



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> ?                                | \$450/individual or \$900 /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> ?    | 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> ? | \$3,350/individual or \$6,700 /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        | \$15/visit after deductible                  | 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 after deductible                  | 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 after deductible                  | Not covered                                        |                                                                                                                                                               |
|                                                                                                                                                                                                                                           | Imaging (CT/PET scans, MRIs)                            | \$35/visit after deductible                  | 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                                           | \$9/30 day supply                            | Not covered                                        |                                                                                                                                                               |
|                                                                                                                                                                                                                                           | Brand drugs                                             | \$20/30 day supply                           | Not covered                                        |                                                                                                                                                               |
|                                                                                                                                                                                                                                           | Non-Preferred brand drugs                               | \$40/30 day supply                           | Not covered                                        |                                                                                                                                                               |
|                                                                                                                                                                                                                                           | <a href="#">Specialty drugs</a>                         | \$40/30 day supply                           | Not covered                                        |                                                                                                                                                               |
| <b>If you have outpatient surgery</b>                                                                                                                                                                                                     | Facility fee (e.g., ambulatory surgery center)          | \$75/visit after deductible                  | Not covered                                        |                                                                                                                                                               |
|                                                                                                                                                                                                                                           | Physician/surgeon fees                                  | \$75/visit after deductible                  | Not covered                                        |                                                                                                                                                               |
| <b>If you need immediate medical attention</b>                                                                                                                                                                                            | <a href="#">Emergency room care</a>                     | \$75/visit after deductible                  | \$75/visit after deductible                        |                                                                                                                                                               |
|                                                                                                                                                                                                                                           | <a href="#">Emergency medical transportation</a>        | \$75/visit after deductible                  | \$75/visit after deductible                        |                                                                                                                                                               |
|                                                                                                                                                                                                                                           | <a href="#">Urgent care</a>                             | \$50/visit after deductible                  | 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) |                                                                                                                                                |
| <b>If you have a hospital stay</b>                                               | Facility fee (e.g., hospital room)        | \$250 /admission after deductible                                                       | Not covered                                        |                                                                                                                                                |
|                                                                                  | Physician/surgeon fees                    | \$75/visit after deductible                                                             | Not covered                                        |                                                                                                                                                |
| <b>If you need mental health, behavioral health, or substance abuse services</b> | Outpatient services                       | \$15/visit after deductible                                                             | Not covered                                        | Up to 20 visits per Plan Year may be used for family counseling                                                                                |
|                                                                                  | Inpatient services                        | \$250 /admission after deductible                                                       | Not covered                                        |                                                                                                                                                |
| <b>If you are pregnant</b>                                                       | Office visits                             | Covered in full.                                                                        | Not covered                                        |                                                                                                                                                |
|                                                                                  | Childbirth/delivery professional services | \$75/visit after deductible                                                             | Not covered                                        |                                                                                                                                                |
|                                                                                  | Childbirth/delivery facility services     | \$250 /admission after deductible                                                       | Not covered                                        |                                                                                                                                                |
| <b>If you need help recovering or have other special health needs</b>            | <a href="#">Home health care</a>          | \$15/visit after deductible                                                             | Not covered                                        | 40 visits per plan year.                                                                                                                       |
|                                                                                  | <a href="#">Rehabilitation services</a>   | Outpatient: \$25/visit after deductible<br>Inpatient: \$250 /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="#">Habilitation services</a>     | Outpatient: \$25/visit after deductible<br>Inpatient: \$250 /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>      | \$250 /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> | 10% coinsurance after deductible                                                        | Not covered                                        |                                                                                                                                                |
|                                                                                  | <a href="#">Hospice services</a>          | Outpatient: \$15/visit after deductible                                                 | Not covered                                        | Outpatient: 5 visits for family bereavement<br>Inpatient: 210 days per plan year.                                                              |

| 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) |                                                        |
|                                        |                            | Inpatient: \$250 /admission after deductible |                                                    |                                                        |
| If your child needs dental or eye care | Children's eye exam        | \$15/visit after deductible                  | Not covered                                        |                                                        |
|                                        | Children's glasses         | 10% coinsurance after deductible             | Not covered                                        |                                                        |
|                                        | Children's dental check-up | \$15/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>Acupuncture</li> <li>Cosmetic surgery</li> <li>Dental care (Adult)</li> </ul>                                                                              | <ul style="list-style-type: none"> <li>Long-term care</li> <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 eye care (Adult)</li> <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>Bariatric surgery</li> <li>Chiropractic care</li> </ul>                                                                                                    | <ul style="list-style-type: none"> <li>Hearing aids</li> </ul>                                                                                             | <ul style="list-style-type: none"> <li>Infertility treatment</li> </ul>                                                             |  |

**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> | \$450 |
| ■ <a href="#">Specialist</a> copay                              | \$35  |
| ■ Hospital (facility) copayment                                 | \$250 |
| ■ 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> |
|---------------------------|-----------------|

In this example, Peg would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$450          |
| <a href="#">Copayments</a>        | \$946          |
| <a href="#">Coinsurance</a>       | \$0            |
| What isn't covered                |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$1,356</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> | \$450 |
| ■ <a href="#">Specialist</a> copay                              | \$35  |
| ■ Hospital (facility) copayment                                 | \$250 |
| ■ 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> |
|---------------------------|----------------|

In this example, Joe would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$450          |
| <a href="#">Copayments</a>        | \$1,289        |
| <a href="#">Coinsurance</a>       | \$0            |
| What isn't covered                |                |
| Limits or exclusions              | \$55           |
| <b>The total Joe would pay is</b> | <b>\$1,694</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> | \$450 |
| ■ <a href="#">Specialist</a> copay                              | \$35  |
| ■ Hospital (facility) copayment                                 | \$250 |
| ■ 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> |
|---------------------------|----------------|

In this example, Mia would pay:

| Cost Sharing                      |              |
|-----------------------------------|--------------|
| <a href="#">Deductibles</a>       | \$450        |
| <a href="#">Copayments</a>        | \$465        |
| <a href="#">Coinsurance</a>       | \$9          |
| What isn't covered                |              |
| Limits or exclusions              | \$0          |
| <b>The total Mia would pay is</b> | <b>\$824</b> |

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