This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.mvphealthcare.com or by calling 1-888-687-6277..

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In network -$0/$0	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	No.	There's no limit on how much you could pay during a coverage period for your share of the cost of covered services.
What is not included in the out–of–pocket limit?	Premiums, prescription cost shares and excluded benefits.	Not applicable because there's no out-of-pocket limit on your expenses.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of participating providers see www.mvphealthcare.com.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a specialist?	No.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about excluded services.

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- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating providers by charging you lower deductibles, copayments and coinsurance amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copay	Not covered.	——none——
	Specialist visit	$15 copay	Not covered.	——none——
	Other practitioner office visit	$15 copay for chiropractic visits.	Not covered.	——none——
	Preventive care/ screening/immunization	$0 copay	Not covered.	——none——
If you have a test	Diagnostic test (x-ray, blood work)	Lab Office - $0 copay Lab Facility - $0 copay Radiology Office - $15 copay Radiology Facility - $15 copay	Not covered.	——none——
	Imaging (CT/PET scans, MRIs)	$15 copay	Not covered.	——none——

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Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.mvphealthcare.com.	Generic drugs	Retail $5 copay Mail order $12.50 copay	Not covered.	30 day retail supply, 90 day mail order supply.
	Preferred brand drugs	Retail $20 copay Mail order $50 copay	Not covered.	30 day retail, 90 day mail order.
	Non-preferred brand drugs	Retail $40 copay Mail order $100 copay	Not covered.	30 day retail, 90 day mail order.
	Specialty drugs	Retail Covered as noted in generic, preferred, and non-preferred classes.	Not covered.	——————none——————
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery)	$15 copay	Not covered.	——————none——————
	Physician/surgeon fees	$0 copay	Not covered.	——————none——————
If you need immediate medical attention	Emergency room services	$50 copay	$50 copay	——————none——————
	Emergency medical transportation	$0 copay	$0 copay	——————none——————
	Urgent care	$15 copay	$15 copay	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	$0 copay	Not covered.	——————none——————
	Physician/surgeon fee	$0 copay	Not covered.	——————none——————

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Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient	$15 copay	Not covered.	——none——
	Mental/Behavioral health inpatient services	$0 copay	Not covered.	——none——
	Substance use disorder outpatient services	$15 copay	Not covered.	——none——
	Substance use disorder inpatient services	$0 copay	Not covered.	——none——
If you are pregnant	Prenatal and postnatal	$0 copay	Not covered.	——none——
	Delivery and all inpatient services	$0 copay	Not covered.	——none——
If you need help recovering or have other special health needs	Home health care	$15 copay	Not covered.	60 visits per year.
	Rehabilitation services	$15 copay	Not covered.	30 combined PT/OT/ST visits per year.
	Habilitation services	Not covered.	Not covered.	Certain services covered for autism.
	Skilled nursing care	$0 copay	Not covered.	60 days per year.
	Durable medical equipment	20% coinsurance	Not covered.	——none——
	Hospice service	$0 copay	Not covered.	210 days per lifetime.
If your child needs dental or eye care	Eye exam	$15 copay	Not covered.	One exam every two years.
	Glasses	Not covered.	Not covered.	——none——
	Dental check-up	$25 copay	$25 copay	Preventive dental services to age 19.

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Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Acupuncture
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Long-Term Care
- Non-Emergency care when traveling outside the US
- Private-Duty Nursing
- Routine Foot Care
- Weight Loss Programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Bariatric Surgery
- Chiropractic Care
- Infertility Treatment
- Routine Eye Care (Adult)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-888-687-6277. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: MVP Health Care at 1-888-687-6277 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

The following is the New York State Department of Insurance contact information:

New York State Department of Financial Services, One Commerce Plaza, Albany, NY 12257, 1-800-342-3736 or 1-518-474-6600

Or, 25 Beaver Street, New York, NY 10004, 1-800-342-3736 or 1-212-480-6400

New York State External Appeals, P.O. Box 7209, Albany, NY 12224-0209

1-800-400-8882, 1-888-990-3991 (Expedited appeals on weekend & holidays), Email: externalappealquesions@dfs.ny.gov

Additionally, a consumer assistance program can help you file your appeal. Contact:

Community Service Society of New York, Community Health Advocates, 105 East 22nd Street, 8th floor, New York, NY 10010, 1-888-614-5400

www.communityhealthadvocates.org, Email: cha@cssny.org

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage."
This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value).
This health coverage does meet the minimum value standard for the benefits it provides.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers: $7,466**
- **Plan pays** $7,291
- **Patient pays** $175

Sample care costs:

Hospital charges (mother)	$2,714
Routine obstetric care	$2,084
Hospital charges (baby)	$852
Anesthesia	$905
Laboratory tests	$527
Prescriptions	$173
Radiology	$176
Vaccines, other preventive	$35
Total	**$7,466**

Patient pays:

Deductibles	$0
Co-pays	$25
Co-insurance	$0
Limits or exclusions	$150
Total	$175

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers: $5,490**
- **Plan pays** $4,312
- **Patient pays** $1,178

Sample care costs:

Prescriptions	$2,889
Medical Equipment and Supplies	$1,311
Office Visits and Procedures	$725
Education	$288
Laboratory tests	$137
Vaccines, other preventive	$140
Total	**$5,490**

Patient pays:

Deductibles	$0
Co-pays	$1178
Co-insurance	$0
Limits or exclusions	$0
Total	$1,178

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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