MetroPlusHealth Gold Plan Summary of Benefits

2026

MetroPlusHealth

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Summary of Benefits and Coverage

What this plan covers and what you pay for covered services

MetroPlus Gold: MetroPlusHealth Gold Plan

Coverage period: July 1, 2025 – June 30, 2026

Coverage for: Individual + Family | Plan Type: HMO

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 **877.475.3795** (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 **metroplus.org** or call **877.475.3795** (TTY: 711) to request a copy.

Important questions	Answers	Why this matters
What is the overall deductible?	$0	This is the amount you owe for your care before the plan begins to pay for your care. To find your costs, please see the Common Medical Events chart on page 5.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$7,150 Individual $14,300 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, you'll need to meet the overall out-of-pocket limit.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Balance billing is when providers charge patients more than their insurance covers, especially for out-of-network care. They don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See **metroplus.org/member-services/provider-directories** or call **877.475.3795** (TTY: 711) for a list of network providers.	This plan uses a group of doctors, clinics, and hospitals called a provider network. If you go to a doctor or hospital outside of this group, the plan will not pay for it. Sometimes, a network doctor might send part of your care to someone who is not in the network (a lab, for example). It's a good idea to ask your doctor about this before getting care. If you go to someone who is not in the network, you might get a bill for the extra cost that your plan doesn't pay. This is called balance billing.
Do you need a referral to see a specialist?	Yes	Yes, be sure to get a referral to see a specialist. That way, the plan will help pay for the cost of their services.*

*For more details about what the plan does and doesn't cover, visit the certificate of coverage section How Your Coverage Works Part F: Services Not Requiring a Referral from Your PCP located at **metroplus.org/plans/nyc-employees/gold-plan.**

Common medical event	Services you may need	What you will pay		What the plan doesn't cover and other important information*
		Network provider (you will pay the least)	Out-of-network provider (you will pay the most)	
If you visit a doctor or other health care provider's office or clinic	Primary care visit to treat an injury or illness	$0/visit	Not covered	
	Specialist visit	$0/visit	Not covered	
	Preventive care (care to keep you healthy)/ screening/ immunization (shot)	$0/visit	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	Diagnostic test (X-ray, blood work)	$0/visit in freestanding labs $0/visit in hospital	Not covered	No copay for tests done in the doctor's office or clinic.
	Imaging (CT/ PET scans, MRIs)	$0/visit in freestanding labs $0/visit in hospital	Not covered	No copay for tests done in the doctor's office or clinic.
If you need drugs to treat your illness or condition To learn which drugs are covered by the prescription drug benefit, visit **metroplus.org/gold**	The Gold Plan covers over 100 frequently used prescription drugs at no cost to you. You can find out more about which drugs are covered by this discount program. Visit **metroplus.org/gold-rx-list**.**			
If you have outpatient surgery	Facility fee (for example, same day surgery center)	$0/visit	Not covered	
	Physician/ surgeon fees	$0/visit	Not covered	

* For more details about what the plan does and doesn't cover, visit the certificate of coverage located at **metroplus.org/plans/nyc-employees/gold-plan**.

** NOTE: This is a drug discount program, not a prescription drug plan benefit. Gold Plan members can get the listed drugs for free as part of its health and wellness program. To cover drugs that are not in the discount program, you can purchase a "rider." (This is insurance you add to your plan.) You may need to pay copays. To see a list of drugs covered under the rider, visit: **metroplus.org/gold-rx-list**

Common medical event	Services you may need	What you will pay		What the plan doesn't cover and other important information*
		Network provider (you will pay the least)	Out-of-network provider (you will pay the most)	
If you need medical care right away	Emergency room care	$100/visit	$100/visit	You don't have a copay if you're admitted to the hospital. Exams done under Public Health Law §2805-i are also no cost to you.
	Emergency ride to the ER or hospital	$0/visit	$0/visit	
	Urgent care	$25/visit	Not covered	
If you have a hospital stay	Facility fee (such as for hospital room)	$0/visit	Not covered	
	Physician/ surgeon fees	Included in admission copay	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$0/visit	Not covered	Unlimited: Up to 20 visits per plan year may be used for family counseling.
	Inpatient services	$0/admission	Not covered	
If you are pregnant	Office visits	Covered in full	Not covered	
	Childbirth/ delivery professional services	Included in admission copay	Not covered	
	Childbirth/ delivery facility services	$0/admission	Not covered	

* For more details about what the plan does and doesn't cover, visit the certificate of coverage located at **metroplus.org/plans/nyc-employees/gold-plan**.

Common medical event	Services you may need	What you will pay		What the plan doesn't cover and other important information*
		Network provider (you will pay the least)	Out-of-network provider (you will pay the most)	
If you need help recovering or have other special health needs	Home health care	$0/visit	Not covered	40 visits per plan year. Each visit by a Home Health Aide (HHA) is considered one (1) visit. Each visit of up to four (4) hours by an HHA is considered one (1) visit.
	Rehabilitation services	Outpatient: $0 Inpatient: $0/admission	Not covered	Outpatient: 90 visits per plan year, combined therapies. Speech and physical therapy are only covered after a hospital stay or surgery.
	Habilitation services	Outpatient: $0 Inpatient: $0/admission	Not covered	• Outpatient: 90 visits per plan year, combined therapies. • Inpatient: 90 visits per plan year, combined therapies.
	Skilled nursing care	$0/admission	Not covered	200 days per plan year
	Durable medical equipment	0% coinsurance	Not covered	
	Hospice services	0% copayment	Not covered	• Outpatient: 5 visits for family counseling • Inpatient: 210 days per plan year
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	

* For more details about what the plan does and doesn't cover, visit the certificate of coverage located at **metroplus.org/plans/nyc-employees/gold-plan**.

