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December 7, 2021

Via NYSECF
Justice Lyle E. Frank
Supreme Court of the State of New York
60 Centre Street
New York, New York 1007

Re: NYC Organization of Public Service Retirees, Inc. et al. v. Renee Campion et al
Index No: 158815/2021
Law Dept. No.: 2021-028140

Dear Justice Frank:

On behalf of Respondents, and in advance of tomorrow's status conference, we write to provide an update of the proposed implementation plan for the new NYC Medicare Advantage Plus Plan (the "MA Plan"), based on discussions with Petitioners' counsel, representatives of the Office of Labor Relations, and counsel for the City, the MLC and the Alliance. A document outlining and explaining the updated proposed implementation plan is attached here, as are several exhibits reflecting additional detail, including proposed communications to retirees and providers about the new proposed implementation schedule. The key features of the plan are as follows:

- **New proposed implementation and opt-out dates**. The proposed implementation date for the MA Plan is February 1, 2022; retirees will be able to opt out of the MA Plan until January 31, 2022 but will be urged to opt out of the MA Plan as soon as possible to assure that retirees receive ID cards.
- **Open switch period between the MA Plan and Senior Care Plan from February 1, 2022 to June 30, 2022**. As previously discussed with the Court, we are proposing an open switching, "trial" period between the MA Plan and Senior Care, running from February 1, 2022 through June 30, 2022.
- **Additional communication efforts to retirees and providers**. In addition to the efforts already undertaken since October, the proposed implementation plan includes new

additional increased outreach to retirees, including a proposed awareness-building media advertising campaign, and continued work to increase awareness among providers, including new proposed mailings upon Court approval of the new implementation schedule.

This proposed implementation plan is a result of efforts between the parties to address issues raised by the Court and concerns expressed by petitioners through, among other things, extensive messaging efforts and a uniquely flexible implementation process. *See* Exhibit B. The proposed opt-out dates not only give retirees sufficient time to receive and process additional material information – via a proposed new letter mailed to retirees (Exhibit A to the proposed Implementation Plan) which supplements the materials sent out this fall, updated materials, including the Enrollment Guide, on OLR's website, all in addition to the supplemental outreach efforts made since October 21 – in the additional weeks leading up to January 31, 2022. In addition, the proposed five-month "trial period" provides retirees with additional flexibility to change between the MA Plan and the Senior Care Plan.

Heeding the Court's suggestion, representatives of OLR, Respondents' counsel and counsel for the City, MLC and the Alliance met with Petitioners' counsel to discuss this proposed implementation plan last Friday. The meeting helped articulate some of Petitioners' concerns and Respondents have addressed some of Petitioners' suggestions. In particular, the Alliance has agreed to once again reach out to all of their in-network providers and remind them of their contractual obligations to accept the Medicare Advantage Plus program and, to urge provides to share this information with their employees who might be the recipients of telephone inquiries.

We also assessed Petitioners' concerns about the Enrollment Guide for the MA Plan, and after additional review and consideration, we have concluded that only minimal changes were needed to the Enrollment Guide, most of which were precipitated by the changed implementation dates. Upon the Court's approval of a new implementation schedule, retirees will be informed of that new schedule via the proposed letter attached as Exhibit A to the proposed Implementation Plan. The Enrollment Guide will be also updated to reflect that schedule.

Additionally, to address Petitioners' concerns about the prior authorization section of the Enrollment Guide, changes will be made, but are also minimal and do not warrant a full reissuance. Those changes will be to add asterisks (*) to five headings in the Enrollment Guide – Diagnostic Services (PET Scan/MRI), Inpatient mental health, Physical Therapy, Home Health Care, Acupuncture, at pages 20-23 – to indicate that some particular services within these categories are subject to prior authorization. Once those changes are made, the Enrollment Guide's prior authorization section will match the descriptions available in the Summary of Benefits and EOC, both of which are (and have been) available online, including on OLR's website, for some time. Respondents have attached an Enrollment Guide with these proposed changes. *See* Exhibit C.

It bears repeating that prior authorization is not a new concept to the retirees in that many experienced it as active employees and as pre-Medicare retirees. It also bears repeating that, notwithstanding Petitioners' contrary suggestions, prior authorization is handled by providers, not retirees and prior authorization decisions are made by clinical staff, not clerical staff. Retirees can and should direct any service-by-service queries about prior authorization to their providers.

It would be costly and time-consuming to reissue hard copies of the Enrollment Guide, which is more than 80 pages in length. Reprinting and mailing hard copies would be expensive and complex. The Alliance estimates that re-printing and re-mailing approximately a quarter of a million hard copies of the Enrollment Guides would cost approximately $825,000. Additionally, due to a global paper supply shortage worldwide, with "lead times" for new orders currently stretching into February 2022, it would be impossible to quickly secure millions of additional pages of paper stock, as would be necessary to re-print the enrollment guides *en masse*. The Alliance reports that to do so any time soon, the Alliance would have to use the stock of paper currently reserved for the MA Plan's member welcome kits. This would leave the Alliance unable to produce those CMS-mandated materials in a timely way, as required to implement the MA Plan.

Given the minimal changes, reprinting and remailing a quarter of a million copies would be wasteful. Of course, Respondents would mail a new Enrollment Guide to any retiree who requests a copy. Moreover, the revised Enrollment Guide will be available through numerous other sources, including on OLR's website, the Alliance's website, and additional materials will be made available upon request, including a prior authorization-specific flyer, which is currently on OLR's website.

Additionally, some unions have hosted meetings with the New York City retirees to increase outreach. Thousands of additional retirees have been educated about the Medicare Advantage plan through union-specific discussions and webinars, many of which have been posted online on YouTube and the like.

During Friday's meeting, we noted that there would be a "trial period" from February 1 to June 30, 2022, during which Retirees could participate in the Plan and if unsatisfied, still transfer back to the Senior Care Plan. Petitioners suggested that such an option would violate CMS regulations. The matter has been investigated and we assure both the Court and Petitioners that federal regulations and CMS guidelines expressly contemplate "special election periods," or SEPs, outside of a normal enrollment schedule. *See* 42 C.F.R. § 422.62(b) (describing SEPs generally); *id.* § 422.62(b)(4). These provisions expressly allow SEPs where, as here, "the individual [would be] making an MA enrollment request into or out of an employer sponsored MA plan". *See also* Medicare Managed Care Manual, Chapter 2 (Medicare Advantage Enrollment and Disenrollment)[1], Section 30.4.4 (explaining that the SEP provision for group MA plans applies

[1] https://www.cms.gov/files/document/cy2021-ma-enrollment-and-disenrollment-guidance.pdf

both "during the employer's or union's 'open season,' or at other times the employer or union allows") (emphasis added).

With respect to Petitioners' assertion that there are data privacy implications with respect to the proposed implementation of the MA Plan (see November 28, 2021 letter), those concerns remain unwarranted. As previously noted, HIPAA is not implicated by the proposed implementation plan because protected health information is "individually identifiable health information held or transmitted by a covered entity or its business associate."[2] The data being transferred is enrollment data held by the City in its capacity as a group health plan sponsor. The U.S. Department of Health and Human Services has explained that "[n]either employers nor other group health plan sponsors are defined as covered entities under HIPAA."[3] Additionally, HHS states that in transferring participation and enrollment data to the Alliance, the City is acting on behalf of plan participants, not the plan itself. Because enrollment activities are not taken *by* a covered entity or *on behalf of a covered entity*, the Privacy Rule's restrictions on use and disclosure of protected health information do not apply to the transfer of enrollment data to a health insurance issuer like the Alliance.[4] Thus, the data held by the City is not protected health information and is not subject to HIPAA.

