Department of Insurance contact information:

External Appeals Program, Vermont Department of Financial Regulation

89 Main Street, Montpelier, VT 05602, 1-800-631-7788 or 1-802-282-2900, 1-888-236-5966 (Emergency request for external appeal)

Additionally, a consumer assistance program can help you file your appeal. Contact:

Vermont Legal Aid, Office of Health Care Ombudsman, 264 North Winooski Avenue, Burlington, VT 05402

1-800-917-7787 or 1-802-863-2316; TTY: 1-888-884-1955 or 1-802-863-2473, www.vtlegalaid.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.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary

at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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 \$7,466**
- **Patient pays \$0**

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	\$
Co-pays	\$
Co-insurance	\$
Limits or exclusions	\$
Total	\$0

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

- **Amount owed to providers: \$5,490**
- **Plan pays \$5,490**
- **Patient pays \$0**

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	\$
Co-pays	\$
Co-insurance	\$
Limits or exclusions	\$
Total	\$0

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.



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 1-800-348-8515..

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In network -\$1,550 person/\$3,100 family	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> 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 <u>deductible</u> .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	In network -\$5,750 person/\$11,500 family Rx out-of-pocket -\$1,300 person /\$2,600 family	The <u>out-of-pocket limit</u> 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 and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
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 <i>specific</i> 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 <u>provider</u> , 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 <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a specialist?	No.	You can see the <u>specialist</u> 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 <u>excluded services</u> .

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary

at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.



- **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		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you visit a health care provider’s office or clinic	Primary care visit to treat an injury or illness	10% coinsurance*	Not covered.	Deductible applies.
	Specialist visit	20% coinsurance*	Not covered	Deductible applies.
	Other practitioner office visit	20% coinsurance*	Not covered	Deductible applies.
	Preventive care/ screening/immunization	\$0 copay	Not covered	Deductible waived.
If you have a test	Diagnostic test (x-ray, blood work)	Lab Office - 10% coinsurance* PCP/20% coinsurance Specialist Lab Facility - 20% coinsurance* Radiology Office - 10% coinsurance* PCP/20% coinsurance Specialist	Not covered	Deductible applies.
	Imaging (CT/PET scans, MRIs)	20% coinsurance*	Not covered	Deductible applies.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren’t clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary

at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
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 \$25 copay*	Not covered	Deductible applies. 30 day supply retail/90 day supply Mail order. Preventive drugs.
	Preferred brand drugs	Retail \$40 copay* Mail order \$100 copay*	Not covered	Deductible applies. 30 day supply retail/90 day supply Mail order. Preventive drugs, Deductible waived.
	Non-preferred brand drugs	50% coinsurance*	Not covered	Deductible applies. 30 day supply retail/90 day supply Mail order. Preventive drugs, Deductible waived.
	Specialty drugs	Retail Covered at Specialty Pharmacy as noted in generic, preferred, and non-preferred classes.	Not covered	30 day supply available through Specialty Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery)	20% coinsurance*	Not covered	Deductible applies.
	Physician/surgeon fees	20% coinsurance*	Not covered	Deductible applies.
If you need immediate medical attention	Emergency room services	20% coinsurance*	20% coinsurance*	Deductible applies.
	Emergency medical transportation	20% coinsurance*	20% coinsurance*	Deductible applies.
	Urgent care	20% coinsurance*	20% coinsurance*	Deductible applies.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance*	Not covered	Deductible applies.
	Physician/surgeon fee	20% coinsurance*	Not covered	Deductible applies.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient	20% coinsurance* for office visits and 20% coinsurance for outpatient	Not covered	Deductible applies.
	Mental/Behavioral health inpatient services	20% coinsurance*	Not covered	Deductible applies.
	Substance use disorder outpatient services	20% coinsurance* for office visits and 20% coinsurance for outpatient	Not covered	Deductible applies.
	Substance use disorder inpatient services	20% coinsurance*	Not covered	Deductible applies.
If you are pregnant	Prenatal and postnatal	\$0 copay	Not covered	Deductible waived.
	Delivery and all inpatient services	20% coinsurance*	Not covered	Deductible applies.
If you need help recovering or have other special health needs	Home health care	20% coinsurance*	Not covered	Deductible applies.
	Rehabilitation services	20% coinsurance*	Not covered	Deductible applies. 30 combined PT/OT/ST visits/yr.
	Habilitation services	20% coinsurance*	Not covered	Deductible applies. 30 combined PT/OT/ST visits/yr.
	Skilled nursing care	20% coinsurance*	Not covered	Deductible applies.
	Durable medical equipment	20% coinsurance*	Not covered	Deductible applies.
	Hospice service	20% coinsurance*	Not covered	Deductible applies.
If your child needs dental or eye care	Eye exam	20% coinsurance*	Not covered	Deductible applies. One eye exam per year to age 21.
	Glasses	\$150 allowance* per year to age 21.	Not covered	Deductible applies.
	Dental check-up	\$0 copay*	Not covered	Deductible applies. Two dental exams per year to age 21.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary

at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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.)

- Acupuncture
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Infertility Treatment
- Long-Term Care
- Non-Emergency care when traveling outside the US
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight Loss Programs
- MVP Wellness Program

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.)

- Bariatric Surgery
- Chiropractic Care
- Private-Duty Nursing

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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 1-800-637-7788 or <http://www.dfr.vermont.gov/insurance/insurance-consumer/consumer-information>

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 1-800-637-7788 or <http://www.dfr.vermont.gov/insurance/insurance-consumer/consumer-information>

The following is the Vermont State Department of Insurance contact information:

External Appeals Program, Vermont Department of Financial Regulation

89 Main Street, Montpelier, VT 05602, 1-800-631-7788 or 1-802-282-2900, 1-888-236-5966 (Emergency request for external appeal)

Additionally, a consumer assistance program can help you file your appeal. Contact:

Vermont Legal Aid, Office of Health Care Ombudsman, 264 North Winooski Avenue, Burlington, VT 05402

1-800-917-7787 or 1-802-863-2316; TTY: 1-888-884-1955 or 1-802-863-2473, www.vtlegalaid.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.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary

at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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** \$7,466
- **Patient pays** \$0

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	\$
Co-pays	\$
Co-insurance	\$
Limits or exclusions	\$
Total	\$0

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

- **Amount owed to providers: \$5,490**
- **Plan pays** \$5,490
- **Patient pays** \$0

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	\$
Co-pays	\$
Co-insurance	\$
Limits or exclusions	\$
Total	\$0

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.



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 1-800-348-8515..

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In network -\$3,500 person/\$7,000 family	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> 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 <u>deductible</u> .
Are there other deductibles for specific services?	Pharmacy -\$300 person \ \$600 family	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	In network -\$6,350 person/\$12,700 family Rx out-of-pocket -\$1,250 person /\$2,500 family	The <u>out-of-pocket limit</u> 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 and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
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 <i>specific</i> 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 <u>provider</u> , 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 <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a specialist?	No.	You can see the <u>specialist</u> 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 <u>excluded services</u> .

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

- **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		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you visit a health care provider’s office or clinic	Primary care visit to treat an injury or illness	\$35 copay*	Not covered.	Deductible applies.
	Specialist visit	\$80 copay*	Not covered	Deductible applies.
	Other practitioner office visit	\$80 copay*	Not covered	Deductible applies.
	Preventive care/ screening/immunization	\$0 copay	Not covered	Deductible waived.
If you have a test	Diagnostic test (x-ray, blood work)	Lab Office - \$35 copay* PCP/\$80 Spe Lab Facility - 50% coinsurance* Radiology Office - \$35 copay* PCP/\$80 Specialist Radiology Facility - 50% coinsurance*	Not covered	Deductible applies.
	Imaging (CT/PET scans, MRIs)	50% coinsurance*	Not covered	Deductible applies. is per procedure. Hi-Tech Facility - Deductible applies.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren’t clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
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 \$20 copay* Mail order \$50 copay*	Not covered	Deductible applies. Rx 30 day retail/90 day mail order.
	Preferred brand drugs	Retail \$80 copay* Mail order \$200 copay*	Not covered	Deductible applies. Rx 30 day retail/90 day mail order.
	Non-preferred brand drugs	60% coinsurance*	Not covered	Deductible applies. Rx 30 day retail/90 day mail order.
	Specialty drugs	Retail Covered at Specialty Pharmacy as noted in generic, preferred, and non-preferred classes.	Not covered	30 day supply available through Specialty Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery)	50% coinsurance*	Not covered	Deductible applies.
	Physician/surgeon fees	50% coinsurance*	Not covered	Deductible applies.
If you need immediate medical attention	Emergency room services	50% coinsurance*	50% coinsurance*	Deductible applies.
	Emergency medical transportation	\$100 copay*	\$100 copay*	Deductible applies.
	Urgent care	\$100 copay*	\$100 copay*	Deductible applies.
If you have a hospital stay	Facility fee (e.g., hospital room)	50% coinsurance*	Not covered	Deductible applies.
	Physician/surgeon fee	50% coinsurance*	Not covered	Deductible applies.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary

at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient	\$35 copay* for office visits and 50% coinsurance for outpatient services.	Not covered	Deductible applies.
	Mental/Behavioral health inpatient services	50% coinsurance*	Not covered	Deductible applies.
	Substance use disorder outpatient services	\$35 copay* for office visits and 50% coinsurance for outpatient services.	Not covered	Deductible applies.
	Substance use disorder inpatient services	50% coinsurance*	Not covered	Deductible applies.
If you are pregnant	Prenatal and postnatal	\$0 copay	Not covered	Deductible waived.
	Delivery and all inpatient services	50% coinsurance*	Not covered	Deductible applies.
If you need help recovering or have other special health needs	Home health care	50% coinsurance*	Not covered	Deductible applies.
	Rehabilitation services	\$80 copay* office setting/50% coinsurance facility setting.	Not covered	Deductible applies. 30 combined PT/OT/ST visits/yr.
	Habilitation services	\$80 copay* office setting/50% coinsurance facility setting.	Not covered	Deductible applies. 30 combined PT/OT/ST visits/yr.
	Skilled nursing care	50% coinsurance*	Not covered	Deductible applies.
	Durable medical equipment	50% coinsurance*	Not covered	Deductible applies.
	Hospice service	50% coinsurance*	Not covered	Deductible applies.
If your child needs dental or eye care	Eye exam	\$80 copay*	Not covered	Deductible applies. One eye exam per year to age 21.
	Glasses	\$150 allowance* per year to age 21.	Not covered	Deductible applies.
	Dental check-up	\$0 copay	Not covered	Deductible waived. Two dental exams per year to age 21.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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.)

- Acupuncture
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Infertility Treatment
- Long-Term Care
- Non-Emergency care when traveling outside the US
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight Loss Programs
- MVP Wellness Program

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.)

- Bariatric Surgery
- Chiropractic Care
- Private-Duty Nursing

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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 1-800-637-7788 or <http://www.dfr.vermont.gov/insurance/insurance-consumer/consumer-information>

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 1-800-637-7788 or <http://www.dfr.vermont.gov/insurance/insurance-consumer/consumer-information>

The following is the Vermont State Department of Insurance contact information:

External Appeals Program, Vermont Department of Financial Regulation

89 Main Street, Montpelier, VT 05602, 1-800-631-7788 or 1-802-282-2900, 1-888-236-5966 (Emergency request for external appeal)

Additionally, a consumer assistance program can help you file your appeal. Contact:

Vermont Legal Aid, Office of Health Care Ombudsman, 264 North Winooski Avenue, Burlington, VT 05402

1-800-917-7787 or 1-802-863-2316; TTY: 1-888-884-1955 or 1-802-863-2473, www.vtlegalaid.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.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary

at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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 \$7,466**
- **Patient pays \$0**

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	\$
Co-pays	\$
Co-insurance	\$
Limits or exclusions	\$
Total	\$0

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

- **Amount owed to providers: \$5,490**
- **Plan pays \$5,490**
- **Patient pays \$0**

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	\$
Co-pays	\$
Co-insurance	\$
Limits or exclusions	\$
Total	\$0

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.



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 1-800-348-8515..

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In network -\$750 person/\$1,500 family	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> 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 <u>deductible</u> .
Are there other deductibles for specific services?	RX Brand -\$50 person \ \$100 family	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	In network -\$4,250 person/\$8,500 family Rx out-of-pocket -\$1,250 person /\$2,500 family	The <u>out-of-pocket limit</u> 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 and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
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 <i>specific</i> 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 <u>provider</u> , 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 <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a specialist?	No.	You can see the <u>specialist</u> 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 <u>excluded services</u> .

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.



- **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		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
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.
	Specialist visit	\$25 copay	Not covered	Deductible waived.
	Other practitioner office visit	\$25 copay	Not covered	Deductible waived.
	Preventive care/ screening/immunization	\$0 copay	Not covered	Deductible waived.
If you have a test	Diagnostic test (x-ray, blood work)	Lab Office - \$15 copay PCP/\$25 Spec Lab Facility - 20% coinsurance* Radiology Office - \$15 copay PCP/\$25 Specialist Radiology Facility - 20% coinsurance*	Not covered	Lab Office - Deductible waived. Lab Facility - Deductible applies. Radiology Office - Deductible waived. Radiology Facility - Deductible applies.
	Imaging (CT/PET scans, MRIs)	20% coinsurance*	Not covered	Deductible applies. is per procedure. Hi-Tech Facility - Deductible applies.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
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 \$5 copay Mail order \$12.50 copay	Not covered	Deductible waived. 30 day retail/90 day mail order.
	Preferred brand drugs	Retail \$40 copay* Mail order \$100 copay*	Not covered	Deductible applies. Rx 30 day retail/90 day mail order.
	Non-preferred brand drugs	50% coinsurance*	Not covered	Deductible applies. Rx 30 day retail/90 day mail order.
	Specialty drugs	Retail Covered at Specialty Pharmacy as noted in generic, preferred, and non-preferred classes.	Not covered	30 day supply available through Specialty Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery)	20% coinsurance*	Not covered	Deductible applies.
	Physician/surgeon fees	20% coinsurance*	Not covered	Deductible applies.
If you need immediate medical attention	Emergency room services	\$150 copay	\$150 copay	Deductible waived.
	Emergency medical transportation	\$50 copay	\$50 copay	Deductible waived.
	Urgent care	\$45 copay	\$45 copay	Deductible waived.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance*	Not covered	Deductible applies.
	Physician/surgeon fee	20% coinsurance*	Not covered	Deductible applies.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary

at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient	\$15 copay for office visits and 20% coinsurance for outpatient services.	Not covered	Deductible waived. For office visits.
	Mental/Behavioral health inpatient services	20% coinsurance*	Not covered	Deductible applies.
	Substance use disorder outpatient services	\$15 copay for office visits and 20% coinsurance for outpatient services.	Not covered	Deductible waived. For office visits.
	Substance use disorder inpatient services	20% coinsurance*	Not covered	Deductible applies.
If you are pregnant	Prenatal and postnatal	\$0 copay	Not covered	Deductible waived.
	Delivery and all inpatient services	20% coinsurance*	Not covered	Deductible applies.
If you need help recovering or have other special health needs	Home health care	20% coinsurance*	Not covered	Deductible applies.
	Rehabilitation services	\$25 copay for office visits, 20% coinsurance for outpatient services.	Not covered	Deductible waived. For office services. 30 combined PT/OT/ST visits/yr.
	Habilitation services	\$25 copay office setting, 20% coinsurance for outpatient services.	Not covered	Deductible waived. For office services. 30 combined PT/OT/ST visits/yr.
	Skilled nursing care	20% coinsurance*	Not covered	Deductible applies.
	Durable medical equipment	20% coinsurance*	Not covered	Deductible applies.
	Hospice service	20% coinsurance*	Not covered	Deductible applies.
If your child needs dental or eye care	Eye exam	\$25 copay	Not covered	Deductible waived. One eye exam per year to age 21.
	Glasses	\$150 allowance per year to age 21.	Not covered	Deductible waived.
	Dental check-up	\$0 copay	Not covered	Deductible waived. Two dental exams per year to age 21.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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.)

- Acupuncture
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Infertility Treatment
- Long-Term Care
- Non-Emergency care when traveling outside the US
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight Loss Programs
- MVP Wellness Program

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.)

- Bariatric Surgery
- Chiropractic Care
- Private-Duty Nursing

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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 1-800-637-7788 or <http://www.dfr.vermont.gov/insurance/insurance-consumer/consumer-information>

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 1-800-637-7788 or <http://www.dfr.vermont.gov/insurance/insurance-consumer/consumer-information>

The following is the Vermont State Department of Insurance contact information:

External Appeals Program, Vermont Department of Financial Regulation

89 Main Street, Montpelier, VT 05602, 1-800-631-7788 or 1-802-282-2900, 1-888-236-5966 (Emergency request for external appeal)

Additionally, a consumer assistance program can help you file your appeal. Contact:

Vermont Legal Aid, Office of Health Care Ombudsman, 264 North Winooski Avenue, Burlington, VT 05402

1-800-917-7787 or 1-802-863-2316; TTY: 1-888-884-1955 or 1-802-863-2473, www.vtlegalaid.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.*—————

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary

at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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 \$7,466**
- **Patient pays \$0**

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	\$
Co-pays	\$
Co-insurance	\$
Limits or exclusions	\$
Total	\$0

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

- **Amount owed to providers: \$5,490**
- **Plan pays \$5,490**
- **Patient pays \$0**

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	\$
Co-pays	\$
Co-insurance	\$
Limits or exclusions	\$
Total	\$0

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.



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 1-800-348-8515..

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In network -\$1,800 person/\$3,600 family	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> 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 <u>deductible</u> .
Are there other deductibles for specific services?	Pharmacy -\$250 person \ \$500 family	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	In network -\$5,300 person/\$10,600 family Rx out-of-pocket -\$1,300 person /\$1,300 family	The <u>out-of-pocket limit</u> 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 and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
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 <i>specific</i> 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 <u>provider</u> , 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 <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a specialist?	No.	You can see the <u>specialist</u> 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 <u>excluded services</u> .

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.