EXCLUDED SERVICES AND 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 services that are not covered.)

- 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

Other covered services (There may be limits to what the plan covers. This isn't a complete list. Please see your plan document.)

- Bariatric surgery
- Chiropractic care
- Hearing aids
- Infertility treatment
- Weight loss programs
- Rides to medical appointments

Your rights to keep your coverage: There are agencies that can help if you want to continue your coverage after it ends. Reach out to: Department of Labor's Employee Benefits Security Administration at 866.444.EBSA (3272) or dol.gov/ebsa/healthreform. You may be able to buy health insurance through the Health Insurance Marketplace. For more information about the Marketplace, visit HealthCare.gov or call 800.318.2596.

What you can do if you are unhappy with your plan: If you are unhappy with how your plan covers your care, there's help. You can file a complaint, called a grievance or appeal. To learn more about your rights, check the explanation of benefits you get for the claim. Your plan materials also explain how to file a complaint. For help or more information, reach out to: MetroPlus Health Plan at **800.303.9626** (TTY:711), or Department of Labor's Employee Benefits Security Administration at 866.444.EBSA (3272) or dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes
Minimum Essential Coverage (MEC) is health insurance that follows the rules set by the Affordable Care Act. Some examples include Marketplace plans, Medicare, Medicaid, CHIP, and TRICARE. If you qualify for MEC health insurance, you might not qualify for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes
Minimum Value Standards (MVS) is a rule set by the Affordable Care Act. This rule helps make sure all plans cover a certain level of care. If your plan doesn't meet the MVS, you may qualify for a premium tax credit to help pay for a Marketplace plan.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 800.303.9626 (TTY:711).
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 800.303.9626 (TTY:711).
Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 800.303.9626 (TTY:711).
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 800.303.9626 (TTY:711).

To see how the plan might cover costs, see the examples in the next section.

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* For more details about what the plan does and doesn't cover, visit the certificate of coverage located at **metroplus.org/plans/nyc-employees/gold-plan**.

About these examples:

These are not exact examples of what you would pay. They only give an idea of how the plan might cover medical care. Your costs will be different. Why? Because your costs will depend on the actual care you get, what your doctors or hospitals charge, and other details. Look at what you actually pay for care. Also look at what the plan does NOT cover. Use this information to compare different plans. Note: These examples are for one person with an individual plan.

Peg is having a baby (9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$0**
- **Specialist copay** **$0**
- **Hospital (facility) copay** **$0**
- **Other coinsurance** **0%**

This EXAMPLE 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)

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$0
Copays	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$0**

Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$0**
- **Specialist copay** **$0**
- **Hospital (facility) copay** **$0**
- **Other coinsurance** **0%**

This EXAMPLE includes services like:

Primary care doctor office visits (including disease education)
Diagnostic tests (blood work)
Prescription drugs
Durable medical equipment (glucose meter)

Total Example Cost	$5,600
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copays	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$0**

Mia's simple fracture (in-network emergency room visit and follow-up care)

- **The plan's overall deductible** **$0**
- **Specialist copay** **$0**
- **Hospital (facility) copay** **$0**
- **Emergency room copay** **$100**

This EXAMPLE includes services like:

Emergency room care (including medical supplies)
Diagnostic test (X-ray)
Durable medical equipment (crutches)
Rehabilitation services (physical therapy)

Total Example Cost	$2,800
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$0
Copays	$100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$100**

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


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Prescription Drug Rider for Certain Drugs

A. Covered prescription drugs

We cover medically necessary prescription drugs listed below that, except as specifically provided otherwise, can be dispensed only pursuant to a prescription and are:

- Required by law to bear the legend "Caution – Federal law prohibits dispensing without a prescription";
- FDA-approved;
- Ordered by a provider authorized to prescribe and within the provider's scope of practice;
- Prescribed within the approved FDA administration and dosing guidelines;
- On our formulary; and
- Dispensed by a licensed pharmacy.

We cover the following prescription drugs:

1. Prescription drugs for the detoxification or maintenance treatment of substance use disorder ("SUD medications") that are FDA-approved for the treatment of substance use disorder, including drugs for detoxification and maintenance treatment, all buprenorphine products, methadone, and long-acting injectable naltrexone, and opioid overdose reversal medication, including when dispensed over-the-counter.
2. Prescription drugs prescribed in conjunction with covered infertility treatment, in-vitro fertilization services, or fertility preservation services.
3. Contraceptive drugs, devices, and other products, including over-the-counter contraceptive drugs, devices, and other products, approved by the FDA and as prescribed or otherwise authorized under state or federal law.
    a. "Over-the-counter contraceptive products" means those products provided for in comprehensive guidelines supported by HRSA.
    b. Coverage also includes emergency contraception when provided pursuant to a prescription or order or when lawfully provided over-the-counter. You may request coverage for an alternative version of a contraceptive drug, device, and other product if the covered contraceptive drug, device, and other product is not available or is deemed medically inadvisable, as determined by your attending health care provider. You may request an exception by having your attending health care provider complete the Contraception Exception Form and sending it to us. Visit our website at **metroplus.org** or call **1.877.475.3795** (TTY: 711), the number on your ID card, to get a copy of the form or to find out more about this exception process.
4. Prescription drugs to treat diabetes, including insulin, oral hypoglycemics, and diabetic equipment and supplies if recommended or prescribed by a physician or other licensed health care professional legally authorized to prescribe under Part 121 of the New York Education Law Title 8.
5. Preventive prescription drugs (such as smoking cessation drugs), including over-the-counter drugs for which there is a written order, provided in accordance with the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA") or that have an "A" or "B" rating from the United States Preventive Services Task Force ("USPSTF").
6. Prescription drugs for pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) to prevent HIV infection.

