

MetroPlus Platinum Plan (HMO) 2027 Summary of Benefits

This is a summary of drug and health services covered by MetroPlus Platinum Plan (HMO)
January 1, 2027 – December 31, 2027

MetroPlus Platinum Plan is an HMO plan with a Medicare contract. Enrollment in the Plan depends on contract renewal.

MetroPlusHealth



Name _____

Phone _____

Email _____

Our **MetroPlus Platinum Plan (HMO)** offers members all the benefits of Original Medicare, a robust network of providers in all five boroughs, and new benefits such as an OTC card and comprehensive dental coverage — **all for a $0 premium,** plus a great Member Rewards program!



Please contact **Member Services** at **866.986.0356** for additional information (TTY users should call 711). Hours are Monday to Friday, 8am to 8pm, and Saturday, 9am to 5pm. After-hours answering service: 800.442.2560. This call is free.



Dental Services: 866.986.0356 (TTY: 711)
Or contact DentaQuest at 844.831.9099



Vision Services: 866.986.0356 (TTY: 711)

MetroPlus Platinum Plan (HMO) is a Medicare Advantage plan that offers the benefits of Original Medicare plus much more. What makes you eligible to be a plan member?

- You have both Medicare Part A and Medicare Part B
- You live in one of these counties: Bronx, Kings, New York, Queens, or Richmond
- You are a United States citizen or are lawfully present in the United States

MetroPlusHealth is dedicated to making healthcare easy for you. We can help you maximize your benefits, support your health needs, answer your questions, and connect you to the right resources, with no referrals needed to see specialists. If you think you may have Medicaid, Extra Help (also known as Low Income Subsidy), or Medicare Savings Program, we may have a plan that is a better fit for you. Visit **metroplusmedicare.org** to view a copy of the Evidence of Coverage, or please contact our Member Services at **866.986.0356** for additional information (TTY users should call 711). Hours are Monday to Friday, 8am to 8pm, and Saturday, 9am to 5pm. After-hours answering service: 800.442.2560. This call is free.

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Pre-enrollment Checklist (PECL)

Before making an enrollment decision, it is important that you fully understand our benefits and rules. The items below must be reviewed before an enrollment is completed. If you have any questions, call our Help Line to view a copy of the EOC.

☐ The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit **metroplusmedicare.org** to view a copy of the EOC**,** or please contact Member Services at **866.986.0356** for additional information (TTY users should call 711). Hours are Monday to Friday, 8am to 8pm, and Saturday, 9am to 5pm. After-hours answering service: 800.442.2560. This call is free.

☐ Review the Provider/Pharmacy (or ask your doctor) to make sure your current providers (primary care and specialists) are in the network. If they are not listed, it means you will likely have to select a new provider.

☐ Are there any other preferred facilities that need to be in-network? If yes, please explain:

_____

_____

☐ Is your hospital in-network? If it is not in network, you will need to pick a new hospital in network.

☐ Review the Provider/Pharmacy directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for the beneficiary prescriptions.

☐ Understand that the Medicare Prescription Payment Plan program information will be sent to you and will be included with your member ID card mailing upon enrollment.

☐ Did you review the formulary to make sure your drugs are covered? If not, you may need to pay the full cost of those prescriptions.

☐ Do you have any other health care needs, such as needing durable medical equipment, physical therapy? If yes, please explain:

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_____

Understanding Important Rules as follows:

