



**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, 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/](http://www.healthcare.gov/sbc-glossary/) or call 1-800-229-5851 to request a copy.

| Important Questions                                                | Answers                                                                                                                                                                                                                                              | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|--------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>What is the overall deductible?</b>                             | <u>In-Network</u> : <b>\$200</b> Individual / <b>\$600</b> Family<br><u>Out-of-Network</u> : <b>\$300</b> Individual / <b>\$900</b> Family                                                                                                           | See the Common Medical Events chart below for your costs for services this <u>plan</u> covers. Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .                     |
| <b>Are there services covered before you meet your deductible?</b> | Yes. <u>In-network preventive care</u> , prescription drugs, and dental care are covered before you meet your <u>deductible</u> .                                                                                                                    | This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> . |
| <b>Are there other deductibles for specific services?</b>          | No                                                                                                                                                                                                                                                   | You don't have to meet <u>deductibles</u> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>What is the out-of-pocket limit for this plan?</b>              | <u>In-Network</u> : Medical: <b>\$1,750</b> Individual / <b>\$3,500</b> Family<br><u>Prescription Drugs</u> : <b>\$8,850</b> Individual/ <b>\$17,700</b> Family<br><u>Out-of-Network</u> : Medical: <b>\$3,000</b> Individual/ <b>\$6,000</b> Family | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services.<br><br>If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.                                                                                                                                                                                                                                   |
| <b>What is not included in the out-of-pocket limit?</b>            | <u>Premiums</u> , <u>balance-billing</u> charges, penalties for failure to obtain <u>preauthorization</u> and health care this <u>plan</u> doesn't cover                                                                                             | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Will you pay less if you use a network provider?</b>            | Yes. See <a href="http://www.mvphealthcare.com">www.mvphealthcare.com</a> or call 1-800-229-5851 for a list of local and national participating <u>providers</u> .                                                                                   | This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays ( <u>balance billing</u> ). Check with your <u>provider</u> before you get services.                                                                               |
| <b>Do you need a referral to see a specialist?</b>                 | No.                                                                                                                                                                                                                                                  | You can see the <u>specialist</u> you choose without a <u>referral</u> .                                                                                                                                                                                                                                                                                                                                                                                                                                           |



