

MetroPlusHealth Gold Plan Summary of Benefits

2027

✓MetroPlus**Health** Gold

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, 2026 – June 30, 2027

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: 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 means you don't have to pay anything before your plan starts to help pay for your care.
Are there other deductibles for specific services?	No	You don't have to pay any other deductibles for specific services.
What is the out-of-pocket limit for this plan?	$7,150 Individual $14,300 Family	This is the most you will pay in a year for covered care. If your family is on the plan, you may need to meet the full family 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. Visit **metroplus.org** or call **877.475.3795** (TTY: 711) to find a list of network providers.	This plan uses a group of doctors, clinics, and hospitals called a network. If you go outside this network, your plan will not pay. Sometimes, your doctor may send you to someone not in the network, like a lab, so it's best to ask first. If you go outside the network, you may have to pay extra. This is called balance billing.
Do you need a referral to see a specialist?	No	Starting July 1, 2026, you do not need a referral to see a specialist in the MetroPlusHealth Gold Plan network.

New benefits for 2027

Urgent Care
$0 for in-network urgent care.

Podiatry
Routine foot care, up to eight (8) visits per year.

Doula
Eight (8) prenatal or postpartum visits per pregnancy, one (1) in-person Doula support visit during labor and birth per pregnancy.

Up to $250 in rewards for every gold member, including eligible dependents.

Common Medical Event

Network provider: you will pay the least / Out-of-network provider: you will pay the most

If you visit a doctor or clinic

Primary care visit (for injury or illness)

- Network provider: $0/visit
- Out-of-network provider: Not covered

Specialist visit

- Network provider: $0/visit
- Out-of-network provider: Not covered

Preventive care (checkups, screenings, shots)

- Network provider: $0/visit
- Out-of-network provider: Not covered

What the plan doesn't cover and other important information[1]: You may have to pay for services that are not preventive. Ask your doctor if the service is preventive, and check what your plan will pay.

If you have a test

Diagnostic tests (X-rays, blood tests)

- Network provider: $0/visit at labs or hospitals
- Out-of-network provider: Not covered

Imaging (CT/PET scans, MRIs)

- Network provider: $0/visit at labs or hospitals
- Out-of-network provider: Not covered

If you need medicine for an illness or condition

The Gold Plan covers over 100 common prescription drugs at no cost to you. To see the full list, visit **metroplus.org/gold-rx-list**.[2]

To see which drugs are covered, visit **metroplus.org/gold**.

If you have outpatient surgery

Facility fee (surgery center)

- Network provider: $0/visit
- Out-of-network provider: Not covered

Physician/surgeon fees

- Network provider: $0/visit
- Out-of-network provider: Not covered

If you need medical care right away

Emergency room care

- Network provider: $100/visit
- Out-of-network provider: $100/visit

Important information[1]: You do not pay this if you are admitted to the hospital.

Emergency ride (ambulance)

- Network provider: $0/visit
- Out-of-network provider: $0/visit

Urgent care

- Network provider: $0/visit
- Out-of-network provider: Not covered

If you have a hospital stay

Hospital stay (room and care)

- Network provider: $0/visit
- Out-of-network provider: Not covered

Physician/surgeon fees

- Network provider: Included with admission
- Out-of-network provider: Not covered

If you need mental health or substance-related and addictive disorder services

Outpatient services (no overnight stay)

- Network provider: $0/visit
- Out-of-network provider: Not covered

Important information[1]**:** You can have up to 20 family counseling visits each year.

Inpatient services (stay in a hospital)

- Network provider: $0/admission
- Out-of-network provider: Not covered

If you are pregnant

Office visits

- Network provider: Covered in full
- Out-of-network provider: Not covered

Childbirth (doctor services)

- Network provider: Included with admission
- Out-of-network provider: Not covered

Childbirth (hospital stay)

- Network provider: $0/admission
- Out-of-network provider: Not covered

If you need help recovering or have other special health needs

Home health care

- Network provider: $0/visit
- Out-of-network provider: Not covered

Important information[1]**:** 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 (therapy)

- Network provider: $0 per visit or admission
- Out-of-network provider: Not covered

Important information[1]: Outpatient: 90 visits per plan year, combined therapies. Speech and physical therapy are only covered after a hospital stay or surgery.

Habilitation services (build skills)

- Network provider: $0 per visit or admission
- Out-of-network provider: Not covered

Important information[1]**:** Up to 90 visits each year.

Skilled nursing care

- Network provider: $0/admission
- Out-of-network provider: Not covered

Important information[1]**:** Up to 200 days each year.

Durable medical equipment

- Network provider: 0% coinsurance
- Out-of-network provider: Not covered

Hospice services

- Network provider: 0% copayment
- Out-of-network provider: Not covered

Important information[1]**:** Outpatient: 5 visits for family counseling. Inpatient: 210 days per plan year.

If you need dental or eye care[3]

Eye exam

- Network provider: Not covered
- Out-of-network provider: Not covered

Glasses

- Network provider: Not covered
- Out-of-network provider: Not covered

Dental check-up

- Network provider: Not covered
- Out-of-network provider: Not covered

[1] For more details about plan coverage, visit the certificate of coverage located at **metroplus.org/plans/nyc-employees/gold-plan**. For additional details about health benefits available to New York City employees and their eligible dependents, please visit the **New York City Office of Labor Relations (OLR) Summary Program Description (SPD)**.

