Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services
PlatinumPlus (P3-4): MetroPlus Health Plan

Coverage Period: 1/1/2024-12/31/2024
Coverage for: Child Only | Plan Type: HMO

> ⚠ 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, 1-800-303-9626 (TTY: 711). 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.metroplus.org or call 1-800-303-9626 (TTY: 711) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$0**	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	**No.**	You will have to meet the deductible before the plan pays for any services.
Are there other deductibles for specific services?	**No.**	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**$0/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, the overall family out-of-pocket limit must be 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.metroplus.org/ member-services/provider-directories or call 1-800-303-9626 (TTY: 711) 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?	**Yes.**	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist

MBR 20.208

(DT - OMB control number: 1545-0047/Expiration Date: 12/31/2019)(DOL - OMB control number: 1210-0147/Expiration date: 5/31/2022)
(HHS - OMB control number: 0938-1146/Expiration date: 05/31/2026)

Page 1 of 5

⚠ 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	$0/visit	Not covered	
	Specialist visit	$0/visit	Not covered	
	Preventive care/screening/ Immunization	$0/visit	Not covered	You may have to pay for services that aren't preventative. Ask your provider if the services needed are preventative. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	$0/visit	Not covered	
	Imaging (CT/PET scans, MRIs)	$0/visit	Not covered	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.metroplus.org/member/pharmacy	Generic drugs	$0/30 day supply	Not covered	
	Brand drugs	$0/30 day supply	Not covered	
	Specialty drugs	$0/30 day supply	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$0/visit	Not covered	
	Physician/surgeon fees	$0/visit	Not covered	
If you need immediate medical attention	Emergency room care	$0/visit	$0/visit	
	Emergency medical transportation	$0/visit	$0/visit	
	Urgent care	$0/visit	Not covered	
If you have a hospital stay	Facility fee (e.g., hospital room)	$0/visit	Not covered	
	Physician/surgeon fees	$0/visit	Not covered	

* For more information about limitations and exceptions, see the plan or policy document at www.metroplus.org.

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 need mental health, behavioral health, or substance abuse services	Outpatient services	$0/visit	Not covered	Up to 20 visits per Plan Year may be used for family counseling
	Inpatient services	$0/visit	Not covered	
If you are pregnant	Office visits	$0/visit	Not covered	
	Childbirth/delivery professional services	$0/visit	Not covered	
	Childbirth/delivery facility services	$0/admission	Not covered	
If you need help recovering or have other special health needs	Home health care	$0/visit	Not covered	40 visits per plan year.
	Rehabilitation services	$0/visit	Not covered	Outpatient: 60 visits per condition, per Plan Year combined therapies Inpatient: 60 days per Plan Year combined therapies
	Habilitation services	$0/visit	Not covered	Outpatient: 60 visits per condition, per Plan Year combined therapies Inpatient: 60 days per Plan Year combined therapies
	Skilled nursing care	$0/admission	Not covered	200 days per Plan Year Copay waived for each admission if directly transferred from hospital inpatient setting to skilled nursing facility
	Durable medical equipment	0% coinsurance	Not covered	
	Hospice services	$0/visit	Not covered	Outpatient: 5 visits for family bereavement Inpatient: 210 days per plan year.
If your child needs dental or eye care	Children's eye exam	$0/visit	Not covered	
	Children's glasses	0% coinsurance	Not covered	
	Children's dental check-up	$0/visit	Not covered	

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 • Dental care (Adult)	• Long-term care • Non-emergency care when traveling outside the U.S. • Private-duty nursing	• Routine eye care (Adult) • 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 • Chiropractic care	• Hearing aids	• Infertility treatment

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 Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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: MetroPlus Health Plan at 1-800-303-9626 (TTY:711), or Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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 1-800-303-9626 (TTY:711)
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-303-9626 (TTY:711).
Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-303-9626 (TTY:711).
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-303-9626 (TTY:711).

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

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

* For more information about limitations and exceptions, see the plan or policy document at www.metroplus.org.

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)	**Managing Joe's Type 2 Diabetes** (a year of routine in-network care of a well-controlled condition)	**Mia's Simple Fracture** (in-network emergency room visit and follow up care)

■ The plan's overall deductible	$0	■ The plan's overall deductible	$0	■ The plan's overall deductible	$0
■ Specialist copayment	$0	■ Specialist copayment	$0	■ Specialist copayment	$0
■ Hospital (facility) copayment	$0	■ Hospital (facility) copayment	$0	■ Hospital (facility) copayment	$0
■ Other coinsurance	0%	■ Other coinsurance	0%	■ Other coinsurance	0%

This EXAMPLE event includes services like:

Peg	Joe	Mia
Specialist office visits *(prenatal care)*	Primary care physician office visits *(including disease education)*	Emergency room care *(including medical supplies)*
Childbirth/Delivery Professional Services	Diagnostic tests *(blood work)*	Diagnostic test *(x-ray)*
Childbirth/Delivery Facility Services	Prescription drugs	Durable medical equipment *(crutches)*
Diagnostic tests *(ultrasounds and blood work)*	Durable medical equipment *(glucose meter)*	Rehabilitation services *(physical therapy)*
Specialist visit *(anesthesia)*		

Total Example Cost	$12,700	Total Example Cost	$5,600	Total Example Cost	$2,800

In this example, Peg would pay:

Cost Sharing		Cost Sharing		Cost Sharing	
Deductibles	$0	Deductibles	$0	Deductibles	$0
Copayments	$0	Copayments	$0	Copayments	$0
Coinsurance	$0	Coinsurance	$0	Coinsurance	$0
What isn't covered		*What isn't covered*		*What isn't covered*	
Limits or exclusions	$60	Limits or exclusions	$20	Limits or exclusions	$0
The total Peg would pay is	**$60**	**The total Joe would pay is**	**$20**	**The total Mia would pay is**	**$0**

The plan would be responsible for the other costs of these EXAMPLE covered services.