



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> ?                                | \$775/individual or \$1,550 /family                                                                                                                                                                            | Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay.                                                                                                                                                                                                                                                                                                   |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Yes. Your first 3 visits to a primary care, outpatient mental health or substance use disorder visit, or any combination thereof are covered before you meet your deductible.                                  | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.                                                                                                                                                                                                                                                                                                                                 |
| 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> ? | \$10,600/individual or \$21,200 /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) |                                                                                                                                                               |
| If you visit a health care <a href="#">provider's</a> office or clinic                                                                                                                                                             | Primary care visit to treat an injury or illness        | \$25/visit (first 3 visits to PCP, Outpatient Mental Health Care or Outpatient Substance Use Services not subject to Deductible)<br><br>After 3 visits, \$25/visit after deductible | Not covered                                        | 3 PCP office visits are covered before the deductible is met.                                                                                                 |
|                                                                                                                                                                                                                                    | <a href="#">Specialist</a> visit                        | \$35/visit after deductible                                                                                                                                                         | Not covered                                        |                                                                                                                                                               |
|                                                                                                                                                                                                                                    | <a href="#">Preventive care/screening/</a> 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                                                                                                                                                                                                                 | <a href="#">Diagnostic test</a> (x-ray, blood work)     | \$35/visit after deductible                                                                                                                                                         | Not covered                                        |                                                                                                                                                               |
|                                                                                                                                                                                                                                    | Imaging (CT/PET scans, MRIs)                            | \$35/visit after deductible                                                                                                                                                         | Not covered                                        |                                                                                                                                                               |
| If you need drugs to treat your illness or condition<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                                           | \$10/30 day supply                                                                                                                                                                  | Not covered                                        |                                                                                                                                                               |
|                                                                                                                                                                                                                                    | Preferred brand drugs                                   | \$40/30 day supply                                                                                                                                                                  | Not covered                                        |                                                                                                                                                               |
|                                                                                                                                                                                                                                    | Non-Preferred brand drugs                               | \$80/30 day supply                                                                                                                                                                  | Not covered                                        |                                                                                                                                                               |
|                                                                                                                                                                                                                                    | <a href="#">Specialty drugs</a>                         | \$80/30 day supply                                                                                                                                                                  | Not covered                                        |                                                                                                                                                               |
| If you have outpatient surgery                                                                                                                                                                                                     | Facility fee (e.g., ambulatory surgery center)          | \$105/visit after deductible                                                                                                                                                        | Not covered                                        |                                                                                                                                                               |
|                                                                                                                                                                                                                                    | Physician/surgeon fees                                  | \$105/visit after                                                                                                                                                                   | 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<br>(You will pay the least)                                                                                                                                        | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                              |
|                                                                           |                                                  | deductible                                                                                                                                                                          |                                                    |                                                                                                                              |
| If you need immediate medical attention                                   | <a href="#">Emergency room care</a>              | \$150/visit after deductible                                                                                                                                                        | \$150/visit after deductible                       |                                                                                                                              |
|                                                                           | <a href="#">Emergency medical transportation</a> | \$150/visit after deductible                                                                                                                                                        | \$150/visit after deductible                       |                                                                                                                              |
|                                                                           | <a href="#">Urgent care</a>                      | \$50/visit after deductible                                                                                                                                                         | Not covered                                        |                                                                                                                              |
| 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 (first 3 visits to PCP, Outpatient Mental Health Care or Outpatient Substance Use Services not subject to Deductible)<br><br>After 3 visits, \$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            | <a href="#">Home health care</a>                 | \$25/visit after deductible                                                                                                                                                         | Not covered                                        | 40 visits per plan year.                                                                                                     |
|                                                                           | <a href="#">Rehabilitation services</a>          | Outpatient: \$30/visit after deductible<br>Inpatient: \$1,000/admission after                                                                                                       | Not covered                                        | Outpatient: 60 visits per condition, per Plan Year combined therapies<br>Inpatient: 60 days per Plan Year combined therapies |

| 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) |                                                                                                                                                |
|                                               |                                           | deductible                                                                               |                                                    |                                                                                                                                                |
|                                               | <a href="#">Habilitation services</a>     | Outpatient: \$30/visit after deductible<br>Inpatient: \$1,000/admission after deductible | 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>      | \$1,000/admission after deductible                                                       | Not covered                                        | 200 days per Plan Year<br>Copoly waived for each admission if directly transferred from hospital inpatient setting to skilled nursing facility |
|                                               | <a href="#">Durable medical equipment</a> | 20% coinsurance after deductible                                                         | Not covered                                        |                                                                                                                                                |
|                                               | <a href="#">Hospice services</a>          | Outpatient: \$25/visit after deductible<br>Inpatient: \$1,000/admission after deductible | 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                       | \$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 <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .) |                                                                                                                                        |                                                                                                       |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• Long-term care</li> <li>•</li> </ul>                                                                                         | <ul style="list-style-type: none"> <li>• Non-emergency care when traveling outside the U.S.</li> <li>• Private-duty nursing</li> </ul> | <ul style="list-style-type: none"> <li>• Routine foot care</li> <li>• Weight loss programs</li> </ul> |
| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)                                                      |                                                                                                                                        |                                                                                                       |
| <ul style="list-style-type: none"> <li>• Acupuncture</li> </ul>                                                                                                                                   | <ul style="list-style-type: none"> <li>• Dental care (Adult)</li> </ul>                                                                | <ul style="list-style-type: none"> <li>• Infertility treatment</li> </ul>                             |

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

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)**

- Bariatric surgery
- Hearing aids
- Routine eye care (Adult)
- Chiropractic care

**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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## 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> | \$775   |
| ■ <a href="#">Specialist</a> copay                              | \$35    |
| ■ 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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$775          |
| <a href="#">Copayments</a>        | \$1,290        |
| <a href="#">Coinsurance</a>       | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$2,025</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> | \$775   |
| ■ <a href="#">Specialist</a> copay                              | \$35    |
| ■ 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

In this example, Joe would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$775          |
| <a href="#">Copayments</a>        | \$1,260        |
| <a href="#">Coinsurance</a>       | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$55           |
| <b>The total Joe would pay is</b> | <b>\$1,990</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> | \$775   |
| ■ <a href="#">Specialist</a> copay                              | \$35    |
| ■ 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

In this example, Mia would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$733          |
| <a href="#">Copayments</a>        | \$705          |
| <a href="#">Coinsurance</a>       | \$7            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$1,375</b> |

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