



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, [www.ny44.e1b.org](http://www.ny44.e1b.org). 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.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) or [www.ny44.e1b.org/wp-content/uploads/2019/10/Glossary-of-Healthcare-Terms.pdf](http://www.ny44.e1b.org/wp-content/uploads/2019/10/Glossary-of-Healthcare-Terms.pdf) or call 1-716-821-7161 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	<u>In-Network</u> : \$300 per person per calendar year; applies to medical and pharmacy <u>Out-of-Network</u> : \$3,000 single/ \$6,000 family per calendar year	See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers. Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for covered services. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes, for <u>In-Network</u> services only; <u>preventive services</u> are covered before you meet your <a href="#">deductible</a> ; <u>copayments</u> may apply. No, <u>Out-of-Network</u> services are covered before <a href="#">deductible</a>	This <a href="#">plan</a> covers some items and services even if you haven't met your <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <u>preventive services</u> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . 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 <a href="#">deductibles</a> for specific services?</b>	No	You don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	<u>In-Network</u> : \$5,000 single/ \$10,000 family <u>Out-of-Network</u> : \$19,000 single/ \$38,000 family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	Penalties for failure to obtain <a href="#">precertification</a> of services and <a href="#">prescription drug</a> cost differentials, <a href="#">premiums</a> , <a href="#">balance billing</a> charges and health care this <a href="#">plan</a> does not cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .

<p><b>Will you pay less if you use a <a href="#">network provider</a>?</b></p>	<p>Yes, call MVP customer service for a list of <a href="#">network providers</a> 1-800-229-5851</p>	<p>This <a href="#">plan</a> uses a <a href="#">provider network</a>. You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's</a> network. You will pay the most if you use an <a href="#">out-of-network provider</a>, and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays (<a href="#">balance billing</a>). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.</p>
<p><b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b></p>	<p>No</p>	<p>You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a>.</p>

 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)	
<p><b>If you visit a health care <a href="#">provider's</a> office or clinic</b></p>	<p>Primary care visit to treat an injury or illness</p>	<p>\$15 <a href="#">copayment</a></p>	<p>Not covered</p>	<p>None</p>
	<p><a href="#">Specialist</a> visit</p>	<p>\$15 <a href="#">copayment</a></p>	<p>Not covered.</p>	<p><a href="#">Medically necessary</a> chiropractic care limited to 20 visits per calendar year</p>
	<p><a href="#">Preventive care/screening/immunization</a></p>	<p>No charge</p>	<p>Not covered</p>	<p>You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.</p>
<p><b>If you have a test</b></p>	<p><a href="#">Diagnostic test</a> (x-rays, blood work)</p>	<p>No charge</p>	<p>30% <a href="#">coinsurance</a></p>	<p>None</p>
	<p>Imaging (CT/PET scans, MRIs)</p>	<p>\$15 <a href="#">copayment</a></p>	<p>30% <a href="#">coinsurance</a></p>	<p><a href="#">Preauthorization</a> required*</p>
<p><b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at 1-833-772-2779 or <a href="https://caprx.adaptiverx.com/webSearch/index?key=8F02B26A288102C27BAC82D14C006C6FC54D480F80409B68F7175D0DC1577226">https://caprx.adaptiverx.com/webSearch/index?key=8F02B26A288102C27BAC82D14C006C6FC54D480F80409B68F7175D0DC1577226</a></p>	<p>Generic drugs (Tier 1)</p>	<p>Retail: \$5 <a href="#">copayment</a> Mail Order: \$12.50 <a href="#">copayment</a></p>	<p>Not covered</p>	<p>After 2<sup>nd</sup> refill at Retail, all maintenance refills will be filled by Mail Order for 90-day supply</p>
	<p>Preferred brand drugs (Tier 2)</p>	<p>Retail: \$40 <a href="#">copayment</a> Mail Order: \$100 <a href="#">copayment</a></p>	<p>Not covered</p>	<p>After 2<sup>nd</sup> refill at Retail, all maintenance refills will be filled by Mail Order for 90-day supply</p>

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)	
	Non-preferred brand drugs (Tier 3)	Retail: \$75 <u>copayment</u> Mail Order: \$187.50 <u>copayment</u>	Not covered	Member responsible for cost difference between non-preferred brand (Tier 3) medication and generic equivalent (Tier 1), plus <u>copayment</u> ; After 2 <sup>nd</sup> refill at Retail, all maintenance refills will be filled by Mail Order for 90-day supply
	<a href="#">Specialty drugs</a>	7% <u>coinsurance</u> to a maximum of \$120 for a 30-day supply; please see note on Payer Matrix	Not covered	Payer Matrix – participants are required to contact Payer Matrix (877-305-6202). If the Payer Matrix program is not utilized, the full cost of the specialty drug will be the participant's responsibility.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$75 <u>copayment</u> applied to facility charge	Not covered	<u>Preauthorization</u> required*
	Physician/surgeon fees	\$75 <u>copayment</u> applies to both facility charge and procedures in an office setting	Not covered	<u>Preauthorization</u> required*
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$200 <u>copayment</u>	\$200 <u>copayment</u>	<u>Copayments</u> are waived if admitted or for certain long-term observation holds; capped at two times <u>copayment</u> in the event a common accident or injury occurs for a family unit at the same time.
	<a href="#">Emergency medical transportation</a>	\$50 <u>copayment</u>	\$50 <u>copayment</u>	Subject to <u>Medical Necessity</u>
	<a href="#">Urgent care</a>	No charge	No charge	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$500 <u>copayment</u>	Not covered	Maximum two <u>copayments</u> per calendar year <u>In-Network</u> ; not covered <u>Out-of-Network</u> , except in emergency; <u>Preauthorization</u> required*
	Physician/surgeon fees	\$500 <u>copayment</u>	Not covered	Maximum two <u>copayments</u> per calendar year <u>In-Network</u> ; not covered <u>Out-of-Network</u> , except in emergency; <u>Preauthorization</u> required*