Nor does the proposed implementation plan violate any state law, and in particular the "Statewide Health Information Network For New York" ("SHIN-NY") regulations cited by Petitioners, which at most cover certain data transfers by "Qualified Entities" ("QEs") as defined by 10 N.Y.C.R.R. § 300.5(a), which the City is not. *See* Alliance Letter dated Nov. 24, 2021. Citing a press release, Petitioners now claim that the City is a QE through New York City Health and Hospitals Corporation, d/b/a NYC Health + Hospitals (H&H) (Nov. 28, 2021 Letter at 3). Setting aside the irrelevant character of the assertion. even if H&H, a legally distinct entity from the City, were considered part of the City, H&H is not involved with the MA Plan or the transfer of data needed to implement the Plan. Moreover, even if H+H were involved, the NY regulations govern only data accessed or shared through SHIN-NY, which is not how the enrollment data will be conveyed. SHIN-NY is "the electronic exchange of clinical information among qualified entities and qualified entity participants for authorized purposes to improve the quality, coordination and efficiency of patient care, reduce medical errors and carry out public health and health oversight activities, while protecting patient privacy and ensuring data security."[5] The information at issue in this case is enrollment data—not clinical information; the information is being shared for purposes apart from those enumerated in the definition of SHIN-NY; and the

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[2] *See* "Summary of the HIPAA Privacy Rule," HHS.gov (July 26, 2013), available at https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html.

[3] *See* FAQ 499, "As an employer, I sponsor a group health plan for my employees. Am I a covered entity under HIPAA?" HHS.gov (July 26, 2013), available at https://www.hhs.gov/hipaa/for-professionals/faq/499/am-i-a-covered-entity-under-hipaa/index.html.

[4] *See* 65 Fed. Reg. 81,461, 82,509 (Dec. 28, 2000) ("We note that a plan sponsor may perform enrollment functions on behalf of its employees without meeting the conditions above").

[5] 10 N.Y.C.R.R. § 300.1(a).

information is not being shared or accessed through SHIN-NY. This information network has nothing to do with a transfer of data from a plan sponsor to a health insurance plan, and the regulation cited by the Petitioners has nothing to do with this transfer of data.[6]

During the Friday meeting Petitioners made a number of other suggestions, or demands, which, under the guise of either giving retirees more time to consider the MA Plan, or to supposedly analyze the degree of awareness among retirees and providers, were really an attempt to delay implementation by several additional months. Indeed, as the meeting drew to a close, Petitioners made additional suggestions, or demands, that would not so much constitute modifications to an informational campaign, but would be an entirely new approach. We would be happy to inform the Court more about these demands, but in short, Petitioners concluded the meeting by reasserting that their core desire is replace the Plan with one of their own envisioning.

The switch to Medicare Advantage is a long-term project. It is the fruit of extensive study and negotiations, in accord with collective bargaining mandates, between Respondents and the MLC. The current administration and union representatives have the legal authority to move forward with the MA Plan as long as it is not irrational. The possibility that a future administration, no matter how imminent, may take a different view of the MA Plan cannot serve as valid and legal basis for delaying implementation. Such an approach would unlawful.

We look forward to discussion a path forward on the MA Plan tomorrow, and we appreciate the Court's attention to this matter.

Respectfully submitted,

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s/ William S.J. Fraenkel
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[6] Petitioners' citations to other policy guidance that generally proclaims New York's policy in protecting privacy are equally unavailing. Indeed, the Petitioners cite to "HIPAA Preemption Charts," that detail how health care providers may share information under New York law; however, the City is not acting in the capacity of a health care provider, and HIPAA does not apply to this data. Petitioners also point to a Department of Financial Services Office of General Counsel opinion that governs how an insurer may disclose personal information. However, as detailed above, this disclosure is not being made by an insurer—it is being made by a plan sponsor *to* an insurer—and thus, the regulation and GC opinion cited by the Petitioners simply do not apply to this transfer of information.

cc: **(VIA NYSCEF)**

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Proposed Implementation Plan for NYC Medicare Advantage Plus Plan
December 7, 2021

1. New Proposed Implementation Date and Opt-Out Deadlines

a. New Proposed Implementation Date:
February 1, 2022

b. New Proposed Initial Deadline to Opt Out or Rescind an Opt-Out:
December 31, 2021

c. Pursuant to CMS rules, Final Proposed Opt Out Deadline:
January 31, 2021

Explanation: The City has a strong interest in starting the new Medicare Advantage program as soon as possible. However, given the current injunction, the City and the Alliance cannot launch the plan by the previously proposed January 1, 2022 implementation date. As such, the City has selected the next available start-of-month date – February 1, 2022 - as the proposed implementation date.

As of January 1, 2022, retirees will remain in the plan they were in for 2021, unless they utilized the once in a lifetime option to change plans or transferred plans during the annual transfer period.

With respect to the opt-out deadline: as explained during recent correspondence, implementing a new Medicare Advantage plan through a CMS compliant auto-enrollment with opt-out process requires enrolling retirees in the Medicare Advantage program with CMS before the implementation date. Setting an opt-out deadline a month or more before implementation is consistent with usual practice and CMS rules. The proposed December 31, 2021 initial opt out date is appropriate here given that retirees have already had several months to opt out, and given the additional informational efforts made by the City and by the Alliance since the Court's October 21, 2021 decision, and those described below.

We are calling the proposed December 31, 2021 date an "initial deadline" rather than a "deadline" for two reasons.

First, while it is common for large group plans and their insurers to seek to impose an opt-out deadline on members for logistical reasons, CMS rules in fact obligate insurers to honor opt-out requests made up until the implementation date of a plan (*i.e.*, beyond any earlier "deadline"). Initial deadlines are put in place to encourage members to opt out at least 30 days prior to implementation because filing opt-outs close to the implementation date is not recommended, as it can cause delays in re-enrolling members in their alternative coverage, but members have a right to do so if they view it as sufficiently important. Additionally, while CMS rules do not require insurers to offer comparable treatment to "late" opt-out "recissions" (in effect, late

requests to enroll), the Alliance has committed to honor recissions/requests to enroll up until the proposed implementation deadline.

Second, as described previously and below, the City and the Alliance are allowing retirees the additional flexibility of switching between the NYC Medicare Advantage Plus Plan and the Senior Care plan through the end of June 2022. While this is not an opt-out period, it still functionally extends the time period in which retirees can join or leave the NYC Medicare Advantage Plus Plan while the plan is being implemented.

2. Open Switch Period Between NYC Medicare Advantage Plus Plan and Senior Care

a. New Proposed Period for Switching Between NYC Medicare Advantage Plus and Senior Care: February 1, 2022 through June 30, 2022.

Explanation: If retirees want additional time to continue to gather information regarding the NYC Medicare Advantage Plus Plan and test/evaluate the NYC Medicare Advantage Plus Plan, the City and the Alliance have agreed to allow the retirees to switch between the NYC Medicare Advantage Plus Plan and the Senior Care plan for five months after implementation – from the proposed implementation date of February 1, 2022 through June 30, 2022. Requests can be made to switch in either "direction" – *i.e.*, to move from the NYC Medicare Advantage Plus Plan to Senior Care, or vice versa. Requests will be processed and go into effect as soon as possible after the switch request is made, which will generally be the first of the calendar month after the request is made. This option will not involve the so-called "one-time" lifetime switch option.

3. Updated Plan Materials for Retirees

The City proposes to update retirees as to these proposed changes through the following means:

a. An updated letter to retirees, attached here as Exhibit A, which will be posted online on OLR's website and mailed to all retirees, at an estimated cost of more than $100,000
    i. This mailing will be sent once the Court approves the new implementation plan.
b. An updated prior authorization flyer, attached here as Exhibit B, which is already posted online, and which will also be mailed to retirees on demand. Requests can be made via phone to the Alliance hotline.
c. Updated versions of the enrollment guides will be posted online, a proposed version attached here as Exhibit C.
    i. The revised enrollment guide will be mailed to any retiree who requests a revised version. Requests can be made via phone to the Alliance hotline.
d. Continued live retiree education webinars, with Q&A sessions, through January. Six to ten additional general-attendance webinars will be scheduled in December and January.
e. A new archived webinar for retirees, to be posted online as soon as the Court approves the new proposed implementation date and opt-out deadlines.

f. An updated provider finder tool, available online at https://www.empireblue.com/find-care/, through which retirees can find in-network providers or confirm the status of their existing providers.

