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, contact your plan sponsor at: 718-459-5800. Para obtener asistencia en Espanol, llame al 718-459-5800. 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.https://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?	In Network: $250 Individual / $500 Family Out of Network: $500 Individual / $1,000 Family (does not apply to substance abuse services)	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.	This plan covers some items and services even if you haven't yet met the deductible amount. A copayment or coinsurance may apply.
Are there other deductibles for specific services?	Yes. $250 for communicable disease services.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	In Network: $2,500 per Individual Out of Network: $5,000 per Individual	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, 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 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
		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	20% Coinsurance after deductible	50% Coinsurance after deductible	None
	Specialist visit	20% Coinsurance after deductible	50% Coinsurance after deductible	None
	Preventive care/screening/ immunization	20% Coinsurance after deductible	50% Coinsurance after deductible	None
If you have a test	Diagnostic test (x-ray, blood work)	20% Coinsurance after deductible	50% Coinsurance after deductible	None
	Imaging (CT/PET scans, MRIs)	20% Coinsurance after deductible	50% Coinsurance after deductible	None

If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.express-scripts.com 1-866-544-2926.	Generic drugs	Retail: $10 Copayment/prescription Mail Order: $20 Copayment/prescription	Same as Participating Provider *	Covers up to a 30-day supply (retail); up to a 90-day supply (mail order) Multi Source Brand Drugs: If the prescribed drug is a multi-source (available through both a brand name source and a generic source), the pharmacy dispenses the brand name drug, and your doctor has not written “Dispense as Written” on your prescription, your cost is the prescription copayment listed in the chart plus the price differential of the brand name drug over the generic drug. * You pay 100% then submit claim for reimbursement. Reimbursed amount is the participating provider approved amount minus the applicable copayment. Specialty drugs are available only through Specialty Pharmacy Accredo.
	Preferred brand drugs	Retail: $30 Copayment/prescription Mail Order: $60 Copayment/prescription	Same as Participating Provider *	
	Non-preferred brand drugs	Same as Preferred brand drugs	Same as Participating Provider *	
	Specialty drugs	Same as the copayments listed for each of the drug categories shown above	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay Network Provider (You will pay the least)	What You Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance after deductible	50% Coinsurance after deductible	None
	Physician/surgeon fees	20% Coinsurance after deductible	50% Coinsurance after deductible	None

If you need immediate medical attention	Emergency room care	20% Coinsurance after deductible	50% Coinsurance after deductible	None
	Emergency medical transportation	20% Coinsurance after deductible	50% Coinsurance after deductible	None
	Urgent care	20% Coinsurance after deductible	50% Coinsurance after deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance after deductible	50% Coinsurance after deductible	None
	Physician/surgeon fees	20% Coinsurance after deductible	50% Coinsurance after deductible	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% Coinsurance after deductible	50% Coinsurance after deductible	Substance abuse services not subject to deductible
	Inpatient services	20% Coinsurance after deductible	50% Coinsurance after deductible	Substance abuse services not subject to deductible
If you are pregnant	Office visits	20% Coinsurance after deductible	50% Coinsurance after deductible	None
	Childbirth/delivery professional services	20% Coinsurance after deductible	50% Coinsurance after deductible	
	Childbirth/delivery facility services	20% Coinsurance after deductible	50% Coinsurance after deductible	
If you need help recovering or have other special health needs	Home health care	20% Coinsurance after deductible	50% Coinsurance after deductible	None
	Rehabilitation services/Habilitation services	20% Coinsurance after deductible	50% Coinsurance after deductible	No visit limitations
	Durable medical equipment	20% Coinsurance after deductible	50% Coinsurance after deductible	None
	Skilled nursing care	20% Coinsurance after deductible	50% Coinsurance after deductible	None
	Hospice services	20% Coinsurance after deductible	50% Coinsurance after deductible	None

If your child needs dental or eye care	Children's eye exam	Covered under separate Vision plan	Covered under separate Vision plan	Contact the Plan Sponsor for more information
	Children's glasses	Covered under separate Vision plan	Covered under separate Vision plan	Contact the Plan Sponsor for more information
	Children's dental check-up	Covered under separate Dental plan	Covered under separate Dental plan	Contact the Plan Sponsor for more information

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
- Children's Dental Check-up
- Children's Eye Exam
- Dental Care (Adult)
- Long Term Care
- Children's Glasses
- Cosmetic Surgery
- Weight Loss Programs
- Routine Foot Care
- Routine Eye Care (Adult)
- Non-Emergency care when traveling outside the U.S

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

- Bariatric Surgery
- Hearing Aids
- Chiropractic Care
- Infertility Treatment

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. For more information on your rights to continue coverage, contact the plan at 1-800-229-5851. You may also contact your state Insurance Department, U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or US. Department of Health and Human Services at 1 877-267-3232 x 61565 or www.cciio.cms.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 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, contact: [insert applicable contact information from instructions].

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? 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.

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al 1-844-946-8010.

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-946-8010.

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-844-946-8010.

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-844-946-8010.

Kreyòl Ayisyen (French Creole)Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou.Rele 1-844-946-8010

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	**$250**
Specialist [cost sharing]	**$0**
Hospital (facility) *[cost sharing]*	**20%**
Other *[cost sharing]*	**20%**

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	$250
Copayments	$10
Coinsurance	$2,300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,620**

Managing Joe's Type 2 Diabetes

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

The plan's overall deductible	**$250**
Specialist [cost sharing]	**$0**
Hospital (facility) *[cost sharing]*	**20%**
Other *[cost sharing]*	**20%**

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	$250
Copayments	$300
Coinsurance	$400
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$970**

Mia's Simple Fracture

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

The plan's overall deductible	**$250**
Specialist [cost sharing]	**$0**
Hospital (facility) *[cost sharing]*	**20%**
Other *[cost sharing]*	**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	$250
Copayments	$10
Coinsurance	$500
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$760**