



# Shop and Save on New York State Health Insurance

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**1-888-215-4045**

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Our 5-star\* service is available for everyone to find the best suiting and most affordable health insurance package. Don't miss the opportunity to maximize your health insurance tax deductions, save up to thousands per year on health insurance premiums, or even get health insurance for free.



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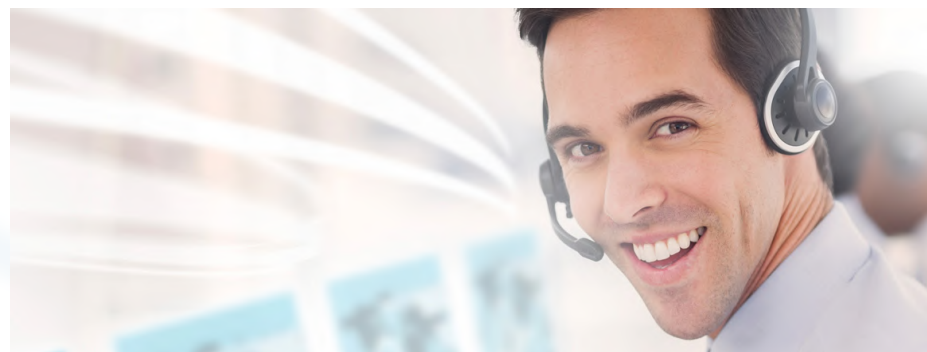
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Get Health Insurance quotes without the need to register or provide any personal information.

You don't need to become an expert on health insurance to find the best option. Our agents are online to guide you through a tedious process of health insurance application. And our free online health insurance quote engine is the fastest and simplest, you are just 2 steps away from the results. See if you qualify for the New York State's free health insurance plan now!



## Save time and money

Find out what health insurance packages and savings are available to you, it's totally free!

**Get Quotes Now**



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.mvphealthcare.com](http://www.mvphealthcare.com) or by calling 1-877-742-4181..

Important Questions	Answers	Why this Matters:
<b>What is the overall deductible?</b>	In network -\$0 person/\$0 family	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u> .
<b>Are there other deductibles for specific services?</b>	Pharmacy -\$0 person	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this plan begins to pay for these services.
<b>Is there an out-of-pocket limit on my expenses?</b>	In network -\$2,000 person/	The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
<b>What is not included in the out-of-pocket limit?</b>	Premiums, balance-billed charges and excluded benefits.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<b>Is there an overall annual limit on what the plan pays?</b>	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
<b>Does this plan use a network of providers?</b>	Yes, for a list of participating providers see <a href="http://www.mvphealthcare.com">www.mvphealthcare.com</a> .	If you use an in-network doctor or other health care <u>provider</u> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
<b>Do I need a referral to see a specialist?</b>	No.	You can see the <u>specialist</u> you choose without permission from this plan.
<b>Are there services this plan doesn't cover?</b>	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about <u>excluded services</u> .

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If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary

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- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating providers by charging you lower deductibles, copayments and coinsurance amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$15 copay	Not covered	—————none—————
	Specialist visit	\$25 copay	Not covered	—————none—————
	Other practitioner office visit	\$25 copay	Not covered	—————none—————
	Preventive care/ screening/immunization	Covered in Full	Not covered	—————none—————
<b>If you have a test</b>	Diagnostic test (x-ray, blood work)	Lab Office - \$15 copay Lab Facility - \$25 copay Radiology Office - PCP: \$15 copay/Spec: \$25 copay Radiology Facility - \$25 copay	Not covered	—————none—————
	Imaging (CT/PET scans, MRIs)	\$25 copay	Not covered	per day, per provider Hi-Tech Facility - per day per provider

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Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
<b>If you need drugs to treat your illness or condition</b>  More information about <b>prescription drug coverage</b> is available at <a href="http://www.mvphealthcare.com">www.mvphealthcare.com</a> .	Generic drugs	Retail \$6 copay Mail order Not covered	Not covered	30 day supply retail
	Preferred brand drugs	Retail \$15 copay Mail order Not covered	Not covered	30 day supply retail
	Non-preferred brand drugs	Retail \$30 copay Mail order Not covered	Not covered	30 day supply retail
	Specialty drugs	Retail \$30 copay Mail order Not covered	Not covered	30 day supply retail available through Specialty Pharmacy
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery)	\$50 copay	Not covered	interruption of pregnancy is covered
	Physician/surgeon fees	\$50 copay	Not covered	interruption of pregnancy is covered
<b>If you need immediate medical attention</b>	Emergency room services	\$75 copay	\$75 copay	None, waived if admitted to hospital
	Emergency medical transportation	\$75 copay	\$75 copay	—————none—————
	Urgent care	\$25 copay	\$25 copay	—————none—————
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$150 copay	Not covered	per continuous confinement
	Physician/surgeon fee	\$50 copay	Not covered	—————none—————