Explanation: The updated draft letter to retirees informs them about the new start date approved by the Court for the NYC Medicare Advantage Plus Plan, the updated opt-out deadline and new trial period, and the practical flexibility provided by these options. The letter also summarizes relevant information about the plan.

In response to Petitioners' request for clarification and more comprehensive information regarding prior authorizations, the City has posted online and the Alliance will mail the new flyer on prior authorization as part of its planned informational mailing to retirees upon demand; retirees can call the Alliance hotline and will be sent a hard copy of the flyer. Once a new implementation plan is confirmed, the City will also update the enrollment guides to reflect the new implementation schedule (*i.e.*, opt-out deadlines and implementation plan) and update the prior authorization section of the enrollment guides so those sections match the information in the Summary of Benefits and Evidence of Coverage documents available on OLR's website. Given the minor changes to the prior authorization section of the enrollment guide, the City does not believe it is necessary to do an additional mailing of the enrollment guide to all retirees, but is willing to provide additional copies upon demand.

The City and the Alliance will also continue offering live webinars, which so far have been attended by more than 38,000 retirees (across 80 sessions). As soon as the Court approves the proposed implementation plan, the City and the Alliance will also ensure that a webinar is posted online on the websites of both OLR and the Alliance for on-demand viewing. (This had previously been done, but the archived webinar – which referred to the original October 31, 2021 opt-out deadline – was removed in light of the Court's injunction.)

The Alliance has continued to update and refine its provider finder database, available at https://www.empireblue.com/find-care/, in light of feedback received from Petitioners.

4. Media Campaign

In addition to the updated plan materials for retirees, the Alliance plans to commence a media advertising campaign as soon as the Court approves a new implementation date. Current copies of the advertisements are enclosed here as Exhibit D. These advertisements are designed to target the 10 most-populated counties in the country for City retirees – nine counties in and around New York City, and Palm Beach County, Florida – and will run in nine prominent publications.[1]

5. Educational outreach to providers

The City and the Alliance are continuing their outreach efforts to providers, as follows:

[1] They are: (1) the New York Times; (2) the Daily News (NY); (3) the Sun Sentinel (Palm Beach, FL); (4) The New York Post; (5) Newsday; (6) The Journal-News (Westchester); (7) Politico; (8) City & State; and (9) Chief Leader.

a. Provider webinars, to run through February 2022.
b. Fax, mail, and email communication efforts to providers, in the form of Exhibit E – were provided to 520,000 providers within the past two months, and will be sent again with updated dates once the Court approves the new proposed implementation date and opt-out deadlines, at an estimated cost of nearly $150,000.
c. Telephone outreach to high-volume providers, in and out of network – underway and the Alliance has already contacted more than 60,000 providers by telephone.
d. A new archived webinar for providers, to be posted online as soon as the Court approves the new proposed implementation date and opt-out deadlines.

Those efforts are in addition to the provider outreach efforts that the Alliance had previously announced and carried out – namely, (1) holding meetings with large provider groups such as Mount Sinai, Northwell Health, Montefiore, and Memorial Sloan Kettering; (2) offering all providers monthly newsletter articles; and (3) posting plan information to Empire and Emblem health provider portals. *See* Exhibit F (examples of December 2021 provider communications including a provider Q&A, a webinar invitation, and newsletter updates, reflecting the status quo).

As soon as the Court approves a new implementation schedule, the Alliance will update its provider materials and broadly re-circulate them to reflect the new implementation schedule. In particular, the Alliance is prepared to: (1) re-send, via mail (at significant expense) and email, an updated version of Exhibit E (the provider communication) to providers; and (2) immediately update the types of provider updates reflected in Exhibit F with the relevant schedule.

In addition, the Alliance will specifically investigate any inquiries made by retirees regarding whether a provider is in-network or should accept the NYC Medicare Advantage Plus Plan. Retirees can direct such inquiries to the Alliance hotline.

EXHIBIT A

Exhibit A

PROPOSED LETTER TO RETIREES

ALL DATES ARE SUBJECT TO COURT APPROVAL

Dear Retiree:

On behalf of the City of New York and the Municipal Labor Committee, we are writing with additional information regarding the new **NYC Medicare Advantage Plus Plan**. In this update, we are providing **new information** about the start date for the new plan and the timeline for retirees to join or opt out of the new plan. We are also providing a new summary of key information about the plan itself.

The two important updates about the timeline for joining or opting out of the NYC Medicare Advantage Plus Plan are as follows.

- **New start date for the NYC Medicare Advantage Plus Plan – February 1, 2022**. In prior communications, we had informed you that the NYC Medicare Advantage Plus Plan would begin effective January 1, 2022. The start date has now been pushed back to February 1, 2022. You will remain on your current insurance plan for the month of January 2022.

- **New to opt-out deadlines**. Previously, the deadline for retirees to opt out of automatic enrollment into the NYC Medicare Advantage Plus Plan was October 31, 2021.

    - The opt-out period has been extended until December 31, 2021. If you are unable to make a decision by then, the final deadline to opt out of the NYC Medicare Advantage Plus Plan is January 31, 2022.

    - If you do not opt out of the NYC Medicare Advantage Plus Plan, you will automatically be enrolled in the plan effective February 1, 2022.

- **New opportunity to switch between NYC Medicare Advantage Plus Plan and the GHI/EBCBS "Senior Care" until June 30, 2022**. Retirees will be able to switch between the NYC Medicare Advantage Plus Plan and the GHI/EBCBS "Senior Care" program until June 30, 2022. In other words: you can test out the NYC Medicare Advantage Plus Plan for up to five months, and if you feel the need to opt out of the plan and into Senior Care, you will be able to do so during that period of time.

More details about these new deadlines are provided in the "Opt-Out and Plan Switch" section on page 5 below.

Additionally, we know you may still have other questions about the new plan, and we want to make sure you have all the information needed to answer them. Much more is below, but the key points all retirees should know are:

- **What it is**. The NYC Medicare Advantage Plus Plan is a **premium-free**, Medicare Advantage program for all Medicare eligible City retirees and their Medicare eligible dependents.

- **Who is providing it**. The NYC Medicare Advantage Plus Plan will be provided by an Alliance between Empire Blue Cross Blue Shield and EmblemHealth.

- **You should have already received an enrollment guide and opt-out form, among other materials**. See details in "Enrollment Materials" below.

- **The plan is flexible.** Under the plan, you may go to any provider that accepts Medicare, at no additional cost to you other than your deductible or co-pay/co-insurance for covered services. See details in "Flexibility" below.

- **The plan's network, while not necessary to use, is broad**. You do not have to see an in-network provider under this plan, but you certainly can – the plan's network, via the combined Medicare Advantage networks of EmblemHealth and Empire and their partners, includes more than a million health providers nationwide. In-network providers are contractually obligated to see members of the plan. See details in "Network" below.

- **You can see out-of-network providers**. You can see out-of-network Medicare providers. See details in "Out-of-Network Providers" below.

- **Prior authorization**. Under the plan, the vast majority of covered services are not subject to a "prior authorization" requirement, but some are. Prior authorization is a feature of all Medicare Advantage plans, and is similar to an existing requirement for many active City employees. A new flyer describing prior authorization in more detail has been posted on the OLR website and will be mailed by the Alliance upon request. See details in "Prior Authorization" below.

- **Prescription drug benefits**. Many retirees get prescription drug coverage directly from their welfare fund and that remains unchanged. For those who do not, the EmblemHealth prescription drug rider that is currently available will still be offered, and at a lower price. Some retirees currently purchase individual Medicare Part D coverage, via a subsidy from their welfare fund; those retirees will not be able to do so, and will have to obtain coverage through the EmblemHealth rider. See details in "Prescription Drug Benefits" below.

- **More information is available online**. See details in "More Information" below.

* * *

Enrollment Materials

In September or October, you should have received an enrollment guide for the new plan, which included a detailed benefits summary, along with the Medicare Part D prescription drug rider. We also informed you that retirees had the option of opting out of the new plan and remaining in their current health plan, whatever that might be, but would have to pay a premium to do so.

