




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](http://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 <a href="#">deductible</a> ?                                | \$0  | See the Common Medical Events chart below for your costs for services this plan covers.   |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | No.  | You will have to meet the deductible before the plan pays for any services.   |
| Are there other <a href="#">deductibles</a> for specific services?              | No.  | You don't have to meet deductibles for specific services.   |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | \$1,000/individual or \$2,000 /family  | 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 <a href="#">out-of-pocket limit</a> ?               | 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 <a href="#">network provider</a> ?               | Yes. See <a href="http://www.metroplus.org/member-services/provider-directories">www.metroplus.org/member-services/provider-directories</a> 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 <a href="#">referral</a> to see a <a href="#">specialist</a> ?    | 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  |

 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<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |   |
| <b>If you visit a health care provider's office or clinic</b>   | Primary care visit to treat an injury or illness           | \$10/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. |
|   | <a href="#">Specialist</a> visit                           | \$20/visit                                   | Not covered  |   |
|   | <a href="#">Preventive care/screening/</a><br>Immunization | Covered in full                              | Not covered  |   |
| <b>If you have a test</b>   | <a href="#">Diagnostic test</a> (x-ray, blood work)        | \$20/visit                                   | Not covered  |   |
|   | Imaging (CT/PET scans, MRIs)                               | \$20/visit                                   | Not covered  |   |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.metroplus.org/member/pharmacy">www.metroplus.org/member/pharmacy</a> | Generic drugs  | \$6/30 day supply                            | Not covered  |   |
|   | Brand drugs  | \$15/30 day supply                           | Not covered  |   |
|   | <a href="#">Specialty drugs</a>                            | \$30/30 day supply                           | Not covered  |   |
| <b>If you have outpatient surgery</b>   | Facility fee (e.g., ambulatory surgery center)             | \$25/visit                                   | Not covered  |   |
|   | Physician/surgeon fees                                     | \$25/visit                                   | Not covered  |   |
| <b>If you need immediate medical attention</b>  | <a href="#">Emergency room care</a>                        | \$50/visit                                   | \$50/visit   |   |
|   | <a href="#">Emergency medical transportation</a>           | \$50/visit                                   | \$50/visit   |   |
|   | <a href="#">Urgent care</a>                                | \$30/visit                                   | Not covered  |   |
| <b>If you have a hospital stay</b>  | Facility fee (e.g., hospital room)                         | \$100 /admission                             | Not covered  |   |
|   | Physician/surgeon fees                                     | \$25/visit                                   | Not covered  |   |
| <b>If you need mental health, behavioral</b>  | Outpatient services  | \$10/visit                                   | Not covered  | Up to 20 visits per Plan Year may be used for family counseling   |

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.metroplus.org](http://www.metroplus.org).

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|---|---|---|--|---|
|   |   | Network Provider<br>(You will pay the least)          | Out-of-Network Provider<br>(You will pay the most) |   |
| <b>health, or substance abuse services</b>                            | Inpatient services                        | \$100 /admission                                      | Not covered  |   |
| <b>If you are pregnant</b>  | Office visits                             | Covered in full.                                      | Not covered  |   |
|   | Childbirth/delivery professional services | \$25/visit  | Not covered  |   |
|   | Childbirth/delivery facility services     | \$100 /admission                                      | Not covered  |   |
| <b>If you need help recovering or have other special health needs</b> | <a href="#">Home health care</a>          | \$10/visit  | Not covered  | 40 visits per plan year.  |
|   | <a href="#">Rehabilitation services</a>   | Outpatient: \$15/visit<br>Inpatient: \$100 /admission | Not covered  | Outpatient: 60 visits per condition, per Plan Year combined therapies<br>Inpatient: 60 days per Plan Year combined therapies                  |
|   | <a href="#">Habilitation services</a>     | Outpatient: \$15/visit<br>Inpatient: \$100 /admission | Not covered  | Outpatient: 60 visits per condition, per Plan Year combined therapies<br>Inpatient: 60 days per Plan Year combined therapies                  |
|   | <a href="#">Skilled nursing care</a>      | \$100 /admission                                      | Not covered  | 200 days per Plan Year<br>Copay waived for each admission if directly transferred from hospital inpatient setting to skilled nursing facility |
|   | <a href="#">Durable medical equipment</a> | 5% coinsurance after deductible                       | Not covered  |   |
|   | <a href="#">Hospice services</a>          | Outpatient: \$10/visit<br>Inpatient: \$100 /admission | Not covered  | Outpatient: 5 visits for family bereavement<br>Inpatient: 210 days per plan year.   |
| <b>If your child needs dental or eye care</b>                         | Children's eye exam                       | \$10/visit  | Not covered  |   |
|   | Children's glasses                        | 5% coinsurance  | Not covered  |   |
|   | Children's dental check-up                | \$10/visit  | Not covered  |   |

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.metroplus.org](http://www.metroplus.org).

## 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](#).)

- <Abortion>
- <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.)

- <Acupuncture>
- Bariatric surgery
- Chiropractic care
- <Dental care (Adult)>
- Hearing aids
- 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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://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](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: 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](http://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, kwijijigo 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.*

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\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.metroplus.org](http://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)

|   |       |
|---|-------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$0   |
| ■ <a href="#">Specialist</a> copay                              | \$20  |
| ■ Hospital (facility) copayment                                 | \$100 |
| ■ Other coinsurance   | 5%    |

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> |
|---------------------------|-----------------|

In this example, Peg would pay:

|                                   |              |
|-----------------------------------|--------------|
| <i>Cost Sharing</i>               |              |
| <a href="#">Deductibles</a>       | \$0          |
| <a href="#">Copayments</a>        | \$844        |
| <a href="#">Coinsurance</a>       | \$0          |
| <i>What isn't covered</i>         |              |
| Limits or exclusions              | \$60         |
| <b>The total Peg would pay is</b> | <b>\$904</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> | \$0   |
| ■ <a href="#">Specialist</a> copay                              | \$20  |
| ■ Hospital (facility) copayment                                 | \$100 |
| ■ Other coinsurance   | 5%    |

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> |
|---------------------------|----------------|

In this example, Joe would pay:

|                                   |              |
|-----------------------------------|--------------|
| <i>Cost Sharing</i>               |              |
| <a href="#">Deductibles</a>       | \$0          |
| <a href="#">Copayments</a>        | \$821        |
| <a href="#">Coinsurance</a>       | \$86         |
| <i>What isn't covered</i>         |              |
| Limits or exclusions              | \$55         |
| <b>The total Joe would pay is</b> | <b>\$962</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> | \$0   |
| ■ <a href="#">Specialist</a> copay                              | \$20  |
| ■ Hospital (facility) copayment                                 | \$100 |
| ■ Other coinsurance   | 5%    |

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> |
|---------------------------|----------------|

In this example, Mia would pay:

|                                   |              |
|-----------------------------------|--------------|
| <i>Cost Sharing</i>               |              |
| <a href="#">Deductibles</a>       | \$0          |
| <a href="#">Copayments</a>        | \$375        |
| <a href="#">Coinsurance</a>       | \$2          |
| <i>What isn't covered</i>         |              |
| Limits or exclusions              | \$0          |
| <b>The total Mia would pay is</b> | <b>\$377</b> |

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