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Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient	\$15 copay	Not covered	—————none—————
	Mental/Behavioral health inpatient services	\$150 copay	Not covered	including residential treatment
	Substance use disorder outpatient services	\$15 copay	Not covered	20 visits for family counseling
	Substance use disorder inpatient services	\$150 copay	Not covered	including residential treatment
<b>If you are pregnant</b>	Prenatal and postnatal	Office Visit: Covered in Full	Not covered	postnatal care visits are included in the
	Delivery and all inpatient services	\$150 copay for admission and \$50 copay for delivery	Not covered	plus \$50 physician copay
<b>If you need help recovering or have other special health needs</b>	Home health care	\$15 copay	Not covered	40 visits per year
	Rehabilitation services	\$15 copay	Not covered	60 combined PT/OT/ST visits per year
	Habilitation services	\$15 copay	Not covered	60 combined PT/OT/ST visits per year
	Skilled nursing care	\$150 copay	Not covered	200 days per calendar year
	Durable medical equipment	5% coinsurance	Not covered	standard equipment covered
	Hospice service	\$150 copay	Not covered	210 days per year
<b>If your child needs dental or eye care</b>	Eye exam	Not covered	Not covered	—————none—————
	Glasses	Not covered	Not covered	—————none—————
	Dental check-up	Not covered	Not covered	—————none—————

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**Excluded Services & Other Covered Services:**

**Services Your Plan Does NOT Cover** (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic Surgery
- Dental Care (Adult)
- Long-Term Care
- Non-Emergency care when traveling outside the US
- Private-Duty Nursing
- Routine Eye Care (Adult)
- Routine Foot Care

**Other Covered Services** (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric Surgery
- Chiropractic Care
- Hearing Aids
- Infertility Treatment
- Weight Loss Programs
- MVP Wellness Program

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## Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-888-687-6277. You may also contact your state insurance department at 1-800-342-3736 or <http://www.dfs.ny.gov/insurance/consindx.htm>

## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: MVP Health Care at 1-888-687-6277 or your state insurance department at 1-800-342-3736 or <http://www.dfs.ny.gov/insurance/consindx.htm>

The following is the New York State Department of Insurance contact information:

New York State Department of Financial Services, One Commerce Plaza, Albany, NY 12257, 1-800-342-3736 or 1-518-474-6600

Or, 25 Beaver Street, New York, NY 10004, 1-800-342-3736 or 1-212-480-6400

New York State External Appeals, P.O. Box 7209, Albany, NY 12224-0209

1-800-400-8882, 1-888-990-3991 (Expedited appeals on weekend & holidays), Email: [externalappealquestions@dfs.ny.gov](mailto:externalappealquestions@dfs.ny.gov)

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, 1-888-614-5400

[www.communityhealthadvocates.org](http://www.communityhealthadvocates.org), Email: [cha@cssny.org](mailto:cha@cssny.org)

## Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.”

**This plan or policy does provide minimum essential coverage.**

## Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value).

**This health coverage does meet the minimum value standard for the benefits it provides.**

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*—————

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## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



### This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby (normal delivery)

- **Amount owed to providers: \$7,466**
- **Plan pays** \$6,887
- **Patient pays** \$579

#### Sample care costs:

Hospital charges (mother)	\$2,714
Routine obstetric care	\$2,084
Hospital charges (baby)	\$852
Anesthesia	\$905
Laboratory tests	\$527
Prescriptions	\$173
Radiology	\$176
Vaccines, other preventive	\$35
<b>Total</b>	<b>\$7,466</b>

#### Patient pays:

Deductibles	\$0
Co-pays	\$429
Co-insurance	\$0
Limits or exclusions	\$150
<b>Total</b>	<b>\$579</b>

### Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- **Amount owed to providers: \$5,490**
- **Plan pays** \$4,162
- **Patient pays** \$1,328

#### Sample care costs:

Prescriptions	\$2,889
Medical Equipment and Supplies	\$1,311
Office Visits and Procedures	\$725
Education	\$288
Laboratory tests	\$137
Vaccines, other preventive	\$140
<b>Total</b>	<b>\$5,490</b>

#### Patient pays:

Deductibles	\$0
Co-pays	\$1328
Co-insurance	\$0
Limits or exclusions	\$0
<b>Total</b>	<b>\$1,328</b>

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## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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# Non-Discrimination Notice

MVP Health Care complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. MVP Health Care does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. MVP Health Care:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides 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, contact Jane Strange. If you believe that MVP Health Care has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Jane Strange, Civil Rights Coordinator, 625 State Street, Schenectady, NY 12305, 1-844-946-8009 (phone), 1-800-662-1220 (TTY), [CivilRightsCoordinator@mvphhealthcare.com](mailto:CivilRightsCoordinator@mvphhealthcare.com). You can file a grievance in person or by mail or email. If you need help filing a grievance, Jane Strange, Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201  
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>

## Getting Help in a Language Other than English.

This is an important document. If you need help to understand it, please call **1-844-946-8010**. We can give you an interpreter for free in the language you speak.