If you did not receive this information or have misplaced the materials previously sent, please call our dedicated call center at **1-833-325-1190**, Monday to Friday, 8 a.m. to 9 p.m., and we will arrange to send you another copy.

Outreach Efforts

Since the new plan was announced, the Alliance and the City have conducted an extensive education program for those retirees with additional questions. We have conducted 81 informational sessions, reaching at least 38,000 retirees, with more on the way throughout December 2021 and January 2022. Retirees can access these programs and obtain additional information regarding the NYC Medicare Advantage Plus Plan on the Office of Labor Relations' website, available at https://www1.nyc.gov/site/olr/health/retiree/health-retiree-responsibilities-assistance.page. This website includes the latest updates, forms, and links to webinars regarding the new plan.

Because we understand that many retirees still have questions about the new plan, we wanted to reemphasize some of them now.

Flexibility

In the NYC Medicare Advantage Plus Plan, you may go to any provider that accepts Medicare, at no additional cost to you other than your deductible or co-pay/co-insurance, for covered services.

- If you go to an in-network provider, you will only need to pay your deductible or co-pay/co-insurance.
- If you go to an out-of-network provider participating in Medicare, you will only need to pay your deductible or co-pay, and the provider can bill the plan directly for services.

Put another way, if *you go to any doctor, in or outside the network, who takes Medicare, you will have no expense other than your deductible or co-pay/coinsurance for the covered services.*

Network

You may be familiar with other Medicare Advantage plans that require you to only use in-network providers. The NYC Medicare Advantage Plus Plan is not one of them – as noted above, you can see any doctor or provider who takes Medicare – and 99 percent of medical providers across the country do.

That said, there is a network that covers the NYC Medicare Advantage Plus Plan – the combined Medicare Advantage networks of EmblemHealth and Empire, including Empire's "Blue" partners across the county. This includes providers in the following networks:

- EmblemHealth's Medicare Choice PPO
- Empire MediBlue PPO
- BlueCross BlueShield (BCBS) Medicare Advantage PPO Network

The NYC Medicare Advantage Plus Plan's network is broad – it encompasses more than a million health care providers across the county, including more than 91 percent of health providers recently used by City retirees in the GHI/EBCBS "Senior Care" program. As to hospitals: approximately 89 percent of retirees live in three states, New York (69 percent), Florida (13 percent, concentrated in Palm Beach and Broward counties), and New Jersey (7 percent), and hospitals in those states are overwhelmingly in-network. With one exception, all New York hospitals (including Cornell, Hospital for Special Services, Montefiore, Memorial Sloan Kettering, Mount Sinai, Northwell, and NYU) are in-network, and the last hospital (Maimonides) has verbally agreed to join the network and is expected to be in contract soon. All New Jersey hospitals are in-network. And more than 90 percent (190 of 211) Florida hospitals are in-network, including the three main Palm Beach/Broward hospitals (Oak Hill, Del Ray Medical Center, Boca Raton Community Hospital)

So, while you do not need to go to an in-network provider in the NYC Medicare Advantage Plus Plan, you can certainly do so, and the odds that your existing provider is already in-network are very, very high.

In-network providers are contractually obligated to see you as a patient (unless their practice is closed to new patients). In-network providers are also required to obtain prior authorization for you where necessary.

If you are interested in finding out whether a particular medical provider is part of the network for the NYC Medicare Advantage Plus Plan, you can contact them directly, or you can look up the status of providers on the following website: https://www.empireblue.com/find-care/. You can call **1-833-325-1190** and the Alliance will assist you with determining wither a medical provider is part of the network.

Out-of-Network Providers

If you go to an out-of-network provider, that provider will almost certainly bill the NYC Medicare Advantage Plus Plan directly, and you will only be responsible for your deductible or co-pay/coinsurance for covered services.

That said, in extremely rare circumstances, the provider may ask you to pay for the services directly. If this happens, your first call should be to the NYC Medicare Advantage Plus Plan at **1-833-325-1190**; our concierge service will attempt to encourage the provider to bill the plan directly and explain the benefits of doing so.

If the provider refuses to bill the plan directly, you can still see that provider, but you will have to pay the provider's bill and obtain reimbursement from the NYC Medicare Advantage Plus Plan. Details about how to do this are available in the enrollment guide and can be discussed with the Alliance's help line, but the short version is that you will submit the related documentation, and so long as all the necessary information is included, the Plan will pay you within 30 days.

Prior Authorization

You may have heard, or seen in the enrollment guide, that some services in the NYC Medicare Advantage Plus Plan have a "prior authorization" requirement. Prior authorization will be familiar if you have been part of the GHI CBP/Empire BlueCross BlueShield plan for active employees and pre-Medicare retirees, which contains a similar requirement. It will also be familiar to the tens of thousands of City retirees in existing Medicare Advantage programs.

Prior authorization is a common part of health care plans. The goal is to ensure members receive high quality evidence-based care, by working with your doctor to evaluate services. In the NYC Medicare Advantage Plus Plan, the vast majority of covered services are not subject to a "prior authorization" requirement, but some – like non-emergency elective hospital admissions – are. For those services, requests are clinically reviewed by the Alliance team of doctors and nurses for prior authorization. The Alliance follows Centers for Medicare & Medicaid Services guidelines for completing reviews but will complete prior authorization as soon as all information is available.

We are including additional information about prior authorization, which includes a summary of the services currently subject to prior authorization. To see the flyer online, please visit OLR's website (https://www1.nyc.gov/site/olr/health/retiree/health-retiree-responsibilities-assistance.page) and click on "Prior Authorization FAQs" or to request another copy, call 1-833-325-1190.

Prescription Drug Benefits

Many retirees currently get prescription drug coverage from their unions or the related welfare funds. That will remain the same under the NYC Medicare Advantage Plus Plan. For retirees who do not receive drug coverage that way, the EmblemHealth prescription drug rider that is currently available will still be offered but at a lower price. The cost has been reduced from $150 per month to $125 per month.

Some retirees currently purchase individual Medicare Part D benefit plans, via a subsidy from their welfare fund. Medicare rules do not allow individuals enrolled in a Medicare Advantage plan to obtain drug coverage in this way. For those retirees to obtain prescription drug coverage, they will have to sign onto the EmblemHealth prescription drug rider.

If you have any questions about whether you fit into this category, contact your union or welfare fund plan administrator.

Opt-Out and Plan Switch

Opt-Out. As you may know, the original deadline for retirees to opt out of the new NYC Medicare Advantage Plus Plan was October 31, 2021.

The opt out period has been extended until December 31, 2021.. The procedure for opting out remains the same as before, and if you have any questions about how to opt out, you can call the NYC Medicare Advantage Plus Plan at **1-833-325-1190**. Retirees who do not opt out will be automatically enrolled in the NYC Medicare Advantage Plus Plan effective February 1, 2022.

If you previously opted out of the NYC Medicare Advantage Plus Plan, but have reconsidered that decision, you can withdraw your opt-out and remain in the NYC Medicare Advantage Plus Plan. To do so, please call the NYC Medicare Advantage Plus Plan at **1-833-325-1190**. You can also submit a written statement containing your name, address, date of birth, and Medicare Beneficiary Number via mail to NYC Medicare Advantage Plus Plan, PO Box 1620, 90 Church Street, New York, New York 10007-9988, or via fax to 877-494-7195. Telephone and mail are preferred because they are more secure ways of transmitting sensitive personal information, but Alliance will honor opt-out requests received via fax if that is how you send it.

Late Opt-Outs Will Be Honored Until January 31, 2022. While the period for opting out of the NYC Medicare Advantage Plus Plan has been extended until December 31, 2021, you can opt out of the NYC Medicare Advantage Plus Plan in January 2022 if you feel it is necessary. We urge you to make your decision before December 31, 2021 because opt-out requests take time to process and can lead to confusion about insurance status. The final deadline to opt out of the NYC Medicare Advantage Plus Plan is January 31, 2022.

If you file an opt-out request in January 2022, please be aware that you may still receive materials from the federal Centers for Medicare and Medicaid Services ("CMS") indicating that you are being enrolled in the NYC Medicare Advantage Plus Plan. You can disregard these materials; if you opt out, you will be re-enrolled in your current insurance plan.

