

### Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services Coverage Period 07/01/2024 – 06/30/2025 NY HMO Coverage for: Single/Family | Plan Type: HMO

The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) 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, <a href="www.mvphealthcare.com">www.mvphealthcare.com</a>. For general definitions of common terms, such as <a href="allowed amount">allowed amount</a>, <a href="balance billing">balance billing</a>, <a href="coinsurance">coinsurance</a>, <a href="copayment">copayment</a>, <a href="deductible">deductible</a>, <a href="provider">provider</a>, or other <a href="underlined">underlined</a> terms see the Glossary. You can view the Glossary at <a href="www.healthcare.gov/sbc-glossary/">www.healthcare.gov/sbc-glossary/</a> or call 1-888-687-6277 to request a copy.

Important Questions	Answers	Why This Matters:
	\$0.	See the Common Medical Events chart below for your costs for services this plan covers.
What is the overall		
<u>deductible</u> ?		•
Are there services covered before you meet your deductible?	Yes. Preventive care services 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.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the <u>out-of-pocket</u>	Not Applicable.	This plan does not have an out-of-pocket limit on your expenses. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
<u>limit</u> for this <u>plan</u> ?	Man A a self-a della	
What is not included in	Not Applicable.	This plan does not have an out-of-pocket limit on your expenses.
the <u>out-of-pocket limit?</u>		
Will you pay less if you use a <u>network provider</u> ?		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 <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the specialist you choose without a referral.

		What You Will Pay			
Common Medical Event	Services You May Need	In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information	
	Primary care visit to treat an injury or illness	\$20 copay/office visit	Not covered	None	
If you visit a health care <u>provider's</u> office or clinic	Specialist visit	\$20 copay/visit	Not covered	None	
	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.	
, use and an electron section and section and electrical processing of the control and an electrical processing	Diagnostic test (x-ray, blood work)	Lab Office - No charge; Lab Facility - No charge; Radiology Office - \$20/visit; Radiology Facility - \$20/visit	Not covered	Lab Office - None; Lab Facility - None; Radiology Office - None; Radiology Facility - None	
If you have a test		Office \$20 canaulareadure	Not covered	None	
	Imaging (CT/PET scans, MRIs)	Office - \$20 copay/procedure; Facility - \$20 copay/procedure	Not covered	None	

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Common Medical Event		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information	
		Not covered	Not covered	SUD and Fertility Drugs only - 30 day supply retail	
	Tier 1			takes PCP Copay; Mail Order, takes 3 x PCP Copay,	
	(Generic drugs)		· ·	Up to a 90-day supply	
	Tarasana.		<u></u>		
If you need drugs to	,	Retail Not covered;	Not covered	None	
treat your illness or condition	Tier 2	Mail order Not covered			
More information about	(Preferred brand drugs)		}		
prescription drug			in the state of th		
<u>coverage</u> is available at	The state of the s	Retail Not covered;	Not covered	None	
	Tier 3 (Non-preferred brand drugs)	Mail order Not covered	ROMANIANA		
			***	TELEPA	
	r				
	Tier 4 Specialty drugs	Retail Covered as noted in Tier 1, Tier 2, and	Not covered	None	
		Tier 3 classes;	1	TATALON	
		\$75 copay/day	Not covered	None	
<u> </u>	Facility fee (e.g., ambulatory surgery center)	фто сораулаау	Not covered	Notice	
If you have outpatient surgery	dargery defilery	No charge	Not covered	None	
ou.gory	Physician/surgeon fees	The Ghange	, in the control of t	Thomas and the same of the sam	
		\$50 copay/visit	\$50 copay/visit	None	
a a a	Emergency room care	4	400 copajition	,	
	Emorgonov room ouro				
- International Control of the Contr	, and the second	No charge	No charge	None	
	Emergency medical		- v		
	transportation				
		\$20 copay/visit	\$20 copay/visit	None	
	Urgent care				