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<br>(You will pay the least)                                         | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                         |
| <b>If you visit a health care provider's office or clinic</b>                                                                                                                                                         | Primary care visit to treat an injury or illness | \$25 <u>copay</u> /visit after <u>deductible</u> ; includes 24/7 Online Doctor Visits   | 30% <u>coinsurance</u> after <u>deductible</u>     | No charge for Telemedicine visits through GIA/myVisitNow®.                                                                                                                                              |
|                                                                                                                                                                                                                       | <u>Specialist</u> visit                          | \$40 <u>copay</u> /visit after <u>deductible</u>                                        | 30% <u>coinsurance</u> after <u>deductible</u>     | OB-GYN covered as primary care.                                                                                                                                                                         |
|                                                                                                                                                                                                                       | <u>Preventive care/screening/immunization</u>    | No charge; <u>deductible</u> does not apply                                             | 30% <u>coinsurance</u> after <u>deductible</u>     | Age and frequency limits apply. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for. |
| <b>If you have a test</b>                                                                                                                                                                                             | <u>Diagnostic test</u> (x-ray, blood work)       | No charge after <u>deductible</u>                                                       | 30% <u>coinsurance</u> after <u>deductible</u>     | None.                                                                                                                                                                                                   |
|                                                                                                                                                                                                                       | Imaging (CT/PET scans, MRIs)                     | No charge after <u>deductible</u>                                                       | 30% <u>coinsurance</u> after <u>deductible</u>     | None.                                                                                                                                                                                                   |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <b><u>prescription drug coverage</u></b> is available at <a href="http://www.optumrx.com">www.optumrx.com</a> or 1-855-505-8107 | Generic drugs                                    | Retail: \$10 <u>copay</u> /prescription<br>Mail Order: \$25 <u>copay</u> /prescription  | Not covered                                        | <u>Deductible</u> does not apply.<br><br>Limit: Retail: 30-day supply; Mail order: 31-90 day supply.                                                                                                    |
|                                                                                                                                                                                                                       | Preferred brand drugs                            | Retail: \$30 <u>copay</u> /prescription<br>Mail Order: \$75 <u>copay</u> /prescription  | Not covered                                        | Step therapy and quantity limits apply to certain drugs. <u>Preauthorization</u> required for certain drugs or coverage may be denied.                                                                  |
|                                                                                                                                                                                                                       | Non-preferred brand drugs                        | Retail: \$50 <u>copay</u> /prescription<br>Mail Order: \$125 <u>copay</u> /prescription | Not covered                                        | 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.           |
|                                                                                                                                                                                                                       | <u>Specialty drugs</u>                           | 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<br>(You will pay the least)                                       | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                        |
| If you have outpatient surgery                                            | Facility fee (e.g., ambulatory surgery center) | \$100 <u>copay</u> /visit after <u>deductible</u>                                     | 30% <u>coinsurance</u> after <u>deductible</u>     | <u>Preauthorization</u> required or coverage may be denied.                                                                                            |
|                                                                           | Physician/surgeon fees                         | No charge after <u>deductible</u>                                                     | 30% <u>coinsurance</u> after <u>deductible</u>     | None.                                                                                                                                                  |
| If you need immediate medical attention                                   | <u>Emergency room care</u>                     | \$150 <u>copay</u> /visit after <u>deductible</u>                                     | \$150 <u>copay</u> /visit after <u>deductible</u>  | <u>Copay</u> waived if admitted to hospital.                                                                                                           |
|                                                                           | <u>Emergency medical transportation</u>        | \$150 <u>copay</u> /use after <u>deductible</u>                                       | \$150 <u>copay</u> /use after <u>deductible</u>    | Certain limitations in the use of air ambulance services.                                                                                              |
|                                                                           | <u>Urgent care</u>                             | \$25 <u>copay</u> /visit after <u>deductible</u>                                      | 30% <u>coinsurance</u> after <u>deductible</u>     | The \$25 <u>copay</u> applies to the visit only. If additional services are provided, additional out-of-pocket costs apply based on services received. |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)             | \$250 <u>copay</u> /continuous confinement after <u>deductible</u>                    | 30% <u>coinsurance</u> after <u>deductible</u>     | Maximum:; No family maximum.                                                                                                                           |
|                                                                           | Physician/surgeon fees                         | No charge after <u>deductible</u>                                                     | 30% <u>coinsurance</u> after <u>deductible</u>     | None.                                                                                                                                                  |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                            | \$25 <u>copay</u> /visit after <u>deductible</u> ; includes 24/7 Online Doctor Visits | 30% <u>coinsurance</u> after <u>deductible</u>     | No charge for Telemedicine visits through GIA/myVisitNow®.                                                                                             |
|                                                                           | Inpatient services                             | \$250 <u>copay</u> /continuous confinement after                                      | 30% <u>coinsurance</u> after <u>deductible</u>     | Maximum: One inpatient <u>copay</u> per individual; no family maximum.                                                                                 |