- **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		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
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.
	Specialist visit	\$50 copay*	Not covered	Deductible applies.
	Other practitioner office visit	\$50 copay*	Not covered	Deductible applies.
	Preventive care/ screening/immunization	\$0 copay	Not covered	Deductible waived.
If you have a test	Diagnostic test (x-ray, blood work)	Lab Office - \$15 copay PCP/\$50 Spec Lab Facility - \$50 copay* Radiology Office - \$15 copay PCP/\$50 Specialist Radiology Facility - \$100 copay*	Not covered	Lab Office - Deductible waived. PCP. Lab Facility - Deductible applies. Radiology Office - Deductible waived. PCP. Radiology Facility - Deductible applies.
	Imaging (CT/PET scans, MRIs)	\$650 copay*	Not covered	Deductible applies. is per procedure.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren’t clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
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 \$12 copay* Mail order \$30 copay*	Not covered	Deductible applies. Rx 30 day retail/90 day mail order. VBID retail copay is \$3/mail order \$7.50.
	Preferred brand drugs	Retail \$40 copay* Mail order \$100 copay*	Not covered	Deductible applies. Rx 30 day retail/90 day mail order. VBID retail copay is \$3/mail order \$7.50.
	Non-preferred brand drugs	50% coinsurance*	Not covered	Deductible applies. Rx 30 day retail/90 day mail order. VBID retail copay is \$3/mail order \$7.50.
	Specialty drugs	Retail Covered at Specialty Pharmacy as noted in generic, preferred, and non-preferred classes.	Not covered	30 day supply available through Specialty Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery)	\$1,400 copay*	Not covered	Deductible applies.
	Physician/surgeon fees	\$600 copay*	Not covered	Deductible applies.
If you need immediate medical attention	Emergency room services	\$250 copay*	\$250 copay*	Deductible applies.
	Emergency medical transportation	\$100 copay*	\$100 copay*	Deductible applies.
	Urgent care	\$60 copay*	\$60 copay*	Deductible applies.
If you have a hospital stay	Facility fee (e.g., hospital room)	50% coinsurance*	Not covered	Deductible applies.
	Physician/surgeon fee	50% coinsurance*	Not covered	Deductible applies.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary

at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient	\$15 copay for office visits and \$50 copay for other outpatient services.	Not covered	Deductible waived. For office visits.
	Mental/Behavioral health inpatient services	50% coinsurance*	Not covered	Deductible applies.
	Substance use disorder outpatient services	\$15 copay for office visits and \$50 copay for other outpatient services.	Not covered	Deductible waived. For office visits.
	Substance use disorder inpatient services	50% coinsurance*	Not covered	Deductible applies.
If you are pregnant	Prenatal and postnatal	\$0 copay	Not covered	Deductible waived.
	Delivery and all inpatient services	50% coinsurance*	Not covered	Deductible applies.
If you need help recovering or have other special health needs	Home health care	\$50 copay*	Not covered	Deductible applies.
	Rehabilitation services	\$50 copay*	Not covered	Deductible applies. 30 combined PT/OT/ST visits/yr.
	Habilitation services	\$50 copay*	Not covered	Deductible applies. 30 combined PT/OT/ST visits/yr.
	Skilled nursing care	50% coinsurance*	Not covered	Deductible applies.
	Durable medical equipment	50% coinsurance*	Not covered	Deductible applies.
	Hospice service	50% coinsurance*	Not covered	Deductible applies.
If your child needs dental or eye care	Eye exam	\$50 copay*	Not covered	Deductible applies. One eye exam per year to age 21.
	Glasses	\$150 allowance* per year to age 21.	Not covered	Deductible applies.
	Dental check-up	\$0 copay	Not covered	Deductible waived. Two dental exams per year to age 21.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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.)

- Acupuncture
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Infertility Treatment
- Long-Term Care
- Non-Emergency care when traveling outside the US
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight Loss Programs

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.)

- Bariatric Surgery
- Chiropractic Care
- Private-Duty Nursing
- MVP Wellness Program

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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 1-800-637-7788 or <http://www.dfr.vermont.gov/insurance/insurance-consumer/consumer-information>

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 1-800-637-7788 or <http://www.dfr.vermont.gov/insurance/insurance-consumer/consumer-information>

The following is the Vermont State Department of Insurance contact information:

External Appeals Program, Vermont Department of Financial Regulation

89 Main Street, Montpelier, VT 05602, 1-800-631-7788 or 1-802-282-2900, 1-888-236-5966 (Emergency request for external appeal)

Additionally, a consumer assistance program can help you file your appeal. Contact:

Vermont Legal Aid, Office of Health Care Ombudsman, 264 North Winooski Avenue, Burlington, VT 05402

1-800-917-7787 or 1-802-863-2316; TTY: 1-888-884-1955 or 1-802-863-2473, www.vtlegalaid.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.*—————

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary

at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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 \$7,466**
- **Patient pays \$0**

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	\$
Co-pays	\$
Co-insurance	\$
Limits or exclusions	\$
Total	\$0

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

- **Amount owed to providers: \$5,490**
- **Plan pays \$5,490**
- **Patient pays \$0**

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	\$
Co-pays	\$
Co-insurance	\$
Limits or exclusions	\$
Total	\$0

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.



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 1-800-348-8515..

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In network -\$150 person/\$300 family	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> 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 <u>deductible</u> .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	In network -\$1,250 person/\$2,500 family Rx out-of-pocket -\$1,250 person /\$1,250 family	The <u>out-of-pocket limit</u> 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 and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
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 <i>specific</i> 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 <u>provider</u> , 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 <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a specialist?	No.	You can see the <u>specialist</u> 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 <u>excluded services</u> .

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.



- **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		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$10 copay	Not covered.	Deductible waived.
	Specialist visit	\$20 copay	Not covered	Deductible waived.
	Other practitioner office visit	\$20 copay	Not covered	Deductible waived.
	Preventive care/ screening/immunization	\$0 copay	Not covered	Deductible waived.
If you have a test	Diagnostic test (x-ray, blood work)	Lab Office - \$10 copay PCP/\$20 Spec Lab Facility - 10% coinsurance* Radiology Office - \$10 copay PCP/\$20 Specialist Radiology Facility - 10% coinsurance*	Not covered	Lab Office - Deductible waived. Lab Facility - Deductible applies. Radiology Office - Deductible waived. Radiology Facility - Deductible applies.
	Imaging (CT/PET scans, MRIs)	10% coinsurance*	Not covered	Deductible applies. is per procedure. Hi-Tech Facility - Deductible applies.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
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 \$5 copay Mail order \$12.50 copay	Not covered	Deductible waived. 30 day retail/90 day mail order.
	Preferred brand drugs	Retail \$40 copay Mail order \$100 copay	Not covered	Deductible waived. 30 day retail/90 day mail order.
	Non-preferred brand drugs	50% coinsurance	Not covered	Deductible waived. 30 day retail/90 day mail order.
	Specialty drugs	Retail Covered at Specialty Pharmacy as noted in generic, preferred, and non-preferred classes.	Not covered	30 day supply available through Specialty Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery)	10% coinsurance*	Not covered	Deductible applies.
	Physician/surgeon fees	10% coinsurance*	Not covered	Deductible applies.
If you need immediate medical attention	Emergency room services	\$100 copay	\$100 copay	Deductible waived.
	Emergency medical transportation	\$50 copay	\$50 copay	Deductible waived.
	Urgent care	\$40 copay	\$40 copay	Deductible waived.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance*	Not covered	Deductible applies.
	Physician/surgeon fee	10% coinsurance*	Not covered	Deductible applies.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary

at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient	10% coinsurance* for office visits and 10% coinsurance for outpatient	Not covered	Deductible applies. For office visits.
	Mental/Behavioral health inpatient services	10% coinsurance*	Not covered	Deductible applies.
	Substance use disorder outpatient services	10% coinsurance* for office visits and 10% coinsurance for outpatient	Not covered	Deductible applies. For office visits.
	Substance use disorder inpatient services	10% coinsurance*	Not covered	Deductible applies.
If you are pregnant	Prenatal and postnatal	\$0 copay	Not covered	Deductible waived.
	Delivery and all inpatient services	10% coinsurance*	Not covered	Deductible applies.
If you need help recovering or have other special health needs	Home health care	10% coinsurance*	Not covered	Deductible applies.
	Rehabilitation services	\$20 copay for office visits, 10% coinsurance for outpatient services.	Not covered	Deductible waived. For office services. 30 combined PT/OT/ST visits/yr.
	Habilitation services	\$20 copay office setting, 10% coinsurance for outpatient services.	Not covered	Deductible waived. For office services. 30 combined PT/OT/ST visits/yr.
	Skilled nursing care	10% coinsurance*	Not covered	Deductible applies.
	Durable medical equipment	10% coinsurance*	Not covered	Deductible applies.
	Hospice service	10% coinsurance*	Not covered	Deductible applies.
If your child needs dental or eye care	Eye exam	\$20 copay	Not covered	Deductible waived. One eye exam per year to age 21.
	Glasses	\$150 allowance per year to age 21.	Not covered	Deductible waived.
	Dental check-up	\$0 copay	Not covered	Deductible waived. Two dental exams per year to age 21.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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.)

- Acupuncture
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Infertility Treatment
- Long-Term Care
- Non-Emergency care when traveling outside the US
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight Loss Programs
- MVP Wellness Program

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.)

- Bariatric Surgery
- Chiropractic Care
- Private-Duty Nursing

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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 1-800-637-7788 or <http://www.dfr.vermont.gov/insurance/insurance-consumer/consumer-information>

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 1-800-637-7788 or <http://www.dfr.vermont.gov/insurance/insurance-consumer/consumer-information>

The following is the Vermont State Department of Insurance contact information:

External Appeals Program, Vermont Department of Financial Regulation

89 Main Street, Montpelier, VT 05602, 1-800-631-7788 or 1-802-282-2900, 1-888-236-5966 (Emergency request for external appeal)

Additionally, a consumer assistance program can help you file your appeal. Contact:

Vermont Legal Aid, Office of Health Care Ombudsman, 264 North Winooski Avenue, Burlington, VT 05402

1-800-917-7787 or 1-802-863-2316; TTY: 1-888-884-1955 or 1-802-863-2473, www.vtlegalaid.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.* —————

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary

at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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** \$7,466
- **Patient pays** \$0

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	\$
Co-pays	\$
Co-insurance	\$
Limits or exclusions	\$
Total	\$0

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

- **Amount owed to providers: \$5,490**
- **Plan pays** \$5,490
- **Patient pays** \$0

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	\$
Co-pays	\$
Co-insurance	\$
Limits or exclusions	\$
Total	\$0

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.



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 1-800-348-8515..

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In network -\$1,900 person/\$3,800 family	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> 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 <u>deductible</u> .
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 <u>deductible</u> amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	In network -\$5,100 person/\$10,200 family Rx out-of-pocket -\$1,250 person /\$2,500 family	The <u>out-of-pocket limit</u> 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 and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
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 <i>specific</i> 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 <u>provider</u> , 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 <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a specialist?	No.	You can see the <u>specialist</u> 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 <u>excluded services</u> .

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.



- **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		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$25 copay	Not covered.	Deductible waived.
	Specialist visit	\$45 copay	Not covered	Deductible waived.
	Other practitioner office visit	\$45 copay	Not covered	Deductible waived.
	Preventive care/ screening/immunization	\$0 copay	Not covered	Deductible waived.
If you have a test	Diagnostic test (x-ray, blood work)	Lab Office - \$25 copay PCP/\$40 Spec Lab Facility - 40% coinsurance* Radiology Office - \$25 copay PCP/\$40 Specialist Radiology Facility - 40% coinsurance*	Not covered	Lab Office - Deductible waived. Lab Facility - Deductible applies. Radiology Office - Deductible waived. Radiology Facility - Deductible applies.
	Imaging (CT/PET scans, MRIs)	40% coinsurance*	Not covered	Deductible applies. is per procedure. Hi-Tech Facility - Deductible applies.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
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 \$12 copay Mail order \$30 copay	Not covered	Deductible waived. 30 day retail/90 day mail order.
	Preferred brand drugs	Retail \$50 copay* Mail order \$125 copay*	Not covered	Deductible applies. Rx 30 day retail/90 day mail order.
	Non-preferred brand drugs	50% coinsurance*	Not covered	Deductible applies. Rx 30 day retail/90 day mail order.
	Specialty drugs	Retail Covered at Specialty Pharmacy as noted in generic, preferred, and non-preferred classes.	Not covered	30 day supply available through Specialty Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery)	40% coinsurance*	Not covered	Deductible applies.
	Physician/surgeon fees	40% coinsurance*	Not covered	Deductible applies.
If you need immediate medical attention	Emergency room services	\$250 copay*	\$250 copay*	Deductible applies.
	Emergency medical transportation	\$100 copay	\$100 copay	Deductible waived.
	Urgent care	\$60 copay	\$60 copay	Deductible waived.
If you have a hospital stay	Facility fee (e.g., hospital room)	40% coinsurance*	Not covered	Deductible applies.
	Physician/surgeon fee	40% coinsurance*	Not covered	Deductible applies.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary

at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient	\$25 copay for office visits and 40% coinsurance for outpatient services.	Not covered	Deductible waived. For office visits.
	Mental/Behavioral health inpatient services	40% coinsurance*	Not covered	Deductible applies.
	Substance use disorder outpatient services	\$25 copay for office visits and 40% coinsurance for outpatient services.	Not covered	Deductible waived. For office visits.
	Substance use disorder inpatient services	40% coinsurance*	Not covered	Deductible applies.
If you are pregnant	Prenatal and postnatal	\$0 copay	Not covered	Deductible waived.
	Delivery and all inpatient services	40% coinsurance*	Not covered	Deductible applies.
If you need help recovering or have other special health needs	Home health care	40% coinsurance*	Not covered	Deductible applies.
	Rehabilitation services	\$45 copay for office visits, 40% coinsurance for outpatient services.	Not covered	Deductible waived. For office services. 30 combined PT/OT/ST visits/yr.
	Habilitation services	\$45 copay office setting, 40% coinsurance for outpatient services.	Not covered	Deductible waived. For office services. 30 combined PT/OT/ST visits/yr.
	Skilled nursing care	40% coinsurance*	Not covered	Deductible applies.
	Durable medical equipment	40% coinsurance*	Not covered	Deductible applies.
	Hospice service	40% coinsurance*	Not covered	Deductible applies.
If your child needs dental or eye care	Eye exam	\$45 copay	Not covered	Deductible waived. One eye exam per year to age 21.
	Glasses	\$150 allowance per year to age 21.	Not covered	Deductible waived.
	Dental check-up	\$0 copay	Not covered	Deductible waived. Two dental exams per year to age 21.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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.)

- Acupuncture
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Infertility Treatment
- Long-Term Care
- Non-Emergency care when traveling outside the US
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight Loss Programs
- MVP Wellness Program

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.)

- Bariatric Surgery
- Chiropractic Care
- Private-Duty Nursing

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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 1-800-637-7788 or <http://www.dfr.vermont.gov/insurance/insurance-consumer/consumer-information>

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 1-800-637-7788 or <http://www.dfr.vermont.gov/insurance/insurance-consumer/consumer-information>

The following is the Vermont State Department of Insurance contact information:

External Appeals Program, Vermont Department of Financial Regulation

89 Main Street, Montpelier, VT 05602, 1-800-631-7788 or 1-802-282-2900, 1-888-236-5966 (Emergency request for external appeal)

Additionally, a consumer assistance program can help you file your appeal. Contact:

Vermont Legal Aid, Office of Health Care Ombudsman, 264 North Winooski Avenue, Burlington, VT 05402

1-800-917-7787 or 1-802-863-2316; TTY: 1-888-884-1955 or 1-802-863-2473, www.vtlegalaid.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.*—————

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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** \$7,466
- **Patient pays** \$0

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	\$
Co-pays	\$
Co-insurance	\$
Limits or exclusions	\$
Total	\$0

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

- **Amount owed to providers: \$5,490**
- **Plan pays** \$5,490
- **Patient pays** \$0

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	\$
Co-pays	\$
Co-insurance	\$
Limits or exclusions	\$
Total	\$0

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.



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 1-800-348-8515..

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In network -\$0 person/\$0 family	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> 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 <u>deductible</u> .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	No.	There's no limit on how much you could pay during a coverage period for your share of the cost of covered services.
What is not included in the <u>out-of-pocket limit</u>?	This plan has no Out-of-Pocket Limit.	Not applicable because there's no <u>out-of-pocket limit</u> on your expenses.
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 <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u>?	Yes. For a list of participating providers see www.mvphealthcare.com .	If you use an in-network doctor or other health care <u>provider</u> , 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 <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a <u>specialist</u>?	No.	You can see the <u>specialist</u> 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 <u>excluded services</u> .

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary

at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

- **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		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you visit a health care provider’s office or clinic	Primary care visit to treat an injury or illness	\$0 copay	Not covered.	—————none—————
	Specialist visit	\$0 copay	Not covered.	—————none—————
	Other practitioner office visit	\$0 copay	Not covered.	—————none—————
	Preventive care/ screening/immunization	\$0 copay	Not covered.	—————none—————
If you have a test	Diagnostic test (x-ray, blood work)	\$0 copay	Not covered.	—————none—————
	Imaging (CT/PET scans, MRIs)	\$0 copay	Not covered.	—————none—————

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren’t clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.mvphealthcare.com .	Generic drugs	\$0 copay	Not covered.	30 day retail/90 day mail order.
	Preferred brand drugs	\$0 copay	Not covered.	30 day retail/90 day mail order.
	Non-preferred brand drugs	\$0 copay	Not covered.	30 day retail/90 day mail order.
	Specialty drugs	Retail Covered at Specialty Pharmacy as noted in generic, preferred, and non-preferred classes.	Not covered.	30 day supply available through Specialty Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery)	\$0 copay	Not covered.	—————none—————
	Physician/surgeon fees	\$0 copay	Not covered.	—————none—————
If you need immediate medical attention	Emergency room services	\$0 copay	\$0 copay	—————none—————
	Emergency medical transportation	\$0 copay	\$0 copay	—————none—————
	Urgent care	\$0 copay	\$0 copay	—————none—————
If you have a hospital stay	Facility fee (e.g., hospital room)	\$0 copay	Not covered.	—————none—————
	Physician/surgeon fee	\$0 copay	Not covered.	—————none—————

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary

at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient	\$0 copay	Not covered.	—————none—————
	Mental/Behavioral health inpatient services	\$0 copay	Not covered.	—————none—————
	Substance use disorder outpatient services	\$0 copay	Not covered.	—————none—————
	Substance use disorder inpatient services	\$0 copay	Not covered.	—————none—————
If you are pregnant	Prenatal and postnatal	\$0 copay	Not covered.	—————none—————
	Delivery and all inpatient services	\$0 copay	Not covered.	—————none—————
If you need help recovering or have other special health needs	Home health care	\$0 copay	Not covered.	—————none—————
	Rehabilitation services	\$0 copay	Not covered.	30 combined PT/OT/ST visits/yr.
	Habilitation services	\$0 copay	Not covered.	30 combined PT/OT/ST visits/yr.
	Skilled nursing care	\$0 copay	Not covered.	—————none—————
	Durable medical equipment	\$0 copay	Not covered.	—————none—————
	Hospice service	\$0 copay	Not covered.	—————none—————
If your child needs dental or eye care	Eye exam	\$0 copay	Not covered.	One eye exam per year to age 21.
	Glasses	\$150 allowance per year to age 21.	Same as Par Provider.	—————none—————
	Dental check-up	\$0 copay	Same as Par Provider.	Two dental exams per year to age 21.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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.)

- Acupuncture
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Infertility Treatment
- Long-Term Care
- Non-Emergency care when traveling outside the US
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight Loss Programs

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.)

- Bariatric Surgery
- Chiropractic Care
- Private-Duty Nursing
- MVP Wellness Program

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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 1-800-637-7788 or <http://www.dfr.vermont.gov/insurance/insurance-consumer/consumer-information>

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 1-800-637-7788 or <http://www.dfr.vermont.gov/insurance/insurance-consumer/consumer-information>

The following is the Vermont State Department of Insurance contact information:

External Appeals Program, Vermont Department of Financial Regulation

89 Main Street, Montpelier, VT 05602, 1-800-631-7788 or 1-802-282-2900, 1-888-236-5966 (Emergency request for external appeal)

Additionally, a consumer assistance program can help you file your appeal. Contact:

Vermont Legal Aid, Office of Health Care Ombudsman, 264 North Winooski Avenue, Burlington, VT 05402

1-800-917-7787 or 1-802-863-2316; TTY: 1-888-884-1955 or 1-802-863-2473, www.vtlegalaid.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.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary

at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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** \$7,316
- **Patient pays** \$150

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	\$0
Co-pays	\$0
Co-insurance	\$0
Limits or exclusions	\$150
Total	\$150

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

- **Amount owed to providers: \$5,490**
- **Plan pays** \$5,490
- **Patient pays** \$0

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	\$0
Co-pays	\$0
Co-insurance	\$0
Limits or exclusions	\$0
Total	\$0

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.



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 1-800-348-8515..

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In network -\$3,000 person/\$6,000 family	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> 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 <u>deductible</u> .
Are there other deductibles for specific services?	Pharmacy -\$200 person \ \$400 family	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	In network -\$6,600 person/\$13,200 family Rx out-of-pocket -\$1,300 person /\$2,600 family	The <u>out-of-pocket limit</u> 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 and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
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 <i>specific</i> 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 <u>provider</u> , 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 <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a specialist?	No.	You can see the <u>specialist</u> 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 <u>excluded services</u> .