### Español (Spanish)

Este es un documento importante. Si necesita ayuda para entenderlo, llame al **1-844-946-8010**. Le proporcionaremos un intérprete sin ningún costo.

### 中文 (Simplified Chinese)

这是一份重要的文件。如果您需要帮助理解此文件，请打电话至 **1-844-946-8010**。我们可以为您提供相应语种的口译服务。

### 中文 (Traditional Chinese)

這是重要的文件。如果您需要獲得關於瞭解文件內容方面的協助，請致電 **1-844-946-8010**。我們可以為您免費提供您所使用語言的翻譯人員。

### Русский (Russian)

Это важный документ. Если Вам нужна помощь для понимания этого документа, позвоните по телефону **1-844-946-8010**. Мы можем бесплатно предоставить Вам переводчика Вашего языка.

### Français (French Creole)

Sa se yon dokiman ki enpòtan. Si ou bezwen èd pou konprann li, tanpri rele nimewo **1-844-946-8010**. Nou kapab ba ou yon entèprèt gratis nan lang ou pale a.

### 한국어 (Korean)

중요한 서류입니다. 이해하는 데 도움이 필요하시면 **1-844-946-8010** 번으로 연락해 주십시오. 귀하의 언어에 대한 무료 통역 서비스가 제공됩니다.

### Italiano (Italian)

Questo è un documento importante. Per qualsiasi chiarimento può chiamare il numero **1-844-946-8010**. Possiamo metterle a disposizione un interprete nella sua lingua.

### אידיש (Yiddish)

פֿאָר עט, ווייטשארפּ וצ סע פֿליה טראַד ריאַ בויאַ. טנעמוקאַד רעגיסטרוּ אַ זיאַ סאַד **1-844-946-8010**. וואָרפּש ד' וואָ לאַצפּאָ אָפּ וואָ רעשטעמלאַד אַ אָבער וואָ ריאַ אָנעק רימ. **1-844-946-8010** דעדר ריאַ סאַוּ.

### বাংলা (Bengali)

এটি এক গুরুত্বপূর্ণ নথি। এটি বুঝতে আপনার যদি সাহায্যের প্রয়োজন হয় তাহলে, অনুগ্রহ করে **1-844-946-8010** নম্বরে কল করুন। আপনি যে ভাষায় কথা বলতে বিনামূল্যে আমরা আপনাকে একজন দক্ষ ভাষী দিতে পারি।

### Polski (Polish)

To jest ważny dokument. W przypadku konieczności skorzystania z pomocy w celu zrozumienia jego treści należy zadzwonić pod numer **1-844-946-8010**. Istnieje możliwość uzyskania bezpłatnej usługi tłumacza języka, którym się posługujesz.

### العربية (Arabic)

هذه وثيقة مهمة. إذا كنت بحاجة إلى مساعدة لفهم محتواها، يُرجى الاتصال بالرقم **1-844-946-8010** يمكننا توفير مترجم فوري لك باللغة التي تتحدثها مجانًا.

### Français (French)

Ceci est un document important. Si vous avez besoin d'aide pour en comprendre le contenu, appelez le **1-844-946-8010**. Nous pouvons mettre gratuitement à votre disposition un interprète dans votre langue.

### اردو (Urdu)

یہ ایک اہم دستاویز ہے۔ اگر آپ کو اسے سمجھنے کے لیے مدد کی ضرورت ہے تو براہ کرم **1-844-946-8010** پر کال کریں۔ ہم آپ کو آپ کی مادری زبان میں ایک مفت مترجم فراہم کر سکتے ہیں۔

### Tagalog (Tagalog)

Ito ay isang mahalagang dokumento. Kung kailangan mo ng tulong para maintindihan ito, pakitawagan ang **1-844-946-8010**. Maaari ka naming bigyan ng libreng interpreter sa wikang iyong sinasalita.

### Ελληνικά (Greek)

Αυτό το έγγραφο είναι σημαντικό. Αν χρειάζεστε βοήθεια για να το κατανοήσετε, καλέστε μας στο **1-844-946-8010**. Μπορούμε να σας προσφέρουμε δωρεάν διερμηνεία στη μητρική σας γλώσσα.

### Shqip (Albanian)

Ky është një dokument i rëndësishëm. Nëse ju nevojitet ndihmë për ta kuptuar, ju lutemi të telefononi në numrin **1-844-946-8010**. Mund t'ju ofrojmë pa pagesë një interpret për gjuhën që flisni.