- ☐ In addition to your monthly plan premium, if a plan premium applies to you (in some of our plans, members pay a $0 premium), you must continue to pay your Medicare Part B premium. This premium is normally taken out of the beneficiary Social Security check each month.
- ☐ Except for emergency situations, urgent care situations, or certain state/federal mandates, we generally do not cover services performed by out-of-network providers (providers that are not listed in our provider directory).
- ☐ If you are enrolling into one of our Dual Eligible Special Needs plans — either MetroPlus Advantage Plan (HMO D-SNP) or MetroPlus UltraCare (HMO D-SNP) — your ability to enroll will be based on verification that you are entitled to both Medicare and medical assistance from a state plan under Medicaid. If you are enrolling in our MetroPlus Platinum Plan (HMO), your ability to enroll will be based only on verification that you are entitled to Medicare.
- ☐ Effect on Current Coverage. You understand that you can be enrolled in only one MA plan at a time — and that enrollment in this plan will automatically end your enrollment in another MA plan (exceptions apply for MA PFFS, MA MSA plans). For example, if you are in Tricare or a Medicare plan, you will no longer receive benefits from that plan once your new coverage starts.
- ☐ Emergency care is covered for MetroPlus Advantage Plan (HMO D-SNP), MetroPlus UltraCare (HMO D-SNP), and MetroPlus Platinum Plan (HMO) both in the U.S. and worldwide (outside the U.S.). If you have an emergency outside of the U.S. and its territories, you will be responsible to pay for those services upfront and request appropriate reimbursement from us for covered, medically necessary emergency services.
- ☐ Plans operate on a calendar year, meaning that benefits, premiums, and/or copayments/ coinsurance may change as of January 1st of each year.
- ☐ Dental, vision, and hearing benefits are subject to plan limitations and are to be discussed during review of the Summary of Benefits.
- ☐ You have the right to cancel this enrollment prior to effective date of becoming a member by contacting MetroPlusHealth at **866.986.0356** for additional information (TTY users should call 711). Hours are Monday to Friday, 8am to 8pm, and Saturday, 9am to 5pm. After-hours answering service: 800.442.2560.
- ☐ You have the right to file a complaint about the quality of care you received from a provider or pharmacy by calling us at **866.986.0356** for additional information (TTY users should call 711). Hours are Monday to Friday, 8am to 8pm, and Saturday, 9am to 5pm. After-hours answering service: 800.442.2560. Faxing 212.908.5196 or sending a letter to MetroPlus Health Plan 50 Water St. 7th Fl New York, NY 10004.



The benefit information provided does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please request the "Evidence of Coverage" by contacting Member Services (phone numbers are printed on the back of this booklet).

To join the MetroPlus Platinum Plan (HMO), you must be entitled to Medicare Part A, be enrolled in Medicare Part B, you are a US citizen or lawfully present in the US, and reside in Manhattan, Brooklyn, Queens, the Bronx, or Staten Island.

The **MetroPlus Platinum Plan (HMO)** has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, the plan may not pay for these services. You can see our plan's *Provider/Pharmacy Directory* and "Evidence of Coverage" at **metroplusmedicare.org**. Or call us and we will send you a copy of the *Provider/Pharmacy Directory.*

Premiums and benefits	MetroPlus Platinum Plan (HMO)	What you should know
Monthly Plan Premium	You pay $0.	You must continue to pay your Medicare Part B premium.
Deductible	You pay nothing.	This plan does not have a medical deductible.
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	$9,850 annually.	The most you pay for copays, coinsurance, and other costs for medical services for the year.

Premiums and benefits	Original Medicare benefits	MetroPlus Platinum Plan (HMO)	What you should know
Inpatient Hospital Coverage	After meeting the Original Medicare Part A deductible ($1,776) for each benefit period: $0 for inpatient days 1–60 (for each benefit period) and $444 per day for inpatient days 61–90 (for each benefit period) $888 per "lifetime reserve day" after day 90 of each benefit period (up to a maximum of 60 days over your lifetime).	$225 copay per day for days 1 through 8. You pay nothing for days 9 through 90.	Our plan covers 90 days for an inpatient hospital stay. Our plan also covers 60 "lifetime reserve days." Prior authorization required. Referral not required.
Outpatient Hospital Coverage			
• Outpatient Hospital Services	20% coinsurance for each outpatient hospital service. Applies to the Part B deductible.	• You pay 20% of the cost for Outpatient Hospital Services.	• Referral not required.
• Ambulatory Surgical Center		• You pay $50 copay for Ambulatory Surgical Center.	• Referral required for Ambulatory Surgical Center.
Doctor Visits			
• Primary • Specialists	20% coinsurance for each service. Applies to the Part B deductible.	• You pay nothing. • $40 copay per visit.	• Referral not required. • Referral required for specialist.
Preventive Care	$0 copay for Medicare-covered preventive care.	You pay nothing.	Any additional preventive services approved by Medicare during the contract year will be covered.
Emergency Care	20% coinsurance for each service. Applies to the Part B deductible. Original Medicare does NOT cover worldwide emergency and urgent care coverage.	$100 copay.	If you are admitted to the hospital within 3 days, you do not have to pay your share of the cost for emergency care.

