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, call 1-855-809-4073 (TTY: 711) or visit www.metroplus.org. 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.healthcare.gov/sbc-glossary/ or call 1-855-809-4073 (TTY: 711) to request a copy.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$0</td>
<td>See the Common Medical Events chart below for your costs for services this plan covers.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>No</td>
<td>You will have to meet the deductible before the plan pays for any services.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>You don’t have to meet a deductible for specific services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>$200</td>
<td>The out-of-pocket limit is the most you could pay in a year for covered services.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, balance-billing charges, and health care this plan doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. See <a href="http://www.metroplus.org/member-services/provider-directories">www.metroplus.org/member-services/provider-directories</a> or call 1-855-809-4073 (TTY: 711) for a list of network providers.</td>
<td>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.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>Yes</td>
<td>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.</td>
</tr>
</tbody>
</table>
*For more information about limitations and exceptions, see the plan or policy document at [www.metroplus.org](http://www.metroplus.org).*

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider’s office or clinic</strong></td>
<td><strong>Primary care visit to treat an injury or illness</strong></td>
<td><strong>Network Provider</strong>&lt;br&gt;$0/visit (You will pay the least)**&lt;br&gt;<strong>Out-of-Network Provider</strong>&lt;br&gt;Not covered.</td>
<td><strong>Specialist visit</strong>&lt;br&gt;$0/visit&lt;br&gt;Not covered.</td>
</tr>
<tr>
<td></td>
<td><strong>Preventive care/screening/immunization</strong></td>
<td><strong>Network Provider</strong>&lt;br&gt;$0/visit (You will pay the least)**&lt;br&gt;<strong>Out-of-Network Provider</strong>&lt;br&gt;Not covered.</td>
<td><strong>You may have to pay for services that aren’t preventive. Ask your provider if the services needed are preventive. Then check with your plan will pay for.</strong></td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td><strong>Diagnostic test</strong> (x-ray, blood work)</td>
<td><strong>Network Provider</strong>&lt;br&gt;$0/visit (You will pay the least)**&lt;br&gt;<strong>Out-of-Network Provider</strong>&lt;br&gt;Not covered.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Imaging (CT/PET scans, MRIs)</strong></td>
<td><strong>Network Provider</strong>&lt;br&gt;$0/visit (You will pay the least)**&lt;br&gt;<strong>Out-of-Network Provider</strong>&lt;br&gt;Not covered.</td>
<td></td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td><strong>Generic drugs (Tier 1)</strong></td>
<td><strong>Network Provider</strong>&lt;br&gt;$1 / 30 day supply (You will pay the least)**&lt;br&gt;<strong>Out-of-Network Provider</strong>&lt;br&gt;Not covered.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Brand drugs (Tier 2)</strong></td>
<td><strong>Network Provider</strong>&lt;br&gt;$3 / 30 day supply (You will pay the least)**&lt;br&gt;<strong>Out-of-Network Provider</strong>&lt;br&gt;Not covered.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Specialty drugs (Tier 3)</strong></td>
<td><strong>Network Provider</strong>&lt;br&gt;$3 / 30 day supply (You will pay the least)**&lt;br&gt;<strong>Out-of-Network Provider</strong>&lt;br&gt;Not covered.</td>
<td></td>
</tr>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td><strong>Facility fee (e.g., ambulatory surgery center)</strong></td>
<td><strong>Network Provider</strong>&lt;br&gt;$0/visit (You will pay the least)**&lt;br&gt;<strong>Out-of-Network Provider</strong>&lt;br&gt;Not covered.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Physician/surgeon fees</strong></td>
<td><strong>Network Provider</strong>&lt;br&gt;$0/visit (You will pay the least)**&lt;br&gt;<strong>Out-of-Network Provider</strong>&lt;br&gt;Not covered.</td>
<td></td>
</tr>
<tr>
<td><strong>If you need immediate medical attention</strong></td>
<td><strong>Emergency room care</strong></td>
<td><strong>Network Provider</strong>&lt;br&gt;$0/visit (You will pay the least)**&lt;br&gt;<strong>Out-of-Network Provider</strong>&lt;br&gt;$0/visit</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Emergency medical transportation</strong></td>
<td><strong>Network Provider</strong>&lt;br&gt;$0/visit (You will pay the least)**&lt;br&gt;<strong>Out-of-Network Provider</strong>&lt;br&gt;$0/visit</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Urgent care</strong></td>
<td><strong>Network Provider</strong>&lt;br&gt;$0/visit (You will pay the least)**&lt;br&gt;<strong>Out-of-Network Provider</strong>&lt;br&gt;Not covered.</td>
<td></td>
</tr>
<tr>
<td><strong>If you have a hospital stay</strong></td>
<td><strong>Facility fee (e.g., hospital room)</strong></td>
<td><strong>Network Provider</strong>&lt;br&gt;$0/admission (You will pay the least)**&lt;br&gt;<strong>Out-of-Network Provider</strong>&lt;br&gt;Not covered.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Physician/surgeon fees</strong></td>
<td><strong>Network Provider</strong>&lt;br&gt;$0/surgery (You will pay the least)**&lt;br&gt;<strong>Out-of-Network Provider</strong>&lt;br&gt;Not covered.</td>
<td></td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------</td>
<td>-------------------</td>
<td>------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Network Provider</td>
<td>Out-of-Network Provider</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(You will pay the least)</td>
<td>(You will pay the most)</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>$0/visit</td>
<td>Not covered.</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>$0/admission</td>
<td>Not covered.</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>$0/visit</td>
<td>Not covered.</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>$0/visit</td>
<td>Not covered.</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>$0/admission</td>
<td>Not covered.</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>$0/visit</td>
<td>Not covered.</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>$0/visit</td>
<td>Not covered.</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>$0/visit</td>
<td>Not covered.</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>$0/admission</td>
<td>Not covered.</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>0% coinsurance</td>
<td>Not covered.</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>$0/visit</td>
<td>Not covered.</td>
</tr>
</tbody>
</table>

