




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> ?	\$2,000/individual or \$4,000 /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

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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)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$15/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	\$35/visit	Not covered	
	<a href="#">Preventive care/screening/</a> Immunization	Covered in full	Not covered	
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	\$35/visit	Not covered	
	Imaging (CT/PET scans, MRIs)	\$35/visit	Not covered	
<b>If you need drugs to treat your illness or condition</b> 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	\$10/30 day supply	Not covered	
	Brand drugs	\$30/30 day supply	Not covered	
	Non-Preferred brand drugs	\$60/30 day supply	Not covered	
	<a href="#">Specialty drugs</a>	\$60/30 day supply	Not covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$100/visit	Not covered	
	Physician/surgeon fees	\$100/visit	Not covered	
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$100/visit	\$100/visit	
	<a href="#">Emergency medical transportation</a>	\$100/visit	\$100/visit	
	<a href="#">Urgent care</a>	\$55/visit	Not covered	
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$500/admission	Not covered	

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.metroplus.org](http://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)	
	Physician/surgeon fees	\$100/visit	Not covered	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$15/visit	Not covered	Up to 20 visits per Plan Year may be used for family counseling
	Inpatient services	\$500/admission	Not covered	
<b>If you are pregnant</b>	Office visits	Covered in full.	Not covered	
	Childbirth/delivery professional services	\$100/visit	Not covered	
	Childbirth/delivery facility services	\$500/admission	Not covered	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	\$15/visit	Not covered	40 visits per plan year.
	<a href="#">Rehabilitation services</a>	Outpatient: \$25/visit Inpatient: \$500/admission	Not covered	Outpatient: 60 visits per condition, per Plan Year combined therapies Inpatient: 60 days per Plan Year combined therapies
	<a href="#">Habilitation services</a>	Outpatient: \$25/visit Inpatient: \$500/admission	Not covered	Outpatient: 60 visits per condition, per Plan Year combined therapies Inpatient: 60 days per Plan Year combined therapies
	<a href="#">Skilled nursing care</a>	\$500/admission	Not covered	Unlimited Copay waived for each admission if directly transferred from hospital inpatient setting to skilled nursing facility
	<a href="#">Durable medical equipment</a>	10% coinsurance	Not covered	
	<a href="#">Hospice services</a>	Outpatient: \$15/visit Inpatient: \$500/admission	Not covered	Outpatient: 5 visits for family bereavement Inpatient: 210 days per plan year.
<b>If your child needs dental or eye care</b>	Children's eye exam	\$15/visit	Not covered	
	Children's glasses	10% coinsurance	Not covered	
	Children's dental check-up	\$15/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](#).)

- 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](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, 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](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	\$35
■ Hospital (facility) copayment	\$500
■ 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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$1,200
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,260</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	\$35
■ Hospital (facility) copayment	\$500
■ 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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$1,450
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,505</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	\$35
■ Hospital (facility) copayment	\$500
■ 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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$540
<a href="#">Coinsurance</a>	\$4
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$544</b>

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