Premiums and benefits	Original Medicare benefits	MetroPlus Platinum Plan (HMO)	What you should know
Urgently Needed Services	20% coinsurance for each service. Applies to the Part B deductible. Original Medicare does NOT cover worldwide emergency and urgent care coverage.	You pay nothing.	
Diagnostic Services/Labs/ Imaging			
• Diagnostic tests and procedures	Original Medicare pays the full costs of covered diagnostic lab tests. For diagnostic radiology services, outpatient X-rays, and therapeutic radiology services (such as radiation treatment for cancer): 20% coinsurance for each service. Applies to the Part B deductible.	• You pay 20% of the cost.	Referral required. Prior authorization is required for some services by your doctor or other network providers. Please contact the plan for more information.
• Lab services		• You pay 20% of the cost.	
• Diagnostic radiology service (e.g., MRI)		• You pay 20% of the cost.	
• Outpatient x-rays		• You pay 20% of the cost.	
Hearing Services			
• Routine hearing exam (up to 1 every year)	Original Medicare does NOT cover any routine hearing services or hearing aids.	• $20 copay.	Referral required. Prior authorization is required for hearing aids. Our plan pays up to $2,000 per year.
• Exam to diagnose and treat hearing and balance issues		• $20 copay.	
• Fitting/evaluation for hearing aid		• $20 copay.	
• Hearing aid (1 yearly)		• You pay nothing.	

Premiums and benefits	Original Medicare benefits	MetroPlus Platinum Plan (HMO)	What you should know
Preventative Dental Services	Original Medicare does NOT cover any routine dentistry, preventive dental care, or dentures. However, Original Medicare will pay for certain dental services that you get when you're in a hospital, like if you need to have emergency or complicated dental procedures.	$0 for Medicare covered services.	Oral exams, x-rays, cleanings, fluoride treatments (with visit limitations). Prior authorization required.
Comprehensive Dental Services			$1,500 per year limit, no implants.
Vision Services	Original Medicare does NOT cover routine vision services. Original Medicare covers some vision services like those related to glaucoma prevention and services after cataract surgery.	Eyewear is covered up to a total of $500 per year for: • Contact lenses • Eyeglasses (lenses and frames) • Eyeglass lenses • Eyeglass frames • Upgrades	Exams to diagnose and treat diseases and conditions of the eye, including yearly glaucoma screening are covered. You pay nothing for Medicare covered eye exams. Referral required.

Premiums and benefits	Original Medicare benefits	MetroPlus Platinum Plan (HMO)	What you should know
Mental Health Services (Inpatient)	Original Medicare covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital. For services provided in a general hospital: After meeting the Medicare Part A deductible ($1,776) for each benefit period: $0 for inpatient days 1–60 (for each benefit period) and $444 per day for inpatient days 61–90 (for each benefit period) $888 per "lifetime reserve day" after day 90 of each benefit period (up to a maximum of 60 days over your lifetime).	$195 copay per day for day 1 through 8. You pay nothing for days 9 through 90.	Prior authorization required. Referral not required.
Mental Health Services (Outpatient group or individual therapy visits)	20% coinsurance for each service. Applies to the Part B deductible.	$40 copay.	Prior authorization and referral not required.
Skilled Nursing Facility	$0 per day for days 1– 20 each benefit period, $222 per day for days 21–100 each benefit period, 3-day hospital stay required.	You pay nothing for days 1 through 20. $222 copay per day for days 21 through 100.	Our plan covers up to 100 days in a SNF. Prior authorization required. Referral not required.
Physical Therapy	20% coinsurance for each service. Applies to the Part B deductible.	$25 copay.	Referral required. Prior authorization is required.
Ambulance	20% coinsurance for each service. Applies to the Part B deductible.	$100 copay per one-way trip.	If you are admitted to the hospital, you do not have to pay your share of the cost for ambulance services.