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.



- **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		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$30 copay*	Not covered.	Deductible applies.
	Specialist visit	\$100 copay*	Not covered	Deductible applies.
	Other practitioner office visit	\$100 copay*	Not covered	Deductible applies.
	Preventive care/ screening/immunization	\$0 copay	Not covered	Deductible waived.
If you have a test	Diagnostic test (x-ray, blood work)	Lab Office - \$30 copay* PCP/\$100 Sp Lab Facility - 50% coinsurance* Radiology Office - \$30 copay* PCP/\$100 Specialist Radiology Facility - 50% coinsurance*	Not covered	Deductible applies.
	Imaging (CT/PET scans, MRIs)	Office - \$0.50 copay* Facility - 50% coinsurance*	Not covered	Deductible applies. is per procedure. Hi-Tech Facility - Deductible applies.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
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 \$20 copay* Mail order \$50 copay*	Not covered	Deductible applies. Rx 30 day retail/90 day mail order. VBID retail copay is \$3/mail order \$7.50.
	Preferred brand drugs	Retail \$90 copay* Mail order \$225 copay*	Not covered	Deductible applies. Rx 30 day retail/90 day mail order. VBID retail copay is \$3/mail order \$7.50.
	Non-preferred brand drugs	60% coinsurance*	Not covered	Deductible applies. Rx 30 day retail/90 day mail order. VBID retail copay is \$3/mail order \$7.50.
	Specialty drugs	Retail Covered at Specialty Pharmacy as noted in generic, preferred, and non-preferred classes.	Not covered	30 day supply available through Specialty Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery)	50% coinsurance*	Not covered	Deductible applies.
	Physician/surgeon fees	50% coinsurance*	Not covered	Deductible applies.
If you need immediate medical attention	Emergency room services	50% coinsurance*	50% coinsurance*	Deductible applies.
	Emergency medical transportation	\$100 copay*	\$100 copay*	Deductible applies.
	Urgent care	\$100 copay*	\$100 copay*	Deductible applies.
If you have a hospital stay	Facility fee (e.g., hospital room)	50% coinsurance*	Not covered	Deductible applies.
	Physician/surgeon fee	50% coinsurance*	Not covered	Deductible applies.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary

at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient	\$30 copay* for office visits and 50% coinsurance for outpatient services.	Not covered	Deductible applies.
	Mental/Behavioral health inpatient services	50% coinsurance*	Not covered	Deductible applies.
	Substance use disorder outpatient services	\$30 copay* for office visits and 50% coinsurance for outpatient services.	Not covered	Deductible applies.
	Substance use disorder inpatient services	50% coinsurance*	Not covered	Deductible applies.
If you are pregnant	Prenatal and postnatal	\$0 copay	Not covered	Deductible waived.
	Delivery and all inpatient services	50% coinsurance*	Not covered	Deductible applies.
If you need help recovering or have other special health needs	Home health care	50% coinsurance*	Not covered	Deductible applies.
	Rehabilitation services	\$100 copay* office setting/50% coinsurance facility setting.	Not covered	Deductible applies. 30 combined PT/OT/ST visits/yr.
	Habilitation services	\$100 copay* office setting/50% coinsurance facility setting.	Not covered	Deductible applies. 30 combined PT/OT/ST visits/yr.
	Skilled nursing care	50% coinsurance*	Not covered	Deductible applies.
	Durable medical equipment	50% coinsurance*	Not covered	Deductible applies.
	Hospice service	50% coinsurance*	Not covered	Deductible applies.
If your child needs dental or eye care	Eye exam	\$100 copay*	Not covered	Deductible applies. One eye exam per year to age 21.
	Glasses	\$150 allowance* per year to age 21.	Not covered	Deductible applies.
	Dental check-up	\$0 copay	Not covered	Deductible waived. Two dental exams per year to age 21.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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.)

- Acupuncture
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Infertility Treatment
- Long-Term Care
- Non-Emergency care when traveling outside the US
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight Loss Programs

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.)

- Bariatric Surgery
- Chiropractic Care
- Private-Duty Nursing
- MVP Wellness Program

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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 1-800-637-7788 or <http://www.dfr.vermont.gov/insurance/insurance-consumer/consumer-information>

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 1-800-637-7788 or <http://www.dfr.vermont.gov/insurance/insurance-consumer/consumer-information>

The following is the Vermont State Department of Insurance contact information:

External Appeals Program, Vermont Department of Financial Regulation

89 Main Street, Montpelier, VT 05602, 1-800-631-7788 or 1-802-282-2900, 1-888-236-5966 (Emergency request for external appeal)

Additionally, a consumer assistance program can help you file your appeal. Contact:

Vermont Legal Aid, Office of Health Care Ombudsman, 264 North Winooski Avenue, Burlington, VT 05402

1-800-917-7787 or 1-802-863-2316; TTY: 1-888-884-1955 or 1-802-863-2473, www.vtlegalaid.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.*—————

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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 \$7,466**
- **Patient pays \$0**

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	\$
Co-pays	\$
Co-insurance	\$
Limits or exclusions	\$
Total	\$0

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

- **Amount owed to providers: \$5,490**
- **Plan pays \$5,490**
- **Patient pays \$0**

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	\$
Co-pays	\$
Co-insurance	\$
Limits or exclusions	\$
Total	\$0

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.



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 1-800-348-8515..

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In network -\$400 person/\$800 family	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> 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 <u>deductible</u> .
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 <u>deductible</u> amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	In network -\$5,300 person/\$10,600 family Rx out-of-pocket -\$1,300 person /\$2,600 family	The <u>out-of-pocket limit</u> 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 and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
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 <i>specific</i> 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 <u>provider</u> , 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 <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a specialist?	No.	You can see the <u>specialist</u> 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 <u>excluded services</u> .

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.



- **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		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$5 copay	Not covered.	Deductible waived.
	Specialist visit	\$30 copay	Not covered	Deductible waived.
	Other practitioner office visit	\$30 copay	Not covered	Deductible waived.
	Preventive care/ screening/immunization	\$0 copay	Not covered	Deductible waived.
If you have a test	Diagnostic test (x-ray, blood work)	Lab Office - \$5 copay PCP/\$30 Spec Lab Facility - \$30 copay* Radiology Office - \$5 copay PCP/\$30 Specialist Radiology Facility - \$50 copay*	Not covered	Lab Office - Deductible waived. Lab Facility - Deductible applies. Radiology Office - Deductible waived. Radiology Facility - Deductible applies.
	Imaging (CT/PET scans, MRIs)	\$400 copay*	Not covered	Deductible applies. is per procedure.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
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 \$5 copay Mail order \$12.50 copay	Not covered	Deductible waived. 30 day retail/90 day mail order. VBID retail copay is \$1/mail order \$2.50.
	Preferred brand drugs	Retail \$40 copay* Mail order \$100 copay*	Not covered	Deductible applies. Rx 30 day retail/90 day mail order. VBID retail copay is \$1/mail order \$2.50.
	Non-preferred brand drugs	50% coinsurance*	Not covered	Deductible applies. Rx 30 day retail/90 day mail order. VBID retail copay is \$1/mail order \$2.50.
	Specialty drugs	Retail Covered at Specialty Pharmacy as noted in generic, preferred, and non-preferred classes.	Not covered	30 day supply available through Specialty Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery)	\$400 copay*	Not covered	Deductible applies.
	Physician/surgeon fees	\$200 copay*	Not covered	Deductible applies.
If you need immediate medical attention	Emergency room services	\$200 copay*	\$200 copay*	Deductible applies.
	Emergency medical transportation	\$50 copay*	\$50 copay*	Deductible applies.
	Urgent care	\$45 copay	\$45 copay	Deductible waived.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance*	Not covered	Deductible applies.
	Physician/surgeon fee	20% coinsurance*	Not covered	Deductible applies.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary

at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient	\$5 copay for office visits and \$30 copay for other outpatient services.	Not covered	Deductible waived. For office visits.
	Mental/Behavioral health inpatient services	20% coinsurance*	Not covered	Deductible applies.
	Substance use disorder outpatient services	\$5 copay for office visits and \$30 copay for other outpatient services.	Not covered	Deductible waived. For office visits.
	Substance use disorder inpatient services	20% coinsurance*	Not covered	Deductible applies.
If you are pregnant	Prenatal and postnatal	\$0 copay	Not covered	Deductible waived.
	Delivery and all inpatient services	20% coinsurance*	Not covered	Deductible applies.
If you need help recovering or have other special health needs	Home health care	\$30 copay*	Not covered	Deductible applies.
	Rehabilitation services	\$30 copay for office visits, \$30 copay for outpatient services.	Not covered	Deductible waived. For office services. 30 combined PT/OT/ST visits/yr.
	Habilitation services	\$30 copay office setting, \$30 copay for outpatient services.	Not covered	Deductible waived. For office services. 30 combined PT/OT/ST visits/yr.
	Skilled nursing care	20% coinsurance*	Not covered	Deductible applies.
	Durable medical equipment	20% coinsurance*	Not covered	Deductible applies.
	Hospice service	20% coinsurance*	Not covered	Deductible applies.
If your child needs dental or eye care	Eye exam	\$30 copay	Not covered	Deductible waived. One eye exam per year to age 21.
	Glasses	\$150 allowance per year to age 21.	Not covered	Deductible waived.
	Dental check-up	\$0 copay	Not covered	Deductible waived. Two dental exams per year to age 21.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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.)

- Acupuncture
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Infertility Treatment
- Long-Term Care
- Non-Emergency care when traveling outside the US
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight Loss Programs

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.)

- Bariatric Surgery
- Chiropractic Care
- Private-Duty Nursing
- MVP Wellness Program

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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 1-800-637-7788 or <http://www.dfr.vermont.gov/insurance/insurance-consumer/consumer-information>

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 1-800-637-7788 or <http://www.dfr.vermont.gov/insurance/insurance-consumer/consumer-information>

The following is the Vermont State Department of Insurance contact information:

External Appeals Program, Vermont Department of Financial Regulation

89 Main Street, Montpelier, VT 05602, 1-800-631-7788 or 1-802-282-2900, 1-888-236-5966 (Emergency request for external appeal)

Additionally, a consumer assistance program can help you file your appeal. Contact:

Vermont Legal Aid, Office of Health Care Ombudsman, 264 North Winooski Avenue, Burlington, VT 05402

1-800-917-7787 or 1-802-863-2316; TTY: 1-888-884-1955 or 1-802-863-2473, www.vtlegalaid.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.*—————

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary

at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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 \$7,466**
- **Patient pays \$0**

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	\$
Co-pays	\$
Co-insurance	\$
Limits or exclusions	\$
Total	\$0

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

- **Amount owed to providers: \$5,490**
- **Plan pays \$5,490**
- **Patient pays \$0**

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	\$
Co-pays	\$
Co-insurance	\$
Limits or exclusions	\$
Total	\$0

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.



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 1-800-348-8515..

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In network -\$6,350 person/\$12,700 family	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> 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 <u>deductible</u> .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	In network - /Rx out-of-pocket - \$1,250 person/\$2,500 family.	The <u>out-of-pocket limit</u> 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 <u>out-of-pocket limit</u>?	This plan has no Out -of-Pocket Limit.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
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 <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u>?	Yes. For a list of participating providers see www.mvphealthcare.com .	If you use an in-network doctor or other health care <u>provider</u> , 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 <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a <u>specialist</u>?	No.	You can see the <u>specialist</u> 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 <u>excluded services</u> .

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

- 
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		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$0 copay	Not covered.	Deductible waived. For first three PCP visits.
	Specialist visit	\$0 copay*	Not covered.	Deductible applies.
	Other practitioner office visit	\$0 copay*	Not covered.	Deductible applies.
	Preventive care/ screening/immunization	\$0 copay	Not covered.	Deductible waived.
If you have a test	Diagnostic test (x-ray, blood work)	\$0 copay*	Not covered.	Deductible applies.
	Imaging (CT/PET scans, MRIs)	\$0 copay*	Not covered.	Deductible applies.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.mvphealthcare.com .	Generic drugs	\$0 copay*	Not covered.	Deductible applies.
	Preferred brand drugs	\$0 copay*	Not covered.	Deductible applies.
	Non-preferred brand drugs	\$0 copay*	Not covered.	Deductible applies.
	Specialty drugs	Retail \$0 copay.* Covered at Specialty Pharmacy as noted in generic, preferred, and non-preferred.	Not covered.	Deductible applies. 30 day supply available through Specialty Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery)	\$0 copay*	Not covered.	Deductible applies.
	Physician/surgeon fees	\$0 copay*	Not covered.	Deductible applies.
If you need immediate medical attention	Emergency room services	\$0 copay*	\$0 copay*	Deductible applies.
	Emergency medical transportation	\$0 copay*	\$0 copay*	Deductible applies.
	Urgent care	\$0 copay*	\$0 copay*	Deductible applies.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$0 copay*	Not covered.	Deductible applies.
	Physician/surgeon fee	\$0 copay*	Not covered.	Deductible applies.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary

at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient	\$0 copay*	Not covered.	Deductible applies.
	Mental/Behavioral health inpatient services	\$0 copay*	Not covered.	Deductible applies.
	Substance use disorder outpatient services	\$0 copay*	Not covered.	Deductible applies.
	Substance use disorder inpatient services	\$0 copay*	Not covered.	Deductible applies.
If you are pregnant	Prenatal and postnatal	\$0 copay	Not covered.	Deductible waived.
	Delivery and all inpatient services	\$0 copay*	Not covered.	Deductible applies.
If you need help recovering or have other special health needs	Home health care	\$0 copay*	Not covered.	Deductible applies.
	Rehabilitation services	\$0 copay*	Not covered.	Deductible applies. 30 combined PT/OT/ST visits/yr.
	Habilitation services	\$0 copay*	Not covered.	Deductible applies. 30 combined PT/OT/ST visits/yr.
	Skilled nursing care	\$0 copay*	Not covered.	Deductible applies.
	Durable medical equipment	\$0 copay*	Not covered.	Deductible applies.
	Hospice service	\$0 copay*	Not covered.	Deductible applies.
If your child needs dental or eye care	Eye exam	\$0 copay*	Not covered.	Deductible applies. One eye exam per year to age 21.
	Glasses	\$150 allowance* per year to age 21.	Not covered	Deductible applies.
	Dental check-up	\$0 copay*	Same as Par Provider.*	Deductible applies. Two dental exams per year to age 21.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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.)

- Acupuncture
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Infertility Treatment
- Long-Term Care
- Non-Emergency care when traveling outside the US
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight Loss Programs
- MVP Wellness Program

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.)

- Bariatric Surgery
- Chiropractic Care
- Private-Duty Nursing

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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 1-800-637-7788 or <http://www.dfr.vermont.gov/insurance/insurance-consumer/consumer-information>

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 1-800-637-7788 or <http://www.dfr.vermont.gov/insurance/insurance-consumer/consumer-information>

The following is the Vermont State Department of Insurance contact information:

External Appeals Program, Vermont Department of Financial Regulation

89 Main Street, Montpelier, VT 05602, 1-800-631-7788 or 1-802-282-2900, 1-888-236-5966 (Emergency request for external appeal)

Additionally, a consumer assistance program can help you file your appeal. Contact:

Vermont Legal Aid, Office of Health Care Ombudsman, 264 North Winooski Avenue, Burlington, VT 05402

1-800-917-7787 or 1-802-863-2316; TTY: 1-888-884-1955 or 1-802-863-2473, www.vtlegalaid.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.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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** \$7,466
- **Patient pays** \$0

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	\$
Co-pays	\$
Co-insurance	\$
Limits or exclusions	\$
Total	\$0

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

- **Amount owed to providers: \$5,490**
- **Plan pays** \$5,490
- **Patient pays** \$0

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	\$
Co-pays	\$
Co-insurance	\$
Limits or exclusions	\$
Total	\$0

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.



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 1-800-348-8515..

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In network -\$2,000 person/\$4,000 family	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> 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 <u>deductible</u> .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	In network -\$6,250 person/\$12,500 family Rx out-of-pocket -\$1,300 person /\$2,600 family	The <u>out-of-pocket limit</u> 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 and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
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 <i>specific</i> 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 <u>provider</u> , 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 <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a specialist?	No.	You can see the <u>specialist</u> 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 <u>excluded services</u> .

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary

at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

- 
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		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	50% coinsurance*	Not covered.	Deductible applies.
	Specialist visit	50% coinsurance*	Not covered	Deductible applies.
	Other practitioner office visit	50% coinsurance*	Not covered	Deductible applies.
	Preventive care/ screening/immunization	\$0 copay	Not covered	Deductible waived.
If you have a test	Diagnostic test (x-ray, blood work)	50% coinsurance*	Not covered	Deductible applies.
	Imaging (CT/PET scans, MRIs)	50% coinsurance*	Not covered	Deductible applies.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
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 \$12 copay* Mail order \$30 copay*	Not covered	Deductible applies. 30 day supply retail/90 day supply Mail order. Preventive drugs.
	Preferred brand drugs	40% coinsurance*	Not covered	Deductible applies. 30 day supply retail/90 day supply Mail order. Preventive drugs, Deductible waived.
	Non-preferred brand drugs	60% coinsurance*	Not covered	Deductible applies. 30 day supply retail/90 day supply Mail order. Preventive drugs, Deductible waived.
	Specialty drugs	Retail Covered at Specialty Pharmacy as noted in generic, preferred, and non-preferred classes.	Not covered	30 day supply available through Specialty Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery)	50% coinsurance*	Not covered	Deductible applies.
	Physician/surgeon fees	50% coinsurance*	Not covered	Deductible applies.
If you need immediate medical attention	Emergency room services	50% coinsurance*	50% coinsurance*	Deductible applies.
	Emergency medical transportation	50% coinsurance*	50% coinsurance*	Deductible applies.
	Urgent care	50% coinsurance*	50% coinsurance*	Deductible applies.
If you have a hospital stay	Facility fee (e.g., hospital room)	50% coinsurance*	Not covered	Deductible applies.
	Physician/surgeon fee	50% coinsurance*	Not covered	Deductible applies.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary

at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient	50% coinsurance*	Not covered	Deductible applies.
	Mental/Behavioral health inpatient services	50% coinsurance*	Not covered	Deductible applies.
	Substance use disorder outpatient services	50% coinsurance*	Not covered	Deductible applies.
	Substance use disorder inpatient services	50% coinsurance*	Not covered	Deductible applies.
If you are pregnant	Prenatal and postnatal	\$0 copay	Not covered	Deductible waived.
	Delivery and all inpatient services	50% coinsurance*	Not covered	Deductible applies.
If you need help recovering or have other special health needs	Home health care	50% coinsurance*	Not covered	Deductible applies.
	Rehabilitation services	50% coinsurance*	Not covered	Deductible applies. 30 combined PT/OT/ST visits/yr.
	Habilitation services	50% coinsurance*	Not covered	Deductible applies. 30 combined PT/OT/ST visits/yr.
	Skilled nursing care	50% coinsurance*	Not covered	Deductible applies.
	Durable medical equipment	50% coinsurance*	Not covered	Deductible applies.
	Hospice service	50% coinsurance*	Not covered	Deductible applies.
If your child needs dental or eye care	Eye exam	50% coinsurance*	Not covered	Deductible applies. One eye exam per year to age 21.
	Glasses	\$150 allowance* per year to age 21.	Not covered	Deductible applies.
	Dental check-up	\$0 copay*	Not covered	Deductible applies. Two dental exams per year to age 21.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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.)

- Acupuncture
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Infertility Treatment
- Long-Term Care
- Non-Emergency care when traveling outside the US
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight Loss Programs
- MVP Wellness Program

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.)