Plan Switch Between the NYC Medicare Advantage Plus Plan and Senior Care through June 30, 2022. In addition to the opt-out procedure, retirees will also be able to make a one-time switch between the NYC Medicare Advantage Plus Plan and the Senior Care plan through June 30, 2022. This means that:

- A retiree enrolled in the NYC Medicare Advantage Plus Plan as of February 1, 2022 can switch to Senior Care until the end of June 2022.
- A retiree who has opted out into Senior Care plan as of February 1, 2022 can switch to the NYC Medicare Advantage Plus Plan until the end of June 2022.
- This option will not be available to retirees who opted out into plans other than Senior Care.

To make a switch between the NYC Medicare Advantage Plus Plan and Senior Care, retirees should use the City's change of plans form, which will be available on OLR's website, or can be requested from the NYC Medicare Advantage Plus Plan's call center. Plan switches will become

effective on the first day of the month after they are made – for example, a plan switch submitted on February 15, 2022 would become effective March 1, 2022. Please note that this option will not involve the so-called "one-time" lifetime switch option; it is a special switching option unique to this five-month period.

More Information

More information about all these points, as well as others, is available to retirees from a number of sources.

In addition to the copy of the enrollment guide you already received, you can also find the most updated versions on OLR's website.

OLR's dedicated website for the NYC Medicare Advantage Plus Plan contains the latest and most updated information. A link is above.

EXHIBIT B

Empire BlueCross BlueShield

An Anthem Company

EmblemHealth

Questions about prior authorization? Here's what you need to know.

What does prior authorization mean?

Some types of care require your provider to get an approval from us before you receive care. This is called prior authorization.

Why is prior authorization needed?

Prior authorization helps ensure you get proper care. It helps us work with your doctor to evaluate services for medical necessity before you receive treatment or services.

What is medical necessity?

Medical necessity means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice. We use medical records and recognized clinical guidelines to establish medical necessity.

Your NYC Medicare Advantage Plus Plan will generally cover care as long as it is medically necessary and the service is included in your *Evidence of Coverage* and benefits charts.

How do I know if I need prior authorization before I receive care?

It is the provider's responsibility to ask for prior authorization from Empire BlueCross BlueShield (Empire). **You aren't responsible for asking for it when you see a provider that accepts NYC Medicare Advantage Plus.** We've provided a list on the pages that follow of some common services to help you know when to ask.

How does prior authorization work?

Providers who accept NYC Medicare Advantage Plus are required to ask for prior authorization before providing certain types of care, and once approved by Empire, the provider will only bill you for your applicable copay or coinsurance. If your provider doesn't ask for prior authorization when required, the claim will be denied. The provider CANNOT bill you for the treatment if they did not get prior authorization.

Out-of-network providers aren't required to ask for prior authorization. We encourage you to ask your provider to request it for you before you get care. Here's why:

- If the provider doesn't ask for prior authorization, Anthem will review the claim after you've been treated.
- If the claim is determined to be medically necessary, we will process it according to the rules of your plan.
- If the claim is determined to not be medically necessary, we will deny the claim and let you know that you have the right to appeal the decision. The provider CAN bill you for the treatment.

Whether you see an in-network or out-of-network provider, if your provider does ask for prior authorization and it is denied:

- You will be notified. If you choose to continue with the treatment, you will be responsible for the cost.
- We will let you know that you have the right to appeal the decision.

The important thing to remember is that you are not responsible for asking for prior authorization when you see an in-network provider. If you see an out-of-network provider, you can ask them to request it for you.

Below is a general list of services to help you know when prior authorization is required or when to ask your provider to request it. Please note, this is not a complete list and is provided as a guide to help you get the most out of your plan. Detailed prior authorization information is available for your providers.

Inpatient admissions

- Elective inpatient admissions
- Rehabilitation facility admissions
- Skilled nursing facility admissions
- Long-term acute care (LTAC) care

Select outpatient services

- Orthotics (performed primarily on ankle, back, foot, and knee)
- Elective inpatient surgery
- All potentially cosmetic surgeries
- Arthroscopies/arthroplasties
- Bariatric/gastric obesity surgery
- Breast reconstruction
- Cervical fusions
- Continuous glucose monitoring (CGM)
- Coronary artery bypass graft (CABG)
- Defibrillator/pacemaker insertion or replacement
- Genetic testing
- Endoscopies
- Epidermal growth factor receptor testing
- Home health
- Hyperbaric oxygen therapy
- Intracardiac electrophysiological studies (EPS) catheter ablation
- Knee and hip replacements
- Knee orthoses
- Laminectomies/laminotomies
- Laparoscopies
- Nerve destructions
- Nonemergency ground, air, and water transportation
- Occupational therapy
- Oncology (Breast), mRNA, gene expression profiling
- Pain management
- Physical therapy
- Sleep studies and sleep-study-related equipment and supplies
- Spinal orthoses
- Spinal procedures
- Tonsillectomy/adenoidectomy
- UPPP surgery (Uvulopalatopharyngoplasty - removal of excessive soft tissue in the back of the throat to relieve obstruction)
- Vascular angioplasty and stents
- Vascular embolization and occlusion services
- Vascular ultrasound

Durable medical equipment (DME) and prosthetics

- Automated external defibrillators
- Bone stimulators
- Cochlear implants
- Cough assist (insufflator/exsufflator)
- High-frequency chest wall oscillator
- Insulin and infusion pumps
- Left ventricular assist device
- Nonstandard wheelchairs
- Nonstandard beds
- Oral appliances for obstructive sleep apnea
- Patient transfer systems
- Pneumatic compression devices
- Power wheelchair repairs
- Power wheelchairs, accessories, and power-operated vehicles (POVs)
- Prosthetics, orthotics
- Sleep-study-related equipment and supplies
- Speech-generating devices and accessories
- Spinal cord stimulators
- Tumor treatment field therapy
- Ventilators
- Wound pump

Radiology services

- CT scan (including CT angiography)
- Echocardiograms
- MRA scan
- MRI scan
- MRS scan
- Nuclear cardiac scan
- PET scan
- Radiation (oncology)
- Radiation therapy

Behavioral health services

- Day hospital/partial hospital admissions
- Inpatient admissions
- Intensive outpatient therapy
- Psychological and neuropsychological testing
- Rehabilitation facility admissions
- Transcranial magnetic stimulation (TMS) for depression

Transplants: human organ and bone marrow/stem cell transplants

Prior authorization is required for Medicare-covered transplant admissions.

Inpatient services:

- Heart transplant
- Islet cell transplant
- Kidney transplant
- Liver transplant
- Lung or double lung transplant
- Multivisceral transplant
- Pancreas transplant
- Simultaneous pancreas/kidney transplant
- Small bowel transplant
- Stem cell/bone marrow transplant (with or without myeloablative therapy)

Outpatient services:

- Donor leukocyte infusion
- Stem cell/bone marrow transplant (with or without myeloablative therapy)

Out-of-network/noncontracted providers are under no obligation to treat NYC Medicare Advantage Plus Plan members, except in emergency situations. Please call our Member Services number or see your *Evidence of Coverage* for more information, including the cost sharing that applies to out-of-network services.

The NYC Medicare Advantage Plus Plan is offered through an alliance between Empire BlueCross BlueShield Retiree Solutions and EmblemHealth. Empire and EmblemHealth have come together to create a new, customized, fully insured group Medicare Advantage program for the City of New York.

Empire BlueCross BlueShield Retiree Solutions is an LPPO plan with a Medicare contract. Enrollment in Empire BlueCross BlueShield Retiree Solutions depends on contract renewal. Empire BlueCross BlueShield Retiree Solutions is the trade name of Anthem Insurance Companies, Inc. Independent licensee of the Blue Cross Blue Shield Association.

EmblemHealth insurance plans are underwritten by EmblemHealth Plan, Inc., EmblemHealth Insurance Company, and Health Insurance Plan of Greater New York (HIP). EmblemHealth Services Company, LLC provides administrative services to EmblemHealth companies. The EmblemHealth companies are separate companies from Empire BlueCross BlueShield.