You may request a copy of our formulary. Our formulary is also available on our website **metroplus.org**. You may inquire if a specific drug is covered under this rider by contacting us at **877.475.3795** (TTY: 711), the number on your ID card.

B. Refills

We cover refills of prescription drugs only when dispensed at a retail or mail order pharmacy and only after ¾ of the original prescription drug has been used. Benefits for refills will not be provided beyond one (1) year from the original prescription date.

C. Benefit and payment information

1. **Cost-sharing expenses.** Your cost-sharing for prescription drugs is as follows:

SUD medications; and prescription drugs for infertility treatment, in vitro fertilization and fertility preservation; PEP; and diabetic drugs, equipment, and supplies	**Participating provider member responsibility for cost-sharing**	**Non-participating provider member responsibility for cost-sharing**
Retail pharmacy – 30-day supply		
Tier 1	15% copayment, insulin covered in full	Non-participating provider services are not covered and you pay the full cost.
Tier 2	40% copayment, insulin covered in full.	Non-participating provider services are not covered and you pay the full cost.
Tier 3 Preauthorization is not required for a covered prescription drug used to treat a substance use disorder, including a prescription drug to manage opioid withdrawal and/or stabilization and for opioid overdose reversal.	50% copayment, insulin covered in full	Non-participating provider services are not covered and you pay the full cost.
Mail order pharmacy – Up to 90-day supply		
Tier 1	15% copayment, insulin covered in full	Non-participating provider services are not covered and you pay the full cost.
Tier 2	40% copayment, insulin covered in full	Non-participating provider services are not covered and you pay the full cost.
Tier 3	50% copayment, insulin covered in full	Non-participating provider services are not covered and you pay the full cost.

SUD medications; and prescription drugs for infertility treatment, in vitro fertilization and fertility preservation; PEP; and diabetic drugs, equipment, and supplies	Participating provider member responsibility for cost-sharing	Non-participating provider member responsibility for cost-sharing
Contraceptive drugs, devices, and other products		
Retail pharmacy – Up to a 12-month supply		
Tier 1	Covered in full	Non-participating provider services are not covered and you pay the full cost.
Tier 2	Covered in full	Non-participating provider services are not covered and you pay the full cost.
Tier 3	Covered in full	Non-participating provider services are not covered and you pay the full cost.
Mail order pharmacy – Up to a 12-month supply		
Tier 1	Covered in full	Non-participating provider services are not covered and you pay the full cost.
Tier 2	Covered in full	Non-participating provider services are not covered and you pay the full cost.
Tier 3	Covered in full	Non-participating provider services are not covered and you pay the full cost.
Preventive prescription drugs (including prep)		
Retail pharmacy – 30-day supply		
Tier 1	Covered in full	Non-participating provider services are not covered and you pay the full cost.
Tier 2	Covered in full	Non-participating provider services are not covered and you pay the full cost.
Tier 3	Covered in full	Non-participating provider services are not covered and you pay the full cost.
Mail order pharmacy – 90-day supply		
Tier 1	Covered in full	Non-participating provider services are not covered and you pay the full cost.
Tier 2	Covered in full	Non-participating provider services are not covered and you pay the full cost.
Tier 3	Covered in full	Non-participating provider services are not covered and you pay the full cost.

You have a three (3) tier plan design, which means that your out-of-pocket expenses will generally be lowest for prescription drugs on tier 1 and highest for prescription drugs on tier 3. Your out-of-pocket expense for prescription drugs on tier 2 will generally be more than for tier 1 but less than tier 3.

You are responsible for paying the full cost (the amount the pharmacy charges You) for any non-covered prescription drugs, and our contracted rates (our prescription drug cost) will not be available to you.

Coupons and other financial assistance. We will apply any third-party payments, financial assistance, discounts, or other coupons that help you pay your cost-sharing towards your in-network deductible and in-network out-of-pocket limit.

This provision only applies to:

1. A brand-name drug without an AB-rated generic equivalent, as determined by the FDA;
2. A brand-name drug with an AB-rated generic equivalent, as determined by the FDA, and you have accessed the brand-name drug through preauthorization or an appeal, including step-therapy protocol; and
3. All generic drugs.

2. **Participating pharmacies.** For prescription drugs purchased at a participating pharmacy, you are responsible for paying the lower of:
   - The applicable cost-sharing; or
   - The prescription drug cost for that prescription drug.

   (Your cost-sharing will never exceed the usual and customary charge of the prescription drug.)

   In the event that our participating pharmacies are unable to provide the covered prescription drug and cannot order the prescription drug within a reasonable time, you may, with our prior written approval, go to a non-participating pharmacy that is able to provide the prescription drug. We will pay you the prescription drug cost for such approved prescription drug less your required in-network cost-sharing upon receipt of a complete claim form. Contact us at **877.475.3795** (TTY: 711), the number on your ID card, or visit our website at **metroplus.org** to request approval.

3. **Non-participating pharmacies.** We will not pay for any prescription drugs that you purchase at a non-participating pharmacy other than as described above.

4. **Designated pharmacies.** We may direct you to a designated pharmacy with whom we have an arrangement to provide those prescription drugs for certain prescription drugs covered by this rider, including specialty prescription drugs.