- Bariatric Surgery
- Chiropractic Care
- Private-Duty Nursing

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-888-687-6277. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

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 the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

The following is the Vermont State Department of Insurance contact information:

External Appeals Program, Vermont Department of Financial Regulation

89 Main Street, Montpelier, VT 05602, 1-800-631-7788 or 1-802-282-2900, 1-888-236-5966 (Emergency request for external appeal)

Additionally, a consumer assistance program can help you file your appeal. Contact:

Vermont Legal Aid, Office of Health Care Ombudsman, 264 North Winooski Avenue, Burlington, VT 05402

1-800-917-7787 or 1-802-863-2316; TTY: 1-888-884-1955 or 1-802-863-2473, www.vtlegalaid.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.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary

at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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 \$7,466**
- **Patient pays \$0**

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	\$
Co-pays	\$
Co-insurance	\$
Limits or exclusions	\$
Total	\$0

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

- **Amount owed to providers: \$5,490**
- **Plan pays \$5,490**
- **Patient pays \$0**

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	\$
Co-pays	\$
Co-insurance	\$
Limits or exclusions	\$
Total	\$0

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.



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 1-800-348-8515..

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In network -\$1,550 person/\$3,100 family	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> 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 <u>deductible</u> .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	In network -\$5,750 person/\$11,500 family Rx out-of-pocket -\$1,300 person /\$2,600 family	The <u>out-of-pocket limit</u> 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 and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
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 <i>specific</i> 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 <u>provider</u> , 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 <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a specialist?	No.	You can see the <u>specialist</u> 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 <u>excluded services</u> .

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary

at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

- **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		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you visit a health care provider’s office or clinic	Primary care visit to treat an injury or illness	10% coinsurance*	Not covered.	Deductible applies.
	Specialist visit	20% coinsurance*	Not covered	Deductible applies.
	Other practitioner office visit	20% coinsurance*	Not covered	Deductible applies.
	Preventive care/ screening/immunization	\$0 copay	Not covered	Deductible waived.
If you have a test	Diagnostic test (x-ray, blood work)	Lab Office - 10% coinsurance* PCP/20% coinsurance Specialist Lab Facility - 20% coinsurance* Radiology Office - 10% coinsurance* PCP/20% coinsurance Specialist	Not covered	Deductible applies.
	Imaging (CT/PET scans, MRIs)	20% coinsurance*	Not covered	Deductible applies.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren’t clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
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 \$25 copay*	Not covered	Deductible applies. 30 day supply retail/90 day supply Mail order. Preventive drugs.
	Preferred brand drugs	Retail \$40 copay* Mail order \$100 copay*	Not covered	Deductible applies. 30 day supply retail/90 day supply Mail order. Preventive drugs, Deductible waived.
	Non-preferred brand drugs	50% coinsurance*	Not covered	Deductible applies. 30 day supply retail/90 day supply Mail order. Preventive drugs, Deductible waived.
	Specialty drugs	Retail Covered at Specialty Pharmacy as noted in generic, preferred, and non-preferred classes.	Not covered	30 day supply available through Specialty Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery)	20% coinsurance*	Not covered	Deductible applies.
	Physician/surgeon fees	20% coinsurance*	Not covered	Deductible applies.
If you need immediate medical attention	Emergency room services	20% coinsurance*	20% coinsurance*	Deductible applies.
	Emergency medical transportation	20% coinsurance*	20% coinsurance*	Deductible applies.
	Urgent care	20% coinsurance*	20% coinsurance*	Deductible applies.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance*	Not covered	Deductible applies.
	Physician/surgeon fee	20% coinsurance*	Not covered	Deductible applies.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary

at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient	20% coinsurance* for office visits and 20% coinsurance for outpatient	Not covered	Deductible applies.
	Mental/Behavioral health inpatient services	20% coinsurance*	Not covered	Deductible applies.
	Substance use disorder outpatient services	20% coinsurance* for office visits and 20% coinsurance for outpatient	Not covered	Deductible applies.
	Substance use disorder inpatient services	20% coinsurance*	Not covered	Deductible applies.
If you are pregnant	Prenatal and postnatal	\$0 copay	Not covered	Deductible waived.
	Delivery and all inpatient services	20% coinsurance*	Not covered	Deductible applies.
If you need help recovering or have other special health needs	Home health care	20% coinsurance*	Not covered	Deductible applies.
	Rehabilitation services	20% coinsurance*	Not covered	Deductible applies. 30 combined PT/OT/ST visits/yr.
	Habilitation services	20% coinsurance*	Not covered	Deductible applies. 30 combined PT/OT/ST visits/yr.
	Skilled nursing care	20% coinsurance*	Not covered	Deductible applies.
	Durable medical equipment	20% coinsurance*	Not covered	Deductible applies.
	Hospice service	20% coinsurance*	Not covered	Deductible applies.
If your child needs dental or eye care	Eye exam	20% coinsurance*	Not covered	Deductible applies. One eye exam per year to age 21.
	Glasses	\$150 allowance* per year to age 21.	Not covered	Deductible applies.
	Dental check-up	\$0 copay*	Not covered	Deductible applies. Two dental exams per year to age 21.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary

at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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.)

- Acupuncture
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Infertility Treatment
- Long-Term Care
- Non-Emergency care when traveling outside the US
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight Loss Programs
- MVP Wellness Program

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.)

- Bariatric Surgery
- Chiropractic Care
- Private-Duty Nursing

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-888-687-6277. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

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 the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

The following is the Vermont State Department of Insurance contact information:

External Appeals Program, Vermont Department of Financial Regulation

89 Main Street, Montpelier, VT 05602, 1-800-631-7788 or 1-802-282-2900, 1-888-236-5966 (Emergency request for external appeal)

Additionally, a consumer assistance program can help you file your appeal. Contact:

Vermont Legal Aid, Office of Health Care Ombudsman, 264 North Winooski Avenue, Burlington, VT 05402

1-800-917-7787 or 1-802-863-2316; TTY: 1-888-884-1955 or 1-802-863-2473, www.vtlegalaid.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.*—————

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary

at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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 \$7,466**
- **Patient pays \$0**

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	\$
Co-pays	\$
Co-insurance	\$
Limits or exclusions	\$
Total	\$0

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

- **Amount owed to providers: \$5,490**
- **Plan pays \$5,490**
- **Patient pays \$0**

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	\$
Co-pays	\$
Co-insurance	\$
Limits or exclusions	\$
Total	\$0

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.



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 1-800-348-8515..

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In network -\$3,500 person/\$7,000 family	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> 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 <u>deductible</u> .
Are there other deductibles for specific services?	Pharmacy -\$300 person \ \$600 family	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	In network -\$6,350 person/\$12,700 family Rx out-of-pocket -\$1,250 person /\$2,500 family	The <u>out-of-pocket limit</u> 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 and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
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 <i>specific</i> 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 <u>provider</u> , 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 <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a specialist?	No.	You can see the <u>specialist</u> 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 <u>excluded services</u> .

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.



- **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		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$35 copay*	Not covered.	Deductible applies.
	Specialist visit	\$80 copay*	Not covered	Deductible applies.
	Other practitioner office visit	\$80 copay*	Not covered	Deductible applies.
	Preventive care/ screening/immunization	\$0 copay	Not covered	Deductible waived.
If you have a test	Diagnostic test (x-ray, blood work)	Lab Office - \$35 copay* PCP/\$80 Spe Lab Facility - 50% coinsurance* Radiology Office - \$35 copay* PCP/\$80 Specialist Radiology Facility - 50% coinsurance*	Not covered	Deductible applies.
	Imaging (CT/PET scans, MRIs)	50% coinsurance*	Not covered	Deductible applies. is per procedure. Hi-Tech Facility - Deductible applies.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
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 \$20 copay* Mail order \$50 copay*	Not covered	Deductible applies. Rx 30 day retail/90 day mail order.
	Preferred brand drugs	Retail \$80 copay* Mail order \$200 copay*	Not covered	Deductible applies. Rx 30 day retail/90 day mail order.
	Non-preferred brand drugs	60% coinsurance*	Not covered	Deductible applies. Rx 30 day retail/90 day mail order.
	Specialty drugs	Retail Covered at Specialty Pharmacy as noted in generic, preferred, and non-preferred classes.	Not covered	30 day supply available through Specialty Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery)	50% coinsurance*	Not covered	Deductible applies.
	Physician/surgeon fees	50% coinsurance*	Not covered	Deductible applies.
If you need immediate medical attention	Emergency room services	50% coinsurance*	50% coinsurance*	Deductible applies.
	Emergency medical transportation	\$100 copay*	\$100 copay*	Deductible applies.
	Urgent care	\$100 copay*	\$100 copay*	Deductible applies.
If you have a hospital stay	Facility fee (e.g., hospital room)	50% coinsurance*	Not covered	Deductible applies.
	Physician/surgeon fee	50% coinsurance*	Not covered	Deductible applies.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient	\$35 copay* for office visits and 50% coinsurance for outpatient services.	Not covered	Deductible applies.
	Mental/Behavioral health inpatient services	50% coinsurance*	Not covered	Deductible applies.
	Substance use disorder outpatient services	\$35 copay* for office visits and 50% coinsurance for outpatient services.	Not covered	Deductible applies.
	Substance use disorder inpatient services	50% coinsurance*	Not covered	Deductible applies.
If you are pregnant	Prenatal and postnatal	\$0 copay	Not covered	Deductible waived.
	Delivery and all inpatient services	50% coinsurance*	Not covered	Deductible applies.
If you need help recovering or have other special health needs	Home health care	50% coinsurance*	Not covered	Deductible applies.
	Rehabilitation services	\$80 copay* office setting/50% coinsurance facility setting.	Not covered	Deductible applies. 30 combined PT/OT/ST visits/yr.
	Habilitation services	\$80 copay* office setting/50% coinsurance facility setting.	Not covered	Deductible applies. 30 combined PT/OT/ST visits/yr.
	Skilled nursing care	50% coinsurance*	Not covered	Deductible applies.
	Durable medical equipment	50% coinsurance*	Not covered	Deductible applies.
	Hospice service	50% coinsurance*	Not covered	Deductible applies.
If your child needs dental or eye care	Eye exam	\$80 copay*	Not covered	Deductible applies. One eye exam per year to age 21.
	Glasses	\$150 allowance* per year to age 21.	Not covered	Deductible applies.
	Dental check-up	\$0 copay	Not covered	Deductible waived. Two dental exams per year to age 21.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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.)

- Acupuncture
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Infertility Treatment
- Long-Term Care
- Non-Emergency care when traveling outside the US
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight Loss Programs
- MVP Wellness Program

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.)

- Bariatric Surgery
- Chiropractic Care
- Private-Duty Nursing

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-888-687-6277. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

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 the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

The following is the Vermont State Department of Insurance contact information:

External Appeals Program, Vermont Department of Financial Regulation

89 Main Street, Montpelier, VT 05602, 1-800-631-7788 or 1-802-282-2900, 1-888-236-5966 (Emergency request for external appeal)

Additionally, a consumer assistance program can help you file your appeal. Contact:

Vermont Legal Aid, Office of Health Care Ombudsman, 264 North Winooski Avenue, Burlington, VT 05402

1-800-917-7787 or 1-802-863-2316; TTY: 1-888-884-1955 or 1-802-863-2473, www.vtlegalaid.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.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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 \$7,466**
- **Patient pays \$0**

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	\$
Co-pays	\$
Co-insurance	\$
Limits or exclusions	\$
Total	\$0

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

- **Amount owed to providers: \$5,490**
- **Plan pays \$5,490**
- **Patient pays \$0**

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	\$
Co-pays	\$
Co-insurance	\$
Limits or exclusions	\$
Total	\$0

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.



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 1-800-348-8515..

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u>?	In network -\$750 person/\$1,500 family	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> 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 <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	RX Brand -\$50 person \ \$100 family	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this plan begins to pay for these services.
Is there an <u>out-of-pocket limit</u> on my expenses?	In network -\$4,250 person/\$8,500 family Rx out-of-pocket -\$1,250 person /\$2,500 family	The <u>out-of-pocket limit</u> 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 <u>out-of-pocket limit</u>?	Premiums and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
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 <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u>?	Yes. For a list of participating providers see www.mvphealthcare.com .	If you use an in-network doctor or other health care <u>provider</u> , 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 <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a <u>specialist</u>?	No.	You can see the <u>specialist</u> 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 <u>excluded services</u> .

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.



- **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		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
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.
	Specialist visit	\$25 copay	Not covered	Deductible waived.
	Other practitioner office visit	\$25 copay	Not covered	Deductible waived.
	Preventive care/ screening/immunization	\$0 copay	Not covered	Deductible waived.
If you have a test	Diagnostic test (x-ray, blood work)	Lab Office - \$15 copay PCP/\$25 Spec Lab Facility - 20% coinsurance* Radiology Office - \$15 copay PCP/\$25 Specialist Radiology Facility - 20% coinsurance*	Not covered	Lab Office - Deductible waived. Lab Facility - Deductible applies. Radiology Office - Deductible waived. Radiology Facility - Deductible applies.
	Imaging (CT/PET scans, MRIs)	20% coinsurance*	Not covered	Deductible applies. is per procedure. Hi-Tech Facility - Deductible applies.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
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 \$5 copay Mail order \$12.50 copay	Not covered	Deductible waived. 30 day retail/90 day mail order.
	Preferred brand drugs	Retail \$40 copay* Mail order \$100 copay*	Not covered	Deductible applies. Rx 30 day retail/90 day mail order.
	Non-preferred brand drugs	50% coinsurance*	Not covered	Deductible applies. Rx 30 day retail/90 day mail order.
	Specialty drugs	Retail Covered at Specialty Pharmacy as noted in generic, preferred, and non-preferred classes.	Not covered	30 day supply available through Specialty Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery)	20% coinsurance*	Not covered	Deductible applies.
	Physician/surgeon fees	20% coinsurance*	Not covered	Deductible applies.
If you need immediate medical attention	Emergency room services	\$150 copay	\$150 copay	Deductible waived.
	Emergency medical transportation	\$50 copay	\$50 copay	Deductible waived.
	Urgent care	\$45 copay	\$45 copay	Deductible waived.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance*	Not covered	Deductible applies.
	Physician/surgeon fee	20% coinsurance*	Not covered	Deductible applies.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary

at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient	\$15 copay for office visits and 20% coinsurance for outpatient services.	Not covered	Deductible waived. For office visits.
	Mental/Behavioral health inpatient services	20% coinsurance*	Not covered	Deductible applies.
	Substance use disorder outpatient services	\$15 copay for office visits and 20% coinsurance for outpatient services.	Not covered	Deductible waived. For office visits.
	Substance use disorder inpatient services	20% coinsurance*	Not covered	Deductible applies.
If you are pregnant	Prenatal and postnatal	\$0 copay	Not covered	Deductible waived.
	Delivery and all inpatient services	20% coinsurance*	Not covered	Deductible applies.
If you need help recovering or have other special health needs	Home health care	20% coinsurance*	Not covered	Deductible applies.
	Rehabilitation services	\$25 copay for office visits, 20% coinsurance for outpatient services.	Not covered	Deductible waived. For office services. 30 combined PT/OT/ST visits/yr.
	Habilitation services	\$25 copay office setting, 20% coinsurance for outpatient services.	Not covered	Deductible waived. For office services. 30 combined PT/OT/ST visits/yr.
	Skilled nursing care	20% coinsurance*	Not covered	Deductible applies.
	Durable medical equipment	20% coinsurance*	Not covered	Deductible applies.
	Hospice service	20% coinsurance*	Not covered	Deductible applies.
If your child needs dental or eye care	Eye exam	\$25 copay	Not covered	Deductible waived. One eye exam per year to age 21.
	Glasses	\$150 allowance per year to age 21.	Not covered	Deductible waived.
	Dental check-up	\$0 copay	Not covered	Deductible waived. Two dental exams per year to age 21.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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.)

- Acupuncture
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Infertility Treatment
- Long-Term Care
- Non-Emergency care when traveling outside the US
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight Loss Programs
- MVP Wellness Program

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.)

- Bariatric Surgery
- Chiropractic Care
- Private-Duty Nursing

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-888-687-6277. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

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 the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

The following is the Vermont State Department of Insurance contact information:

External Appeals Program, Vermont Department of Financial Regulation

89 Main Street, Montpelier, VT 05602, 1-800-631-7788 or 1-802-282-2900, 1-888-236-5966 (Emergency request for external appeal)

Additionally, a consumer assistance program can help you file your appeal. Contact:

Vermont Legal Aid, Office of Health Care Ombudsman, 264 North Winooski Avenue, Burlington, VT 05402

1-800-917-7787 or 1-802-863-2316; TTY: 1-888-884-1955 or 1-802-863-2473, www.vtlegalaid.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.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary

at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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 \$7,466**
- **Patient pays \$0**

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	\$
Co-pays	\$
Co-insurance	\$
Limits or exclusions	\$
Total	\$0

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

- **Amount owed to providers: \$5,490**
- **Plan pays \$5,490**
- **Patient pays \$0**

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	\$
Co-pays	\$
Co-insurance	\$
Limits or exclusions	\$
Total	\$0

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.



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 1-800-348-8515..

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In network -\$150 person/\$300 family	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> 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 <u>deductible</u> .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	In network -\$1,250 person/\$2,500 family Rx out-of-pocket -\$1,250 person /\$2,500 family	The <u>out-of-pocket limit</u> 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 and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
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 <i>specific</i> 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 <u>provider</u> , 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 <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a specialist?	No.	You can see the <u>specialist</u> 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 <u>excluded services</u> .

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.



- **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		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$10 copay	Not covered.	Deductible waived.
	Specialist visit	\$20 copay	Not covered	Deductible waived.
	Other practitioner office visit	\$20 copay	Not covered	Deductible waived.
	Preventive care/ screening/immunization	\$0 copay	Not covered	Deductible waived.
If you have a test	Diagnostic test (x-ray, blood work)	Lab Office - \$10 copay PCP/\$20 Spec Lab Facility - 10% coinsurance* Radiology Office - \$10 copay PCP/\$20 Specialist Radiology Facility - 10% coinsurance*	Not covered	Lab Office - Deductible waived. Lab Facility - Deductible applies. Radiology Office - Deductible waived. Radiology Facility - Deductible applies.
	Imaging (CT/PET scans, MRIs)	10% coinsurance*	Not covered	Deductible applies. is per procedure. Hi-Tech Facility - Deductible applies.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
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 \$5 copay Mail order \$12.50 copay	Not covered	Deductible waived. 30 day retail/90 day mail order.
	Preferred brand drugs	Retail \$40 copay Mail order \$100 copay	Not covered	Deductible waived. 30 day retail/90 day mail order.
	Non-preferred brand drugs	50% coinsurance	Not covered	Deductible waived. 30 day retail/90 day mail order.
	Specialty drugs	Retail Covered at Specialty Pharmacy as noted in generic, preferred, and non-preferred classes.	Not covered	30 day supply available through Specialty Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery)	10% coinsurance*	Not covered	Deductible applies.
	Physician/surgeon fees	10% coinsurance*	Not covered	Deductible applies.
If you need immediate medical attention	Emergency room services	\$100 copay	\$100 copay	Deductible waived.
	Emergency medical transportation	\$50 copay	\$50 copay	Deductible waived.
	Urgent care	\$40 copay	\$40 copay	Deductible waived.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance*	Not covered	Deductible applies.
	Physician/surgeon fee	10% coinsurance*	Not covered	Deductible applies.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary

at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient	\$10 copay for office visits and 10% coinsurance for outpatient services.	Not covered	Deductible waived. For office visits.
	Mental/Behavioral health inpatient services	10% coinsurance*	Not covered	Deductible applies.
	Substance use disorder outpatient services	\$10 copay for office visits and 10% coinsurance for outpatient services.	Not covered	Deductible waived. For office visits.
	Substance use disorder inpatient services	10% coinsurance*	Not covered	Deductible applies.
If you are pregnant	Prenatal and postnatal	\$0 copay	Not covered	Deductible waived.
	Delivery and all inpatient services	10% coinsurance*	Not covered	Deductible applies.
If you need help recovering or have other special health needs	Home health care	10% coinsurance*	Not covered	Deductible applies.
	Rehabilitation services	\$20 copay for office visits, 10% coinsurance for outpatient services.	Not covered	Deductible waived. For office services. 30 combined PT/OT/ST visits/yr.
	Habilitation services	\$20 copay office setting, 10% coinsurance for outpatient services.	Not covered	Deductible waived. For office services. 30 combined PT/OT/ST visits/yr.
	Skilled nursing care	10% coinsurance*	Not covered	Deductible applies.
	Durable medical equipment	10% coinsurance*	Not covered	Deductible applies.
	Hospice service	10% coinsurance*	Not covered	Deductible applies.
If your child needs dental or eye care	Eye exam	\$20 copay	Not covered	Deductible waived. One eye exam per year to age 21.
	Glasses	\$150 allowance per year to age 21.	Not covered	Deductible waived.
	Dental check-up	\$0 copay	Not covered	Deductible waived. Two dental exams per year to age 21.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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.)