<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$15 <u>copayment</u>	30% <u>coinsurance</u>	None
	Inpatient services	\$500 <u>copayment</u>	Not covered	Maximum two <u>copayments</u> per calendar year <u>In-Network</u> ; not covered <u>Out-of-Network</u> , except in emergency; <u>Preauthorization</u> required*
<b>If you are pregnant</b>	Office visits	\$15 <u>copayment</u>	Not covered	Applies to initial visit only for <u>In-Network</u>
	Childbirth/delivery professional services	No charge	Not covered	None
	Childbirth/delivery facility services	\$500 <u>copayment</u>	Not covered	Maximum two <u>copayments</u> per calendar year <u>In-Network</u>
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	\$15 <u>copayment</u>	Not covered	Limit 40 visits per calendar year; <u>Preauthorization</u> required*
	<a href="#">Rehabilitation services</a>	\$15 <u>copayment</u>	Not covered	Number of visits per therapy may be limited per calendar year; <u>Preauthorization</u> required*
	<a href="#">Habilitation services</a>	\$15 <u>copayment</u>	Not covered	Number of visits per therapy may be limited per calendar year; <u>Preauthorization</u> required*
	<a href="#">Skilled nursing care</a>	Inpatient \$500 <u>copayment</u> ; Outpatient services \$15 <u>copayment</u>	Not covered	Maximum two <u>copayments</u> per calendar year <u>In-Network</u> ; limit 45 days per calendar year; <u>Preauthorization</u> required*
	<a href="#">Durable medical equipment</a>	50% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> required*
	<a href="#">Hospice services</a>	Inpatient \$500 <u>copayment</u> ; Outpatient services \$15 <u>copayment</u>	Not covered	Maximum two <u>copayments</u> per calendar year <u>In-Network</u> ; not covered <u>Out-of-Network</u> , except in emergency for Inpatient services
<b>If your child needs dental or eye care</b>	Children's eye exam	\$15 <u>copayment</u>	Not covered	Limit of one exam per calendar year
	Children's glasses	Not covered	Not covered	Not covered
	Children's dental check-up	Not covered	Not covered	Not covered

\* Preauthorization required: Failure to obtain preauthorization may result in MVP denying payment of your claim and you may be responsible for some or all the charges.

## 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
- Cosmetic surgery
- Custodial care
- Dental care
- Hearing aids
- Long term care
- Non-emergency care when traveling outside the U.S.
- Eyeglasses
- Private-duty nursing
- Routine foot care
- 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 with [preauthorization](#)
- Chiropractic services (maintenance therapy excluded; limited to 20 visits)
- Infertility treatment (subject to limitations)
- Routine eye care

**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: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://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](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, contact: MVP Customer Service at 1-800-229-5851. If you receive a denial of coverage for a prescription drug, you can contact Capital Rx Customer Service 1-833-772-2779. Additionally, a consumer assistance program can help you fill your appeal. Contact Community Service Society of New York at 1-888-614-5400 or [cha@cssny.org](mailto:cha@cssny.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 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 1-800-257-2753.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-257-2753.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-257-2753.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-257-2753.

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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$300
■ <a href="#">Specialist</a> ( <a href="#">copayment</a> )	\$15
■ Hospital (facility)	\$500
■ Other ( <a href="#">Diagnostic copayment</a> )	\$15

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>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$300
<a href="#">Copayments</a>	\$560
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$860</b>

### Managing Joe's Type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$300
■ <a href="#">Specialist</a> ( <a href="#">copayment</a> )	\$15
■ Hospital (facility)	\$0
■ Other ( <a href="#">Tier 3 insulin copayment</a> )	\$75

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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$300
<a href="#">Copayments</a> (mail order)	\$765
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$1065</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$300
■ <a href="#">Specialist</a> ( <a href="#">copayment</a> )	\$15
■ Hospital (facility) ( <a href="#">ER copayment</a> )	\$200
■ Other ( <a href="#">DME coinsurance</a> )	\$50

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>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$300
<a href="#">Copayments</a>	\$215
<a href="#">Coinsurance</a>	\$50
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$565</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.