   Generally, specialty prescription drugs are prescription drugs that are approved to treat limited patient populations or conditions; are normally injected, infused or require close monitoring by a provider; or have limited availability, special dispensing and delivery requirements and/or require additional patient supports.

5. **Mail order.** Certain prescription drugs may be ordered through our mail order pharmacy, with the exception of contraceptive drugs or devices which are available for a 12-month supply. We will only cover drugs that have a restricted distribution by the FDA or require special handling, provider coordination or patient supports through a mail order pharmacy. Other drugs may also be purchased at a mail order pharmacy. You are responsible for paying the lower of:
   - The applicable cost-sharing; or
   - The prescription drug cost for that prescription drug.

   Your cost-sharing will never exceed the usual and customary charge of the prescription drug.

   To maximize your benefit, ask your provider to write your prescription order or refill for a 90-day supply, with refills when appropriate (not a 30-day supply with three (3) refills). You may be charged the mail order cost-sharing for any prescription orders or refills sent to the mail order pharmacy regardless of the number of days supply written on the prescription order or refill.

   Prescription drugs purchased through mail order will be delivered directly to your home or office.

We will provide benefits that apply to drugs dispensed by a mail order pharmacy to drugs that are purchased from a retail pharmacy when that retail pharmacy has a participation agreement with us and/or our vendor in which it agrees to be bound by the same terms and conditions as a participating mail order pharmacy.

You or your provider may obtain a copy of the list of prescription drugs available through mail order by visiting our website at **metroplus.org** or by calling **877.475.3795** (TTY: 711), the number on your ID card.

6. **Formulary changes.** Our formulary is subject to our periodic review and modification. However, a prescription drug will not be removed from our formulary during the plan year, except when the FDA determines that such prescription drug should be removed from the market. Before we remove a prescription drug from our formulary at the beginning of the upcoming plan year, we will provide at least 90 days' notice prior to the start of the plan year. We will also post such notice on our website at **metroplus.org**.

   We will not add utilization management restrictions (e.g., Step therapy or preauthorization requirements) to a prescription drug on our formulary during a plan year unless the requirements are added pursuant to FDA safety concerns.

7. **Tier status.** A prescription drug will not be moved to a tier with a higher cost-sharing during the plan year, except a brand-name drug may be moved to a tier with higher cost-sharing if an AB-rated generic equivalent or interchangeable biological product for that prescription drug is added to the formulary at the same time. Additionally, a prescription drug may be moved to a tier with a higher copayment during the plan year, although the change will not apply to you if you are already taking the prescription drug or you have been diagnosed or presented with a condition on or prior to the start of the plan year which is treated by such prescription drug or for which the prescription drug is or would be part of your treatment regimen.

   Before we move a prescription drug to a different tier, we will provide at least 90 days' notice prior to the start of the plan year. We will also post such notice on our website at **metroplus.org**. If a prescription drug is moved to a different tier during the plan year for one of reasons described above, we will provide at least 30 days' notice before the change is effective. You will pay the cost-sharing applicable to the tier to which the prescription drug is assigned. You may access the most up to date tier status on our website at **metroplus.org** or by calling **1.877.475.3795** (TTY: 711), the number on your ID card.

8. **Formulary exception process.** If a prescription drug in a category that is covered under this rider is not on our formulary, you, your designee or your prescribing health care professional may request a formulary exception for a clinically-appropriate prescription drug in writing, electronically or telephonically. The request should include a statement from your prescribing health care professional that all formulary drugs will be or have been ineffective, would not be as effective as the non-formulary drug, or would have adverse effects. If coverage is denied under our standard or expedited formulary exception process, you are entitled to an external appeal as outlined in the External Appeal section of the certificate. Visit our website at **metroplus.org** or call **877.475.3795** (TTY: 711), the number on your ID card, to find out more about this process.

   Standard review of a formulary exception. We will make a decision and notify you or your designee and the prescribing health care professional by telephone and in writing no later than 72 hours after our receipt of your request. We will notify you in writing within three (3) business days of receipt of your request. If we approve the request, we will cover the prescription drug while you are taking the prescription drug, including any refills.

   Expedited review of a formulary exception. If you are suffering from a health condition that may seriously jeopardize your health, life or ability to regain maximum function or if you are undergoing a current course of treatment using a non-formulary prescription drug, you may request an expedited review of a formulary exception. The request should include a statement from your prescribing health care professional that harm could reasonably come to you if the requested drug is not provided within the timeframes for our standard formulary exception process. We will make a decision and notify you or your designee and the prescribing health care professional by telephone and in writing no later than 24 hours after our receipt of your request. We will notify you in writing within three (3) business days of receipt of your request. If we approve the request, we will cover the prescription drug while you suffer from the health condition that may seriously jeopardize your health, life or ability to regain maximum function, or for the duration of your current course of treatment using the non-formulary prescription drug.

9. **Supply limits.** Except for contraceptive drugs, devices or products, we will pay for no more than a 30-day supply of a prescription drug purchased at a retail pharmacy. You are responsible for one (1) cost-sharing amount for up to a 30-day supply. However, for maintenance drugs we will pay for up to a 90-day supply of a drug purchased at a retail pharmacy. You are responsible for up to three (3) cost-sharing amounts for a 90-day supply at a retail pharmacy.

   You may have the entire supply (of up to 12 months) of the contraceptive drug, device, or product dispensed at the same time. contraceptive drugs, devices, or products are not subject to cost-sharing when provided by a participating pharmacy.

   Benefits will be provided for prescription drugs dispensed by a mail order pharmacy in a quantity of up to a 90-day supply. You are responsible for one (1) cost-sharing amount for a 30-day supply up to a maximum of three (3) cost-sharing amounts for a 90-day supply.

