**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 -$5,500 individual /$11,000 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? | Prescription -$900 individual /$1,800 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 -$7,900 individual /$15,800 family<br>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 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. |

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 | $35 copay/office visit | Not covered | Deductible applies;<br>Includes Chiropractic Care |
| | Specialist visit | $90 copay/visit | Not covered | Deductible applies |
| | 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 - $35 copay/visit;<br>Lab Facility - 50% coinsurance;<br>Radiology Office - PCP: $35 copay/visit & Spec: $90 copay/visit;<br>Radiology Facility - 50% coinsurance | Not covered | Lab Office - Deductible applies;<br>Lab Facility - Deductible applies;<br>Radiology Office - Deductible applies;<br>Radiology Facility - Deductible applies |
| | Imaging (CT/PET scans, MRIs) | Office - 50% coinsurance;<br>Facility - 50% coinsurance | Not covered | Deductible applies, per procedure |

| 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) | Retail $20 copay/prescription; Mail order $50 copay/prescription | Not covered | Deductible applies |
| | Tier 2 (Preferred brand drugs) | Retail $85 copay/prescription; Mail order $212.50 copay/prescription | Not covered | Deductible applies |
| | Tier 3 (Non-preferred brand drugs) | 60% coinsurance | Not covered | Deductible applies |
| | Tier 4 Specialty drugs | 60% coinsurance | Not covered | Deductible applies, 30 day supply available through Specialty Pharmacy |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 50% coinsurance | Not covered | Deductible applies |
| | Physician/surgeon fees | 50% coinsurance | Not covered | Deductible applies |
| If you need immediate medical attention | Emergency room care | 50% coinsurance | 50% coinsurance | Deductible applies |
| | Emergency medical transportation | $100 copay/use | $100 copay/use | Deductible applies |
| | Urgent care | $100 copay/visit | $100 copay/visit | Deductible applies |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 50% coinsurance | Not covered | Deductible applies |
| | Physician/surgeon fees | 50% coinsurance | Not covered | 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 need mental health, behavioral health, or substance abuse services | Outpatient services | $35 copay/visit | Not covered | Deductible applies |
| | Inpatient services | 50% coinsurance | Not covered | Deductible applies |
| If you are pregnant | Office visits | No charge | 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 | 50% coinsurance | Not covered | |
| | Childbirth/delivery facility services | 50% coinsurance | Not covered | |
| 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<br>30 combined PT/OT/ST visits per year |
| | Habilitation services | 50% coinsurance | Not covered | Deductible applies<br>30 combined PT/OT/ST visits per year |
| | Skilled nursing care | 50% coinsurance | Not covered | Deductible applies |
| | Durable medical equipment | 50% coinsurance | Not covered | Deductible applies |
| | Hospice services | 50% coinsurance | Not covered | 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 your child needs dental or eye care | Children's eye exam | $90 copay/exam | Not covered | Deductible applies, one eye exam per year to age 21 |
| | Children's glasses | 50% coinsurance | Not covered | Deductible applies, one pair per year to age 21 |
| | Children's dental check-up | No charge | Not covered | Deductible does not apply, two dental exams per year to age 21 |

## 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
- 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
- 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.

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?

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 | $5,500 |
| Specialist Copay | $90 |
| Hospital (facility) Coinsurance | 50% |
| Other Coinsurance | 50% |

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 |

In this example, Peg would pay:

| *Cost Sharing* | |
|---|---|
| Deductibles | $5,500 |
| Copayments | $0 |
| Coinsurance | $2,400 |
| *What isn't covered* | |
| Limits or exclusions | $80 |
| The total Peg would pay is | $7,980 |

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

| | |
|---|---|
| The plan's overall deductible | $5,500 |
| Specialist Copay | $90 |
| Hospital (facility) Coinsurance | 50% |
| Other Copay | $35 |

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 |

In this example, Joe would pay:

| *Cost Sharing* | |
|---|---|
| Deductibles | $2,100 |
| Copayments | $1,200 |
| Coinsurance | $400 |
| *What isn't covered* | |
| Limits or exclusions | $400 |
| The total Joe would pay is | $4,100 |

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

| | |
|---|---|
| The plan's overall deductible | $5,500 |
| Specialist Copay | $90 |
| Hospital (facility) Coinsurance | 50% |
| Other Coinsurance | 50% |

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 |

In this example, Mia would pay:

| *Cost Sharing* | |
|---|---|
| Deductibles | $1,900 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| The total Mia would pay is | $1,900 |

*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/TDD: **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 linguística. 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: **1-800-662-122**0).

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. רופט (TTY: 1-800-662-1220) 1-844-946-8010.

**বাংলা** (Bengali) লক্ষ্য করনঃ যদি আপনি বাংলা, কথা বলেত পারেন, তাহেল নিঃখরচায় ভাষা সহায়তা পিরেষবা উপলব্ধ আছে। ফোন করন ১-844-946-8010 (TTY: ১-800-662-1220)।

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: 1-800-266-0221 ).

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**).