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?	**$775/individual or $1,550 /family**	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay.
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?	**$10,150/individual or $20,300 /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: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25/visit after deductible	Not covered	
	Specialist visit	$40/visit after deductible	Not covered	
	Preventive care/screening/ Immunization	Covered in full	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)	$40/visit after deductible	Not covered	
	Imaging (CT/PET scans, MRIs)	$40/visit after deductible	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	$10/30 day supply	Not covered	
	Brand drugs	$35/30 day supply	Not covered	
	Non-Preferred brand drugs	$70/30 day supply	Not covered	
	Specialty drugs	$70/30 day supply	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100visit after deductible	Not covered	
	Physician/surgeon fees	$100/visit after deductible	Not covered	
If you need immediate medical attention	Emergency room care	$150/visit after deductible	$150/visit after deductible	
	Emergency medical transportation	$150/visit after deductible	$150/visit after deductible	
	Urgent care	$60/visit after deductible	Not covered	

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 have a hospital stay	Facility fee (e.g., hospital room)	$1,000/admission after deductible	Not covered	
	Physician/surgeon fees	$100/visit after deductible	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25/visit after deductible	Not covered	Up to 20 visits per Plan Year may be used for family counseling
	Inpatient services	$1,000/admission after deductible	Not covered	
If you are pregnant	Office visits	Covered in full.	Not covered	
	Childbirth/delivery professional services	$100/visit after deductible	Not covered	
	Childbirth/delivery facility services	$1,000/admission after deductible	Not covered	
If you need help recovering or have other special health needs	Home health care	$25/visit after deductible	Not covered	40 visits per plan year.
	Rehabilitation services	Outpatient: $30/visit after deductible Inpatient: $1,000/admission after deductible	Not covered	Outpatient: 60 visits per condition, per Plan Year combined therapies Inpatient: 60 days per Plan Year combined therapies
	Habilitation services	Outpatient: $30/visit after deductible Inpatient: $1,000/admission after deductible	Not covered	Outpatient: 60 visits per condition, per Plan Year combined therapies Inpatient: 60 days per Plan Year combined therapies
	Skilled nursing care	$1,000/admission after deductible	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	20% coinsurance after deductible	Not covered	
	Hospice services	Outpatient: $25/visit after deductible	Not covered	Outpatient: 5 visits for family bereavement Inpatient: 210 days per plan year.

* 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: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
		Inpatient: $1,000/admission after deductible		
If your child needs dental or eye care	Children's eye exam	$25/visit after deductible	Not covered	
	Children's glasses	20% coinsurance after deductible	Not covered	
	Children's dental check-up	$25/visit after deductible	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.

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** **$775**
- **Specialist copay** **$40**
- **Hospital (facility) copayment** **$1,000**
- **Other coinsurance** **20%**

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	$600
Copayments	$1,630
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,290**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$775**
- **Specialist copay** **$40**
- **Hospital (facility) copayment** **$1,000**
- **Other coinsurance** **20%**

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	$600
Copayments	$1,525
Coinsurance	$0
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$1,420**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$775**
- **Specialist copay** **$40**
- **Hospital (facility) copayment** **$1,000**
- **Other coinsurance** **20%**

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	$600
Copayments	$720
Coinsurance	$7
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,327**

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