	Services You May Need	What You Will Pay			
Common Medical Event		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information	
If you have a hospital stay	Facility fee (e.g., hospital room)	\$240 copay/continuous confinement	Not covered	For the first continuous confinement per Member; per Plan Year	
	Physician/surgeon fees	No charge	Not covered	None	
If you need mental health, behavioral	Outpatient services	\$20 copay/visit	Not covered	None	
health, or substance abuse services	Inpatient services	\$240 copay/stay	Not covered	For the first continuous confinement per Member; per Plan Year	
If you are pregnant	Office visits  Childbirth/delivery professional services	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 facility services	\$240 copay/stay	Not covered	,	

	Services You May Need	What You Will Pay			
Common Medical Event		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information	
	Home health care	\$20 copay/visit	Not covered	60 visits per plan year	
	Rehabilitation services/	OP ReHab: \$20 copay/visit IP ReHab: \$500 copay/visit	OP ReHab: Not covered IP ReHab: Not covered	OP ReHab: 30 visits per plan year combined therapies IP ReHab: 30 days per Plan Year combined therapies	
If you need help recovering or have other special health needs	Habilitation services			The second secon	
	Skilled nursing care	No charge	Not covered	60 days per Plan Year	
	Durable medical equipment	20% coinsurance	Not covered	None	
	Hospice services	No charge	Not covered	210 days per Plan Year; Five (5) visits for family bereavement counseling	
If your child needs dental or eye care	Children's eye exam	\$20 copay/exam	Not covered	One exam every 2 Calendar Years	
	Children's glasses	Not covered	Not covered	None	
	Children's dental check-up	\$25 copay/visit	\$25 copay/visit	preventive dental services 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.)

- Acupuncture
- · Children's Glasses
- Cosmetic Surgery
- Dental Care (Adult)
- Generic drugs
- Hearing Aids
- Long-Term Care

- Non-Emergency care when traveling outside the U.S
- Non-preferred brand drugs
- · Preferred brand drugs
- · Private-Duty Nursing
- Routine Foot Care
- Specialty drugs
- Weight Loss Programs

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

- Bariatric Surgery
- Chiropractic Care
- Infertility Treatment

• Routine Eye Care (Adult)

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 members@mvphealthcare.com

You can also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or cciio.cms.gov. Church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law. 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 <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. 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:1-888-687-6277

www.mvphealthcare.com

members@mvphealthcare.com

You can also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or dol.gov/ebsa/healthreform, or the NYS Department of Insurance at 1-800-342-3736 or dfs.ny.gov. Additionally, a consumer assistance program can help you file your appeal. Contact the Community Health Advocates at 1-888-614-5400 or communityhealthadvocates.org.

Does this plan provide Minimum Essential Coverage? No.

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?	NO.
If your plan doesn't meet the Minimum Value Standards,	you may be eligible for a <u>premium tax credit</u> to help you pay for a <u>plan</u> through the <u>Marketplace</u> .
To see eyamn	les of how this plan might cover costs for a sample medical situation, see the next section

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### **About these Coverage Examples:**



This is not a cost estimator. Treatments shown are just examples of how this <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. 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)

### Managing Joe's type 2 Diabetes (a year of routine in-network care of a wellcontrolled condition)

■ The plan's overall deductible \$0 The plan's overall deductible \$0 Specialist Copay \$20 Specialist Copay \$20 ■ Hospital (facility) Copay \$500 **™ Hospital (facility)** Copay \$500 Other Copay \$20 Other Copay \$50

■ The plan's overall deductible	\$0
■ Specialist Copay	\$20
Hospital (facility) Copay	\$500
■ Other Copay	\$0

### 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)

### 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)

### This EXAMPLE event includes services like:

Emergency room care (including medical supplies)
Diagnostic test (x-ray)
Durable medical equipment (crutches)

Mia's Simple Fracture

(in-network emergency room visit and follow

up care)

Rehabilitation services (physical therapy)

Total Example Cost	\$12,700	Total Example Cost	\$5,600	Total Example Cost	\$2,800
In this example, Peg would pay:  Cost Sharing  In this example, Joe would pay:  Cost Sharing			In this example, Mia would pay:  Cost Sharing		
Deductibles	\$0	Deductibles	\$0	Deductibles	\$0
Copayments	\$500	Copayments	\$800	Copayments	\$200
Coinsurance	\$0	Coinsurance	\$0	Coinsurance	\$10
What isn't covered		What isn't covered		What isn't covered	
Limits or exclusions	\$70	Limits or exclusions	\$200	Limits or exclusions	\$10
The total Peg would pay is	\$570	The total Joe would pay is	\$1,000	The total Mia would pay is	\$220

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to communicate effectively with us, such as: Free aids and services to people with disabilities

- Qualified sign language interpreters
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Free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

# If You Need These Services

Elona Charles-Wilson at 1-844-946-8009 If you need these services, contact (TTY: 1-800-662-1220).