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EXHIBIT C

Empire BlueCross BlueShield
An Anthem Company
The Whole Health Company

The City of New York

EmblemHealth®

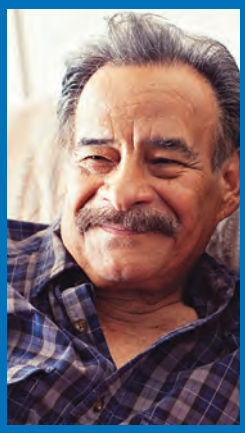
MEDICARE
Group Plan

NYC Medicare Advantage Plus Enrollment Guide

City of New York
Plan Year 2022
Version: All Carriers

Look inside!

SilverSneakers® fitness program
Healthy meal delivery
Transportation
LiveHealth® Online
EmblemHealth Neighborhood Care Centers



What is inside

This guide is designed to help you understand the benefits, tools and resources you receive with this plan.

Overall plan highlights

The City of New York offers you this NYC Medicare Advantage Plus Plan (PPO) that includes many health resources and benefits that Original Medicare does not offer, like:

- A $0 copay for an Annual Wellness visit.
- National Access Plus, which allows you to see any doctor or hospital who accepts Medicare. You're not tied to a provider network, and you pay the same copay or coinsurance percentage whether your provider is in- or out-of-network. *Please refer to page 10 for complete details.*
- Access to SilverSneakers®, LiveHealth Online and SpecialOffers from our partners.
- *NYC Medicare Advantage Plus is holding virtual informational meetings about the new City of New York Medicare Advantage Plan.*
- *For more information, please visit our website at* **www.empireblue.com/nyc-ma-plus** *or call the* **NYC Medicare Advantage Plus Welcome Team** at **1-833-325-1190**, *TTY:* **711**, *Monday to Friday, 8 a.m. to 9 p.m. ET, except holidays.*

The NYC Medicare Advantage Plus Welcome Team

If you need any help or have questions about this plan, call our retiree-dedicated **NYC Medicare Advantage Plus Welcome Team**, located right here in the United States, and they will be happy to give you the answers you need.

Available at **1-833-325-1190**, TTY: **711**, Monday to Friday, 8 a.m. to 9 p.m. ET, except holidays.

Retirees who may not have an email address, nor access to a computer, can still participate in these virtual informational meetings. To participate via phone, contact the NYC Medicare Advantage Plus Welcome Team for the dial-in phone number.

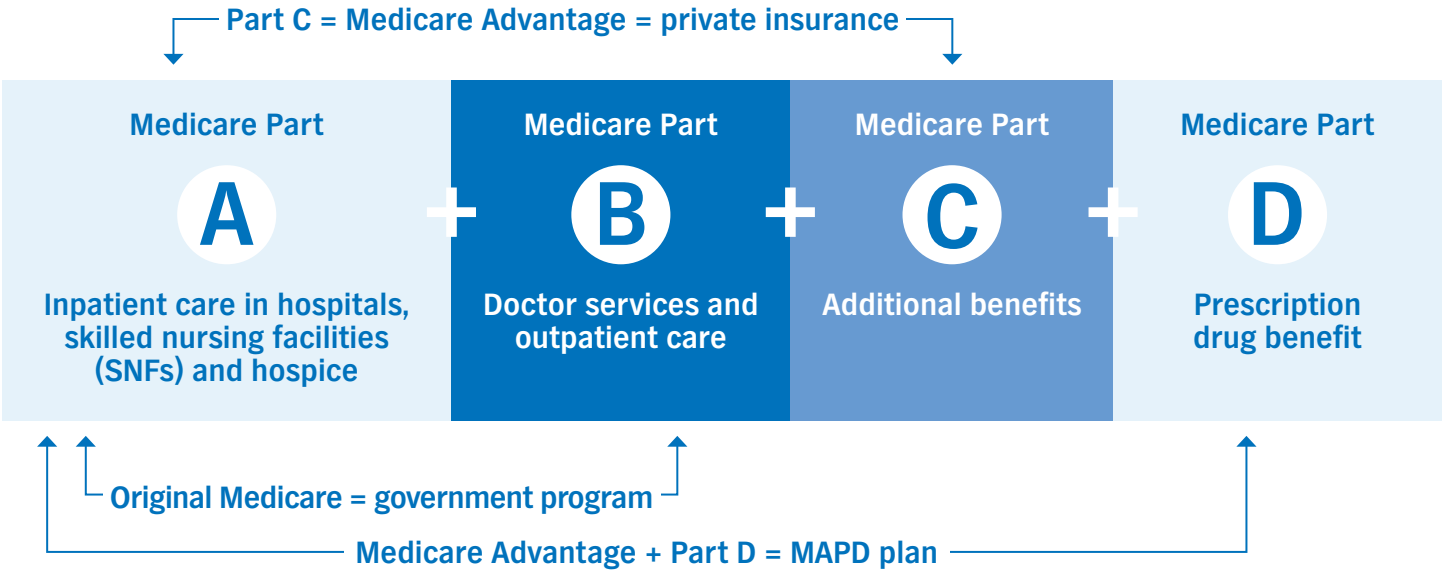
How Medicare works

Medicare is a federal government health insurance program offered to people 65 years of age or older, people under age 65 with certain disabilities and anyone with end-stage renal disease (ESRD) or amyotrophic lateral sclerosis (ALS), also called Lou Gehrig's disease.

The A-B-C-Ds of Medicare

You may have heard about the different parts of Medicare. Here is a quick look at what they mean to your medical coverage:

- **Medicare Parts A + B =** Original Medicare, the government program.
- **Medicare Part C =** Original Medicare + additional benefits. Part C is also called Medicare Advantage (MA).
- **Medicare Part D =** The prescription drug benefit.



Please visit **www.medicare.gov** to learn more about Medicare and find more ways to maximize your benefits. You can also contact Medicare at **1-800-MEDICARE** (**1-800-633-4227**), 24 hours a day, seven days a week. TTY users, call **1-877-486-2048**.

How is Medicare Advantage different?

This plan is a Medicare Advantage preferred provider organization (PPO) plan.

Medicare Advantage is a Medicare Part C plan. That means it is a Medicare plan offered by a private insurance company. Empire BlueCross BlueShield Retiree Solutions (Empire) and EmblemHealth are the private insurance companies that manage this plan.

Medicare Advantage offers more than Original Medicare. Original Medicare covers Part A (hospital benefits) and Part B (doctor and outpatient care). Medicare Advantage covers both Parts A and B, and more. See examples in the chart below.

Overview	Original Medicare	MEDICARE ADVANTAGE
Copays and coinsurance	20% coinsurance for common services such as outpatient surgery and health visits	**Copays are used more often** than coinsurance to help make cost share amounts simple and transparent.
Emergency care when traveling outside the U.S.	No coverage when traveling outside the U.S.	**Emergency care is provided** when traveling outside the U.S.
Annual out-of-pocket maximum (or Max OOP) is the amount members pay each year	There is no maximum amount members will pay annually	After the Max OOP is met, **the plan pays 100% of covered costs** for the rest of the plan year.
Additional benefits	Not offered	**This plan gives you access to:** • 24/7 NurseLine • SilverSneakers • LiveHealth Online

Note: Not all medical costs are included or subject to the annual out-of-pocket maximum. For more details and what services are covered by this plan, please see the *Summary of Benefits* included in this guide.

Frequently asked questions

Whom can I call if I have questions about this plan?

Call the **NYC Medicare Advantage Plus Welcome Team** at **1-833-325-1190**, TTY: **711**, Monday to Friday, 8 a.m. to 9 p.m. ET, except holidays.

What is a deductible?

When applicable, a deductible is the amount of money you pay for health care services before your plan starts paying. After you reach your deductible, you will still have to pay toward your cost share for services. Certain plans have no deductible and will cover your health care services from the start. Other services will be covered by your plan before you reach the deductible. For more details, please see the *Summary of Benefits* included in this guide.

What is a copay?

When applicable, a copay is a fixed dollar amount that you pay for covered services. A copay is often charged to you after your appointment.

