



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE:** Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.mvphealthcare.com/vermont. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-800-348-8515 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	Individual: \$3,000 Family: \$6,000	You will have to pay all costs for covered services up to the amount the plan pays for covered services. After you reach the deductible, the plan will start paying for covered services.
Are there services covered before you meet your deductible ?	Yes, some services are covered before you meet your deductible.	This plan covers some services before you meet your deductible. These services are called "covered before deductible" services. The plan will pay for these services, but you will have to pay a copayment for each service.
Are there other deductibles for specific services?	Yes.	You will have to pay for some services before you reach the deductible. These services are called "covered before deductible" services. The plan will pay for these services, but you will have to pay a copayment for each service.
What is the out-of-pocket limit for this plan ?	Individual: \$7,000 Family: \$14,000 Maximum out-of-pocket: \$7,000 (individual) and \$14,000 (family) Maximum out-of-pocket: \$7,000 (individual) and \$14,000 (family) Maximum out-of-pocket: \$7,000 (individual) and \$14,000 (family)	The out-of-pocket limit is the most you will have to pay for covered services in a year. After you reach the out-of-pocket limit, the plan will pay 100% of the costs for covered services for the rest of the year.
What is not included in the out-of-pocket limit ?	Payments for non-covered services, payments for services not covered by the plan, and payments for services not covered by the plan.	Payments for non-covered services, payments for services not covered by the plan, and payments for services not covered by the plan.
Will you pay less if you use a network provider ?	Yes, you will pay less if you use a network provider.	This plan uses a preferred provider network (PPN). The PPN is a group of providers that the plan has contracted with. The plan will pay more for services provided by PPN providers than for services provided by non-PPN providers.
Do you need a referral to see a specialist ?	Yes.	You will need a referral from your primary care provider to see a specialist.



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	10% coinsurance Deductible applies	Not covered	None
	Specialist visit	25% coinsurance Deductible applies	Not covered	None
	Other practitioner office visit	25% coinsurance Deductible applies for Chiropractic Care and Physical Therapy	Not covered	No visit limit for Chiropractic Care
	Preventive care/screening/immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Lab Office - 10% coinsurance Deductible applies; Lab Facility - 25% coinsurance Deductible applies; Radiology Office - PCP: 10% coinsurance Deductible applies & Spec: 25% coinsurance Deductible applies; Radiology Facility - 25% coinsurance Deductible applies	Not covered	Lab Office - None; Lab Facility - None; Radiology Office - None; Radiology Facility - None
	Imaging (CT/PET scans, MRIs)	Office - 25% coinsurance Deductible applies; Facility - 25% coinsurance Deductible applies	Not covered	Prior authorization is required for some services

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.mvphealthcare.com/vermont	Tier 1 (Generic drugs)	30 day supply \$10/prescription Deductible applies; 90 day supply \$25/prescription Deductible applies	Not covered	Preventive drugs deductible waived
	Tier 2 (Preferred brand drugs)	30 day supply \$40/prescription Deductible applies; 90 day supply \$100/prescription Deductible applies	Not covered	Preventive drugs deductible waived. Prior authorization is required for some prescriptions
	Tier 3 (Non-preferred brand drugs)	50% coinsurance Deductible applies	Not covered	Preventive drugs deductible waived. Prior authorization is required for some prescriptions. Includes Diabetic Supplies and Equipment
	Tier 4 Specialty drugs	50% coinsurance Deductible applies	Not covered	Prior authorization is required for some prescriptions. 30 day supply available through Specialty Pharmacy
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% coinsurance Deductible applies	Not covered	Prior authorization is required for some services
	Physician/surgeon fees	25% coinsurance Deductible applies	Not covered	Prior authorization is required for some services
If you need immediate medical attention	Emergency room care	25% coinsurance Deductible applies	25% coinsurance Deductible applies	None
	Emergency medical transportation	25% coinsurance Deductible applies	25% coinsurance Deductible applies	None
	Urgent care	25% coinsurance Deductible applies	25% coinsurance Deductible applies	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance Deductible applies	Not covered	Prior authorization is required for some services
	Physician/surgeon fees	25% coinsurance Deductible applies	Not covered	Prior authorization is required for some services
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance Deductible applies	Not covered	None
	Inpatient services	25% coinsurance Deductible applies	Not covered	None
If you are pregnant	Office visits	10% coinsurance Deductible applies	Not covered	Cost sharing does not apply to certain preventive services. Depending on the type of services, a copay, coinsurance, and/or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	25% coinsurance Deductible applies	Not covered	
	Childbirth/delivery facility services	25% coinsurance Deductible applies	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	25% coinsurance Deductible applies	Not covered	None
	Rehabilitation services/ Habilitation services	OP ReHab: 25% coinsurance Deductible applies IP ReHab: 25% coinsurance Deductible applies	OP ReHab: Not covered IP ReHab: Not covered	OP ReHab: 30 combined PT/OT/ST visits per year IP ReHab: None
	Skilled nursing care	25% coinsurance Deductible applies	Not covered	None
	Durable medical equipment	25% coinsurance Deductible applies	Not covered	Prior authorization is required for some items
	Hospice services	25% coinsurance Deductible applies	Not covered	None
If your child needs dental or eye care	Children's eye exam	\$20 copay/exam Deductible applies	Not covered	One eye exam per year to age 21
	Children's glasses	\$20 copay/pair Deductible applies	\$20 copay/pair Deductible applies	One pair per year to age 21. Eyewear can be purchased from any provider
	Children's dental check-up	Class 1: 0% coinsurance Deductible applies Class 2: 30% coinsurance Deductible applies Class 3 and Orthodontic: 50% coinsurance Deductible applies	Class 1: Not covered Class 2: Not covered Class 3 and Orthodontic: Not covered	Two dental exams per year to age 21. Adult Dental not covered