Premiums and benefits	Original Medicare benefits	MetroPlus Platinum Plan (HMO)	What you should know
Non-Emergent Transportation	Original Medicare does not cover non-emergent transportation.	Not covered.	
Medicare Part B Drugs	20% coinsurance for each service. Applies to the Part B deductible.	Chemotherapy administration performed in a PCP office: $0 copay. Performed in a specialist office: $40 copay. Up to $35 for 1 month supply of insulin. Performed as outpatient hospital services: 20% of cost. Injectable Drugs covered under Medicare Part B: 20% of the cost for chemotherapy drugs. 20% of the cost for other Part B drugs.	Injectable chemotherapeutic drugs are covered when administered in an MD office and billed as part of an MD visit. Prior authorization or Step Therapy may be required.
Foot Care (podiatry services) Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions	Original Medicare does NOT cover routine foot care. 20% coinsurance for medically necessary treatment of foot injuries or diseases. Applies to the Part B deductible.	$30 copay.	Referral required.

Premiums and benefits	Original Medicare benefits	MetroPlus Platinum Plan (HMO)	What you should know
Medical Equipment/ Supplies			
• Durable Medical Equipment (e.g., wheelchairs, oxygen)	20% coinsurance for each service. Applies to the Part B deductible.	• You pay 20% of the cost.	Prior authorization is required.
• Prosthetics (e.g., braces, artificial limbs)		• You pay 20% of the cost.	
• Diabetes supplies		• You pay 20% of the cost.	
Telehealth Services	After December 31, 2024, under original Medicare, member will still be able to get certain Medicare telehealth services without being in a rural health care setting, including: • Monthly End-Stage Renal Disease (ESRD) visits for home dialysis • Services for diagnosis, evaluation, or treatment of symptoms of an acute stroke wherever you are, including in a mobile stroke unit • Services to treat a substance use disorder or a co-occurring mental health disorder (sometimes called a "dual disorder"), or for the diagnosis, evaluation or treatment of a mental health disorder, including in your home • Behavioral health services (also called mental health services), including in your home • Diabetes self-management training • Medicare nutrition therapy	$0 24/7 visits with Express Care doctors and therapists from your smart phone, tablet, or computer.	Covered telehealth services include: Urgently Needed Services; Physician Specialist Services; Individual Sessions for Mental Health Specialty Services; Other Health Care Professional; Individual Sessions for Psychiatric Services; Individual Sessions for Outpatient Substance Abuse; and Diabetes Self-Management Training. Referral required except for Behavioral Health Services.

Premiums and benefits	Original Medicare benefits	MetroPlus Platinum Plan (HMO)	What you should know
Opioid Treatment Program Services	20% coinsurance for each service. Applies to the Part B deductible.	You pay nothing.	Prior authorization is required for inpatient services only.
Acupuncture (to treat chronic lower back pain)	Original Medicare covers acupuncture for chronic lower back pain up to 12 visits in 90 days under certain circumstances. An additional eight sessions will be covered when improvement is demonstrated. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if no improvement or regression is noted.	You pay 20% of the cost.	Covered services include: • 12 sessions covered in a 90 day period. • 8 additional sessions are covered for patients demonstrating improvement. • Treatment must be discontinued if the member is not improving or is regressing. • Limit of 20 acupuncture treatments per year. • Referral and prior authorization are required.

Premiums and benefits	Original Medicare benefits	MetroPlus Platinum Plan (HMO)	What you should know
Diabetes self-management training, diabetic services, and supplies	Medicare covers up to 2 blood glucose (blood sugar) laboratory test screenings (with and without a carbohydrate challenge) each year if your doctor determines you're at risk for developing diabetes. You pay nothing for the test if your doctor or other qualified health care practitioner accepts assignment. Medicare covers diabetes outpatient self-management training to teach you to cope with and manage your diabetes. The program may include tips for eating healthy, being active, monitoring blood glucose (blood sugar), taking prescription drugs, and reducing risks. You must have been diagnosed with diabetes and have a written order from your doctor or other health care provider. Some patients may also be eligible for medical nutrition therapy services. You pay 20% of the Medicare-approved amount. The Part B deductible applies.	20% coinsurance for therapeutic shoes or inserts. $0 copay for diabetes self-management training. Diabetic supplies are limited to Abbott diabetic test strips or Ascensia diabetic test strips. If you have a medical reason to use another brand of test strips, your provider must contact Member Services.	For all people who have diabetes (insulin and non-insulin users). Covered services include: Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors. For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting. Diabetes self-management training is covered under certain conditions. 20% coinsurance for supplies to monitor your blood glucose.

