

## METROPLUS GOLD



Beginning January 1, 2016, MetroPlus Gold will be available to all NYC employees, non-Medicare eligible retirees, their spouses or qualified domestic partners, and eligible dependents. MetroPlus Gold's basic plan is offered at no cost to the employee. There are no copays for most in-network services, including PCPs, specialists, lab, and x-rays. No pre-authorizations are required for any outpatient services, and there are no written referrals to an in-network specialist. A low-cost optional prescription drug rider is available. MetroPlus has an extensive network of participating physicians and hospitals, with providers in over 22,000 sites in all five boroughs.

At a Glance	
<b>Plan Type:</b>	HMO
<b>Geographic Service Area</b>	Metro Plus service area currently includes Manhattan, Brooklyn, Queens, and the Bronx. Staten Island is pending for 2016. Visit the web site for updates on confirmation of inclusion of Staten Island: <a href="http://www.metroplus.org">www.metroplus.org</a> .
<b>Does this plan use a network of providers?</b>	Yes. Visit the Web site at <a href="http://www.metroplus.org">www.metroplus.org</a> for the most current list of participating providers.
<b>Do I need a referral to see a specialist?</b>	Written referral is not required to see an in-network specialist
<b>Contact Information</b>	1-877-475-3795 Representatives are available Monday through Saturday, 8:00 a.m. to 8:00 p.m.
<b>Web Site</b>	<a href="http://www.metroplus.org">www.metroplus.org</a>

Plan Features	Cost
<b>What is the overall deductible for this plan?</b>	<ul style="list-style-type: none"> <li>• \$0</li> </ul>
<b>What are the costs when you visit a health care provider's office or clinic?</b>	<ul style="list-style-type: none"> <li>• Primary care visit to treat an injury or illness: No charge Not covered for non-participating provider</li> <li>• Specialist visit: No charge Not covered for non-participating provider</li> <li>• Other practitioner office visit Chiropractor: No charge Not covered for non-participating provider</li> <li>• Preventive care/screening/immunization: No charge Not covered for non-participating provider Mammography (limits based on age), cervical cytology , gynecological exams, bone density, prostate cancer screening, etc. per New York State mandates and the ACA Prostate cancer screening :Annual for men age 50 and over; age 10 and over if family history or risk factors; any age if prior history. Includes exam and antigen test, per mandate.</li> </ul>
<b>What are the costs if you have a test?</b>	Diagnostic test (x-ray, blood work): No charge Not covered for non-participating provider Imaging (CT/PET scans, MRIs): No charge Not covered for non-participating provider
<b>What are the costs if you have outpatient surgery?</b>	Facility fee (e.g., ambulatory surgery center): \$50 co-pay Not covered for non-participating provider Physician/surgeon fees: No charge Not covered for non-participating provider
<b>What are the costs if you need immediate medical attention?</b>	Emergency room services: \$50 co-pay \$50 co-pay for non-participating provider Emergency medical transportation: No charge No charge for non-participating provider Urgent Care: No charge Not covered for non-participating provider (Covered with PCP referral)
<b>What are the costs if you have a hospital stay?</b>	Facility fee (e.g., hospital room): \$100 co-pay Not covered for non-participating provider Physician/surgeon fee: No charge Not covered for non-participating provider
<b>What are the costs if you are pregnant?</b>	Prenatal and postnatal care: No charge

Not covered for non-participating provider  
 Delivery and all inpatient services: No charge  
 Not covered for non-participating provider  
 Limited to 48 hours for natural delivery and 96 hours for caesarean delivery.

**WHAT ARE THE COSTS IF YOU HAVE MENTAL HEALTH, BEHAVIORAL HEALTH, OR SUBSTANCE ABUSE NEEDS?**

Service	Cost
<b>Mental/Behavioral health Outpatient services</b>	<ul style="list-style-type: none"> <li>No charge</li> <li>Not covered for non-participating provider</li> </ul>
<b>Mental/Behavioral health Inpatient services</b>	<ul style="list-style-type: none"> <li>No charge</li> <li>Not covered for non-participating provider</li> </ul>
<b>Substance abuse Outpatient services</b>	<ul style="list-style-type: none"> <li>No charge</li> <li>Not covered for non-participating provider</li> <li>Up to 20 visits may be used by family members for family therapy related to the Member's alcohol or substance abuse</li> </ul>
<b>Substance abuse Inpatient services</b>	<ul style="list-style-type: none"> <li>No charge</li> <li>Not covered for non-participating provider</li> <li>Detoxification must not exceed 5 days per admission</li> </ul>

**WHAT ARE THE COSTS IF YOU NEED HELP RECOVERING OR HAVE OTHER SPECIAL HEALTH NEEDS?**

Service	Cost
<b>Home health care</b>	<ul style="list-style-type: none"> <li>No charge</li> <li>Not covered for non-participating provider</li> <li>Coverage limited to 40 visits per year</li> </ul>
<b>Rehabilitation services</b>	<ul style="list-style-type: none"> <li>No charge</li> <li>Not covered for non-participating provider</li> <li>60 visits per condition, per lifetime combined therapies</li> </ul>
<b>Habilitation services</b>	<ul style="list-style-type: none"> <li>No charge</li> <li>Not covered for non-participating provider</li> <li>Limited to 60 visits per condition, per lifetime combined therapies</li> </ul>
<b>Skilled nursing care</b>	<ul style="list-style-type: none"> <li>No charge</li> <li>Not covered for non-participating provider</li> <li>200 days per Plan Year</li> </ul>
<b>Durable medical equipment (DME)</b>	<ul style="list-style-type: none"> <li>No charge</li> <li>Not covered for non-participating provider</li> <li>Authorized by PCP and MetroPlus</li> </ul>
<b>Hospice service</b>	<ul style="list-style-type: none"> <li>No charge</li> <li>Not covered for non-participating provider</li> <li>Six months per Plan year; Five visits for family bereavement counseling</li> </ul>

**OPTIONAL RIDER**

What is the cost if you need drugs to treat your illness or condition?

	Retail	Mail Order
<b>Generic drugs</b>	\$5 co-pay/30 day supply	\$10 co-pay/90 day supply
<b>Preferred brand drugs</b>	\$35 co-pay/30 day supply	\$70 co-pay/90 day supply
<b>Non-preferred brand drugs</b>	\$70 co-pay/30 day supply	\$140 co-pay/90 day supply
<b>Specialty drugs</b>	Generic drugs	\$70 co-pay/30 day supply
	Preferred brand drugs	\$70 co-pay/30 day supply
	Non-preferred brand drugs	\$70 co-pay/30day supply
		\$140 co-pay/90 day supply

Please refer to the Summary of Benefits and Coverage (SBC) for additional information and to see what this plan covers and any cost-sharing responsibilities.