   Specialty prescription drugs may be limited to a 30-day supply when obtained at a retail or mail order pharmacy. You may access our website at **metroplus.org** or by calling **877.475.3795** (TTY: 711), the number on your ID card, for more information on supply limits for specialty prescription drugs.

   Some prescription drugs may be subject to quantity limits based on criteria that we have developed, subject to our periodic review and modification. The limit may restrict the amount dispensed per prescription order or refill and/or the amount dispensed per month's supply. You can determine whether a prescription drug has been assigned a maximum quantity level for dispensing by accessing our website at **metroplus.org** or by calling **1.877.475.3795** (TTY: 711), the number on your ID card. If we deny a request to cover an amount that exceeds our quantity level, you are entitled to an appeal pursuant to the utilization review and external appeal sections of the certificate.

10. **Emergency refill during a state disaster emergency.** If a state disaster emergency is declared, you, your designee, or your health care provider on your behalf, may immediately get a 30-day refill of a prescription drug you are currently taking that is covered under this rider. You will pay the cost-sharing that applies to a 30-day refill. Certain prescription drugs, as determined by the New York Commissioner of Health, are not eligible for this emergency refill, including schedule II and III controlled substances.

D. Medical management

This rider includes certain features to determine when prescription drugs should be covered, which are described below. As part of these features, your prescribing provider may be asked to give more details before we can decide if the prescription drug is medically necessary.

1. **Preauthorization.** Preauthorization may be needed for certain prescription drugs to make sure proper use and guidelines for prescription drug coverage are followed. When appropriate, we will contact your provider to determine if preauthorization should be given ask your provider to complete a preauthorization form your provider will be responsible for obtaining preauthorization for the prescription drug. should you choose to purchase the prescription drug without obtaining preauthorization, you must pay for the cost of the entire prescription drug and submit a claim to us for reimbursement. Preauthorization is not required for SUD medications, including opioid overdose reversal medications prescribed or dispensed to you.

   For a list of prescription drugs that need preauthorization, please visit our website at **metroplus.org** or call **1.877.475.3795** (TTY: 711), the number on your ID card. The list will be reviewed and updated from time to time. We also reserve the right to require preauthorization for any new prescription drug on the market. However, we will not add preauthorization requirements to a prescription drug on our formulary during a plan year unless the requirements are added pursuant to FDA safety concerns. Your provider may check with us to find out which prescription drugs are covered.

2. **Step therapy.** Step therapy is a process in which you may need to use one (1) or more types of prescription drug before we will cover another as medically necessary. A "step therapy protocol" means our policy, protocol or program that establishes the sequence in which we approve prescription drugs for your medical condition. When establishing a step therapy protocol, we will use recognized evidence-based and peer reviewed clinical review criteria that also takes into account the needs of atypical patient populations and diagnoses. We check certain prescription drugs to make sure that proper prescribing guidelines are followed. These guidelines help you get high quality and cost-effective prescription drugs. the prescription drugs that

require preauthorization under the step therapy program are also included on the preauthorization drug list. If a step therapy protocol is applicable to your request for coverage of a prescription drug, you, your designee, or your health care professional can request a step therapy override determination as outlined in the utilization review section of the certificate. We will not add step therapy requirements to a prescription drug on our formulary during a plan year unless the requirements are added pursuant to FDA safety concerns.

E. Limitations/terms of coverage

1. We reserve the right to limit quantities, day supply, early refill access and/or duration of therapy for certain prescription drugs based on medical necessity including acceptable medical standards and/or FDA recommended guidelines.
2. If we determine that you may be using a prescription drug in a harmful or abusive manner, or with harmful frequency, your selection of participating pharmacies may be limited. If this happens, we may require you to select a single participating pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the selected single participating pharmacy. If you do not make a selection within 31 days of the date, we notify you, we will select a single participating pharmacy for you.
3. Various specific and/or generalized "use management" protocols will be used from time to time in order to ensure appropriate utilization of prescription drugs. Such protocols will be consistent with standard medical/drug treatment guidelines. The primary goal of the protocols is to provide our members with a quality-focused prescription drug benefit. In the event a use management protocol is implemented, and you are taking the drug(s) affected by the protocol, you will be notified in advance.
4. Injectable drugs (other than self-administered injectable drugs) are not covered under this section but are covered under other sections of the certificate.
5. We do not cover charges for the administration or injection of any prescription drug. Prescription drugs given or administered in a physician's office are covered under other sections of the certificate.
6. We do not cover drugs that do not by law require a prescription, except for smoking cessation drugs, over-the-counter preventive drugs or devices provided in accordance with the comprehensive guidelines supported by HRSA or with an "A" or "B" rating from USPSTF, or as otherwise provided in this rider. We do not cover prescription drugs that have over-the-counter non-prescription equivalents, except if specifically designated as covered in the drug formulary. Non-prescription equivalents are drugs available without a prescription that have the same name/chemical entity as their prescription counterparts. We do not cover repackaged products such as therapeutic kits or convenience packs that contain a covered prescription drug unless the prescription drug is only available as part of a therapeutic kit or convenience pack. Therapeutic kits or convenience packs contain one (1) or more prescription drug(s) and may be packaged with over-the-counter items, such as gloves, finger coats, hygienic wipes or topical emollients.
7. We do not cover prescription drugs to replace those that may have been lost or stolen.
8. We do not cover prescription drugs dispensed to you while in a hospital, nursing home, other institution, facility, or if you are a home care patient, except in those cases where the basis of payment by or on behalf of you to the hospital, nursing home, home health agency or home care services agency, or other institution, does not include services for drugs.
9. We reserve the right to deny benefits as not medically necessary or experimental or investigational for any drug prescribed or dispensed in a manner contrary to standard medical practice. If coverage is denied, you are entitled to an appeal as described in the utilization review and external appeal sections of the certificate.
10. A pharmacy need not dispense a prescription order that, in the pharmacist's professional judgment, should not be filled.