- Acupuncture
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Infertility Treatment
- Long-Term Care
- Non-Emergency care when traveling outside the US
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight Loss Programs
- MVP Wellness Program

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.)

- Bariatric Surgery
- Chiropractic Care
- Private-Duty Nursing

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-888-687-6277. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

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 the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

The following is the Vermont State Department of Insurance contact information:

External Appeals Program, Vermont Department of Financial Regulation

89 Main Street, Montpelier, VT 05602, 1-800-631-7788 or 1-802-282-2900, 1-888-236-5966 (Emergency request for external appeal)

Additionally, a consumer assistance program can help you file your appeal. Contact:

Vermont Legal Aid, Office of Health Care Ombudsman, 264 North Winooski Avenue, Burlington, VT 05402

1-800-917-7787 or 1-802-863-2316; TTY: 1-888-884-1955 or 1-802-863-2473, www.vtlegalaid.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.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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 \$7,466**
- **Patient pays \$0**

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	\$
Co-pays	\$
Co-insurance	\$
Limits or exclusions	\$
Total	\$0

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

- **Amount owed to providers: \$5,490**
- **Plan pays \$5,490**
- **Patient pays \$0**

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	\$
Co-pays	\$
Co-insurance	\$
Limits or exclusions	\$
Total	\$0

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.



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 1-800-348-8515..

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In network -\$1,900 person/\$3,800 family	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> 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 <u>deductible</u> .
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 <u>deductible</u> amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	In network -\$5,100 person/\$10,200 family Rx out-of-pocket -\$1,250 person /\$2,500 family	The <u>out-of-pocket limit</u> 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 and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
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 <i>specific</i> 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 <u>provider</u> , 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 <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a specialist?	No.	You can see the <u>specialist</u> 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 <u>excluded services</u> .

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.



- **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		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you visit a health care provider’s office or clinic	Primary care visit to treat an injury or illness	\$25 copay	Not covered.	Deductible waived.
	Specialist visit	\$45 copay	Not covered	Deductible waived.
	Other practitioner office visit	\$45 copay	Not covered	Deductible waived.
	Preventive care/ screening/immunization	\$0 copay	Not covered	Deductible waived.
If you have a test	Diagnostic test (x-ray, blood work)	Lab Office - \$25 copay PCP/\$45 Specialist Lab Facility - 40% coinsurance* Radiology Office - \$25 copay PCP/\$45 Specialist	Not covered	Lab Office - Deductible waived. Lab Facility - Deductible applies. Radiology Office - Deductible waived. Radiology Facility - Deductible applies.
	Imaging (CT/PET scans, MRIs)	40% coinsurance*	Not covered	Deductible applies. is per procedure. Hi-Tech Facility - Deductible applies.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren’t clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
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 \$12 copay Mail order \$30 copay	Not covered	Deductible waived. 30 day retail/90 day mail order.
	Preferred brand drugs	Retail \$50 copay* Mail order \$125 copay*	Not covered	Deductible applies. Rx 30 day retail/90 day mail order.
	Non-preferred brand drugs	50% coinsurance*	Not covered	Deductible applies. Rx 30 day retail/90 day mail order.
	Specialty drugs	Retail Covered at Specialty Pharmacy as noted in generic, preferred, and non-preferred classes.	Not covered	30 day supply available through Specialty Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery)	40% coinsurance*	Not covered	Deductible applies.
	Physician/surgeon fees	40% coinsurance*	Not covered	Deductible applies.
If you need immediate medical attention	Emergency room services	\$250 copay*	\$250 copay*	Deductible applies.
	Emergency medical transportation	\$100 copay	\$100 copay	Deductible waived.
	Urgent care	\$60 copay	\$60 copay	Deductible waived.
If you have a hospital stay	Facility fee (e.g., hospital room)	40% coinsurance*	Not covered	Deductible applies.
	Physician/surgeon fee	40% coinsurance*	Not covered	Deductible applies.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary

at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient	\$25 copay for office visits and 40% coinsurance for outpatient services.	Not covered	Deductible waived. For office visits.
	Mental/Behavioral health inpatient services	40% coinsurance*	Not covered	Deductible applies.
	Substance use disorder outpatient services	\$25 copay for office visits and 40% coinsurance for outpatient services.	Not covered	Deductible waived. For office visits.
	Substance use disorder inpatient services	40% coinsurance*	Not covered	Deductible applies.
If you are pregnant	Prenatal and postnatal	\$0 copay	Not covered	Deductible waived.
	Delivery and all inpatient services	40% coinsurance*	Not covered	Deductible applies.
If you need help recovering or have other special health needs	Home health care	40% coinsurance*	Not covered	Deductible applies.
	Rehabilitation services	\$45 copay for office visits, 40% coinsurance for outpatient services.	Not covered	Deductible waived. For office services. 30 combined PT/OT/ST visits/yr.
	Habilitation services	\$45 copay office setting, 40% coinsurance for outpatient services.	Not covered	Deductible waived. For office services. 30 combined PT/OT/ST visits/yr.
	Skilled nursing care	40% coinsurance*	Not covered	Deductible applies.
	Durable medical equipment	40% coinsurance*	Not covered	Deductible applies.
	Hospice service	40% coinsurance*	Not covered	Deductible applies.
If your child needs dental or eye care	Eye exam	\$45 copay	Not covered	Deductible waived. One eye exam per year to age 21.
	Glasses	\$150 allowance per year to age 21.	Not covered	Deductible waived.
	Dental check-up	\$0 copay	Not covered	Deductible waived. Two dental exams per year to age 21.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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.)

- Acupuncture
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Infertility Treatment
- Long-Term Care
- Non-Emergency care when traveling outside the US
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight Loss Programs
- MVP Wellness Program

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.)

- Bariatric Surgery
- Chiropractic Care
- Private-Duty Nursing

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-888-687-6277. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

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 the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

The following is the Vermont State Department of Insurance contact information:

External Appeals Program, Vermont Department of Financial Regulation

89 Main Street, Montpelier, VT 05602, 1-800-631-7788 or 1-802-282-2900, 1-888-236-5966 (Emergency request for external appeal)

Additionally, a consumer assistance program can help you file your appeal. Contact:

Vermont Legal Aid, Office of Health Care Ombudsman, 264 North Winooski Avenue, Burlington, VT 05402

1-800-917-7787 or 1-802-863-2316; TTY: 1-888-884-1955 or 1-802-863-2473, www.vtlegalaid.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.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary

at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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 \$7,466**
- **Patient pays \$0**

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	\$
Co-pays	\$
Co-insurance	\$
Limits or exclusions	\$
Total	\$0

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

- **Amount owed to providers: \$5,490**
- **Plan pays \$5,490**
- **Patient pays \$0**

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	\$
Co-pays	\$
Co-insurance	\$
Limits or exclusions	\$
Total	\$0

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.



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 1-800-348-8515..

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In network -\$3,000 person/\$6,000 family	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> 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 <u>deductible</u> .
Are there other deductibles for specific services?	Pharmacy -\$200 person \ \$400 family	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	In network -\$6,600 person/\$13,200 family Rx out-of-pocket -\$1,300 person /\$2,600 family	The <u>out-of-pocket limit</u> 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 and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
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 <i>specific</i> 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 <u>provider</u> , 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 <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a specialist?	No.	You can see the <u>specialist</u> 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 <u>excluded services</u> .

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.



- **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		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you visit a health care provider’s office or clinic	Primary care visit to treat an injury or illness	\$30 copay*	Not covered.	Deductible applies.
	Specialist visit	\$100 copay*	Not covered	Deductible applies.
	Other practitioner office visit	\$100 copay*	Not covered	Deductible applies.
	Preventive care/ screening/immunization	\$0 copay	Not covered	Deductible waived.
If you have a test	Diagnostic test (x-ray, blood work)	Lab Office - \$30 copay* PCP/\$100 Sp Lab Facility - 50% coinsurance* Radiology Office - \$30 copay* PCP/\$100 Specialist Radiology Facility - 50% coinsurance*	Not covered	Deductible applies.
	Imaging (CT/PET scans, MRIs)	50% coinsurance*	Not covered	Deductible applies. is per procedure. Hi-Tech Facility - Deductible applies.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren’t clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
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 \$20 copay* Mail order \$50 copay*	Not covered	Deductible applies. Rx 30 day retail/90 day mail order. VBID retail copay is \$3/mail order \$7.50.
	Preferred brand drugs	Retail \$90 copay* Mail order \$225 copay*	Not covered	Deductible applies. Rx 30 day retail/90 day mail order. VBID retail copay is \$3/mail order \$7.50.
	Non-preferred brand drugs	60% coinsurance*	Not covered	Deductible applies. Rx 30 day retail/90 day mail order. VBID retail copay is \$3/mail order \$7.50.
	Specialty drugs	Retail Covered at Specialty Pharmacy as noted in generic, preferred, and non-preferred classes.	Not covered	30 day supply available through Specialty Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery)	50% coinsurance*	Not covered	Deductible applies.
	Physician/surgeon fees	50% coinsurance*	Not covered	Deductible applies.
If you need immediate medical attention	Emergency room services	50% coinsurance*	50% coinsurance*	Deductible applies.
	Emergency medical transportation	\$100 copay*	\$100 copay*	Deductible applies.
	Urgent care	\$100 copay*	\$100 copay*	Deductible applies.
If you have a hospital stay	Facility fee (e.g., hospital room)	50% coinsurance*	Not covered	Deductible applies.
	Physician/surgeon fee	50% coinsurance*	Not covered	Deductible applies.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient	\$30 copay* for office visits and 50% coinsurance for outpatient services.	Not covered	Deductible applies.
	Mental/Behavioral health inpatient services	50% coinsurance*	Not covered	Deductible applies.
	Substance use disorder outpatient services	\$30 copay* for office visits and 50% coinsurance for outpatient services.	Not covered	Deductible applies.
	Substance use disorder inpatient services	50% coinsurance*	Not covered	Deductible applies.
If you are pregnant	Prenatal and postnatal	\$0 copay	Not covered	Deductible waived.
	Delivery and all inpatient services	50% coinsurance*	Not covered	Deductible applies.
If you need help recovering or have other special health needs	Home health care	50% coinsurance*	Not covered	Deductible applies.
	Rehabilitation services	\$100 copay* office setting/50% coinsurance facility setting.	Not covered	Deductible applies. 30 combined PT/OT/ST visits/yr.
	Habilitation services	\$100 copay* office setting/50% coinsurance facility setting.	Not covered	Deductible applies. 30 combined PT/OT/ST visits/yr.
	Skilled nursing care	50% coinsurance*	Not covered	Deductible applies.
	Durable medical equipment	50% coinsurance*	Not covered	Deductible applies.
	Hospice service	50% coinsurance*	Not covered	Deductible applies.
If your child needs dental or eye care	Eye exam	\$100 copay*	Not covered	Deductible applies. One eye exam per year to age 21.
	Glasses	\$150 allowance* per year to age 21.	Not covered	Deductible applies.
	Dental check-up	\$0 copay	Not covered	Deductible waived. Two dental exams per year to age 21.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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.)

- Acupuncture
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Infertility Treatment
- Long-Term Care
- Non-Emergency care when traveling outside the US
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight Loss Programs

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.)

- Bariatric Surgery
- Chiropractic Care
- Private-Duty Nursing
- MVP Wellness Program

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-888-687-6277. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

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 the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

The following is the Vermont State Department of Insurance contact information:

External Appeals Program, Vermont Department of Financial Regulation

89 Main Street, Montpelier, VT 05602, 1-800-631-7788 or 1-802-282-2900, 1-888-236-5966 (Emergency request for external appeal)

Additionally, a consumer assistance program can help you file your appeal. Contact:

Vermont Legal Aid, Office of Health Care Ombudsman, 264 North Winooski Avenue, Burlington, VT 05402

1-800-917-7787 or 1-802-863-2316; TTY: 1-888-884-1955 or 1-802-863-2473, www.vtlegalaid.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.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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 \$7,466**
- **Patient pays \$0**

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	\$
Co-pays	\$
Co-insurance	\$
Limits or exclusions	\$
Total	\$0

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

- **Amount owed to providers: \$5,490**
- **Plan pays \$5,490**
- **Patient pays \$0**

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	\$
Co-pays	\$
Co-insurance	\$
Limits or exclusions	\$
Total	\$0

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.



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 1-800-348-8515..

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In network -\$400 person/\$800 family	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> 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 <u>deductible</u> .
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 <u>deductible</u> amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	In network -\$5,300 person/\$10,600 family Rx out-of-pocket -\$1,300 person /\$2,600 family	The <u>out-of-pocket limit</u> 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 and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
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 <i>specific</i> 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 <u>provider</u> , 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 <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a specialist?	No.	You can see the <u>specialist</u> 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 <u>excluded services</u> .

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.



- **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		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you visit a health care provider’s office or clinic	Primary care visit to treat an injury or illness	\$5 copay	Not covered.	Deductible waived.
	Specialist visit	\$30 copay	Not covered	Deductible waived.
	Other practitioner office visit	\$30 copay	Not covered	Deductible waived.
	Preventive care/ screening/immunization	\$0 copay	Not covered	Deductible waived.
If you have a test	Diagnostic test (x-ray, blood work)	Lab Office - \$5 copay PCP/\$30 Spec Lab Facility - \$30 copay* Radiology Office - \$5 copay PCP/\$30 Specialist Radiology Facility - \$50 copay*	Not covered	Lab Office - Deductible waived. Lab Facility - Deductible applies. Radiology Office - Deductible waived. Radiology Facility - Deductible applies.
	Imaging (CT/PET scans, MRIs)	\$400 copay*	Not covered	Deductible applies. is per procedure.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren’t clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
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 \$5 copay Mail order \$12.50 copay	Not covered	Deductible waived. 30 day retail/90 day mail order. VBID retail copay is \$1/mail order \$2.50.
	Preferred brand drugs	Retail \$40 copay* Mail order \$100 copay*	Not covered	Deductible applies. Rx 30 day retail/90 day mail order. VBID retail copay is \$1/mail order \$2.50.
	Non-preferred brand drugs	50% coinsurance*	Not covered	Deductible applies. Rx 30 day retail/90 day mail order. VBID retail copay is \$1/mail order \$2.50.
	Specialty drugs	Retail Covered at Specialty Pharmacy as noted in generic, preferred, and non-preferred classes.	Not covered	30 day supply available through Specialty Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery)	\$400 copay*	Not covered	Deductible applies.
	Physician/surgeon fees	\$200 copay*	Not covered	Deductible applies.
If you need immediate medical attention	Emergency room services	\$200 copay*	\$200 copay*	Deductible applies.
	Emergency medical transportation	\$50 copay*	\$50 copay*	Deductible applies.
	Urgent care	\$45 copay	\$45 copay	Deductible waived.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance*	Not covered	Deductible applies.
	Physician/surgeon fee	20% coinsurance*	Not covered	Deductible applies.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary

at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient	\$5 copay for office visits and \$30 copay for other outpatient services.	Not covered	Deductible waived. For office visits.
	Mental/Behavioral health inpatient services	20% coinsurance*	Not covered	Deductible applies.
	Substance use disorder outpatient services	\$5 copay for office visits and \$30 copay for other outpatient services.	Not covered	Deductible waived. For office visits.
	Substance use disorder inpatient services	20% coinsurance*	Not covered	Deductible applies.
If you are pregnant	Prenatal and postnatal	\$0 copay	Not covered	Deductible waived.
	Delivery and all inpatient services	20% coinsurance*	Not covered	Deductible applies.
If you need help recovering or have other special health needs	Home health care	\$30 copay*	Not covered	Deductible applies.
	Rehabilitation services	\$30 copay for office visits, \$30 copay for outpatient services.	Not covered	Deductible waived. For office services. 30 combined PT/OT/ST visits/yr.
	Habilitation services	\$30 copay office setting, \$30 copay for outpatient services.	Not covered	Deductible waived. For office services. 30 combined PT/OT/ST visits/yr.
	Skilled nursing care	20% coinsurance*	Not covered	Deductible applies.
	Durable medical equipment	20% coinsurance*	Not covered	Deductible applies.
	Hospice service	20% coinsurance*	Not covered	Deductible applies.
If your child needs dental or eye care	Eye exam	\$30 copay	Not covered	Deductible waived. One eye exam per year to age 21.
	Glasses	\$150 allowance per year to age 21.	Not covered	Deductible waived.
	Dental check-up	\$0 copay	Not covered	Deductible waived. Two dental exams per year to age 21.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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.)

- Acupuncture
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Infertility Treatment
- Long-Term Care
- Non-Emergency care when traveling outside the US
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight Loss Programs

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.)

- Bariatric Surgery
- Chiropractic Care
- Private-Duty Nursing
- MVP Wellness Program

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-888-687-6277. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

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 the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

The following is the Vermont State Department of Insurance contact information:

External Appeals Program, Vermont Department of Financial Regulation

89 Main Street, Montpelier, VT 05602, 1-800-631-7788 or 1-802-282-2900, 1-888-236-5966 (Emergency request for external appeal)

Additionally, a consumer assistance program can help you file your appeal. Contact:

Vermont Legal Aid, Office of Health Care Ombudsman, 264 North Winooski Avenue, Burlington, VT 05402

1-800-917-7787 or 1-802-863-2316; TTY: 1-888-884-1955 or 1-802-863-2473, www.vtlegalaid.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.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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 \$7,466**
- **Patient pays \$0**

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	\$
Co-pays	\$
Co-insurance	\$
Limits or exclusions	\$
Total	\$0

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

- **Amount owed to providers: \$5,490**
- **Plan pays \$5,490**
- **Patient pays \$0**

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	\$
Co-pays	\$
Co-insurance	\$
Limits or exclusions	\$
Total	\$0

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.



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 1-800-348-8515..

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In network -\$1,800 person/\$3,600 family	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> 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 <u>deductible</u> .
Are there other deductibles for specific services?	Pharmacy -\$250 person \ \$500 family	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	In network -\$5,300 person/\$10,600 family Rx out-of-pocket -\$1,300 person /\$2,600 family	The <u>out-of-pocket limit</u> 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 and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
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 <i>specific</i> 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 <u>provider</u> , 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 <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a specialist?	No.	You can see the <u>specialist</u> 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 <u>excluded services</u> .

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.



