



This is only a summary. Please read the FEHB Plan brochure (RI 73-465) that contains the complete terms of this plan. **All benefits are subject to the definitions, limitations, and exclusions set forth in the FEHB Plan brochure.** Benefits may vary if you have other coverage, such as Medicare. You can get the FEHB Plan brochure at www.mvphealthcare.com or by calling 1-888-687-6277.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$0 self only \$0 self and family	You must pay all the costs up to the deductible amount before this plan begins to pay for certain covered services you use. Copayments and coinsurance amounts do not count toward your deductible , which generally starts over January 1st. When a covered service or supply is subject to a deductible , only the Plan allowance for the service or supply counts toward the deductible . See the chart starting on page 2 for how much you pay for covered services after you meet the deductible and for which services are subject to the deductible .
Are there other deductibles for specific services?	Yes, for brand name prescription drugs only. Individual - \$500 Family - \$1,000	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.
Is there an out-of-pocket limit on my expenses?	\$6,600 self only \$13,200 self and family	The out-of-pocket limit , or catastrophic maximum, is the most you could pay during the year for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance billed 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 .
Is there an overall annual limit on what the plan pays?	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.
Does this plan use a network of providers?	Yes. For a list of participating providers, see www.mvphealthcare.com or call 1-888-687-6277	If you use an in-network doctor or other health care provider , 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 provider for some services. [We use the terms preferred or participating for providers in our network .] See the chart starting on page 2 for how this plan pays different kinds of providers .

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MVP Health Care: Standard Option

Summary of Benefits and Coverage

Coverage Period: 01/01/2015 – 12/31/2015

Coverage for: Self Only -or- Self and Family | Plan Type: HMO

Do I need a referral to see a specialist?	No referrals needed for participating specialists	You can see the specialist you choose without permission from this plan
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 4. See this plan's FEHB brochure for additional information about <u>excluded services</u> .

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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 Participating Provider	Your Cost If You Use a Non- Participating Provider (plus you may be balance billed)	Limitations & Exceptions
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$30 per visit	Not covered	
	Specialist visit	\$50 per visit	Not covered	
	Other practitioner office visit (chiropractor)	\$50 per visit	Not covered	You must obtain a prescription from your primary care physician
	Preventive care/screening/immunization	No charge	Not covered	
If you have a test	Diagnostic test (x-ray, blood work)	\$50 per visit for x-rays. No charge for blood work	Not covered	
	Imaging (CT/PET scans, MRIs)	\$50 per visit	Not covered	Prior authorization required
If you need drugs to treat your illness or condition	Generic drugs	Retail - \$5 Mail-order - \$12.50	Not covered	
	Preferred brand drugs	Retail - \$45 Mail-order - \$112.50	Not covered	Copays apply after brand name deductible has been met
	Non-preferred brand drugs	Retail - \$90 Mail-order - \$225.00	Not covered	Copays apply after brand name deductible has been met
More information about <u>prescription</u>				

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MVP Health Care: Standard Option
Summary of Benefits and Coverage

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Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non- Participating Provider (plus you may be balance billed)	Limitations & Exceptions
<u>drug coverage</u> is available at www.mvphealthcare.com .	Specialty drugs	Applicable Rx copays apply	Not covered	Copays apply after brand name deductible has been met
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$150 per visit	Not covered	
	Physician/surgeon fees	\$150 per visit	Not covered	
If you need immediate medical attention	Emergency room services	\$150 per visit	\$50 per visit	Benefits are available out of network for emergencies only
	Emergency medical transportation	\$100 per trip	\$100 per trip	
	Urgent care	\$30 per visit	Not covered	
If you have a hospital stay	Facility fee (e.g., hospital room)	\$750 per admission	Not covered	Inpatient hospital copay applies to all hospital confinements separated by 90 days
	Physician/surgeon fee	\$150 per visit	Not covered	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$30 per visit	Not covered	
	Mental/Behavioral health inpatient services	\$750 per admission	Not covered	
	Substance use disorder outpatient services	\$25 per visit	Not covered	
	Substance use disorder inpatient services	\$750 per admission	Not covered	
If you are pregnant	Prenatal and postnatal care	\$30 or \$50 per visit	Not covered	Copay applies to the first diagnostic visit only
	Delivery and all inpatient services	\$750 per admission	Not covered	\$200 delivery copay also applies

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MVP Health Care: Standard Option

Summary of Benefits and Coverage

Coverage Period: 01/01/2015 – 12/31/2015

Coverage for: Self Only -or- Self and Family | Plan Type: HMO

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non- Participating Provider (plus you may be balance billed)	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	\$25 per visit	Not covered	
	Rehabilitation services	\$50 per visit	Not covered	30 combined PT/OT/ST visits per year
	Habilitation services	Not covered	Not covered	Certain services covered for autism
	Skilled nursing care	No charge	Not covered	60 days per member per calendar year. Requires prior approval
	Durable medical equipment	50% co-insurance	Not covered	
	Hospice service	No charge	Not covered	210 days per lifetime. Includes 5 family bereavement visits
If your child needs dental or eye care	Eye exam	\$50 per visit	Not covered	Routine eye refractions, covered once every 24 months
	Glasses	Not covered	Not covered	
	Dental check-up	\$25 per visit	Not covered	Preventive and diagnostic services are covered for children under age 19

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check this plan's FEHB brochure for other excluded services.)

- Acupuncture
- Cosmetic Surgery
- Dental care (Adult)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check this plan's FEHB brochure for other covered services and your costs for these services.)

- Bariatric surgery – pre-authorization required
- Routine eye care (Adult)
- Chiropractic care – requires primary care doctor prescription
- Infertility treatment – applicable copayments apply

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Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending on the circumstances, you may be eligible for a 31-day free extension of coverage, to convert to an individual policy, and to receive temporary continuation of coverage (TCC). Your TCC rights will be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. An individual policy may also provide different benefits than you had while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, see the FEHB Plan brochure, contact your HR office/retirement system, contact your plan at [contact number] or visit www.opm.gov/insure/health.

Your Appeal Rights:

If you are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal**. For information about your **appeal** rights please see Section 3, “How you get care,” and Section 8 “The disputed claims process,” in your plan's FEHB brochure. If you need assistance, you can contact: [insert applicable contact information from instructions].

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.” **Coverage under this plan qualifies as 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). **The health coverage of this plan does meet the minimum value standard for the benefits the plan provides.**

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al [insert telephone number].]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [insert telephone number].]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 [insert telephone number].]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' [insert telephone number].]

—————*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: \$7,540
- Plan pays \$6,380
- Patient pays \$1,160

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$0
Copays	\$1,010
Coinsurance	\$0
Limits or exclusions	\$150
Total	\$1,160

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

- Amount owed to providers: \$5,400
- Plan pays \$4,180
- Patient pays \$1,220

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$0
Copays	\$500
Coinsurance	\$640
Limits or exclusions	\$80
Total	\$1,220

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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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