What is coinsurance?

When applicable, coinsurance is the percentage of a covered health care cost that you would pay after you meet your deductible, while the plan pays the rest of the covered cost. If you have not yet met your deductible, you pay the full allowed amount.

What is a primary care provider (PCP)?

A primary care provider (PCP) is a general practice doctor who treats basic medical conditions. Primary care doctors do physicals or checkups and give vaccinations. They can help diagnose health problems and either provide care or refer patients to specialists if the condition requires. They are often the first doctor most patients see when they have a health concern.

Note: This plan does not require you to select a PCP or require referrals to see a specialist.

What is an annual out-of-pocket maximum (or Max OOP)?

One feature of Medicare Advantage is the Max OOP. It is the maximum total amount you may pay every plan year for your covered health care costs, including copays, coinsurance and deductibles. Once you reach the Max OOP, you pay nothing for your covered health care costs until the start of the next plan year. Not all medical costs are included or subject to the annual out-of-pocket maximum. To learn more details and what services are covered by this plan, please see the *Summary of Benefits* included in this guide.

How is inpatient care different from outpatient care?

Inpatient care is medical treatment that is provided when you have been formally admitted to the hospital or other facility with a doctor's order. If you are not admitted with a doctor's order, you may be considered an outpatient, even if you stay in the hospital overnight. Outpatient care is any health care services provided to a patient who is not admitted to a facility. Outpatient care may be provided in a doctor's office, clinic or hospital outpatient department.

What are preventive care and services?

Preventive care and services help you avoid an illness or injury. Common examples of preventive care are immunizations and an Annual Wellness visit. Any screening test done in order to catch a disease early is considered a preventive service. Advice or counseling, such as nutrition and exercise guidance, is also an example of preventive care and services.

Before enrolling, what do I need to provide my group sponsor?

To ensure a smooth enrollment, make sure your group sponsor has your most up-to-date information and that it matches your Social Security information.

Medical benefit overview

This plan offers a wealth of benefits designed to help you utilize many health resources while keeping expenses down.

Health, access and well-being

- Flu and pneumonia vaccines and most health screenings
- Inpatient hospital care and ambulance services
- Emergency and urgent care
- Skilled nursing facility benefits
- Complex radiology services and radiation therapy
- Diagnostic procedures and testing services received in a doctor's office
- Lab services and outpatient X-rays
- Home health agency care
- Routine hearing exams and hearing aid coverage
- Outpatient surgery and rehabilitation
- Nonemergency Transportation

See the full Summary of Benefits starting on page 18 for more details.

Nutrition

- Diabetes services and supplies
- Healthy Meals
- Healthy Pantry

Devices

- Durable medical equipment and related supplies
- Prosthetic devices
- Wearable health and fitness tracker

Programs and services

- 24/7 NurseLine
- SilverSneakers® fitness program
- Medicare Community Resource Support
- Doctors available anytime, anywhere with LiveHealth Online
- Foreign travel emergency and urgently needed services

No-cost special benefits, services and access to care

Members can choose from a variety of programs and tools to help make choices toward better health in all aspects of life.

Annual health exams and preventive care

The plan offers the following and more with no additional cost, as long as you see a doctor who accepts Medicare:

- Annual Wellness visit
- Preventive care services
- Flu and pneumonia shots
- Tobacco cessation counseling

MyHealth Advantage

This program sends regular reminders via postal mail about needed care, tests or preventive health steps to keep you healthy. It also offers prescription drug cost-cutting tips and access to health specialists who can answer your questions.

These resources are available at no additional cost to you.

House Call program[1]

Too sick to go out to see a doctor? Having mobility issues? The House Call program offers a personalized visit in your home or other appropriate health care setting that can lead to a treatment plan tailored to you. The House Call program is available at no additional cost for members who qualify based on their health needs.

24/7 NurseLine[2]

When health issues arise after hours, and the doctor's office is closed, you can still obtain the answers you need — right away. The 24/7 NurseLine puts you in touch with a registered nurse anytime of the day or night.

1 House Call program is administered by an independent vendor. It is available to members who qualify.

2 The information contained in this program is for general guidelines only. Your doctor will be specific regarding recommendations for your individual circumstances.

More no-cost special benefits, services and access to care

LiveHealth Online*

Using LiveHealth Online, you can visit with a doctor, therapist or psychologist through live video on your smartphone, tablet or computer with a webcam. It's a great way to:

- Access a board-certified doctor in the comfort of your home, 24/7.
- Get help with common conditions like the flu, colds, sinus infections, pink eye and skin rash – this even includes having prescriptions sent to the pharmacy, if needed.
- Set up a 45-minute counseling session with a licensed therapist or psychologist to find help when you feel depressed, anxious or stressed.

Video visits using LiveHealth Online are $0 with your plan. Sign up today at **livehealthonline.com**. Or use the free LiveHealth Online mobile app.

Healthy Meals

If you are not able to prepare a meal for yourself after being discharged from the hospital, or if you have a body mass index (BMI) of 18.5 or less, or 25 or more, or an A1C level of more than 9.0%, we will provide prepared meals that only need to be reheated, delivered directly to your home. You may receive up to 14 healthy meals per event, up to four events.

Healthy Pantry

Once approved, you receive monthly nutritional counseling sessions via phone and a monthly delivery of nonperishable healthy pantry items.

Wearable health and fitness tracker

Request your no-cost wearable fitness device to monitor your progress toward healthy behaviors. You will have access to apps that can help you track your physical activity and goals, as well as an online program with exercises that work out your attention span, brain speed, memory fitness, people and navigation skills, and intelligence.

* LiveHealth Online is the trade name of Health Management Corporation, a separate company providing telehealth services on behalf of this plan.

SilverSneakers®[1]

SilverSneakers is a fitness and lifestyle benefit that gives you the opportunity to connect with your community, make friends and stay active. Your membership gives you:

- Memberships to thousands of participating locations with use of basic amenities,[2] plus group exercise classes[3] for all levels at select locations.
- The SilverSneakers GO™ app with adjustable workout programs tailored to individual fitness levels, schedule reminders for favorite activities, the option to find convenient locations and more.
- SilverSneakers On-Demand™ online videos for at-home workouts, plus health and nutrition tips.

To find a location near you, visit **www.SilverSneakers.com** or call **1-888-423-4632**, TTY: **711**, Monday to Friday, 8 a.m. to 8 p.m. ET.

Care and support with Aspire

Aspire Health is a community-based program that specializes in providing an extra layer of support to patients facing serious illness and their families. This support is provided by a team of doctors, nurse practitioners, nurses and social workers who work closely with a patient's primary care provider and other providers to coordinate care and improve communication. Aspire's clinical team is available 24/7 to provide extra care and attention, as well as education about illness, the plan of care and medications. Aspire's services are provided through a combination of home-based visits and telehealth support, depending upon location.

1 Always talk with your doctor before starting an exercise program. SilverSneakers and the SilverSneakers shoe logotype are registered trademarks of Tivity Health, Inc. SilverSneakers On-Demand and SilverSneakers GO are trademarks of Tivity Health, Inc. © 2020 Tivity Health, Inc. All rights reserved.

2 Participating locations ("PL") are not owned or operated by Tivity Health, Inc. or its affiliates. Use of PL facilities and amenities is limited to terms and conditions of PL basic membership. Facilities and amenities vary by PL.

3 Membership includes SilverSneakers instructor-led group fitness classes. Some locations offer members additional classes. Classes vary by location.

Your doctor, your choice — nationwide

How National Access Plus works

- **Convenience** — see any doctor, provider or specialist who participates in Medicare.
- **Your copay or coinsurance remains the same** — whether in or out of this plan's provider network, your cost share doesn't change.
- **Your benefits and coverage won't change**, locally or nationwide, in or out of network, giving you added value.

What if a doctor or other provider says they don't accept this plan?