- **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		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
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.
	Specialist visit	\$50 copay*	Not covered	Deductible applies.
	Other practitioner office visit	\$50 copay*	Not covered	Deductible applies.
	Preventive care/ screening/immunization	\$0 copay	Not covered	Deductible waived.
If you have a test	Diagnostic test (x-ray, blood work)	Lab Office - \$15 copay PCP/\$50 Spec Lab Facility - \$50 copay* Radiology Office - \$15 copay PCP/\$50 Specialist Radiology Facility - \$100 copay*	Not covered	Lab Office - Deductible waived. PCP. Lab Facility - Deductible applies. Radiology Office - Deductible waived. PCP. Radiology Facility - Deductible applies.
	Imaging (CT/PET scans, MRIs)	\$650 copay*	Not covered	Deductible applies. is per procedure.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren’t clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
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 \$12 copay* Mail order \$30 copay*	Not covered	Deductible applies. Rx 30 day retail/90 day mail order. VBID retail copay is \$3/mail order \$7.50.
	Preferred brand drugs	Retail \$40 copay* Mail order \$100 copay*	Not covered	Deductible applies. Rx 30 day retail/90 day mail order. VBID retail copay is \$3/mail order \$7.50.
	Non-preferred brand drugs	50% coinsurance*	Not covered	Deductible applies. Rx 30 day retail/90 day mail order. VBID retail copay is \$3/mail order \$7.50.
	Specialty drugs	Retail Covered at Specialty Pharmacy as noted in generic, preferred, and non-preferred classes.	Not covered	30 day supply available through Specialty Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery)	\$1,400 copay*	Not covered	Deductible applies.
	Physician/surgeon fees	\$600 copay*	Not covered	Deductible applies.
If you need immediate medical attention	Emergency room services	\$250 copay*	\$250 copay*	Deductible applies.
	Emergency medical transportation	\$100 copay*	\$100 copay*	Deductible applies.
	Urgent care	\$60 copay*	\$60 copay*	Deductible applies.
If you have a hospital stay	Facility fee (e.g., hospital room)	50% coinsurance*	Not covered	Deductible applies.
	Physician/surgeon fee	50% coinsurance*	Not covered	Deductible applies.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient	\$15 copay for office visits and \$50 copay for other outpatient services.	Not covered	Deductible waived. For office visits.
	Mental/Behavioral health inpatient services	50% coinsurance*	Not covered	Deductible applies.
	Substance use disorder outpatient services	\$15 copay for office visits and \$50 copay for other outpatient services.	Not covered	Deductible waived. For office visits.
	Substance use disorder inpatient services	50% coinsurance*	Not covered	Deductible applies.
If you are pregnant	Prenatal and postnatal	\$0 copay	Not covered	Deductible waived.
	Delivery and all inpatient services	50% coinsurance*	Not covered	Deductible applies.
If you need help recovering or have other special health needs	Home health care	\$50 copay*	Not covered	Deductible applies.
	Rehabilitation services	\$50 copay*	Not covered	Deductible applies. 30 combined PT/OT/ST visits/yr.
	Habilitation services	\$50 copay*	Not covered	Deductible applies. 30 combined PT/OT/ST visits/yr.
	Skilled nursing care	50% coinsurance*	Not covered	Deductible applies.
	Durable medical equipment	50% coinsurance*	Not covered	Deductible applies.
	Hospice service	50% coinsurance*	Not covered	Deductible applies.
If your child needs dental or eye care	Eye exam	\$50 copay*	Not covered	Deductible applies. One eye exam per year to age 21.
	Glasses	\$150 allowance* per year to age 21.	Not covered	Deductible applies.
	Dental check-up	\$0 copay	Not covered	Deductible waived. Two dental exams per year to age 21.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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.)

- Acupuncture
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Infertility Treatment
- Long-Term Care
- Non-Emergency care when traveling outside the US
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight Loss Programs

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.)

- Bariatric Surgery
- Chiropractic Care
- Private-Duty Nursing
- MVP Wellness Program

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-888-687-6277. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

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 the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

The following is the Vermont State Department of Insurance contact information:

External Appeals Program, Vermont Department of Financial Regulation

89 Main Street, Montpelier, VT 05602, 1-800-631-7788 or 1-802-282-2900, 1-888-236-5966 (Emergency request for external appeal)

Additionally, a consumer assistance program can help you file your appeal. Contact:

Vermont Legal Aid, Office of Health Care Ombudsman, 264 North Winooski Avenue, Burlington, VT 05402

1-800-917-7787 or 1-802-863-2316; TTY: 1-888-884-1955 or 1-802-863-2473, www.vtlegalaid.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.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary

at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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 \$7,466**
- **Patient pays \$0**

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	\$
Co-pays	\$
Co-insurance	\$
Limits or exclusions	\$
Total	\$0

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

- **Amount owed to providers: \$5,490**
- **Plan pays \$5,490**
- **Patient pays \$0**

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	\$
Co-pays	\$
Co-insurance	\$
Limits or exclusions	\$
Total	\$0

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.



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 1-800-348-8515..

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In network -\$1,400 person/\$2,800 family	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> 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 <u>deductible</u> .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	In network -\$3,400 person/\$6,800 family Rx out-of-pocket -\$1,300 person /\$2,600 family	The <u>out-of-pocket limit</u> 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 and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
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 <i>specific</i> 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 <u>provider</u> , 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 <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a specialist?	No.	You can see the <u>specialist</u> 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 <u>excluded services</u> .

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary

at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

- 
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		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	10% coinsurance*	Not covered.	Deductible applies.
	Specialist visit	20% coinsurance*	Not covered	Deductible applies.
	Other practitioner office visit	20% coinsurance*	Not covered	Deductible applies.
	Preventive care/ screening/immunization	\$0 copay	Not covered	Deductible waived.
If you have a test	Diagnostic test (x-ray, blood work)	Lab Office - 10% coinsurance* PCP/20% coinsurance Specialist Lab Facility - 20% coinsurance* Radiology Office - 10% coinsurance* PCP/20% coinsurance Specialist	Not covered	Deductible applies.
	Imaging (CT/PET scans, MRIs)	20% coinsurance*	Not covered	Deductible applies.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
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 \$25 copay*	Not covered	Deductible applies. 30 day supply retail/90 day supply Mail order. Preventive drugs.
	Preferred brand drugs	Retail \$40 copay* Mail order \$100 copay*	Not covered	Deductible applies. 30 day supply retail/90 day supply Mail order. Preventive drugs, Deductible waived.
	Non-preferred brand drugs	50% coinsurance*	Not covered	Deductible applies. 30 day supply retail/90 day supply Mail order. Preventive drugs, Deductible waived.
	Specialty drugs	Retail Covered at Specialty Pharmacy as noted in generic, preferred, and non-preferred classes.	Not covered	30 day supply available through Specialty Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery)	20% coinsurance*	Not covered	Deductible applies.
	Physician/surgeon fees	20% coinsurance*	Not covered	Deductible applies.
If you need immediate medical attention	Emergency room services	20% coinsurance*	20% coinsurance*	Deductible applies.
	Emergency medical transportation	20% coinsurance*	20% coinsurance*	Deductible applies.
	Urgent care	20% coinsurance*	20% coinsurance*	Deductible applies.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance*	Not covered	Deductible applies.
	Physician/surgeon fee	20% coinsurance*	Not covered	Deductible applies.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient	20% coinsurance* for office visits and 20% coinsurance for outpatient	Not covered	Deductible applies.
	Mental/Behavioral health inpatient services	20% coinsurance*	Not covered	Deductible applies.
	Substance use disorder outpatient services	20% coinsurance* for office visits and 20% coinsurance for outpatient	Not covered	Deductible applies.
	Substance use disorder inpatient services	20% coinsurance*	Not covered	Deductible applies.
If you are pregnant	Prenatal and postnatal	\$0 copay	Not covered	Deductible waived.
	Delivery and all inpatient services	20% coinsurance*	Not covered	Deductible applies.
If you need help recovering or have other special health needs	Home health care	20% coinsurance*	Not covered	Deductible applies.
	Rehabilitation services	20% coinsurance*	Not covered	Deductible applies. 30 combined PT/OT/ST visits/yr.
	Habilitation services	20% coinsurance*	Not covered	Deductible applies. 30 combined PT/OT/ST visits/yr.
	Skilled nursing care	20% coinsurance*	Not covered	Deductible applies.
	Durable medical equipment	20% coinsurance*	Not covered	Deductible applies.
	Hospice service	20% coinsurance*	Not covered	Deductible applies.
If your child needs dental or eye care	Eye exam	20% coinsurance*	Not covered	Deductible applies. One eye exam per year to age 21.
	Glasses	\$150 allowance* per year to age 21.	Not covered	Deductible applies.
	Dental check-up	\$0 copay*	Not covered	Deductible applies. Two dental exams per year to age 21.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary

at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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.)

- Acupuncture
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Infertility Treatment
- Long-Term Care
- Non-Emergency care when traveling outside the US
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight Loss Programs
- MVP Wellness Program

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.)

- Bariatric Surgery
- Chiropractic Care
- Private-Duty Nursing

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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 1-800-637-7788 or <http://www.dfr.vermont.gov/insurance/insurance-consumer/consumer-information>

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 1-800-637-7788 or <http://www.dfr.vermont.gov/insurance/insurance-consumer/consumer-information>

The following is the Vermont State Department of Insurance contact information:

External Appeals Program, Vermont Department of Financial Regulation

89 Main Street, Montpelier, VT 05602, 1-800-631-7788 or 1-802-282-2900, 1-888-236-5966 (Emergency request for external appeal)

Additionally, a consumer assistance program can help you file your appeal. Contact:

Vermont Legal Aid, Office of Health Care Ombudsman, 264 North Winooski Avenue, Burlington, VT 05402

1-800-917-7787 or 1-802-863-2316; TTY: 1-888-884-1955 or 1-802-863-2473, www.vtlegalaid.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.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary

at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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** \$7,466
- **Patient pays** \$0

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	\$
Co-pays	\$
Co-insurance	\$
Limits or exclusions	\$
Total	\$0

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

- **Amount owed to providers: \$5,490**
- **Plan pays** \$5,490
- **Patient pays** \$0

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	\$
Co-pays	\$
Co-insurance	\$
Limits or exclusions	\$
Total	\$0

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.



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 1-800-348-8515..

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In network -\$1,000 person/\$2,000 family	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> 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 <u>deductible</u> .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	In network -\$1,000 person/\$2,000 family Rx out-of-pocket is included in the annual out-of-pocket maximum	The <u>out-of-pocket limit</u> 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 and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
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 <i>specific</i> 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 <u>provider</u> , 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 <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a specialist?	No.	You can see the <u>specialist</u> 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 <u>excluded services</u> .

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary

at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

- **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		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you visit a health care provider’s office or clinic	Primary care visit to treat an injury or illness	\$0 copay*	Not covered.	Deductible applies.
	Specialist visit	\$0 copay*	Not covered	Deductible applies.
	Other practitioner office visit	\$0 copay*	Not covered	Deductible applies.
	Preventive care/ screening/immunization	\$0 copay	Not covered	Deductible waived.
If you have a test	Diagnostic test (x-ray, blood work)	\$0 copay*	Not covered	Deductible applies.
	Imaging (CT/PET scans, MRIs)	\$0 copay*	Not covered	Deductible applies.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren’t clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.mvphealthcare.com .	Generic drugs	\$0 copay*	Not covered	Deductible applies. 30 day supply retail/90 day supply Mail order. Preventive drugs.
	Preferred brand drugs	\$0 copay*	Not covered	Deductible applies. 30 day supply retail/90 day supply Mail order. Preventive drugs, Deductible waived.
	Non-preferred brand drugs	\$0 copay*	Not covered	Deductible applies. 30 day supply retail/90 day supply Mail order. Preventive drugs, Deductible waived.
	Specialty drugs	Retail Not covered Mail order Retail Covered at Specialty Pharmacy as noted in generic,	Not covered	30 day supply available through Specialty Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery)	\$0 copay*	Not covered	Deductible applies.
	Physician/surgeon fees	\$0 copay*	Not covered	Deductible applies.
If you need immediate medical attention	Emergency room services	\$0 copay*		Deductible applies.
	Emergency medical transportation	\$0 copay*		Deductible applies.
	Urgent care	\$0 copay*	\$0 copay*	Deductible applies.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$0 copay*	Not covered	Deductible applies.
	Physician/surgeon fee	\$0 copay*	Not covered	Deductible applies.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient	\$0 copay*	Not covered	Deductible applies.
	Mental/Behavioral health inpatient services	\$0 copay*	Not covered	Deductible applies.
	Substance use disorder outpatient services	\$0 copay*	Not covered	Deductible applies.
	Substance use disorder inpatient services	\$0 copay*	Not covered	Deductible applies.
If you are pregnant	Prenatal and postnatal	\$0 copay	Not covered	Deductible waived.
	Delivery and all inpatient services	\$0 copay*	Not covered	Deductible applies.
If you need help recovering or have other special health needs	Home health care	\$0 copay*	Not covered	Deductible applies.
	Rehabilitation services	\$0 copay*	Not covered	Deductible applies. 30 combined PT/OT/ST visits/yr.
	Habilitation services	\$0 copay*	Not covered	Deductible applies. 30 combined PT/OT/ST visits/yr.
	Skilled nursing care	\$0 copay*	Not covered	Deductible applies.
	Durable medical equipment	\$0 copay*	Not covered	Deductible applies.
	Hospice service	\$0 copay*	Not covered	Deductible applies.
If your child needs dental or eye care	Eye exam	\$0 copay*	Not covered	Deductible applies. One eye exam per year to age 21.
	Glasses	\$150 allowance* per year to age 21.	Not covered	Deductible applies.
	Dental check-up	\$0 copay*	Not covered	Deductible applies. Two dental exams per year to age 21.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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.)

- Acupuncture
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Infertility Treatment
- Long-Term Care
- Non-Emergency care when traveling outside the US
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight Loss Programs
- MVP Wellness Program

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.)

- Bariatric Surgery
- Chiropractic Care
- Private-Duty Nursing

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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 1-800-637-7788 or <http://www.dfr.vermont.gov/insurance/insurance-consumer/consumer-information>

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 1-800-637-7788 or <http://www.dfr.vermont.gov/insurance/insurance-consumer/consumer-information>

The following is the Vermont State Department of Insurance contact information:

External Appeals Program, Vermont Department of Financial Regulation

89 Main Street, Montpelier, VT 05602, 1-800-631-7788 or 1-802-282-2900, 1-888-236-5966 (Emergency request for external appeal)

Additionally, a consumer assistance program can help you file your appeal. Contact:

Vermont Legal Aid, Office of Health Care Ombudsman, 264 North Winooski Avenue, Burlington, VT 05402

1-800-917-7787 or 1-802-863-2316; TTY: 1-888-884-1955 or 1-802-863-2473, www.vtlegalaid.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.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary

at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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 \$7,466**
- **Patient pays \$0**

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	\$
Co-pays	\$
Co-insurance	\$
Limits or exclusions	\$
Total	\$0

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

- **Amount owed to providers: \$5,490**
- **Plan pays \$5,490**
- **Patient pays \$0**

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	\$
Co-pays	\$
Co-insurance	\$
Limits or exclusions	\$
Total	\$0

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.



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 1-800-348-8515..

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In network -\$450 person/\$900 family	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> 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 <u>deductible</u> .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	In network -\$450 person/\$900 family Rx out-of-pocket is included in the annual out-of-pocket maximum	The <u>out-of-pocket limit</u> 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 and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
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 <i>specific</i> 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 <u>provider</u> , 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 <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a specialist?	No.	You can see the <u>specialist</u> 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 <u>excluded services</u> .

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary

at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

- 
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		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$0 copay*	Not covered.	Deductible applies.
	Specialist visit	\$0 copay*	Not covered	Deductible applies.
	Other practitioner office visit		Not covered	Deductible applies.
	Preventive care/ screening/immunization	\$0 copay	Not covered	Deductible waived.
If you have a test	Diagnostic test (x-ray, blood work)	\$0 copay*	Not covered	Deductible applies.
	Imaging (CT/PET scans, MRIs)	\$0 copay*	Not covered	Deductible applies.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.mvphealthcare.com .	Generic drugs	\$0 copay*	Not covered	Deductible applies. 30 day supply retail/90 day supply Mail order. Preventive drugs.
	Preferred brand drugs	\$0 copay*	Not covered	Deductible applies. 30 day supply retail/90 day supply Mail order. Preventive drugs, Deductible waived.
	Non-preferred brand drugs	\$0 copay*	Not covered	Deductible applies. 30 day supply retail/90 day supply Mail order. Preventive drugs, Deductible waived.
	Specialty drugs	Retail Covered at Specialty Pharmacy as noted in generic, preferred, and non-preferred classes.	Not covered	30 day supply available through Specialty Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery)	\$0 copay*	Not covered	Deductible applies.
	Physician/surgeon fees	\$0 copay*	Not covered	Deductible applies.
If you need immediate medical attention	Emergency room services	\$0 copay*		Deductible applies.
	Emergency medical transportation	\$0 copay*		Deductible applies.
	Urgent care	\$0 copay*	\$0 copay*	Deductible applies.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$0 copay*	Not covered	Deductible applies.
	Physician/surgeon fee	\$0 copay*	Not covered	Deductible applies.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient	\$0 copay*	Not covered	Deductible applies.
	Mental/Behavioral health inpatient services	\$0 copay*	Not covered	Deductible applies.
	Substance use disorder outpatient services	\$0 copay*	Not covered	Deductible applies.
	Substance use disorder inpatient services	\$0 copay*	Not covered	Deductible applies.
If you are pregnant	Prenatal and postnatal	\$0 copay	Not covered	Deductible waived.
	Delivery and all inpatient services	\$0 copay*	Not covered	Deductible applies.
If you need help recovering or have other special health needs	Home health care	\$0 copay*	Not covered	Deductible applies.
	Rehabilitation services	\$0 copay*	Not covered	Deductible applies. 30 combined PT/OT/ST visits/yr.
	Habilitation services	\$0 copay*	Not covered	Deductible applies. 30 combined PT/OT/ST visits/yr.
	Skilled nursing care	\$0 copay*	Not covered	Deductible applies.
	Durable medical equipment	\$0 copay*	Not covered	Deductible applies.
	Hospice service	\$0 copay*	Not covered	Deductible applies.
If your child needs dental or eye care	Eye exam	\$0 copay*	Not covered	Deductible applies. One eye exam per year to age 21.
	Glasses	\$150 allowance* per year to age 21.	Not covered	Deductible applies.
	Dental check-up	\$0 copay*	Not covered	Deductible applies. Two dental exams per year to age 21.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary

at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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.)

- Acupuncture
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Infertility Treatment
- Long-Term Care
- Non-Emergency care when traveling outside the US
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight Loss Programs
- MVP Wellness Program

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.)

- Bariatric Surgery
- Chiropractic Care
- Private-Duty Nursing

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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 1-800-637-7788 or <http://www.dfr.vermont.gov/insurance/insurance-consumer/consumer-information>

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 1-800-637-7788 or <http://www.dfr.vermont.gov/insurance/insurance-consumer/consumer-information>

The following is the Vermont State Department of Insurance contact information:

External Appeals Program, Vermont Department of Financial Regulation

89 Main Street, Montpelier, VT 05602, 1-800-631-7788 or 1-802-282-2900, 1-888-236-5966 (Emergency request for external appeal)

Additionally, a consumer assistance program can help you file your appeal. Contact:

Vermont Legal Aid, Office of Health Care Ombudsman, 264 North Winooski Avenue, Burlington, VT 05402

1-800-917-7787 or 1-802-863-2316; TTY: 1-888-884-1955 or 1-802-863-2473, www.vtlegalaid.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.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary

at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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 \$7,466**
- **Patient pays \$0**

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	\$
Co-pays	\$
Co-insurance	\$
Limits or exclusions	\$
Total	\$0

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

- **Amount owed to providers: \$5,490**
- **Plan pays \$5,490**
- **Patient pays \$0**

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	\$
Co-pays	\$
Co-insurance	\$
Limits or exclusions	\$
Total	\$0

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.