F. General conditions

1. You must show your ID card to a retail pharmacy at the time you obtain your prescription drug or you must provide the pharmacy with identifying information that can be verified by us during regular business hours. You must include your id number on the forms provided by the mail order pharmacy from which you make a purchase.

2. **Drug utilization, cost management and rebates.** We conduct various utilization management activities designed to ensure appropriate prescription drug usage, to avoid inappropriate usage, and to encourage the use of cost-effective drugs. Through these efforts, you benefit by obtaining appropriate prescription drugs in a cost-effective manner. The cost savings resulting from these activities are reflected in the premiums for your coverage.

   We may also, from time to time, enter into agreements that result in us receiving rebates or other funds ("rebates") directly or indirectly from prescription drug manufacturers, prescription drug distributors or others. Any rebates are based upon utilization of prescription drugs across all of our business and not solely on any one member's utilization of prescription drugs. Any rebates received by us may or may not be applied, in whole or part, to reduce premiums either through an adjustment to claims costs or as an adjustment to the administrative expenses component of our prescription drug premiums. Any such rebates may be retained by us, in whole or part, in order to fund such activities as new utilization management activities, community benefit activities and increasing reserves for the protection of members. Rebates will not, may change, or reduce the amount of any copayment or coinsurance applicable under our prescription drug coverage. If a prescription drug is eligible for a rebate, most of the rebate will be used to reduce the allowed amount for the prescription drug. Your deductible or coinsurance is calculated using that reduced allowed amount. The remaining value of that rebate will be used to reduce costs for all members enrolled in coverage. Not all prescription drugs are eligible for a rebate, and rebates can be discontinued or applied at any time based on the terms of the rebate agreements. Because the exact value of the rebate will not be known at the time you purchase the prescription drug, the amount of the rebate applied to your claim will be based on an estimate. Payment on your claim and your cost-sharing will not be adjusted if the later-determined rebate value is higher or lower than our estimate.

G. Definitions

Terms used in this rider are defined as follows. (Other defined terms can be found in the definitions section of the certificate.)

1. **Brand-name drug:** A prescription drug that: 1) is manufactured and marketed under a trademark or name by a specific drug manufacturer; or 2) we identify as a brand-name prescription drug, based on available data resources. All prescription drugs identified as "brand name" by the manufacturer, pharmacy, or your physician may not be classified as a brand-name drug by us.
2. **Designated pharmacy:** A pharmacy that has entered into an agreement with us or with an organization contracting on our behalf, to provide specific prescription drugs, including but not limited to, specialty prescription drugs. The fact that a pharmacy is a participating pharmacy does not mean that it is a designated pharmacy.
3. **Formulary:** The list that identifies those prescription drugs for which coverage may be available under this rider. To determine which tier a particular prescription drug has been assigned, visit our website at **metroplus.org** or call **1.877.475.3795** (TTY: 711), the number on your ID card.
4. **Generic drug:** A prescription drug that: 1) is chemically equivalent to a brand-name drug; or 2) we identify as a generic prescription drug based on available data resources. All prescription drugs identified as "generic" by the manufacturer, pharmacy or your physician may not be classified as a generic drug by us.
5. **Maintenance drug:** A prescription drug used to treat a condition that is considered chronic or long-term and which usually requires daily use of prescription drugs.
6. **Non-participating pharmacy:** A pharmacy that has not entered into an agreement with us to provide prescription drugs to members. We will not make any payment for prescriptions or refills filled at a non-participating pharmacy other than as described above.
7. **Participating pharmacy:** A pharmacy that has:
   - Entered into an agreement with us or our designee to provide prescription drugs to members;
   - Agreed to accept specified reimbursement rates for dispensing prescription drugs; and
   - Been designated by us as a participating pharmacy. A participating pharmacy can be either a retail or mail-order pharmacy.

8. **Prescription drug:** A medication, product, or device that has been approved by the FDA and that can, under federal or state law, be dispensed only pursuant to a prescription order or refill and is on our formulary. A prescription drug includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver.
9. **Prescription drug cost:** The amount, including a dispensing fee and any sales tax, we have agreed to pay our participating pharmacies; as contracted between us and our pharmacy benefit manager for a covered prescription drug dispensed at a participating pharmacy. If your rider includes coverage at non-participating pharmacies, the prescription drug cost for a prescription drug dispensed at a non-participating pharmacy is calculated using the prescription drug cost that applies for that particular prescription drug at most participating pharmacies.
10. **Prescription order or refill:** The directive to dispense a prescription drug issued by a duly licensed health care professional who is acting within the scope of his or her practice.
11. **Usual and customary charge:** The usual fee that a pharmacy charges individuals for a prescription drug without reference to reimbursement to the pharmacy by third parties as required by New York Education Law Section 6826-a.

H. Controlling certificate

All of the terms, conditions, limitations, and exclusions of your certificate to which this rider is attached shall also apply to this rider except where specifically changed by this rider.

Age 29 Coverage Rider

Rider to cover young adults through age 29

This rider (add-on) was chosen by your employer. It allows your children to stay on your plan longer. They will also be covered by other similar riders you buy.