Excluded Services & Other Covered Services:

Services Your [Plan](#) Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other [excluded services](#).)

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

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

- Abortion
- Bariatric Surgery(Requires Prior Authorization)
- Chiropractic Care
- Infertility Treatment
- Private-Duty Nursing

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is:

MVP Health Care
P.O. Box 2207
Schenectady, NY 12301
Toll Free: 1-888-687-6277
www.mvphealthcare.com/vermont
members@mvphealthcare.com

You can also contact the Vermont Department of Financial Regulation at 1-800-631-7788 or dfr.vermont.gov, or the Vermont Legal Aid at 1-800-889-2047 or vtlegalaid.org, or Vermont Health Connect at 1-855-899-9600 or portal.healthconnect.vermont.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact:

MVP Health Care
Attn: Member Appeals
P.O.Box 2207
Schenectady, NY 12301
Toll Free:1-800-348-8515
www.mvphealthcare.com
members@mvphealthcare.com

You can also contact the Vermont Department of Financial Regulation at 1-800-631-7788 or dfr.vermont.gov. Additionally, a consumer assistance program can help you file your appeal. Contact the Vermont Legal Aid at 1-800-889-2047 or vtlegalaid.org.

Does this plan provide Minimum Essential Coverage? Yes.

[Minimum Essential Coverage](#) generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Not Applicable.

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

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

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall deductible	\$1,600
■ Specialist Coinsurance	25%
■ Hospital (facility) Coinsurance	25%
■ Other Coinsurance	25%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

Total Example Cost	\$12,700
---------------------------	-----------------

In this example, Peg would pay:

Cost Sharing	
Deductibles	\$1,600
Copayments	\$0
Coinsurance	\$2,200
What isn't covered	
Limits or exclusions	\$70
The total Peg would pay is	\$3,870

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$1,600
■ Specialist Coinsurance	25%
■ Hospital (facility) Coinsurance	25%
■ Other Coinsurance	10%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

Total Example Cost	\$5,600
---------------------------	----------------

In this example, Joe would pay:

Cost Sharing	
Deductibles	\$1,600
Copayments	\$600
Coinsurance	\$200
What isn't covered	
Limits or exclusions	\$100
The total Joe would pay is	\$2,500

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$1,600
■ Specialist Coinsurance	25%
■ Hospital (facility) Coinsurance	25%
■ Other Coinsurance	25%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
 Diagnostic test (*x-ray*)
 Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

Total Example Cost	\$2,800
---------------------------	----------------

In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,600
Copayments	\$0
Coinsurance	\$300
What isn't covered	
Limits or exclusions	\$10
The total Mia would pay is	\$1,910

Non-Discrimination Notice

for MVP Commercial Plans

MVP Health Care® complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. MVP Health Care does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

What MVP Health Care Provides

Free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If You Need These Services

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

How to File a Grievance or Complaint

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

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

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

In person: 625 State Street, Schenectady, NY

Email: civilrightscoordinator@mvphealthcare.com

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

Online: ocrportal.hhs.gov

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

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

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

Multi-Language Interpreter Services

Español (Spanish)

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

繁體中文 (Chinese)

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

Русский (Russian)

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

Kreyòl Ayisyen (French Creole)

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

한국어 (Korean)

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

Italiano (Italian)

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

אײדיש (Yiddish)

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

বাংলা (Bengali)

লক্ষ্য করনঃ যিদ আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পিরেষবা উপলব্ধ আছে। ফোন করন **১-৮৪৪-৯৪৬-৮০১০** (TTY: **১-৮০০-৬৬২-১২২০**)।

Polski (Polish)

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

العربية (Arabic)

ملحوظة: إذا كنت تتحدث أذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **0108-649-448-1** (رقم هاتف الصم والبكم: **0221-266-008-1**).

Français (French)

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

اُردُو (Urdu)

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

Tagalog (Tagalog-Filipino)

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

Ελληνικά (Greek)

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

Shqip (Albanian)

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