| Common Medical Event                                           | Services You May Need                                                              | What You Will Pay                                                                                                                               |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                      |
|----------------------------------------------------------------|------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                |                                                                                    | In-Network Provider<br>(You will pay the least)                                                                                                 | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                             |
| If you are pregnant                                            | Office visits                                                                      | \$25 <u>copay</u> after <u>deductible</u><br>(Initial visit only)                                                                               | 30% <u>coinsurance</u> after <u>deductible</u>     | No charge after initial \$25 <u>copay</u> . <u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>copay</u> , <u>coinsurance</u> and/or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). |
|                                                                | Childbirth/delivery professional services<br>Childbirth/delivery facility services | \$250 <u>copay</u> /continuous confinement after <u>deductible</u>                                                                              | 30% <u>coinsurance</u> after <u>deductible</u>     | None.                                                                                                                                                                                                                                                                                                                       |
| If you need help recovering or have other special health needs | <u>Home health care</u>                                                            | \$40 <u>copay</u> /visit after <u>deductible</u>                                                                                                | 30% <u>coinsurance</u> after <u>deductible</u>     | Limit: up to 200 visits/year                                                                                                                                                                                                                                                                                                |
|                                                                | <u>Rehabilitation services</u>                                                     | Outpatient: \$40 <u>copay</u> / visit after <u>deductible</u><br>Inpatient: \$250 <u>copay</u> / continuous confinement after <u>deductible</u> | 30% <u>coinsurance</u> after <u>deductible</u>     | 80 visits/year for physical therapy, speech therapy, and occupational therapy combined                                                                                                                                                                                                                                      |
|                                                                | <u>Habilitation services</u>                                                       | Not covered                                                                                                                                     | Not covered                                        | You must pay 100% for these services, even <u>in-network</u> .                                                                                                                                                                                                                                                              |
|                                                                | <u>Skilled nursing care</u>                                                        | \$250 <u>copay</u> /continuous confinement after <u>deductible</u>                                                                              | 30% <u>coinsurance</u> after <u>deductible</u>     | Limit: 120 days/year                                                                                                                                                                                                                                                                                                        |
|                                                                | <u>Durable medical equipment</u>                                                   | No charge after <u>deductible</u>                                                                                                               | 30% <u>coinsurance</u> after <u>deductible</u>     | <u>Preauthorization</u> required or coverage may be denied.                                                                                                                                                                                                                                                                 |
|                                                                | <u>Hospice services</u>                                                            | No charge after <u>deductible</u>                                                                                                               | 30% <u>coinsurance</u> after <u>deductible</u>     | Limit: lifetime maximum of 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<br>(You will pay the least)                                | Out-of-Network Provider<br>(You will pay the most)                             |                                                                                                                       |
| If your child needs dental or eye care | Children's eye exam        | \$25 <u>copay</u> /visit after <u>deductible</u>                               | 30% <u>coinsurance</u> after <u>deductible</u>                                 | One (1) exam every two (2) calendar years<br>Vision screening covered in well-child visit at no charge.               |
|                                        | Children's glasses         | No charge after <u>deductible</u> .                                            | No charge after <u>deductible</u> .                                            | Limit: 1 pair glasses every two (2) calendar years.<br>Individuals over 19: limit \$150 every two (2) calendar years. |
|                                        | Children's dental check-up | MVP: not covered<br>Delta Dental: No charge, <u>Deductible</u> does not apply. | MVP: not covered<br>Delta Dental: No charge. <u>Deductible</u> does not apply. | Separate election with Delta Dental of New York.                                                                      |

## 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
- Habilitation services
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care

### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids
- Dental care (Adult) (separate election with Delta Dental of New York)
- Infertility treatment (Limit \$10,000/year per family)
- 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: the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://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](http://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](http://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 <u>deductible</u> | \$200 |
| ■ First prenatal visit <u>copay</u>    | \$25  |
| ■ Hospital (facility) <u>copay</u>     | \$250 |
| ■ Prescription drug <u>copay</u>       | \$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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

| <u>Cost Sharing</u>               |              |
|-----------------------------------|--------------|
| <u>Deductibles</u>                | \$200        |
| <u>Copayments</u>                 | \$290        |
| <u>Coinsurance</u>                | \$0          |
| <i>What isn't covered</i>         |              |
| Limits or exclusions              | \$60         |
| <b>The total Peg would pay is</b> | <b>\$550</b> |

### Managing Joe's Type 2 Diabetes

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

|                                        |       |
|----------------------------------------|-------|
| ■ The plan's overall <u>deductible</u> | \$200 |
| ■ <u>Specialist copay</u>              | \$40  |
| ■ Hospital (facility) <u>copay</u>     | \$250 |
| ■ Prescription drug <u>copay</u>       | \$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 drug*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

In this example, Joe would pay:

| <u>Cost Sharing</u>               |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$200          |
| <u>Copayments</u>                 | \$1,000        |
| <u>Coinsurance</u>                | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Joe would pay is</b> | <b>\$1,200</b> |

### Mia's Simple Fracture

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

|                                        |       |
|----------------------------------------|-------|
| ■ The plan's overall <u>deductible</u> | \$200 |
| ■ <u>Specialist copay</u>              | \$40  |
| ■ Emergency room <u>copay</u>          | \$150 |
| ■ <u>DME coinsurance</u>               | 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

In this example, Mia would pay:

| <u>Cost Sharing</u>               |              |
|-----------------------------------|--------------|
| <u>Deductibles</u>                | \$200        |
| <u>Copayments</u>                 | \$630        |
| <u>Coinsurance</u>                | \$0          |
| <i>What isn't covered</i>         |              |
| Limits or exclusions              | \$0          |
| <b>The total Mia would pay is</b> | <b>\$830</b> |

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