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 1-800-348-8515..

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In network -\$1,900 person/\$3,800 family	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> 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 <u>deductible</u> .
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 <u>deductible</u> amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	In network -\$4,000 person/\$8,000 family Rx out-of-pocket -\$1,200 person /\$2,400 family	The <u>out-of-pocket limit</u> 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 and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
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 <i>specific</i> 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 <u>provider</u> , 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 <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a specialist?	No.	You can see the <u>specialist</u> 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 <u>excluded services</u> .

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.



- **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		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you visit a health care provider’s office or clinic	Primary care visit to treat an injury or illness	\$25 copay	Not covered.	Deductible waived.
	Specialist visit	\$45 copay	Not covered	Deductible waived.
	Other practitioner office visit	\$45 copay	Not covered	Deductible waived.
	Preventive care/ screening/immunization	\$0 copay	Not covered	Deductible waived.
If you have a test	Diagnostic test (x-ray, blood work)	Lab Office - \$25 copay PCP/\$45 Spec Lab Facility - 40% coinsurance* Radiology Office - \$25 copay PCP/\$45 Spec Radiology Facility - 40% coinsurance*	Not covered	Lab Office - Deductible waived. Lab Facility - Deductible applies. Radiology Office - Deductible waived. Radiology Facility - Deductible applies.
	Imaging (CT/PET scans, MRIs)	40% coinsurance*	Not covered	Deductible applies. is per procedure. Hi-Tech Facility - Deductible applies.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren’t clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
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 \$12 copay Mail order \$30 copay	Not covered	Deductible waived. Rx 30 day retail/90 day mail order.
	Preferred brand drugs	Retail \$50 copay* Mail order \$125 copay*	Not covered	Deductible applies. Rx 30 day retail/90 day mail order.
	Non-preferred brand drugs	50% coinsurance*	Not covered	Deductible applies. Rx 30 day retail/90 day mail order.
	Specialty drugs	Retail Covered at Specialty Pharmacy as noted in generic, preferred, and non-preferred classes.	Not covered	30 day supply available through Specialty Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery)	40% coinsurance*	Not covered	Deductible applies.
	Physician/surgeon fees	40% coinsurance*	Not covered	Deductible applies.
If you need immediate medical attention	Emergency room services	\$250 copay*	\$250 copay*	Deductible applies.
	Emergency medical transportation	\$100 copay	\$100 copay	Deductible waived.
	Urgent care	\$60 copay	\$60 copay	Deductible waived.
If you have a hospital stay	Facility fee (e.g., hospital room)	40% coinsurance*	Not covered	Deductible applies.
	Physician/surgeon fee	40% coinsurance*	Not covered	Deductible applies.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary

at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

MVP Health Care: MVP VT Vitality Silver Subsidy 73

Coverage Period: 01/01/2015 – 12/31/2015

Summary of Benefits and Coverage: What this Plan Covers & What it Costs Coverage for: Single/Family

Plan Type: HMO

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient	\$25 copay for office visits and 40% coinsurance for outpatient services.	Not covered	Deductible waived. For office visits.
	Mental/Behavioral health inpatient services	40% coinsurance*	Not covered	Deductible applies.
	Substance use disorder outpatient services	\$25 copay for office visits and 40% coinsurance for outpatient services.	Not covered	Deductible waived. For office visits.
	Substance use disorder inpatient services	40% coinsurance*	Not covered	Deductible applies.
If you are pregnant	Prenatal and postnatal	\$0 copay	Not covered	Deductible waived.
	Delivery and all inpatient services	40% coinsurance*	Not covered	Deductible applies.
If you need help recovering or have other special health needs	Home health care	40% coinsurance*	Not covered	Deductible applies.
	Rehabilitation services	\$45 copay for office visits, 40% coinsurance for outpatient services.	Not covered	Deductible waived. For office services. 30 combined PT/OT/ST visits/yr.
	Habilitation services	\$45 copay office setting, 40% coinsurance for outpatient services.	Not covered	Deductible waived. For office services. 30 combined PT/OT/ST visits/yr.
	Skilled nursing care	40% coinsurance*	Not covered	Deductible applies.
	Durable medical equipment	40% coinsurance*	Not covered	Deductible applies.
	Hospice service	40% coinsurance*	Not covered	Deductible applies.
If your child needs dental or eye care	Eye exam	\$45 copay	Not covered	Deductible waived. One eye exam per year to age 21.
	Glasses	\$150 allowance per year to age 21.	Not covered	Deductible waived.
	Dental check-up	\$0 copay	Not covered	Deductible waived. Two dental exams per year to age 21.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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.)

- Acupuncture
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Infertility Treatment
- Long-Term Care
- Non-Emergency care when traveling outside the US
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight Loss Programs
- MVP Wellness Program

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.)

- Bariatric Surgery
- Chiropractic Care
- Private-Duty Nursing

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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 1-800-637-7788 or <http://www.dfr.vermont.gov/insurance/insurance-consumer/consumer-information>

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 1-800-637-7788 or <http://www.dfr.vermont.gov/insurance/insurance-consumer/consumer-information>

The following is the Vermont State Department of Insurance contact information:

External Appeals Program, Vermont Department of Financial Regulation

89 Main Street, Montpelier, VT 05602, 1-800-631-7788 or 1-802-282-2900, 1-888-236-5966 (Emergency request for external appeal)

Additionally, a consumer assistance program can help you file your appeal. Contact:

Vermont Legal Aid, Office of Health Care Ombudsman, 264 North Winooski Avenue, Burlington, VT 05402

1-800-917-7787 or 1-802-863-2316; TTY: 1-888-884-1955 or 1-802-863-2473, www.vtlegalaid.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.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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 \$7,466**
- **Patient pays \$0**

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	\$
Co-pays	\$
Co-insurance	\$
Limits or exclusions	\$
Total	\$0

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

- **Amount owed to providers: \$5,490**
- **Plan pays \$5,490**
- **Patient pays \$0**

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	\$
Co-pays	\$
Co-insurance	\$
Limits or exclusions	\$
Total	\$0

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.



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 1-800-348-8515..

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In network -\$600 person/\$1,200 family	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> 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 <u>deductible</u> .
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 <u>deductible</u> amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	In network -\$1,250 person/\$2,500 family Rx out-of-pocket -\$400 person /\$800 family	The <u>out-of-pocket limit</u> 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 and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
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 <i>specific</i> 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 <u>provider</u> , 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 <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a specialist?	No.	You can see the <u>specialist</u> 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 <u>excluded services</u> .

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.



- **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		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$10 copay	Not covered.	Deductible waived.
	Specialist visit	\$30 copay	Not covered	Deductible waived.
	Other practitioner office visit	\$30 copay	Not covered	Deductible waived.
	Preventive care/ screening/immunization	\$0 copay	Not covered	Deductible waived.
If you have a test	Diagnostic test (x-ray, blood work)	Lab Office - \$10 copay PCP/\$30 Spec Lab Facility - 40% coinsurance* Radiology Office - \$10 copay PCP/\$30 Specialist Radiology Facility - 40% coinsurance*	Not covered	Lab Office - Deductible waived. Lab Facility - Deductible applies. Radiology Office - Deductible waived. Radiology Facility - Deductible applies.
	Imaging (CT/PET scans, MRIs)	40% coinsurance*	Not covered	Deductible applies. is per procedure. Hi-Tech Facility - Deductible applies.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
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 \$25 copay	Not covered	Deductible waived. Rx 30 day retail/90 day mail order.
	Preferred brand drugs	Retail \$50 copay* Mail order \$125 copay*	Not covered	Deductible applies. Rx 30 day retail/90 day mail order.
	Non-preferred brand drugs	50% coinsurance*	Not covered	Deductible applies. Rx 30 day retail/90 day mail order.
	Specialty drugs	Retail Covered at Specialty Pharmacy as noted in generic, preferred, and non-preferred classes.	Not covered	30 day supply available through Specialty Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery)	40% coinsurance*	Not covered	Deductible applies.
	Physician/surgeon fees	40% coinsurance*	Not covered	Deductible applies.
If you need immediate medical attention	Emergency room services	\$250 copay*	\$250 copay*	Deductible applies.
	Emergency medical transportation	\$100 copay	\$100 copay	Deductible waived.
	Urgent care	\$50 copay	\$50 copay	Deductible waived.
If you have a hospital stay	Facility fee (e.g., hospital room)	40% coinsurance*	Not covered	Deductible applies.
	Physician/surgeon fee	40% coinsurance*	Not covered	Deductible applies.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient	\$10 copay for office visits and 40% coinsurance for outpatient services.	Not covered	Deductible waived. For office visits.
	Mental/Behavioral health inpatient services	40% coinsurance*	Not covered	Deductible applies.
	Substance use disorder outpatient services	\$10 copay for office visits and 40% coinsurance for outpatient services.	Not covered	Deductible waived. For office visits.
	Substance use disorder inpatient services	40% coinsurance*	Not covered	Deductible applies.
If you are pregnant	Prenatal and postnatal	\$0 copay	Not covered	Deductible waived.
	Delivery and all inpatient services	40% coinsurance*	Not covered	Deductible applies.
If you need help recovering or have other special health needs	Home health care	40% coinsurance*	Not covered	Deductible applies.
	Rehabilitation services	\$30 copay for office visits, 40% coinsurance for outpatient services.	Not covered	Deductible waived. For office services. 30 combined PT/OT/ST visits/yr.
	Habilitation services	\$30 copay office setting, 40% coinsurance for outpatient services.	Not covered	Deductible waived. For office services. 30 combined PT/OT/ST visits/yr.
	Skilled nursing care	40% coinsurance*	Not covered	Deductible applies.
	Durable medical equipment	40% coinsurance*	Not covered	Deductible applies.
	Hospice service	40% coinsurance*	Not covered	Deductible applies.
If your child needs dental or eye care	Eye exam	\$30 copay	Not covered	Deductible waived. One eye exam per year to age 21.
	Glasses	\$150 allowance per year to age 21.	Not covered	Deductible waived.
	Dental check-up	\$0 copay	Not covered	Deductible waived. Two dental exams per year to age 21.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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.)

- Acupuncture
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Infertility Treatment
- Long-Term Care
- Non-Emergency care when traveling outside the US
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight Loss Programs
- MVP Wellness Program

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.)

- Bariatric Surgery
- Chiropractic Care
- Private-Duty Nursing

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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 1-800-637-7788 or <http://www.dfr.vermont.gov/insurance/insurance-consumer/consumer-information>

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 1-800-637-7788 or <http://www.dfr.vermont.gov/insurance/insurance-consumer/consumer-information>

The following is the Vermont State Department of Insurance contact information:

External Appeals Program, Vermont Department of Financial Regulation

89 Main Street, Montpelier, VT 05602, 1-800-631-7788 or 1-802-282-2900, 1-888-236-5966 (Emergency request for external appeal)

Additionally, a consumer assistance program can help you file your appeal. Contact:

Vermont Legal Aid, Office of Health Care Ombudsman, 264 North Winooski Avenue, Burlington, VT 05402

1-800-917-7787 or 1-802-863-2316; TTY: 1-888-884-1955 or 1-802-863-2473, www.vtlegalaid.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.*—————

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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 \$7,466**
- **Patient pays \$0**

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	\$
Co-pays	\$
Co-insurance	\$
Limits or exclusions	\$
Total	\$0

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

- **Amount owed to providers: \$5,490**
- **Plan pays \$5,490**
- **Patient pays \$0**

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	\$
Co-pays	\$
Co-insurance	\$
Limits or exclusions	\$
Total	\$0

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.



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 1-800-348-8515..

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In network -\$100 person/\$200 family	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> 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 <u>deductible</u> .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	In network -\$500 person/\$1,000 family Rx out-of-pocket -\$200 person /\$400 family	The <u>out-of-pocket limit</u> 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 and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
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 <i>specific</i> 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 <u>provider</u> , 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 <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a specialist?	No.	You can see the <u>specialist</u> 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 <u>excluded services</u> .

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.



- **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		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you visit a health care provider’s office or clinic	Primary care visit to treat an injury or illness	\$5 copay	Not covered.	Deductible waived.
	Specialist visit	\$15 copay	Not covered	Deductible waived.
	Other practitioner office visit	\$15 copay	Not covered	Deductible waived.
	Preventive care/ screening/immunization	\$0 copay	Not covered	Deductible waived.
If you have a test	Diagnostic test (x-ray, blood work)	Lab Office - \$5 copay PCP/\$15 Spec Lab Facility - \$15 copay Radiology Office - \$5 copay PCP/\$15 Specialist Radiology Facility - 10% coinsurance*	Not covered	Lab Office - Deductible waived. Lab Facility - Deductible waived. Radiology Office - Deductible waived. Radiology Facility - Deductible applies.
	Imaging (CT/PET scans, MRIs)	10% coinsurance*	Not covered	Deductible applies. is per procedure. Hi-Tech Facility - Deductible applies.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren’t clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
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 \$5 copay Mail order \$12.50 copay	Not covered	30 day retail/90 day mail order.
	Preferred brand drugs	Retail \$20 copay Mail order \$50 copay	Not covered	30 day retail/90 day mail order.
	Non-preferred brand drugs	30% coinsurance	Not covered	30 day retail/90 day mail order.
	Specialty drugs	Retail Covered at Specialty Pharmacy as noted in generic, preferred, and non-preferred classes.	Not covered	30 day supply available through Specialty Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery)	10% coinsurance*	Not covered	Deductible applies.
	Physician/surgeon fees	10% coinsurance*	Not covered	Deductible applies.
If you need immediate medical attention	Emergency room services	\$75 copay*	\$75 copay*	Deductible applies.
	Emergency medical transportation	\$50 copay*	\$50 copay	Deductible applies.
	Urgent care	\$35 copay	\$35 copay	Deductible waived.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance*	Not covered	Deductible applies.
	Physician/surgeon fee	10% coinsurance*	Not covered	Deductible applies.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient	10% coinsurance* for office visits and 10% coinsurance for outpatient	Not covered	Deductible applies. For office visits.
	Mental/Behavioral health inpatient services	10% coinsurance*	Not covered	Deductible applies.
	Substance use disorder outpatient services	10% coinsurance* for office visits and 10% coinsurance for outpatient	Not covered	Deductible applies. For office visits.
	Substance use disorder inpatient services	10% coinsurance*	Not covered	Deductible applies.
If you are pregnant	Prenatal and postnatal	\$0 copay	Not covered	Deductible waived.
	Delivery and all inpatient services	10% coinsurance*	Not covered	Deductible applies.
If you need help recovering or have other special health needs	Home health care	10% coinsurance*	Not covered	Deductible applies.
	Rehabilitation services	\$15 copay for office visits, 10% coinsurance for outpatient services.	Not covered	Deductible waived. For office services. 30 combined PT/OT/ST visits/yr.
	Habilitation services	\$15 copay office setting, 10% coinsurance for outpatient services.	Not covered	Deductible waived. For office services. 30 combined PT/OT/ST visits/yr.
	Skilled nursing care	10% coinsurance*	Not covered	Deductible applies.
	Durable medical equipment	10% coinsurance*	Not covered	Deductible applies.
	Hospice service	10% coinsurance*	Not covered	Deductible applies.
If your child needs dental or eye care	Eye exam	\$15 copay	Not covered	Deductible waived. One eye exam per year to age 21.
	Glasses	\$150 allowance per year to age 21.	Not covered	Deductible waived.
	Dental check-up	\$0 copay	Not covered	Deductible waived. Two dental exams per year to age 21.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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.)

- Acupuncture
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Infertility Treatment
- Long-Term Care
- Non-Emergency care when traveling outside the US
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight Loss Programs
- MVP Wellness Program

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.)

- Bariatric Surgery
- Chiropractic Care
- Private-Duty Nursing

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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 1-800-637-7788 or <http://www.dfr.vermont.gov/insurance/insurance-consumer/consumer-information>

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 1-800-637-7788 or <http://www.dfr.vermont.gov/insurance/insurance-consumer/consumer-information>

The following is the Vermont State Department of Insurance contact information:

External Appeals Program, Vermont Department of Financial Regulation

89 Main Street, Montpelier, VT 05602, 1-800-631-7788 or 1-802-282-2900, 1-888-236-5966 (Emergency request for external appeal)

Additionally, a consumer assistance program can help you file your appeal. Contact:

Vermont Legal Aid, Office of Health Care Ombudsman, 264 North Winooski Avenue, Burlington, VT 05402

1-800-917-7787 or 1-802-863-2316; TTY: 1-888-884-1955 or 1-802-863-2473, www.vtlegalaid.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.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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 \$7,466**
- **Patient pays \$0**

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	\$
Co-pays	\$
Co-insurance	\$
Limits or exclusions	\$
Total	\$0

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

- **Amount owed to providers: \$5,490**
- **Plan pays \$5,490**
- **Patient pays \$0**

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	\$
Co-pays	\$
Co-insurance	\$
Limits or exclusions	\$
Total	\$0

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.



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 1-800-348-8515..

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In network -\$700 person/\$1,400 family	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> 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 <u>deductible</u> .
Are there other deductibles for specific services?	Pharmacy -\$200 person \ \$400 family	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	In network -\$4,000 person/\$8,000 family Rx out-of-pocket -\$1,200 person /\$2,400 family	The <u>out-of-pocket limit</u> 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 and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
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 <i>specific</i> 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 <u>provider</u> , 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 <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a specialist?	No.	You can see the <u>specialist</u> 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 <u>excluded services</u> .

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.



- **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		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you visit a health care provider’s office or clinic	Primary care visit to treat an injury or illness	\$10 copay	Not covered.	Deductible waived.
	Specialist visit	\$50 copay*	Not covered	Deductible applies.
	Other practitioner office visit	\$50 copay*	Not covered	Deductible applies.
	Preventive care/ screening/immunization	\$0 copay	Not covered	Deductible waived.
If you have a test	Diagnostic test (x-ray, blood work)	Lab Office - \$10 copay PCP/\$50 Spec Lab Facility - \$50 copay* Radiology Office - \$10 copay PCP/\$50 Specialist Radiology Facility - \$100 copay*	Not covered	Lab Office - Deductible waived. PCP. Lab Facility - Deductible applies. Radiology Office - Deductible waived. PCP. Radiology Facility - Deductible applies.
	Imaging (CT/PET scans, MRIs)	\$400 copay*	Not covered	Deductible applies. is per procedure.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren’t clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
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 \$12 copay* Mail order \$30 copay*	Not covered	Deductible applies. Rx 30 day retail/90 day mail order. VBID retail copay is \$3/mail order \$7.50.
	Preferred brand drugs	Retail \$40 copay* Mail order \$100 copay*	Not covered	Deductible applies. Rx 30 day retail/90 day mail order. VBID retail copay is \$3/mail order \$7.50.
	Non-preferred brand drugs	50% coinsurance*	Not covered	Deductible applies. Rx 30 day retail/90 day mail order. VBID retail copay is \$3/mail order \$7.50.
	Specialty drugs	Retail Covered at Specialty Pharmacy as noted in generic, preferred, and non-preferred classes.	Not covered	30 day supply available through Specialty Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery)	\$800 copay*	Not covered	Deductible applies.
	Physician/surgeon fees	\$400 copay*	Not covered	Deductible applies.
If you need immediate medical attention	Emergency room services	\$150 copay*	\$150 copay*	Deductible applies.
	Emergency medical transportation	\$100 copay*	\$100 copay*	Deductible applies.
	Urgent care	\$60 copay*	\$60 copay*	Deductible applies.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance*	Not covered	Deductible applies.
	Physician/surgeon fee	30% coinsurance*	Not covered	Deductible applies.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient	\$10 copay for office visits and \$50 copay for other outpatient services.	Not covered	Deductible waived. For office visits.
	Mental/Behavioral health inpatient services	30% coinsurance*	Not covered	Deductible applies.
	Substance use disorder outpatient services	\$10 copay for office visits and \$50 copay for other outpatient services.	Not covered	Deductible waived. For office visits.
	Substance use disorder inpatient services	30% coinsurance*	Not covered	Deductible applies.
If you are pregnant	Prenatal and postnatal	\$0 copay	Not covered	Deductible waived.
	Delivery and all inpatient services	30% coinsurance*	Not covered	Deductible applies.
If you need help recovering or have other special health needs	Home health care	\$50 copay*	Not covered	Deductible applies.
	Rehabilitation services	\$50 copay*	Not covered	Deductible applies. 30 combined PT/OT/ST visits/yr.
	Habilitation services	\$50 copay*	Not covered	Deductible applies. 30 combined PT/OT/ST visits/yr.
	Skilled nursing care	30% coinsurance*	Not covered	Deductible applies.
	Durable medical equipment	30% coinsurance*	Not covered	Deductible applies.
	Hospice service	30% coinsurance*	Not covered	Deductible applies.
If your child needs dental or eye care	Eye exam	\$50 copay*	Not covered	Deductible applies. One eye exam per year to age 21.
	Glasses	\$150 allowance* per year to age 21.	Not covered	Deductible applies.
	Dental check-up	\$0 copay	Not covered	Deductible waived. Two dental exams per year to age 21.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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.)