A. Young adults covered through age 29.

If you selected parent and child/children or family coverage, your young adult child will be covered until the end of the month they turn 30, as long as:

1. They are not married.
2. They don't have health insurance through their own job. Also, they don't qualify for health insurance through their job.
3. They live, work or reside in New York State or our service area. ("Reside" means they have a legal right to live in the state or our service area.)

The young adult does not have to live with you, be a student, or be supported by you. This rider does not cover their children. It will cover your young adult until the end of the month they turn 30.

B. Controlling certificate.

All of your health plan's rules and limits hold true for this rider, unless the rider's rules disagree with your plan's rules.

C. Can your child buy a rider to cover them through age 29?

Your child may be able to buy their own rider under your employer plan (group contract) to cover them through age 29. But they can do so if they:

1. Are under 30.
2. Are not married.
3. Don't have health insurance through their job, or don't quality for it through their job.
4. Live, work or reside in New York State of our service area.
5. Don't have Medicare.

✓MetroPlus**Health**

Gold Exercise Facility Reimbursement Form

Need an incentive to get back in the gym? MetroPlusHealth has what you're looking for.

As a MetroPlusHealth Gold member, we want to help you stay healthy. To help you do this, MetroPlusHealth may reimburse you up to $1,400 per year to help you pay for your fitness membership ($250 per Member, $250 per Spouse every six months, $100 every six months per dependent, up to 2 dependents).

What types of health clubs qualify? The exercise facility must promote cardiovascular wellness, such as a health center that has at least two or more pieces of equipment or a program that incorporates the following: elliptical, cross-trainer, group exercise, pool, stationary bike, step machine/climber, treadmill, or walking and running.

How do I become eligible? In order to be eligible, you must be an active member of the exercise facility. Your membership with MetroPlusHealth must be current and paid to date at time of submission.

If you are eligible to receive Health and Fitness Reimbursement through the New York City Management Benefits Fund, you are not eligible to receive reimbursement through MetroPlusHealth.

Exclusions:

* The program does not reimburse expenses incurred for equipment, locker rentals, clothing, vitamins, or other services that might be offered by the facility for an additional fee (massages, personal trainers, etc.).

For a full list of exclusions, please review your Certificate of Coverage.

How do I obtain the reimbursement? A 6-month claim period must be completed to submit a request. The 6-month period must be consecutive with no breaks in coverage.

- Submit a copy of your current bill which shows the fee paid for your membership.
- Submit proof of payment. Acceptable proof includes: Payment receipts (must have the same name as the health club), credit card statements, printout on health club letterhead detailing payments.
- Submit all required documentation no later than 120 days from the claim period end date.
- **Email or mail your form to MetroPlusHealth at:**

MetroPlusHealth
Att: Customer Services Department
50 Water Street, 7th Fl.
New York, NY 10004

EMAIL: mph_reimbursements@metroplus.org

✓MetroPlus**Health**

Gold Exercise Facility Reimbursement Form

Important: Please complete the form in its entirety or the processing of your claim may be delayed or denied. Any missing documentation must be submitted within 30 days of notice. Please complete one form (per member) for each six month period for which you are submitting a claim. Note: This may be a taxable benefit. Please check with your accountant. If you have any questions, please call our exclusive line for Gold Members at 1.877.475.3795 (TTY: 711).

PLEASE PRINT. MEMBER INFORMATION:			
MetroPlusHealth ID Number:	Last Name:	First Name:	Middle Initial:
Address (Number, Street, Apt. #):	City:	State:	Zip Code:
Six-Month Period Requested (mm/dd/yyyy — mm/dd/yyyy):	to		
ACCOUNT HOLDER INFORMATION:			
ID Number:	Last Name:	First Name:	Middle Initial:
HEALTH CLUB INFORMATION:			
Gym / Health Club's Name:	City, State:		
Phone Number (xxx) xxx-xxxx:	Amount Being Claimed:		
	$		

I certify that the information on the form and all supporting documents are complete, accurate and unaltered, and that I am NOT eligible for this reimbursement through the NYC Management Benefits Fund.

Member's Signature: _____ **Date:** _____

Gym Representative's Signature: _____ **Date:** _____

Account Holder's Signature: _____ **Date:** _____
(To be signed if the Member is under age 18)

Alteration or falsification of any information or documentation will be subject to disqualification from participation in the gym reimbursement program.

If you need assistance because you are hearing impaired and / or speech impaired, please call TTY: 711.
Please be advised that oral interpretation and written materials in other languages are available as needed.

✓MetroPlus**Health**

Gold Wellness App Reimbursement Form

As a MetroPlusHealth member, we want to help you stay healthy.

MetroPlusHealth may reimburse you up to $300 per year to help you pay for your wellness and fitness applications (apps).

Single Basic Plan: $150 per subscriber every six months.
Family Basic Plan: $100 per subscriber; $50 for qualifying spouse every six months.

If allocated portion of reimbursement is not utilized by spouse or the family plan consists of subscriber and children only, subscriber may utilize entire reimbursement amount of $150 every six months.

Which Wellness and Fitness Apps can be used? Apps are exclusively limited to the list below (there are no exceptions, additions, or modifications):

- Calm
- CitiBike
- HeadSpace
- Lifesum
- MyFitnessPal
- Equinox+
- Noom
- One Peleton
- Sleep Cycle
- Strava
- WW (Weight Watchers)
- ClassPass

Exclusions: The following are **not covered by MetroPlusHealth** as part of your Plan's Wellness Benefit program:

- The cost of food, beverages, supplements, vitamins or other items associated with the App, including books, scales, exercise equipment, one-time initiation and / or termination fees.
- The reimbursement is limited to membership fee.
- Subscriber and their Spouse are limited to the use of two Apps each per 6-month reimbursement period, not to exceed the maximum amount of $150 reimbursement per household.