**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
- Bariatric surgery
- Cosmetic surgery
- Dental care
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care
- 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.):**

- Chiropractic care
- Hearing aids
**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 Financial Services, One State Street, New York, NY 10004-1511, 1-(800) 342-3736, [http://www.dfs.ny.gov/consumer/chealth.htm](http://www.dfs.ny.gov/consumer/chealth.htm). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](http://www.HealthCare.gov). For more information about the [Marketplace](http://www.HealthCare.gov), 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 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: Department of Labor’s Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/contactEBSA/consumerassistance.html](http://www.dol.gov/ebsa/contactEBSA/consumerassistance.html).

**Does this plan provide Minimum Essential Coverage?** Yes
If you don’t have [Minimum Essential Coverage](http://www.HealthCare.gov) for a month, you’ll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**Does this plan meet the Minimum Value Standards?** Yes
If your plan doesn’t meet the [Minimum Value Standards](http://www.HealthCare.gov), you may be eligible for a premium tax credit to help you pay for a plan through the [Marketplace](http://www.HealthCare.gov).

**Language Access Services:**
- Navajo (Dine): Dinek’ehgo shika a’t’ohwol ninisingo, kwijjigo holne’ 1-855-809-4073 (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.

<table>
<thead>
<tr>
<th>Peg is Having a Baby</th>
<th>Managing Joe’s type 2 Diabetes</th>
<th>Mia’s Simple Fracture</th>
</tr>
</thead>
<tbody>
<tr>
<td>(9 months of in-network pre-natal care and a hospital delivery)</td>
<td>(a year of routine in-network care of a well-controlled condition)</td>
<td>(in-network emergency room visit and follow up care)</td>
</tr>
<tr>
<td>The plan’s overall deductible $0</td>
<td>The plan’s overall deductible $0</td>
<td>The plan’s overall deductible $0</td>
</tr>
<tr>
<td>Specialist copayment $0</td>
<td>Specialist copayment $0</td>
<td>Specialist copayment $0</td>
</tr>
<tr>
<td>Hospital (facility) copayment $0</td>
<td>Hospital (facility) copayment $0</td>
<td>Hospital (facility) copayment $0</td>
</tr>
<tr>
<td>Other coinsurance 0%</td>
<td>Other coinsurance 0%</td>
<td>Other coinsurance 0%</td>
</tr>
</tbody>
</table>

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)

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)

This EXAMPLE event includes services like:
- Emergency room care (including medical supplies)
- Diagnostic test (x-ray)
- Durable medical equipment (crutches)
- Rehabilitation services (physical therapy)

<table>
<thead>
<tr>
<th>Total Example Cost</th>
<th>$12,725</th>
<th>Total Example Cost</th>
<th>$7,390</th>
<th>Total Example Cost</th>
<th>$1,925</th>
</tr>
</thead>
</table>

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles</th>
<th>$0</th>
<th>Copayments</th>
<th>$0</th>
<th>Coinsurance</th>
<th>$0</th>
</tr>
</thead>
</table>

What isn’t covered
- Limits or exclusions $60

The total Peg would pay is $60

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles</th>
<th>$0</th>
<th>Copayments</th>
<th>$30</th>
<th>Coinsurance</th>
<th>$0</th>
</tr>
</thead>
</table>

What isn’t covered
- Limits or exclusions $55

The total Joe would pay is $85

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles</th>
<th>$0</th>
<th>Copayments</th>
<th>$0</th>
<th>Coinsurance</th>
<th>$0</th>
</tr>
</thead>
</table>

What isn’t covered
- Limits or exclusions $40

The total Mia would pay is $40

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