

 **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](http://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/](http://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 <a href="#">deductible</a> ?	In-Network -\$7,900 individual /\$15,800 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 <a href="#">deductible</a> ?	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 <a href="#">deductibles</a> for specific services?	No.	You don't have to meet deductibles for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	In-Network -\$7,900 individual /\$15,800 family Integrated Pharmacy -\$1,350 individual /\$2,700 family	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 <a href="#">out-of-pocket limit</a> ?	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 <a href="#">network provider</a> ?	Yes. See <a href="http://www.mvphealthcare.com">www.mvphealthcare.com</a> 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 <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the specialist you choose without a referral.



















# 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](mailto: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](http://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](http://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**).