For a full list of exclusions, please review your Certificate of Coverage.

How do I become eligible? In order to be eligible, you must be an active member of the Wellness App. Your membership with MetroPlusHealth must be current at time of submission.

How do I obtain the reimbursement? Reimbursement must be requested within 120 days of the end of the six (6)-month period. Reimbursement will be issued only after you have completed each six (6)-month period.

- Proof of payment for a qualifying Wellness / Fitness App for a consecutive 6-month period must be included with the reimbursement form.
- Submit proof of payment. Acceptable proof includes: Payment receipts (must have the same name as the Wellness / Fitness App), credit card statements, printout on Wellness / Fitness App's letterhead detailing payments.
- Submit all required documentation no later than 120 days from the claim period end date.
- **Email or mail your form to MetroPlusHealth at:**

MetroPlusHealth
Att: Customer Services Department
50 Water Street, 7th Fl.
New York, NY 10004

EMAIL: mph_reimbursements@metroplus.org

✓MetroPlus**Health**

Gold Wellness App Reimbursement Form

Important: Please complete the form in its entirety or the processing of your claim may be delayed or denied. Any missing documentation must be submitted within 30 days of notice. Please complete one form (per member) for each six month period for which you are submitting a claim. Note: This may be a taxable benefit. Please check with your accountant. If you have any questions, please call our exclusive line for Gold Members at 1.877.475.3795 (TTY: 711).

PLEASE PRINT.			
MetroPlusHealth ID Number:	Last Name:	First Name:	Middle Initial:
Address (Number, Street, Apt. #):	City:	State:	Zip Code:
Six-Month Period Requested (mm/dd/yyyy — mm/dd/yyyy):		to	
ACCOUNT HOLDER INFORMATION:			
ID Number:	Last Name:	First Name:	Middle Initial:
WELLNESS / FITNESS APP INFORMATION:			
Wellness / Fitness App's Name:			
Wellness / Fitness App's Website		Amount Being Claimed:	
		$	

I certify that the information on the form and all supporting documents are complete, accurate and unaltered.

Member's Signature: _____ **Date:** _____

Account Holder's Signature: _____ **Date:** _____

Alteration or falsification of any information or documentation will be subject to disqualification from participation in the Wellness Benefit reimbursement program.

If you need assistance because you are hearing impaired and / or speech impaired, please call TTY: 711.
Please be advised that oral interpretation and written materials in other languages are available as needed.

✓MetroPlus**Health**

TRANSPORTATION REIMBURSEMENT FORM

As a MetroPlusHealth Gold member, we want to help you stay healthy.

To help you do this, MetroPlusHealth will reimburse you up to $60 per plan year or the full cost of one ride (whichever is lower) for transportation to see a doctor.

What types of transportation qualify?

All varieties of taxis, car service, rideshare apps such as Uber or Lyft, qualify. Reimbursement is only for single rides via an approved modality (for instance, a $15 metrocard does not qualify).

How do I become eligible?

In order to be eligible, you must be an active subscriber of **MetroPlus Gold.**

How do I obtain the reimbursement?

Obtaining reimbursement is easy! Simply complete and submit this form. You may combine multiple trips into a single reimbursement form, however **MetroPlusHealth** will not accept reimbursement requests which are received by us more than 120 days from the date of the trip.

- **Complete the reimbursement form included with this document**
- **Submit proof of payment.** Acceptable proof includes: Payment receipts, screenshot(s) from a rideshare application, a credit card statement which shows payment for the ride
- **Submit all required documentation no later than 120 days from the date of the trip**
- **Mail** or **fax your form to MetroPlusHealth at the following address:**

MetroPlus Health Plan
Att: Customer Services Department
50 Water Street, 7th Floor
New York, NY 10004

Email: mph_reimbursements@metroplus.org

IMPORTANT: Please complete the form in its entirety or the processing of your claim may be delayed or denied.

If you have any questions, please call our exclusive line for Gold Members at 877.475.3795 (TTY: 711).

PLEASE PRINT. SUBSCRIBER INFORMATION (PERSON WHO HOLDS COVERAGE):			
Member ID Number:	**Last Name:**	**First Name:**	**Middle Initial:**
Address (Number, Street, Apt. #):	**City:**	**State:**	**Zip Code:**

TRIP 1 DETAILS:	
Name of Transportation Provider:	
Date of Trip:	**Trip Amount:**
Medical Office Address:	

TRIP 2 DETAILS:	
Name of Transportation Provider:	
Date of Trip:	**Trip Amount:**
Medical Office Address:	

TRIP 3 DETAILS:	
Name of Transportation Provider:	
Date of Trip:	**Trip Amount:**
Medical Office Address:	

TRIP 4 DETAILS:	
Name of Transportation Provider:	
Date of Trip:	**Trip Amount:**
Medical Office Address:	

TOTAL AMOUNT OF REIMBURSEMENT REQUESTED: _____

Please attach appropriate documentation of payment for the trips for which you are seeking reimbursement, including receipts, screenshots of the rideshare app showing payment, credit card statements.

I certify that the information on the form and all supporting documents are complete, accurate and unaltered.

Member's Signature: _____ **Date:** _____

Alteration or falsification of any information or documentation will be subject to disqualification from participation in the reimbursement program.

If you need assistance because you are hearing impaired and / or speech impaired, please call TTY: 711. Please be advised that oral interpretation and written materials in other languages are available as needed. MBR 25.338 6-25

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MBR 25.483