



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> ?	\$2,250/individual or \$4,500 /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> ?	\$9,100/individual or \$18,200 /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 (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	\$35/visit (first 3 visits to PCP, Outpatient Mental Health Care or Outpatient Substance Use Services not subject to Deductible)  After 3 visits, \$35/visit after deductible	Not covered	
	<a href="#">Specialist</a> visit	\$55/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.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	\$55/visit after deductible	Not covered	
	Imaging (CT/PET scans, MRIs)	\$75/visit after deductible	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	\$15/30 day supply	Not covered	
	Brand drugs	\$40/30 day supply	Not covered	
	<a href="#">Specialty drugs</a>	\$80/30 day supply	Not covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$150/visit after deductible	Not covered	
	Physician/surgeon fees	\$150/visit after deductible	Not covered	
<b>If you need immediate</b>	<a href="#">Emergency room care</a>	\$500/visit after	\$500/visit after deductible	

\* 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)	
<b>medical attention</b>		deductible		
	<a href="#">Emergency medical transportation</a>	\$150/visit after deductible	\$150/visit after deductible	
	<a href="#">Urgent care</a>	\$70/visit after deductible	Not covered	
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$1,500 /admission after deductible	Not covered	
	Physician/surgeon fees	\$150/visit after deductible	Not covered	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$35/visit (first 3 visits to PCP, Outpatient Mental Health Care or Outpatient Substance Use Services not subject to Deductible)  After 3 visits, \$35/visit after deductible	Not covered	Up to 20 visits per Plan Year may be used for family counseling
	Inpatient services	\$1,500/admission after deductible	Not covered	
<b>If you are pregnant</b>	Office visits	Covered in full.	Not covered	
	Childbirth/delivery professional services	\$150/visit after deductible	Not covered	
	Childbirth/delivery facility services	\$1,500/admission after deductible	Not covered	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	\$35/visit after deductible	Not covered	40 visits per plan year.
	<a href="#">Rehabilitation services</a>	Outpatient: \$35/visit after deductible Inpatient: \$1,500/admission after deductible	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: \$35/visit	Not covered	Outpatient: 60 visits per condition, per Plan

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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)	
		after deductible Inpatient: \$1,500/admission after deductible		Year combined therapies Inpatient: 60 days per Plan Year combined therapies
	<a href="#">Skilled nursing care</a>	\$1,500/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
	<a href="#">Durable medical equipment</a>	30% coinsurance after deductible	Not covered	
	<a href="#">Hospice services</a>	Outpatient: \$35/visit after deductible  Inpatient: \$1,500/admission after deductible	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	\$35/visit after deductible	Not covered	
	Children's glasses	30% coinsurance after deductible	Not covered	
	Children's dental check-up	\$35/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> </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> <li>• Bariatric surgery</li> <li>• Chiropractic care</li> </ul>	<ul style="list-style-type: none"> <li>• Dental care (Adult)</li> <li>• Hearing aids</li> </ul>	<ul style="list-style-type: none"> <li>• Infertility treatment</li> <li>• Routine eye care (Adult)</li> </ul>

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

**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>	\$2,250
■ <a href="#">Specialist</a> copay	\$55
■ Hospital (facility) copayment	\$1,500
■ Other coinsurance	30%

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>	\$1,875
<a href="#">Copayments</a>	\$3,535
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$5,470</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>	\$2,250
■ <a href="#">Specialist</a> copay	\$55
■ Hospital (facility) copayment	\$1,500
■ Other coinsurance	30%

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>	\$1,875
<a href="#">Copayments</a>	\$2,100
<a href="#">Coinsurance</a>	\$518
<i>What isn't covered</i>	
Limits or exclusions	\$55
<b>The total Joe would pay is</b>	<b>\$4,548</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>	\$2,250
■ <a href="#">Specialist</a> copay	\$55
■ Hospital (facility) copayment	\$1,500
■ Other coinsurance	30%

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>	\$966
<a href="#">Copayments</a>	\$1,205
<a href="#">Coinsurance</a>	\$11
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,182</b>

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