## or Complaint How to File a Grievance

of race, color, national origin, age, disability, or services or has treated you differently because If you believe that MVP nas not given you these sex, you can file a grievance with MVP by:

ATTN: ELONA CHARLES-WILSON

CIVIL RIGHTS COORDINATOR

MVP HEALTH CARE

**625 STATE ST** 

SCHENECTADY NY 12305-2111

Phone:

1-844-946-8009

625 State Street, Schenectady, NY (TTY/TDD: 1-800-662-1220)

civilrightscoordinator@ mvphealthcare.com

Office for Civil Rights by: U.S. Department of Health and Human Services You can also file a civil rights complaint with the

Online: ocrportal.hhs.gov

US DEPT OF HEALTH & HUMAN SRVS 200 INDEPENDENCE AVE SW

HHH BLDG ROOM 509F

WASHINGTON DC 20201

Phone: 1-800-368-1019

TTY/TTD: 1-800-537-7697)

to file a complaint. Complaints & Appeals. then Civil Rights: How hhs.gov/regulations and selecting Complaint forms are available by visiting

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# Multi-Language Interpreter Services

## Español (Spanish)

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia linguística. Llame al **1-844-946-8010** (TTY: 1-800-662-1220).

繁體中文(Chinese)

注意:如果您使用繁體中文、您可以免費獲得語言援助服務。請致電

1-844-946-8010 (TTY: 1-800-662-1220)

## Русский (Russian)

услуги перевода. Звоните **1-844-946-8010** (телетайп: 1-800-662-1220) ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные

## Kreyòl Ayisyen (French Creole)

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou Rele **1-844-946-8010** (TTY: 1-800-662-1220).

## 한국어 (Korean)

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 **1-844-946-8010** (TTY: 1-800-662-1220) 번으로 전화해 주십시오. 수 있습니다.

## Italiano (Italian)

linguistica gratuiti. Chiamare il numero 1-844-946-8010 (TTY: 1-800-662-1220). ATTENZIONE: In caso la lingua pariata sia l'italiano, sono disponibili servizi di assistenza

## אידיש (Yiddish)

אויפמערקואם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף מערוויסעס פריי פון אפצאל. רופט **1220-662-1270 (TTY). 1-804-946.** 

বাংলা (Bengali) লক্ষ্য করুলঃ যদি আপলি বাংলা, কথা বলতে পারেল, ভাষণে লিঃথরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছি। কোল করুল ১-**844-946-8010** (TTY: ১-800-662-1220)|

### Polski (Polish)

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej Zadzwoń pod numer **1-844-946-8010** (TTY: 1-800-662-1220).

## (Arabic) العربية

ملحوظة ؛إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-**021-449-449 (ر**قم هاتف الصم والنكم: 1-0221-265-021).

## Français (French)

ATTENTION : Si vous parlez français, des services d'aide Inguistique vous sont proposés gratuitement. Appelez le **1-844-946-8010** (ATS: 1-800-662-1220)

### (Urdu) اردو

فردار: اگر آپ اردو بولئے میں، تو آپ کو زبان کی مدو کی ضعات مفت میں و سیاب میں ۔ کال کریں TTY: 1-800-662-1220) **1-844-946**-8010).

**Tagalog (Tagalog-Filipino)**PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-844-946-8010** (TTY: 1-800-662-1220)

## Ελληνικά (Greek)

υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε **1-844-946-8010** (TTY: 1-800-662-1220) ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικήν

## Shqip (Albanian)

pagesë. Telefononi në **1-844-946-8010** (TTY: 1-800-662-1220) KUJDES: Nêse flitni shqıp, për ju ka ne dispozicion shërbime të asistences gjuhesore, pa