



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.metroplus.org](http://www.metroplus.org) or by calling 1-877-475-3795.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	\$ 0	See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Are there other <u>deductibles</u> for specific services?	No	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	\$ 6,850 individual / \$ 13,700 family	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u> ?	All covered services are included.	The out-of-pocket limit is an aggregate over all covered services (medical, pediatric dental, pediatric vision, and prescription drugs), and includes the deductible.
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	Yes. For a list of in-network providers, see <a href="http://www.metroplus.org">www.metroplus.org</a> or call 1-877-475-3795.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a <u>specialist</u> ?	Yes. Members must get verbal or written approval from their doctor in order to see an in-network specialist.	This plan will pay some or all of the costs to see a <b>specialist</b> for covered services but only if you have the plan's permission before you see the <b>specialist</b> .
Are there services this plan doesn't cover?	Yes	See your policy or plan document for information about excluded services.

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- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **in-network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	No charge	Not covered.	---none---
	Specialist visit	No charge	Not covered.	---none---
	Other practitioner office visit	No charge	Not covered.	---none---
	Preventive care/screening/immunization	No charge	Not covered.	Mammography (limits based on age), cervical cytology, gynecological exams, bone density, prostate cancer screening, etc. per New York State mandates and the ACA Prostate cancer screening: Annual for men age 50 and over; age 40 and over if family history or risk factors; any age if prior history. Includes exam and antigen test, per mandate.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered.	---none---
	Imaging (CT/PET scans, MRIs)	No charge	Not covered.	---none---

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# MetroPlus Gold: MetroPlus Health Plan

Coverage Period: 01/01/2016-12/31/16

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual + Family | Plan Type: HMO

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
<b>If you need drugs to treat your illness or condition</b>  More information about <u>prescription drug coverage</u> is available at <a href="http://www.metroplus.org">www.metroplus.org</a>	Generic drugs	\$5 with rider	Not covered.	30 day supply per month *Mail Order for up to a 90 day supply. Mail order copays are 2 times retail.
	Formulary brand drugs	\$35 with rider	Not covered.	
	Non-Formulary brand drugs	\$70 with rider	Not covered.	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$50 copay	Not covered.	---none---
	Physician/surgeon fees	No charge	Not covered.	---none---
<b>If you need immediate medical attention</b>	Emergency room services	\$50 copay	\$50 copay	---none---
	Emergency medical transportation	No charge	No charge	---none---
	Urgent care	No charge	Not covered.	Covered with PCP referral
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$100 copay	Not covered.	---none---
	Physician/surgeon fee	No charge	Not covered.	---none---
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	No charge	Not covered.	---none---
	Mental/Behavioral health inpatient services	No charge	Not covered.	---none---
	Substance use disorder outpatient services	No charge	Not covered.	Up to 20 visits may be used by family members for family therapy related to the Member's alcohol or substance abuse
	Substance use disorder inpatient services	No charge	Not covered.	Detoxification must not exceed 5 days per admission
<b>If you are pregnant</b>	Prenatal and postnatal care	No charge	Not covered.	Mother and Newborn for up to 48 hours after childbirth; up to 96 hours after cesarean section
	Delivery and all inpatient services	No charge	Not covered.	---none---

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Coverage for: Individual + Family | Plan Type: HMO

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
<b>If you need help recovering or have other special health needs</b>	Home health care	No charge	Not covered.	40 visits Plan Year
	Rehabilitation services	No charge	Not covered.	60 visits per condition, per lifetime combined therapies
	Habilitation services	No charge	Not covered.	60 visits per condition, per lifetime combined therapies
	Skilled nursing care	No charge	Not covered.	200 days per Plan Year
	Durable medical equipment	No charge	Not covered.	Authorized by PCP and MetroPlus
	Hospice service	No charge	Not covered.	Six (6) months per Plan Year; Five (5) visits for family bereavement counseling
<b>If your child needs dental or eye care</b>	Eye exam	Not covered.	Not covered.	
	Glasses	Not covered.	Not covered.	
	Dental check-up	Not covered.	Not covered.	

## Excluded Services & Other Covered Services:

**Services Your Plan Does NOT Cover** (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

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## Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care
- Hearing aids
- Infertility treatment

## Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-877-475-3795. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877- 267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

- MetroPlus Gold Customer Services at 877-475-3795 or TTY 800- 881-2812. The appeal can be made in person or in writing. Written appeal request should be sent to MetroPlus Health Plan, Attention: Appeals Coordinator, 160 Water Street, 3rd Floor, New York, NY 10038.
- Additionally, a consumer assistance program can help you file your appeal. Contact Community Service Society Community Health Advocates at (888) 614-5400 or at [www.communityhealthadvocates.org](http://www.communityhealthadvocates.org).

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*—————

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## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



### This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby (normal delivery)

- **Amount owed to providers: \$7,540**
- **Plan pays \$7,270**
- **Patient pays \$270**

#### Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

#### Patient pays:

Deductibles	
Copays	\$120
Coinsurance	
Limits or exclusions	\$150
<b>Total</b>	<b>\$270</b>

### Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- **Amount owed to providers: \$5,400**
- **Plan pays \$5,160**
- **Patient pays \$240**

#### Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,400</b>

#### Patient pays:

Deductibles	
Copays	\$200
Coinsurance	
Limits or exclusions	\$40
<b>Total</b>	<b>\$240</b>

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## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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