2024 METROPLUSHEALTH GOLD PLAN SUMMARY OF BENEFITS

January 1, 2024 – December 31, 2024

✓MetroPlus**Health**Gold

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SUMMARY OF BENEFITS AND COVERAGE

What this Plan Covers & What You Pay for Covered Services

MetroPlus Gold: MetroPlus Health Plan

Coverage Period: 10/1/2023-9/30/2024

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	See the Common Medical Events chart below for your costs for services this plan covers.
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, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, 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 provider network. Out of Network services are not covered. Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. You might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing).
Do you need a referral to see a specialist?	Yes	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a 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/ screening/ immunization	$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 in-office tests completed in the PCP or specialist's office.
	Imaging (CT/ PET scans, MRIs)	$0/visit in freestanding labs; $0/visit in hospital	Not covered	No copay for in-office tests completed in the PCP or specialist's office.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at **metroplus.org/member/pharmacy**	Generic drugs	Not covered	Not covered	
	Brand drugs	Not covered	Not covered	
	Specialty drugs	Not covered	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$0/visit	Not covered	
	Physician/ surgeon fees	$0/visit	Not covered	

*For more information about limitations and exceptions, see the plan or policy document at **metroplus.org**.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$100/visit	$100/visit	Copayment waived if admitted to Hospital. Health care forensic examinations performed under Public Health Law § 2805-i are not subject to Cost-Sharing.
	Emergency medical transportation	$0/visit	$0/visit	
	Urgent care	$25/visit	Not covered	
If you have a hospital stay	Facility fee (e.g., 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 information about limitations and exceptions, see the plan or policy document at **metroplus.org**.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & 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 member of the HHA is considered one (1) visit. Each visit of up to four (4) hours by a HHA is considered one (1) visit.
	Rehabilitation services	Outpatient: $0 Inpatient: $0/admission	Not covered	Outpatient: 20 visits per condition per Plan Year combined therapies Inpatient: 20 visits per condition per Plan Year combined therapies Speech and physical therapy are only Covered following a Hospital stay or surgery.
	Habilitation services	Outpatient: $0 Inpatient: $0/admission	Not covered	• Outpatient: 20 visits per condition per Plan Year combined therapies • Inpatient: 20 visits per condition 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 bereavement • 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 information about limitations and exceptions, see the plan or policy document at **metroplus.org**.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Acupuncture • 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 (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric surgery • Chiropractic care	• Hearing aids • Infertility treatment	• Weight loss programs • Transportation to medical appointments

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 866.444.EBSA (3272) or dol.gov/ebsa/healthreform. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit HealthCare.gov or call 800.318.2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:
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 generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

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 examples of how this plan might cover costs for a sample medical situation, see the next section.

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*For more information about limitations and exceptions, see the plan or policy document at **metroplus.org**.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

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

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

This EXAMPLE event includes services like:

Specialist office visits *(prenatal care)*

Childbirth/Delivery Professional Services

Childbirth/Delivery Facility Services

Diagnostic tests *(ultrasounds and blood work)*

Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$70
The total Peg would pay is	**$70**

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 copayment** **$0**
- **Hospital (facility) copayment** **$0**
- **Other coinsurance** **0%**

This EXAMPLE event includes services like:

Primary care physician office visits *(including disease education)*

Diagnostic tests (*blood work)*

Prescription drugs

Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$70
Coinsurance	$0
What isn't covered	
Limits or exclusions	$400
The total Joe would pay is	**$470**

Mia's Simple Fracture (in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$0**
- **Hospital (facility) copayment** **$0**
- **Emergency room copayment** **$150**

This EXAMPLE event 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
Copayments	$100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$10
The total Mia would pay is	**$110**

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

PRESCRIPTION DRUG RIDER

Please refer to the Schedule of Benefits section of this Certificate for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

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 877.475.3795 (TTY: 711); the number on Your ID card 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 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.** You are responsible for paying the costs outlined in the Schedule of Benefits section of this Certificate when Covered Prescription Drugs are obtained from a retail, mail order or designated pharmacy.

