



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 -\$350 individual /\$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, Office Visits, Emergency Medical Transportation, Urgent Care, Prescription Drugs, Dental Class 1	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 -\$1,400 individual /\$2,800 family. Includes Diabetic Supplies and Equipment. Pharm -\$1,400 individual /\$2,800 family Medical and Pharmacy Out of Pocket Limits are separate.	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	\$15 copay/office visit Deductible does not apply	Not covered	None
	Specialist visit	\$40 copay/visit Deductible does not apply	Not covered	None
	Other practitioner office visit	\$20 copay/visit Deductible does not apply 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 - \$15/visit Deductible does not apply; Lab Facility - 10% coinsurance Deductible applies; Radiology Office - PCP: \$15/visit Deductible does not apply & Spec: \$40/visit Deductible does not apply; Radiology Facility - 10% coinsurance Deductible applies	Not covered	Lab Office - None; Lab Facility - None; Radiology Office - None; Radiology Facility - None
	Imaging (CT/PET scans, MRIs)	Office - 10% coinsurance Deductible applies; Facility - 10% 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 does not apply; Mail order \$25/prescription Deductible does not apply	Not covered	30 day retail/90 day mail order
	Tier 2 (Preferred brand drugs)	Retail \$50/prescription Deductible does not apply; Mail order \$125/prescription Deductible does not apply	Not covered	Prior authorization is required for some prescriptions. 30 day retail/90 day mail order
	Tier 3 (Non-preferred brand drugs)	50% coinsurance Deductible does not apply	Not covered	Prior authorization is required for some prescriptions. 30 day retail/90 day mail order. Includes Diabetic Supplies and Equipment
	Tier 4 Specialty drugs	50% coinsurance Deductible does not apply	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)	10% coinsurance Deductible applies	Not covered	Prior authorization is required for some services
	Physician/surgeon fees	10% coinsurance Deductible applies	Not covered	Prior authorization is required for some services
If you need immediate medical attention	Emergency room care	\$100 copay/visit Deductible applies	\$100 copay/visit Deductible applies	None
	Emergency medical transportation	\$60 copay/trip Deductible does not apply	\$60 copay/trip Deductible does not apply	None
	Urgent care	\$50 copay/visit Deductible does not apply	\$50 copay/visit Deductible does not apply	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)	10% coinsurance Deductible applies	Not covered	Prior authorization is required for some services
	Physician/surgeon fees	10% coinsurance Deductible applies	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$15 copay/visit Deductible does not apply	Not covered	None
	Inpatient services	10% coinsurance Deductible applies	Not covered	
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	10% coinsurance Deductible applies	Not covered	
	Childbirth/delivery facility services	10% 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	10% coinsurance Deductible applies	Not covered	None
	Rehabilitation services/ Habilitation services	OP ReHab: 10% coinsurance Deductible applies IP ReHab: 10% 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	10% coinsurance Deductible applies	Not covered	None
	Durable medical equipment	10% coinsurance Deductible applies	Not covered	Prior authorization is required for some items
	Hospice services	10% coinsurance Deductible applies	Not covered	None
If your child needs dental or eye care	Children's eye exam	\$40 copay/exam Deductible does not apply	Not covered	One eye exam per year to age 21
	Children's glasses	50% coinsurance Deductible does not apply	Not covered	One pair per year to age 21
	Children's dental check-up	Class 1: No charge 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	\$350
■ Specialist Copay	\$40
■ Hospital (facility) Coinsurance	10%
■ Other Coinsurance	10%

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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$350
Copayments	\$90
Coinsurance	\$900
What isn't covered	
Limits or exclusions	\$70
The total Peg would pay is	\$1,410

Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	\$350
■ Specialist Copay	\$40
■ Hospital (facility) Coinsurance	10%
■ 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	\$5,600
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$1,100
Coinsurance	\$200
What isn't covered	
Limits or exclusions	\$200
The total Joe would pay is	\$1,500

Mia's Simple Fracture

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

■ The plan's overall deductible	\$350
■ Specialist Copay	\$40
■ Hospital (facility) Coinsurance	10%
■ Other Copay	\$100

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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$350
Copayments	\$300
Coinsurance	\$800
What isn't covered	
Limits or exclusions	\$10
The total Mia would pay is	\$1,460