- Acupuncture
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Infertility Treatment
- Long-Term Care
- Non-Emergency care when traveling outside the US
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight Loss Programs

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.)

- Bariatric Surgery
- Chiropractic Care
- Private-Duty Nursing
- MVP Wellness Program

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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 1-800-637-7788 or <http://www.dfr.vermont.gov/insurance/insurance-consumer/consumer-information>

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 1-800-637-7788 or <http://www.dfr.vermont.gov/insurance/insurance-consumer/consumer-information>

The following is the Vermont State Department of Insurance contact information:

External Appeals Program, Vermont Department of Financial Regulation

89 Main Street, Montpelier, VT 05602, 1-800-631-7788 or 1-802-282-2900, 1-888-236-5966 (Emergency request for external appeal)

Additionally, a consumer assistance program can help you file your appeal. Contact:

Vermont Legal Aid, Office of Health Care Ombudsman, 264 North Winooski Avenue, Burlington, VT 05402

1-800-917-7787 or 1-802-863-2316; TTY: 1-888-884-1955 or 1-802-863-2473, www.vtlegalaid.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.*—————

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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 \$7,466**
- **Patient pays \$0**

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	\$
Co-pays	\$
Co-insurance	\$
Limits or exclusions	\$
Total	\$0

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

- **Amount owed to providers: \$5,490**
- **Plan pays \$5,490**
- **Patient pays \$0**

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	\$
Co-pays	\$
Co-insurance	\$
Limits or exclusions	\$
Total	\$0

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.



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 1-800-348-8515..

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In network -\$60 person/\$120 family	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> 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 <u>deductible</u> .
Are there other deductibles for specific services?	Pharmacy -\$50 person \ \$100 family	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	In network -\$1,800 person/\$3,600 family Rx out-of-pocket -\$450 person /\$900 family	The <u>out-of-pocket limit</u> 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 and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
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 <i>specific</i> 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 <u>provider</u> , 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 <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a specialist?	No.	You can see the <u>specialist</u> 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 <u>excluded services</u> .

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.



- **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		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you visit a health care provider’s office or clinic	Primary care visit to treat an injury or illness	\$5 copay	Not covered.	Deductible waived.
	Specialist visit	\$30 copay*	Not covered	Deductible applies.
	Other practitioner office visit	\$30 copay*	Not covered	Deductible applies.
	Preventive care/ screening/immunization	\$0 copay	Not covered	Deductible waived.
If you have a test	Diagnostic test (x-ray, blood work)	Lab Office - \$5 copay PCP/\$30 Spec Lab Facility - \$30 copay* Radiology Office - \$5 copay PCP/\$30 Specialist Radiology Facility - \$30 copay*	Not covered	Lab Office - Deductible waived. PCP. Lab Facility - Deductible applies. Radiology Office - Deductible waived. PCP. Radiology Facility - Deductible applies.
	Imaging (CT/PET scans, MRIs)	\$100 copay*	Not covered	Deductible applies. is per procedure.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren’t clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
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 \$25 copay*	Not covered	Deductible applies. Rx 30 day retail/90 day mail order. VBID retail copay is \$3/mail order \$7.50.
	Preferred brand drugs	Retail \$25 copay* Mail order \$62.50 copay*	Not covered	Deductible applies. Rx 30 day retail/90 day mail order. VBID retail copay is \$3/mail order \$7.50.
	Non-preferred brand drugs	40% coinsurance*	Not covered	Deductible applies. Rx 30 day retail/90 day mail order. VBID retail copay is \$3/mail order \$7.50.
	Specialty drugs	Retail Covered at Specialty Pharmacy as noted in generic, preferred, and non-preferred classes.	Not covered	30 day supply available through Specialty Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery)	\$100 copay*	Not covered	Deductible applies.
	Physician/surgeon fees	\$75 copay*	Not covered	Deductible applies.
If you need immediate medical attention	Emergency room services	\$100 copay*	\$100 copay*	Deductible applies.
	Emergency medical transportation	\$100 copay*	\$100 copay*	Deductible applies.
	Urgent care	\$40 copay*	\$40 copay*	Deductible applies.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance*	Not covered	Deductible applies.
	Physician/surgeon fee	10% coinsurance*	Not covered	Deductible applies.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary

at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient	\$5 copay for office visits and \$30 copay for other outpatient services.	Not covered	Deductible waived. For office visits.
	Mental/Behavioral health inpatient services	10% coinsurance*	Not covered	Deductible applies.
	Substance use disorder outpatient services	\$5 copay for office visits and \$30 copay for other outpatient services.	Not covered	Deductible waived. For office visits.
	Substance use disorder inpatient services	10% coinsurance*	Not covered	Deductible applies.
If you are pregnant	Prenatal and postnatal	\$0 copay	Not covered	Deductible waived.
	Delivery and all inpatient services	10% coinsurance*	Not covered	Deductible applies.
If you need help recovering or have other special health needs	Home health care	\$30 copay*	Not covered	Deductible applies.
	Rehabilitation services	\$30 copay*	Not covered	Deductible applies. 30 combined PT/OT/ST visits/yr.
	Habilitation services	\$30 copay*	Not covered	Deductible applies. 30 combined PT/OT/ST visits/yr.
	Skilled nursing care	10% coinsurance*	Not covered	Deductible applies.
	Durable medical equipment	10% coinsurance*	Not covered	Deductible applies.
	Hospice service	10% coinsurance*	Not covered	Deductible applies.
If your child needs dental or eye care	Eye exam	\$30 copay*	Not covered	Deductible applies. One eye exam per year to age 21.
	Glasses	\$150 allowance* per year to age 21.	Not covered	Deductible applies.
	Dental check-up	\$0 copay	Not covered	Deductible waived. Two dental exams per year to age 21.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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.)

- Acupuncture
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Infertility Treatment
- Long-Term Care
- Non-Emergency care when traveling outside the US
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight Loss Programs

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.)

- Bariatric Surgery
- Chiropractic Care
- Private-Duty Nursing
- MVP Wellness Program

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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 1-800-637-7788 or <http://www.dfr.vermont.gov/insurance/insurance-consumer/consumer-information>

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 1-800-637-7788 or <http://www.dfr.vermont.gov/insurance/insurance-consumer/consumer-information>

The following is the Vermont State Department of Insurance contact information:

External Appeals Program, Vermont Department of Financial Regulation

89 Main Street, Montpelier, VT 05602, 1-800-631-7788 or 1-802-282-2900, 1-888-236-5966 (Emergency request for external appeal)

Additionally, a consumer assistance program can help you file your appeal. Contact:

Vermont Legal Aid, Office of Health Care Ombudsman, 264 North Winooski Avenue, Burlington, VT 05402

1-800-917-7787 or 1-802-863-2316; TTY: 1-888-884-1955 or 1-802-863-2473, www.vtlegalaid.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.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary

at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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 \$7,466**
- **Patient pays \$0**

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	\$
Co-pays	\$
Co-insurance	\$
Limits or exclusions	\$
Total	\$0

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

- **Amount owed to providers: \$5,490**
- **Plan pays \$5,490**
- **Patient pays \$0**

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	\$
Co-pays	\$
Co-insurance	\$
Limits or exclusions	\$
Total	\$0

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.



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 1-800-348-8515..

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In network -\$100 person/\$200 family	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> 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 <u>deductible</u> .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	In network -\$500 person/\$1,000 family Rx out-of-pocket -\$200 person /\$400 family	The <u>out-of-pocket limit</u> 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 and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
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 <i>specific</i> 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 <u>provider</u> , 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 <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a specialist?	No.	You can see the <u>specialist</u> 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 <u>excluded services</u> .

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.



- **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		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you visit a health care provider’s office or clinic	Primary care visit to treat an injury or illness	\$5 copay	Not covered.	Deductible waived.
	Specialist visit	\$15 copay	Not covered	Deductible waived.
	Other practitioner office visit	\$15 copay	Not covered	Deductible waived.
	Preventive care/ screening/immunization	\$0 copay	Not covered	Deductible waived.
If you have a test	Diagnostic test (x-ray, blood work)	Lab Office - \$5 copay PCP/\$15 Spec Lab Facility - \$15 copay Radiology Office - \$5 copay PCP/\$15 Specialist Radiology Facility - 10% coinsurance*	Not covered	Lab Office - Deductible waived. Lab Facility - Deductible waived. Radiology Office - Deductible waived. Radiology Facility - Deductible applies.
	Imaging (CT/PET scans, MRIs)	10% coinsurance*	Not covered	Deductible applies. is per procedure. Hi-Tech Facility - Deductible applies.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren’t clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
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 \$5 copay Mail order \$12.50 copay	Not covered	30 day retail/90 day mail order.
	Preferred brand drugs	Retail \$20 copay Mail order \$50 copay	Not covered	30 day retail/90 day mail order.
	Non-preferred brand drugs	30% coinsurance	Not covered	30 day retail/90 day mail order.
	Specialty drugs	Retail Covered at Specialty Pharmacy as noted in generic, preferred, and non-preferred classes.	Not covered	30 day supply available through Specialty Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery)	10% coinsurance*	Not covered	Deductible applies.
	Physician/surgeon fees	10% coinsurance*	Not covered	Deductible applies.
If you need immediate medical attention	Emergency room services	\$75 copay*	\$75 copay*	Deductible applies.
	Emergency medical transportation	\$50 copay*	\$50 copay	Deductible applies.
	Urgent care	\$35 copay	\$35 copay	Deductible waived.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance*	Not covered	Deductible applies.
	Physician/surgeon fee	10% coinsurance*	Not covered	Deductible applies.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient	10% coinsurance* for office visits and 10% coinsurance for outpatient	Not covered	Deductible applies. For office visits.
	Mental/Behavioral health inpatient services	10% coinsurance*	Not covered	Deductible applies.
	Substance use disorder outpatient services	10% coinsurance* for office visits and 10% coinsurance for outpatient	Not covered	Deductible applies. For office visits.
	Substance use disorder inpatient services	10% coinsurance*	Not covered	Deductible applies.
If you are pregnant	Prenatal and postnatal	\$0 copay	Not covered	Deductible waived.
	Delivery and all inpatient services	10% coinsurance*	Not covered	Deductible applies.
If you need help recovering or have other special health needs	Home health care	10% coinsurance*	Not covered	Deductible applies.
	Rehabilitation services	\$15 copay for office visits, 10% coinsurance for outpatient services.	Not covered	Deductible waived. For office services. 30 combined PT/OT/ST visits/yr.
	Habilitation services	\$15 copay office setting, 10% coinsurance for outpatient services.	Not covered	Deductible waived. For office services. 30 combined PT/OT/ST visits/yr.
	Skilled nursing care	10% coinsurance*	Not covered	Deductible applies.
	Durable medical equipment	10% coinsurance*	Not covered	Deductible applies.
	Hospice service	10% coinsurance*	Not covered	Deductible applies.
If your child needs dental or eye care	Eye exam	\$15 copay	Not covered	Deductible waived. One eye exam per year to age 21.
	Glasses	\$150 allowance per year to age 21.	Not covered	Deductible waived.
	Dental check-up	\$0 copay	Not covered	Deductible waived. Two dental exams per year to age 21.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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.)

- Acupuncture
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Infertility Treatment
- Long-Term Care
- Non-Emergency care when traveling outside the US
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight Loss Programs
- MVP Wellness Program

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.)

- Bariatric Surgery
- Chiropractic Care
- Private-Duty Nursing

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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 1-800-637-7788 or <http://www.dfr.vermont.gov/insurance/insurance-consumer/consumer-information>

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 1-800-637-7788 or <http://www.dfr.vermont.gov/insurance/insurance-consumer/consumer-information>

The following is the Vermont State Department of Insurance contact information:

External Appeals Program, Vermont Department of Financial Regulation

89 Main Street, Montpelier, VT 05602, 1-800-631-7788 or 1-802-282-2900, 1-888-236-5966 (Emergency request for external appeal)

Additionally, a consumer assistance program can help you file your appeal. Contact:

Vermont Legal Aid, Office of Health Care Ombudsman, 264 North Winooski Avenue, Burlington, VT 05402

1-800-917-7787 or 1-802-863-2316; TTY: 1-888-884-1955 or 1-802-863-2473, www.vtlegalaid.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.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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 \$7,466**
- **Patient pays \$0**

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	\$
Co-pays	\$
Co-insurance	\$
Limits or exclusions	\$
Total	\$0

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

- **Amount owed to providers: \$5,490**
- **Plan pays \$5,490**
- **Patient pays \$0**

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	\$
Co-pays	\$
Co-insurance	\$
Limits or exclusions	\$
Total	\$0

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.



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 1-800-348-8515..

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In network -\$1,300 person/\$2,600 family	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> 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 <u>deductible</u> .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	In network -\$2,500 person/\$5,000 family Rx out-of-pocket -\$1,300 person /\$2,600 family	The <u>out-of-pocket limit</u> 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 and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
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 <i>specific</i> 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 <u>provider</u> , 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 <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a specialist?	No.	You can see the <u>specialist</u> 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 <u>excluded services</u> .

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary

at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.



- **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		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you visit a health care provider’s office or clinic	Primary care visit to treat an injury or illness	10% coinsurance*	Not covered.	Deductible applies.
	Specialist visit	20% coinsurance*	Not covered	Deductible applies.
	Other practitioner office visit	20% coinsurance*	Not covered	Deductible applies.
	Preventive care/ screening/immunization	\$0 copay	Not covered	Deductible waived.
If you have a test	Diagnostic test (x-ray, blood work)	Lab Office - 10% coinsurance* PCP/20% coinsurance Specialist Lab Facility - 20% coinsurance* Radiology Office - 10% coinsurance* PCP/20% coinsurance Specialist	Not covered	Deductible applies.
	Imaging (CT/PET scans, MRIs)	20% coinsurance*	Not covered	Deductible applies.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren’t clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
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 \$5 copay* Mail order \$12.50 copay*	Not covered	Deductible applies. 30 day supply retail/90 day supply Mail order. Preventive drugs.
	Preferred brand drugs	Retail \$30 copay* Mail order \$75 copay*	Not covered	Deductible applies. 30 day supply retail/90 day supply Mail order. Preventive drugs, Deductible waived.
	Non-preferred brand drugs	50% coinsurance*	Not covered	Deductible applies. 30 day supply retail/90 day supply Mail order. Preventive drugs, Deductible waived.
	Specialty drugs	Retail Covered at Specialty Pharmacy as noted in generic, preferred, and non-preferred classes.	Not covered	30 day supply available through Specialty Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery)	20% coinsurance*	Not covered	Deductible applies.
	Physician/surgeon fees	20% coinsurance*	Not covered	Deductible applies.
If you need immediate medical attention	Emergency room services	20% coinsurance*	20% coinsurance*	Deductible applies.
	Emergency medical transportation	20% coinsurance*	20% coinsurance*	Deductible applies.
	Urgent care	20% coinsurance*	20% coinsurance*	Deductible applies.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance*	Not covered	Deductible applies.
	Physician/surgeon fee	20% coinsurance*	Not covered	Deductible applies.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient	20% coinsurance* for office visits and 20% coinsurance for outpatient	Not covered	Deductible applies.
	Mental/Behavioral health inpatient services	20% coinsurance*	Not covered	Deductible applies.
	Substance use disorder outpatient services	20% coinsurance* for office visits and 20% coinsurance for outpatient	Not covered	Deductible applies.
	Substance use disorder inpatient services	20% coinsurance*	Not covered	Deductible applies.
If you are pregnant	Prenatal and postnatal	\$0 copay	Not covered	Deductible waived.
	Delivery and all inpatient services	20% coinsurance*	Not covered	Deductible applies.
If you need help recovering or have other special health needs	Home health care	20% coinsurance*	Not covered	Deductible applies.
	Rehabilitation services	20% coinsurance*	Not covered	Deductible applies. 30 combined PT/OT/ST visits/yr.
	Habilitation services	20% coinsurance*	Not covered	Deductible applies. 30 combined PT/OT/ST visits/yr.
	Skilled nursing care	20% coinsurance*	Not covered	Deductible applies.
	Durable medical equipment	20% coinsurance*	Not covered	Deductible applies.
	Hospice service	20% coinsurance*	Not covered	Deductible applies.
If your child needs dental or eye care	Eye exam	20% coinsurance*	Not covered	Deductible applies. One eye exam per year to age 21.
	Glasses	\$150 allowance* per year to age 21.	Not covered	Deductible applies.
	Dental check-up	\$0 copay*	Not covered	Deductible applies. Two dental exams per year to age 21.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary

at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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.)

- Acupuncture
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Infertility Treatment
- Long-Term Care
- Non-Emergency care when traveling outside the US
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight Loss Programs
- MVP Wellness Program

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.)

- Bariatric Surgery
- Chiropractic Care
- Private-Duty Nursing

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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 1-800-637-7788 or <http://www.dfr.vermont.gov/insurance/insurance-consumer/consumer-information>

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 1-800-637-7788 or <http://www.dfr.vermont.gov/insurance/insurance-consumer/consumer-information>

The following is the Vermont State Department of Insurance contact information:

External Appeals Program, Vermont Department of Financial Regulation

89 Main Street, Montpelier, VT 05602, 1-800-631-7788 or 1-802-282-2900, 1-888-236-5966 (Emergency request for external appeal)

Additionally, a consumer assistance program can help you file your appeal. Contact:

Vermont Legal Aid, Office of Health Care Ombudsman, 264 North Winooski Avenue, Burlington, VT 05402

1-800-917-7787 or 1-802-863-2316; TTY: 1-888-884-1955 or 1-802-863-2473, www.vtlegalaid.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.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary

at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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 \$7,466**
- **Patient pays \$0**

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	\$
Co-pays	\$
Co-insurance	\$
Limits or exclusions	\$
Total	\$0

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

- **Amount owed to providers: \$5,490**
- **Plan pays \$5,490**
- **Patient pays \$0**

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	\$
Co-pays	\$
Co-insurance	\$
Limits or exclusions	\$
Total	\$0

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.

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.

Questions: Call 1-800-348-8515 or visit us at www.mvphealthcare.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mvphealthcare.com or call 1-800-348-8515 to request a copy.