Premiums and benefits	Original Medicare benefits	MetroPlus Platinum Plan (HMO)	What you should know
Medicare Diabetes Prevention Program (MDPP)	Medicare covers a once-per-lifetime health behavior change program to help you prevent type 2 diabetes. The program begins with weekly core sessions offered in a group setting over a 6-month period. Once you complete the core sessions, you'll get 6 monthly follow-up sessions to help you maintain healthy habits. If you started the Medicare Diabetes Prevention Program in 2021 or earlier, you'll get an additional 12 monthly sessions if you meet certain weight loss goals. You can get these services from an approved Medicare Diabetes Prevention Program supplier. These suppliers may be traditional health care providers or organizations like community centers or faith-based organizations.	There is no coinsurance, copayment, or deductible for the MDPP benefit.	MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans. MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.

Premiums and benefits	Original Medicare benefits	MetroPlus Platinum Plan (HMO)	What you should know
Worldwide Emergency Room		Emergency care is covered up to the Medicare allowable amount minus any cost sharing the member incurs both in the U.S. and worldwide (outside the U.S.). If you have an emergency (care) outside of the U.S. and its territories, you will be responsible to pay for those services upfront and request appropriate reimbursement from us for covered, medically necessary emergency services.	To request the reimbursement form, call **866.986.0356** (TTY: 711).
OTC Card		You receive $60 quarterly.	Members will receive $60 amount per quarter that can be used for OTC (over-the-counter) drugs. Please allow three weeks from date of enrollment to receive OTC Card.

Outpatient Prescription Drugs			
Stage 1:	**Yearly Deductible Stage**	The plan has a deductible amount of $700 for Part D prescription drugs. Until you have paid the deductible amount, you must pay the full cost for Part D prescription drugs.	
Stage 2:	**Initial Coverage** (After you pay your deductible, if applicable)		
	• **Generic Drugs** (including brand drugs treated as generic)	• You pay 25% coinsurance.	Once your yearly out-of-pocket costs reach $2,400, you will move to the next stage (the **Catastrophic Coverage Stage**).
	• All other drugs	• You pay 25% coinsurance.	
Stage 3:	**Catastrophic Coverage Stage**		
	• **Generic Drugs** (including brand drugs treated as generic)	• You pay $0.	Once you are in the **Catastrophic Coverage Stage**, you will stay in this payment stage until the end of the year.
	• All other drugs	• You pay $0.	

Plans may offer supplemental benefits in addition to Part C benefits and Part D benefits.

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at **medicare.gov** or get a copy by calling **800.MEDICARE (800.633.4227)**, 24 hours a day, 7 days a week. TTY users should call **877.486.2048**.

This document is available in other formats such as Braille, large print, or audio. Please call our Help Line at **866.986.0356** (TTY: 711) and a representative will assist you.

MetroPlusHealth is excited to inform you that you can use our mail order program to get your medications delivered right to your home, at no extra cost to you. This service will save you time — and your medicine will arrive safely in a plain, secure, tamper-proof package.

To enroll in this service, please sign up online at **caremark.com** or call **CVS Caremark's** Customer Care Department at **866.693.4615** (TTY: 711), Monday to Friday, 8am to 8pm, and Saturday, 9am to 5pm. After-hours vendor is available 24 hours a day, 7 days a week.

For more information, please call us at the phone number below or visit us at **metroplusmedicare.org.**

Please call our Help Line at **866.986.0356** (TTY: 711), Monday through Friday, 8 am to 8 pm, and Saturday, 9 am to 5 pm, and a representative will assist you.

We cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider.

You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website at **metroplusmedicare.org.**

MetroPlus Health Plan, Inc. offers HMO and HMO D-SNP plans with contracts with Medicare and New York State Medicaid. Enrollment in MetroPlus Health Plan, Inc. depends on contract renewal. **MetroPlusHealth is not affiliated with, endorsed by, or otherwise related to the federal government, CMS, HHS, and/or Medicare.** MetroPlus Health Plan, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.



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