   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.
2. **Participating Pharmacies.** For Prescription Drugs purchased at a retail,mail order or designated Participating Pharmacy, You are responsible for paying the lower of:
   - The applicable Cost-Sharing; or
   - The Participating Pharmacy's Usual and Customary Charge (which includes a dispensing fee and sales tax) for the 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 Prescription Drug claim form. Contact Us at 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 retail or mail order Pharmacy other than as described above.
4. **Designated Pharmacies.** If You require certain Prescription Drugs including, but not limited to specialty Prescription Drugs, We may direct You to a Designated Pharmacy with whom We have an arrangement to provide those 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.

If You are directed to a Designated Pharmacy and You choose not to obtain Your Prescription Drug from a Designated Pharmacy, You will not have Coverage for that Prescription Drug.

Following are the therapeutic classes of Prescription Drugs or conditions that are included in this program:

- Age related macular edema;
- Anemia, neutropenia, thrombocytopenia;
- Contraceptives;
- Crohn's disease;
- Cystic fibrosis;
- Cytomegalovirus;
- Endocrine disorders/neurologic disorders such as infantile spasms;
- Enzyme deficiencies/liposomal storage disorders;
- Gaucher's disease;
- Growth hormone;
- Hemophilia;
- Hepatitis B, hepatitis C;
- Hereditary angioedema;
- HIV/AIDS;
- Immune deficiency;
- Immune modulator;
- Infertility;
- Iron overload;
- Iron toxicity;
- Multiple sclerosis;
- Oral oncology;
- Osteoarthritis;
- Osteoporosis;
- Parkinson's disease;
- Pulmonary arterial hypertension;
- Respiratory condition;
- Rheumatologic and related conditions (rheumatoid arthritis, psoriatic arthritis, ankylosing spondylitis, juvenile rheumatoid arthritis, psoriasis)
- Transplant;
- RSV prevention.

5. **Mail Order.** Certain Prescription Drugs may be ordered through Our 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 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 the number on Your ID card.

6. **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 877.475.3795 (TTY: 711); the number on Your ID card.

7. **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.

8. **Supply Limits.** We will pay for no more than a 30-day supply of a Prescription Drug purchased at a retail pharmacy. You are responsible for up to three (3) Cost-Sharing amounts for up to a 90-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 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.

9. **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 Certificate 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 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 medications 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 medications. 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 the Outpatient and Professional Services section of this 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 cots, 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 identification number on the forms provided by the mail order pharmacy from which You make a purchase.

G. Definitions.

Terms used in this section are defined as follows. (Other defined terms can be found in the Definitions section of this 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 Certificate. This list is subject to Our periodic review and modification (generally quarterly, but no more than six (6) times per Plan Year). You may determine to which tier a particular Prescription Drug has been assigned by visiting Our website at **metroplus.org** or by calling 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 rate We have agreed to pay Our Participating Pharmacies, including a dispensing fee and any sales tax, for a Covered Prescription Drug dispensed at a Participating Pharmacy. If Your Certificate 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 Section 6826-a of the New York Education Law.

AGE 29 COVERAGE RIDER

Rider to Extend Coverage for Young Adults through Age 29

This rider, which has been selected by the Group, extends the eligibility of Children for coverage under Your Certificate and any applicable rider(s) thereto.

A. Young Adults Covered through Age 29.

If You selected parent and child/children or family coverage, Your young adult Child will be eligible for coverage until the end of the month in which the Child turns 30 years of age, when the young adult:

1. Is unmarried;
2. Is not insured by or eligible for coverage under an employer-sponsored health benefit plan covering him or her as an employee or member, whether insured or self-insured; and
3. Lives, works or resides in New York State or Our Service Area.

The young adult need not live with or be financially dependent upon You or be a student in order to be covered under this rider. The young adult's children are not eligible for coverage under this rider. Coverage under this rider terminates the end of the month in which the Child turns 30 years of age.

B. 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.

C. Availability of Age 29 Dependent Coverage Extension – Young Adult Option.

The Subscriber's Child may be eligible to purchase continuation coverage under the Group's Contract through the age of 29 if he or she:

1. Is under the age of 30;
2. Is not married;
3. Is not insured by or eligible for coverage under an employer-sponsored health benefit plan covering him or her as an employee or member, whether insured or self-insured;
4. Lives, works or resides in New York State or Our Service Area; and
5. Is not covered by Medicare.

