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 -$1,700 individual /$3,400 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 policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes, Preventive Care	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network -$5,000 individual /$10,000 family (Max $8,150 per family mbr). Includes Diabetic Supplies and Equipment. Pharmacy - $1,400 individual /$2,800 family. Medical and Pharmacy Out of Pocket Limits are combined.	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, the overall family out-of-pocket limit must be 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.

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, Physical and Occupational 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)	Retail $10/prescription Deductible applies; Mail order $25/prescription Deductible applies	Not covered	30 day retail/90 day mail order; preventive drugs deductible waived
	Tier 2 (Preferred brand drugs)	Retail $40/prescription Deductible applies; Mail order $100/prescription Deductible applies	Not covered	30 day retail/90 day mail order; preventive drugs deductible waived. Prior authorization is required for some prescriptions
	Tier 3 (Non-preferred brand drugs)	50% coinsurance Deductible applies	Not covered	30 day retail/90 day mail order; 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	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	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 outpatient and office visits per plan 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	25% coinsurance Deductible applies	Not covered	One eye exam per year to age 21
	Children's glasses	50% coinsurance Deductible applies	Not covered	One pair per year to age 21
	Children's dental check-up	Class 1: $0 copay/visit, Deductible applies Class 2: 30% coinsurance, Deductible applies Class 3 and Orthodontic: 50% coinsurance, Deductible applies	Not covered	Two dental exams per year up to age 21. Adult Dental is 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 U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or cciio.cms.gov. Church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law. 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 Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or dol.gov/ebsa/healthreform, or 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	$1,700
Specialist	25%
Hospital (facility)	25%
Other	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	$13,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,700
Copayments	$10
Coinsurance	$2,100
What isn't covered	
Limits or exclusions	$70
The total Peg would pay is	**$3,880**

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

The plan's overall deductible	$1,700
Specialist	25%
Hospital (facility)	25%
Other	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	$7,800

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,700
Copayments	$800
Coinsurance	$400
What isn't covered	
Limits or exclusions	$200
The total Joe would pay is	**$3,100**

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

The plan's overall deductible	$1,700
Specialist	25%
Hospital (facility)	25%
Other	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	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,700
Copayments	$0
Coinsurance	$50
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,750**

The plan would be responsible for the other costs of these EXAMPLE covered services.