4he 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, please contact your plan sponsor at 518-580-5800. 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 1-800-229-5851 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$200** Individual / **$400** Family	See the Common Medical Events chart below for your costs for services this plan covers. 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, prescription drugs, and dental care 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. 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?	Medical: **$1,500** Individual/**$3,000** Family. Prescription Drugs: **$7,950** Individual/**$15,900** 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?	Premiums, balance-billing charges, penalties for failure to obtain preauthorization and health care 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 1-800-229-5851 for a list of local and national participating 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 full cost if you choose to use an out-of-network provider. 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	$25 copay/visit after deductible; includes 24/7 Online Doctor Visits	Not covered	No charge for Telemedicine visits through GIA/myVisitNow®
	Specialist visit	$40 copay/visit after deductible	Not covered	OB-GYN covered as primary care.
	Preventive care/screening/ immunization	No charge; deductible does not apply	Not covered	Age and frequency visits may apply. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Labs: No charge after deductible X-ray: $40 copay/visit after deductible	Not covered	None.
	Imaging (CT/PET scans, MRIs)	$40 copay/visit after deductible	Not covered	None.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.optumrx.com or 1-855-505-8107	Generic drugs	Retail: $10 copay/ prescription Mail Order: $25 copay/ prescription	Not covered	Deductible does not apply. Limit: Retail: 30-day supply; Mail Order: 31-90 day supply. Step therapy and quantity limits apply to certain drugs. Preauthorization required for certain drugs or coverage may be denied. No charge for certain preventive drugs. No charge for ACA-required preventive generic drugs (e.g., contraceptives) or a brand name preventive drug if a generic is not medically appropriate.
	Preferred brand drugs	Retail: $25 copay/ prescription Mail Order: $62.50 copay/ prescription	Not covered	
	Non-preferred brand drugs	Retail: $40 copay/ prescription Mail Order: $100 copay/ prescription	Not covered	
	Specialty drugs	Retail covered as noted for generic, preferred and non-preferred	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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100 copay/visit after deductible	Not covered	Preauthorization required or coverage may be denied.
	Physician/surgeon fees	No charge after deductible	Not covered	None.
If you need immediate medical attention	Emergency room care	$100 copay/visit after deductible	$100 copay/visit after deductible	Copay waived if admitted to hospital
	Emergency medical transportation	$100 copay/use after deductible	$100 copay/use after deductible	Certain limitations in the use of air ambulance services
	Urgent care	$25 copay/visit after deductible	$25 copay/visit after deductible	The $25 copay applies to the visit only. If additional services are provided, additional out-of-pocket costs apply based on service received.
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 copay/continuous confinement after deductible	Not covered	Maximum: One inpatient copay per individual; no family maximum.
	Physician/surgeon fees	No charge after deductible	Not covered	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay/visit after deductible; includes 24/7 Online Doctor Visits	Not covered	No charge for Telemedicine visits through GIA/myVisitNow®
	Inpatient services	$250 copay/continuous confinement after deductible	Not covered	Maximum: One inpatient copay per individual; no family maximum.

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 are pregnant	Office visits	$25 copay after deductible (Initial visit only)	Not covered	No charge after initial $25 copay. Cost sharing does not apply for preventive services. Depending on the type of services, a copay and/or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	$200 copay/delivery after deductible	Not covered	None.
	Childbirth/delivery facility services	$250 copay/continuous confinement after deductible	Not covered	None.
If you need help recovering or have other special health needs	Home health care	$25 copay/visit after deductible	Not covered	Limit: up to 200 visits/year
	Rehabilitation services	Outpatient: $40 copay/ visit after deductible Inpatient: $250 copay/ continuous confinement after deductible	Not covered	80 outpatient visits/year for physical therapy, speech therapy, and occupational therapy combined
	Habilitation services	Not covered	Not covered	You must pay 100% for these services, even in-network.
	Skilled nursing care	No charge after deductible	Not covered	Limit: 120 days/year
	Durable medical equipment	20% coinsurance after deductible	Not covered	Preauthorization required or coverage may be denied.
	Hospice services	No charge after deductible	Not covered	Limit: lifetime maximum up to 210 days; 5 visits/year for family bereavement counseling

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	$40 copay/visit after deductible	Not covered	One (1) exam every two (2) calendar years. Vision screening covered in well-child visit at no charge.
	Children's glasses	50% reimbursement after deductible	50% reimbursement after deductible	Limit: 1 pair glasses every two (2) calendar years. Individuals over 19: limit $75 every two (2) calendar years.
	Children's dental check-up	No charge; deductible does not apply.	No charge; deductible does not apply.	Preventive services: Exam, cleaning, bite wing x-rays, fluoride and sealants every 6 months. Covered for individuals up to age 19.

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.)		
• Cosmetic surgery	• Long-term care	• Private-duty nursing
• Habilitation services	• Non-emergency care when traveling outside the U.S.	• Routine foot care
• Hearing aids		

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture	• Chiropractic care (no limit on number of visits)	• Infertility treatment
• Bariatric surgery	• Dental care (Adult) (separate election under Delta Dental of New York)	• Routine eye care (Adult) • Weight loss programs (Alternative health care limit: $300/year. Medically necessary services: no limit)

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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. 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 on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, you can contact: MVP Health Care, PO Box 2207, Schenectady, NY 12305 or 1-800-229-5851. 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, (888) 614-5400 directly or www.communityhealthadvocates.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 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** **$200**
- **First prenatal visit copay** **$25**
- **Hospital (facility) copay** **$250**
- **Delivery professional services copay** **$200**

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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$200
Copayments	$770
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,030**

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

- **The plan's overall deductible** **$200**
- **Specialist copay** **$40**
- **Hospital (facility) copay** **$250**
- **Prescription drug coinsurance** **$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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$200
Copayments	$960
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,160**

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

- **The plan's overall deductible** **$200**
- **Specialist copay** **$40**
- **Emergency Room copay** **$100**
- **DME coinsurance** **20%**

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**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$200
Copayments	$610
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$810**

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