The Child may purchase continuation coverage even if he or she is not financially dependent on his or her parent(s) and does not need to live with his or her parent(s).

EXERCISE FACILITY REIMBURSEMENT FORM

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

As a MetroPlus Gold member, we want to help you stay healthy. To help you do this, MetroPlusHealth will reimburse you up to $1,000 per year to help you pay for your gym or fitness club membership (up to $500 for you and up to $500 for your participating spouse).

What types of health clubs qualify?

Exercise facilities that maintain equipment and programs that promote cardiovascular wellness qualify for reimbursement. Memberships in tennis clubs, country clubs, weight loss clinics, spas or any other similar facilities will not be reimbursed. Lifetime memberships are not eligible for reimbursement. We will not provide reimbursement for equipment, clothing, vitamins or other services that may be offered by the facility (massages, private personal trainer sessions, etc.)

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.

How do I obtain the reimbursement?

- 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.
- Mail or fax your form to **MetroPlusHealth** to the address or fax to the right.

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

help.memberexperience@metroplus.org

Important: Please complete the form in its entirety or the processing of your claim maybe delayed or denied. 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	

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:**_____

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

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

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 22.324 11-22

WEIGHT LOSS REIMBURSEMENT FORM

As a MetroPlusHealth Gold member, we want to help you stay healthy. We will partially reimburse the Subscriber and the Subscriber's covered Spouse for weight loss program membership fees paid to recognized programs. The weight loss program you select must include counseling and behavioral intervention by a participating provider or program representative. Your treating physician must attest that the specific weight loss program you are enrolled in meets this criteria and that it would be beneficial to your overall health.

What types of Weight Loss Programs qualify?

✓ Weight Watchers (or "WW") ✓ Nutrisystem ✓ Noom ✓ Jenny Craig ✓ Nutritional Counseling

✓ Physician-directed weight loss programs, such as the CDC's Diabetes Prevention Program cdc.gov/diabetes/prevention/index.html

This is not a complete list, for questions please call Member Services at the number listed on your ID card.

Exclusions - the following are **not covered by MetroPlusHealth** as part of your Plan's weight loss program: The cost of food, beverages, supplements, vitamins or other items associated with the weight loss program, including books, scales, exercise equipment, one-time initiation and / or termination fees.

Am I eligible?

In order to be eligible, you must be an active member of a weight loss program. Your membership with **MetroPlusHealth Gold** must be current and paid to date at time of submission.

How do I get reimbursed?

- 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.
- Mail or fax your form to MetroPlusHealth to the address or fax to the right.

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

help.memberexperience@metroplus.org

Important: Please complete the form in its entirety or the processing of your claim maybe delayed or denied. 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	

Weight Loss Program Name	Weight Loss Program City, State
Weight Loss Program 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.

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

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

I attest that the above referenced weight loss program includes counseling and behavioral intervention and would be beneficial for the overall well-being of the above mentioned patient.

Physician's Name: _____ **Physician's NPI#:**

Physician's Signature: _____ **Date:**_____

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 22.324 11-22

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 $15 per trip (up to four (4) trips per plan year) or the full cost of your 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 member of **MetroPlus Gold.**

How do I obtain the reimbursement?

Obtaining reimbursement is easy! Simply complete this form and submit each time you have a ride to see a doctor. 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 claim period end date
- Mail or fax your form to MetroPlusHealth at the following address:

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

help.memberexperience@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):			
MetroPlusHealth ID Number	Last Name	First Name	Middle Initial
Address (Number, Street, Apt. #)	City	State	Zip Code

Trip 1 details:
Type of Transportation Provider
Date of Trip
Reimbursement Amount Being Requested

Trip 2 details:
Type of Transportation Provider
Date of Trip
Reimbursement Amount Being Requested

TRANSPORTATION REIMBURSEMENT FORM (CONT)

Trip 3 details:
Type of Transportation Provider
Date of Trip
Reimbursement Amount Being Requested
Trip 4 details:
Type of Transportation Provider
Date of Trip
Reimbursement Amount Being Requested

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 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. MBR 22.325 11-22

Metro Plus **Health** Gold

MKT 23.072