**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 **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**. |
| **Are there other deductibles for specific services?** | No. | You don't have to meet **deductibles** 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 -**$1,250** person/**$2,500** family. | The **out–of–pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. |
| **What is not included in the out–of–pocket limit?** | Premiums and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the **out–of–pocket limit**. |
| **Is there an overall annual limit on what the plan pays?** | No. | The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits. |
| **Does this plan use a network of providers?** | Yes. For a list of participating providers see **www.mvphealthcare.com.** | If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**. |
| **Do I need a referral to see a specialist?** | No. | You can see the **specialist** you choose without permission from this plan. |
| **Are there services this plan doesn't cover?** | Yes. | Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**. |

**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<br>PCP/20% coinsurance Specialist<br>Lab Facility - 20% coinsurance<br>Radiology Office - 10% coinsurance<br>PCP/20% coinsurance Specialist | Not covered. | Deductible applies. |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | Not covered. | Deductible applies. |

| Common Medical Event | Services You May Need | Your cost if you use a Participating Provider | Your cost if you use a Non-Participating Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at www.mvphealthcare.com. | Generic drugs | Retail $10 copay<br>Mail order $25 copay | Not covered. | Deductible applies. 30 day retail/90 day mail order. |
| | Preferred brand drugs | Retail $40 copay<br>Mail order $100 copay | Not covered. | Deductible applies. 30 day retail/90 day mail order. |
| | Non-preferred brand drugs | 50% coinsurance | Not covered. | Deductible applies. 30 day retail/90 day mail order. |
| | Specialty drugs | Retail Covered 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. |

| Common Medical Event | Services You May Need | Your cost if you use a Participating Provider | Your cost if you use a Non-Participating Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient | 10% coinsurance for office visits and 20% coinsurance for other outpatient | Not covered. | Deductible applies. |
| | Mental/Behavioral health inpatient services | 20% coinsurance | Not covered. | Deductible applies. |
| | Substance use disorder outpatient services | 10% coinsurance for office visits and 20% coinsurance for other outpatient | Not covered. | Deductible applies. |
| | Substance use disorder inpatient services | 20% coinsurance | Not covered. | Deductible applies. |
| **If you are pregnant** | Prenatal and postnatal | 0% coinsurance | 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. | Par allowance | 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

## 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

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

## About these Coverage Examples:

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

**This is not a cost estimator.**

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

See the next page for important information about these examples.

### Having a baby
(normal delivery)

- **Amount owed to providers: $7,466**
- **Plan pays** $4,609
- **Patient pays** $2,857

**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 | $1550 |
| Co-pays | $15 |
| Co-insurance | $1142 |
| Limits or exclusions | $150 |
| **Total** | $2,857 |

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

- **Amount owed to providers: $5,490**
- **Plan pays** $3,556
- **Patient pays** $1,934

**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 | $1550 |
| Co-pays | $0 |
| Co-insurance | $384 |
| Limits or exclusions | $0 |
| **Total** | $1,934 |

# 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.