



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, www.mvphealthcare.com/vermont. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-800-348-8515 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	In-Network -\$850 individual /\$1,700 family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible ?	Yes. Preventive care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	Rx Brand -\$225 individual /\$450 family	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan ?	In-Network -\$6,050 individual /\$12,100 family Pharm -\$1,350 individual /\$2,700 family. OOPM is not integrated.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit ?	Copayments for certain services, premiums, balance-billing charges, and healthcare this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider ?	Yes. See www.mvphealthcare.com or call 1-800-348-8515 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist ?	No.	You can see the specialist you choose without a referral.

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.

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes.

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

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

About these Coverage Examples:



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

Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall deductible	\$850
■ Specialist Copay	\$40
■ Hospital (facility) Coinsurance	20%
■ Other Coinsurance	20%

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	\$13,800
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$850
Copayments	\$90
Coinsurance	\$1,700
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$2,700

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

■ The plan's overall deductible	\$850
■ Specialist Copay	\$40
■ Hospital (facility) Coinsurance	20%
■ Other Copay	\$15

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	\$7,800
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$1,300
Coinsurance	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$80
The total Joe would pay is	\$2,180

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

■ The plan's overall deductible	\$850
■ Specialist Copay	\$40
■ Hospital (facility) Coinsurance	20%
■ Other Copay	\$250

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	\$1,900
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$800
Copayments	\$300
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,100

*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.



Non-Discrimination Notice for MVP Commercial Plans

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

What MVP Health Care Provides

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

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

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

- Qualified interpreters
- Information written in other languages

If You Need These Services

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

How to File a Grievance or Complaint

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

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

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

In person: 625 State Street, Schenectady, NY

Email: civilrightscoordinator@mvphealthcare.com

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

Online: ocrportal.hhs.gov

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

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

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

Multi-Language Interpreter Services

Español (Spanish)

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia 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**).

אידיש (Yiddish)

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

বাংলা (Bengali)

লক্ষ্য করন: যিদি আপন বাংলা, কথা বলেত পারেন, তাহেল নিঃখরচায় ভাষা সহায়তা পিরেষবা উপলব্ধ। ফোন করন **1-844-946-8010** (TTY: **1-800-662-1220**)।

Polski (Polish)

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

العربية (Arabic)

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-844-946-8010** (رقم هاتف الصم والبكم: **1-800-662-1220**).

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**).