[2] 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**.

[3] Need information about dental or vision benefits? Please contact your Union or Management Benefit Fund for coverage details.

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)

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
- Wellness benefit
- Transportation to medical appointments



Coverage examples

These are not exact costs. They are just to show how the plan may help pay for care. Your costs may be different. They depend on the care you get, what doctors charge, and other details. Look at what you actually pay and what the plan does not cover. Use this to compare plans. Note: These examples are for one person.

1

Peg is having a baby

9 months of in-network prenatal care and a hospital delivery.

Plan details

- Overall deductible: $0
- Specialist copay: $0
- Hospital (facility) copay: $0
- 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**
Cost sharing	
Deductibles	$0
Copays	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
Total Peg would pay	**$0**

2

Managing Joe's type 2 diabetes

A year of routine in-network care for a well-controlled condition.

Plan details

- Overall deductible: $0
- Specialist copay: $0
- Hospital (facility) copay: $0
- 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**
Cost sharing	
Deductibles	$0
Copays	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
Total Joe would pay	**$0**

3

Mia's simple fracture

In-network emergency room visit and follow-up care.

Plan details

- 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**
Cost sharing	
Deductibles	$0
Copays	$100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
Total Mia would pay	**$100**

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

Prescription Drug Coverage

Your plan covers many prescription drugs that are medically needed, approved by the FDA, and prescribed by your doctor. The drug must also be on the plan's approved list (called a formulary) and filled at a participating pharmacy.

What is covered

- Many common prescription drugs
- Some over-the-counter drugs with a doctor's order
- Preventive drugs (like vaccines and screenings)
- Birth control
- Drugs to help stop smoking
- HIV prevention drugs (PrEP and PEP)
- Mental health and substance substance-related and addictive disorder treatment drugs
- Cancer medications

Important things to know

- You may have to pay different amounts depending on the drug (tiers)
- Some drugs may need approval first (preauthorization)
- You may need to try a different drug first before getting another one (step therapy)
- Most prescriptions are for a 30-day supply, but some can be 90 days
- Refills are allowed only after most of the medicine is used

Where to get your drugs

- Use a participating (in-network) pharmacy or mail order
- The plan usually does not pay for drugs from non-participating pharmacies

Not covered

- Drugs not on the formulary
- Drugs without a prescription (with some exceptions)
- Lost or stolen medications

Extra Help

- If a drug is not covered, you can ask your doctor if there is a similar covered drug that may work for you
- You can check covered drugs at **metroplus.org** or call the number on your ID card

MPH Gold Plan with optional rider	Retail – 30 day supply	Mail order – 90 day supply
Generic drugs (Tier 1)	15% copayment	15% copayment
Brand drugs (Tier 2)	40% copayment	40% copayment
Non-formulary (Tier 3)	50% copayment	50% copayment
MPH Gold Plan with optional grandfathered rider		
Generic drugs (Tier 1)	$0 copayment	$0 copayment
Brand drugs (Tier 2)	$35 copayment	$70 copayment
Non-formulary (Tier 3)	$70 copayment	$140 copayment

All members, including MetroPlusHealth Gold Standard members, are eligible for the following benefits and services:

Discount Drug Program

This is a drug discount program, not a prescription drug benefit. Drugs on the list are provided to covered individuals at a discounted price of $0 as part of a health and wellness benefit. Coverage for drugs that are not included in the discount program require purchase of the optional rider and may be subject to copays. List of drugs can be found at **metroplus.org/gold-rx-list**.

Affordable Care Act (ACA) prescriptions

Coverage is available at no cost when filled at participating pharmacies.

Durable medical equipment (DME)

Members may obtain durable medical equipment, such as continuous glucose monitors (CGMs), insulin pumps, and other eligible items, from a participating vendor at no cost.

PICA coverage

The PICA Program is a prescription drug benefit provided to all NYC employees, non-Medicare retirees, and their non-Medicare-eligible dependents who are enrolled in a health plan offered through the City's Health Benefits Program.

PICA covers medications in two specific drug categories: self-injectable medications, including most injectable medications that do not require administration by a health care professional, and chemotherapy medications, including medications used to treat cancer and certain side effects of chemotherapy.

For additional information, please refer to the **New York City Summary Program Description** located on the OLR website.

For additional pharmacy details, please see Certificate of Coverage.

The Gold Plan from MetroPlusHealth: Get rewards for taking steps to stay healthy, you've earned it!

New for 2027: Up to $250 in rewards for every Gold member, including eligible dependents!

Ways to earn rewards include:

- **$50 for your annual checkup**
- **$25 for getting your flu vaccine**
- **$25 for staying active**
- **$25 for your annual dentist visit**

There are more ways to reward yourself for staying healthy. It's easy to join and easy to earn. Just register in your member portal and check off completed activities to start earning. Only Gold from MetroPlusHealth offers these rewards to its members.

