




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 ? | \$1,650/individual or \$3,300 /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 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 |

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 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 | \$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. |
| | Specialist visit | \$20/visit | Not covered | |
| | Preventive care/screening/ Immunization | Covered in full | Not covered | |
| If you have a test | Diagnostic test (x-ray, blood work) | \$20/visit | Not covered | |
| | Imaging (CT/PET scans, MRIs) | \$20/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 | |
| | Preferred brand drugs | \$20/30 day supply | Not covered | |
| | Non-Preferred brand drugs | \$50/30 day supply | Not covered | |
| | Specialty drugs | \$50/30 day supply | Not covered | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | \$150/visit | Not covered | |
| | Physician/surgeon fees | \$150/visit | Not covered | |
| If you need immediate medical attention | Emergency room care | \$100/visit | \$100/visit | |
| | Emergency medical transportation | \$100/visit | \$100/visit | |
| | Urgent care | \$55/visit | Not covered | |
| If you have a hospital stay | Facility fee (e.g., hospital room) | \$1000/admission | Not covered | |

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

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| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | Physician/surgeon fees | \$150/visit | Not covered | |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | \$10/visit | Not covered | Up to 20 visits per Plan Year may be used for family counseling |
| | Inpatient services | \$1000/admission | Not covered | |
| If you are pregnant | Office visits | Covered in full. | Not covered | |
| | Childbirth/delivery professional services | \$150/visit | Not covered | |
| | Childbirth/delivery facility services | \$1000/admission | Not covered | |
| If you need help recovering or have other special health needs | Home health care | \$10/visit | Not covered | 40 visits per plan year. |
| | Rehabilitation services | Outpatient: \$35/visit Inpatient: \$1000/admission | Not covered | Outpatient: 60 visits per condition, per Plan Year combined therapies Inpatient: 60 days per Plan Year combined therapies |
| | Habilitation services | Outpatient: \$35/visit Inpatient: \$1000/admission | Not covered | Outpatient: 60 visits per condition, per Plan Year combined therapies Inpatient: 60 days per Plan Year combined therapies |
| | Skilled nursing care | \$1000/admission | Not covered | Unlimited Copay waived for each admission if directly transferred from hospital inpatient setting to skilled nursing facility |
| | Durable medical equipment | 10% coinsurance | Not covered | |
| | Hospice services | Outpatient: \$10/visit Inpatient: \$1000/admission | 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 | \$10/visit | Not covered | |
| | Children's glasses | 10% coinsurance | Not covered | |
| | Children's dental check-up | \$10/visit | Not covered | |

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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](#).)

- Cosmetic surgery
- Long-term care
- Non-emergency care when traveling outside the U.S.
- 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.)

- 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. 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, kwijigo 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.

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 [plan's](#) overall [deductible](#) \$0
- [Specialist](#) copay \$20
- Hospital (facility) copayment \$1000
- Other coinsurance 10%

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*)

| | |
|---------------------------|-----------------|
| Total Example Cost | \$12,700 |
|---------------------------|-----------------|

In this example, Peg would pay:

Cost Sharing

| | |
|-----------------------------|---------|
| Deductibles | \$0 |
| Copayments | \$1,150 |
| Coinsurance | \$0 |

What isn't covered

| | |
|-----------------------------------|----------------|
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$1,210 |

Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist](#) copay \$20
- Hospital (facility) copayment \$1000
- Other coinsurance 10%

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*)

| | |
|---------------------------|----------------|
| Total Example Cost | \$5,600 |
|---------------------------|----------------|

In this example, Joe would pay:

Cost Sharing

| | |
|-----------------------------|-------|
| Deductibles | \$0 |
| Copayments | \$940 |
| Coinsurance | \$0 |

What isn't covered

| | |
|-----------------------------------|--------------|
| Limits or exclusions | \$55 |
| The total Joe would pay is | \$995 |

Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist](#) copay \$20
- Hospital (facility) copayment \$1000
- Other coinsurance 10%

This EXAMPLE event includes services like:

- [Emergency room care](#) (*including medical supplies*)
- [Diagnostic test](#) (*x-ray*)
- [Durable medical equipment](#) (*crutches*)
- [Rehabilitation services](#) (*physical therapy*)

| | |
|---------------------------|----------------|
| Total Example Cost | \$2,800 |
|---------------------------|----------------|

In this example, Mia would pay:

Cost Sharing

| | |
|-----------------------------|-------|
| Deductibles | \$0 |
| Copayments | \$495 |
| Coinsurance | \$4 |

What isn't covered

| | |
|-----------------------------------|--------------|
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$499 |

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

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