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Gold exercise facility reimbursement form

Submit form and proof of payment to:

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

mph_reimbursements@metroplus.org

Member information

MetroPlusHealth ID number	Last name	First name	Middle initial

Address (number, street, apt.)	City	State	ZIP code

Claim period requested (mm/dd/yyyy — mm/dd/yyyy)	to

Subscriber information (if different from above)

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 all information and documents are complete, accurate, and unaltered, and that I am not receiving this reimbursement through the NYC Management Benefits Fund.

Member's signature: _____ **Date:** _____

Account holder's signature: _____ **Date:** _____

(To be signed if the Member is under 18)

Any alteration or falsification of information will result in disqualification from the reimbursement program. To avoid delays or denial, please complete all sections of the form, use one form per member for each six month claim period. Please note that this benefit may be taxable. If you have questions, call the Gold Member line at **877.475.3795 (TTY: 711)**. Language assistance is available.

Refer to your Certificate of Coverage for full details.

As a MetroPlusHealth Gold member, we want to help you stay healthy. You can receive up to $1,400 per year to help pay for fitness memberships. Reimbursement is available every six months as follows: $250 per member, $250 per spouse, and $100 per dependent (up to two dependents).

What types of health clubs qualify? The health club must support cardiovascular fitness and offer at least two types of equipment or programs, such as elliptical machines, stationary bikes, treadmills, step machines/climbers, pools, group exercise classes, or walking and running programs.

How do I become eligible? To qualify, you must be an active member of the fitness facility, and your MetroPlusHealth coverage must be current and paid in full at the time you submit your claim.

Exclusions:

Reimbursement does not cover costs for equipment purchases, locker rentals, clothing, vitamins, or optional services such as massages or personal training.

How do I obtain the reimbursement?

For monthly memberships, you must complete six consecutive months before submitting a claim. Annual memberships are reimbursed once per plan year, up to the limit. Reimbursement is issued within 30 days of receiving complete documentation.

Submit:

- Reimbursement form
- Proof of payment
- Within 120 days after the claim period ends

For a complete list of exclusions and full details, refer to your Certificate of Coverage at **metroplus.org**.

Submit your completed form and documentation by email or mail:

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

mph_reimbursements@metroplus.org

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Gold wellness app reimbursement form

Submit form and proof of payment to:

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

mph_reimbursements@metroplus.org

Member information

MetroPlusHealth ID number	Last name	First name	Middle initial

Address (number, street, apt.)	City	State	ZIP code

Claim period requested (mm/dd/yyyy — mm/dd/yyyy)	to

Subscriber information (if different from above)

ID number	Last name	First name	Middle initial

Wellness/fitness app information

Reimbursement is limited to no more than the use of two apps each per six-month reimbursement period, not to exceed the maximum amount per household.

Allowed amount:

Single Basic Plan: $150 per subscriber every six months.

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

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:** _____

Any alteration or falsification of information will result in disqualification from the reimbursement program. To avoid delays or denial, please complete all sections of the form, use one form per member for each six month claim period. Please note that this benefit may be taxable. If you have questions, call the Gold Member line at **877.475.3795 (TTY: 711)**. Language assistance is available.

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

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 reimbursement?
For monthly memberships, you must complete six consecutive months before submitting a claim. Annual memberships are reimbursed once per plan year, up to the limit. Reimbursement is issued within 30 days of receiving complete documentation.

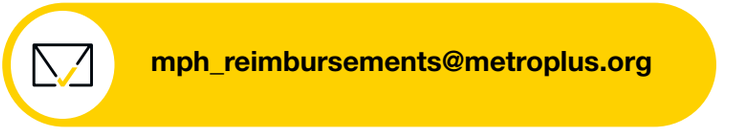
Submit:

- Reimbursement form
- Proof of payment
- Within 120 days after the claim period ends

For a complete list of exclusions and full details, refer to your Certificate of Coverage at **metroplus.org**.

Submit your completed form and documentation by email or mail:

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



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Gold transportation reimbursement form

Submit form and proof of payment to:

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

mph_reimbursements@metroplus.org

Member information

MetroPlusHealth 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:

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, and credit card statements.

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

Member's signature: _____ **Date:** _____

Any alteration or falsification of information will result in disqualification from the reimbursement program. Please note that this benefit may be taxable. If you have questions, call the Gold Member line at **877.475.3795 (TTY: 711)**. Language assistance is available.

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 year or the full cost of one ride (whichever is lower) for transportation to see a doctor.

What types of transportation qualify? Reimbursement is only available for individual rides. Prepaid options, such as purchasing a MetroCard or transit pass, are not eligible.

How do I become eligible? To be eligible, you must be an active subscriber of **MetroPlusHealth Gold.**

How do I obtain the reimbursement?

- Submit the completed reimbursement form (multiple trips may be combined)
- Include proof of payment (e.g., receipt, rideshare screenshot, or credit card statement)
- Submit within 120 days of the trip date

Reimbursement is issued within 30 days of receiving complete documentation. For a complete list of exclusions and full details, refer to your Certificate of Coverage at **metroplus.org**.

Submit your completed form and documentation by email or mail:

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