In the rare instance where a provider that accepts Medicare tells a retiree they will not accept payment from the NYC Medicare Advantage Plus Plan, the retiree should first contact the concierge service that will be provided, so that the plan can work with the provider to make sure they understand it is the same payment schedule and billing protocol, and answer any questions the provider may have. If, despite that effort, the provider still refuses, the member can pay the provider and then submit the claims to the plan for reimbursement. So long as the service is a Medicare-covered benefit and the Medicare fee schedule is followed, the member will only be responsible for his or her copays/coinsurance as defined by the plan.

See any doctor, provider or specialist who participates in Medicare.

EmblemHealth Neighborhood Care

We're here to help you take control of your health — from staying active to understanding your insurance benefits.

With locations across Manhattan, Brooklyn, Queens, Staten Island and Long Island, EmblemHealth Neighborhood Care offers no-cost health and wellness programs and face-to-face support — right in our retirees' neighborhoods.

Each Neighborhood Care location is tailored to the unique needs of its surrounding community, with different programs and classes across locations.

Every Neighborhood Care location offers:

- In-person customer service.
- No-cost health and wellness programs for:
  - Fitness: Zumba, yoga and tai chi.
  - Stress management: meditation.
  - Personal health and wellness: nutrition workshops and asthma and diabetes self-management.
- Connections with community providers and resources for managing the health of retirees and their families.
- Access to EmblemHealth representatives to learn more about your health plan. Retirees can stop by one of the locations or go to **www.emblemhealth.com/about/neighborhood-care** for the events calendar.

NEIGHBORHOOD CARE LOCATIONS

QUEENS

Cambria Heights

Flushing

Jackson Heights

BROOKLYN

Bensonhurst

Brooklyn Heights

Crown Heights

East New York

LONG ISLAND

Bethpage

MANHATTAN

Chinatown

Duane Street

Harlem

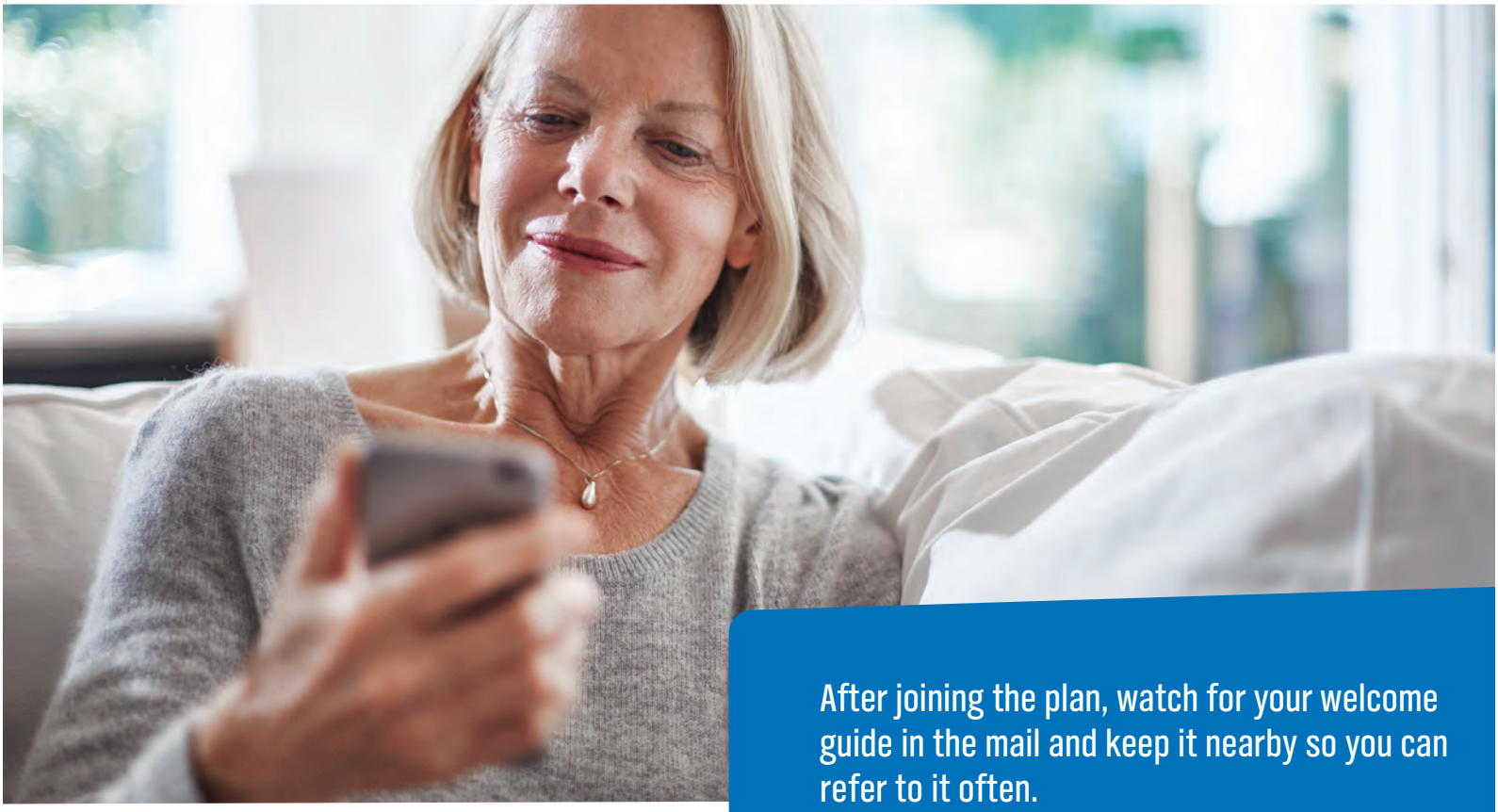
STATEN ISLAND

Annadale

Clove Road

Richmond Avenue, at the Mall

Easy to get started



After joining the plan, watch for your welcome guide in the mail and keep it nearby so you can refer to it often.

Once your enrollment in this plan is processed, we will send you:

- Acknowledgment of your enrollment and your effective start date.
- A letter showing proof of membership — use this until your plan membership card arrives.
- Your plan membership card.
- A simple health survey (within 90 days of enrollment) to help us understand and address your unique needs.

Additionally, you will receive our plan welcome guide. It explains how to:

- Start maximizing your benefits.
- Find doctors, hospitals, urgent care centers and more providers.
- Access your plan documents online and in print, if needed.
- Contact us with questions.
- Find help when you need it.

What is the alliance between Empire BlueCross BlueShield Retiree Solutions and EmblemHealth?

Empire and EmblemHealth have come together to create a new, customized, fully insured group Medicare Advantage program for the City of New York. You'll still have the same health plans you know and trust, and the same providers you have always seen. We have also simplified your experience into one plan with one membership card.

Note: You may receive communications that do not have the City of New York or EmblemHealth logos and/or name; they may only contain the Empire BlueCross BlueShield Retiree Solutions brand name and/or logo. Members may also receive communications from EmblemHealth that only contain the EmblemHealth brand name and/or logo.

Enrollment tips:

- If you use a P.O. Box, please provide your physical address when enrolling in the NYC Medicare Advantage Plus Plan. This is a Centers for Medicare & Medicaid Services (CMS) requirement to ensure that you receive member materials as soon as possible.
- To enroll in this plan, a member must be enrolled in Medicare Part B and must maintain Part B enrollment in order to avoid disenrollment.

Always be on the lookout for letters from NYC Medicare Advantage Plus to ensure that your enrollment has been processed correctly, or in the case that CMS needs to verify any information that you provided. If you receive any letters from NYC Medicare Advantage Plus asking for more information, please respond as soon as possible so that your medical coverage is not disrupted.

Coordination of Benefits (COB) letter

If we receive Coordination of Benefits (COB) information from CMS, we are required to send a letter to you requesting verification of the other coverage information. The benefit verification letter we send will include information from CMS, including any other coverage that needs to be verified. Separately, we could receive COB information from other reporting sources in addition to CMS.

You may receive a COB letter in these situations:

- If the information is not correct in the letter, you can call Member Services or you can fill in the correct information on the letter and return it to the plan for processing.
  - If a response is not received within 21 days, the information on the letter is considered to be accurate.
- If the previous carrier does not notify CMS of the previous plan termination prior to the plan enrollment process, a COB letter could be triggered for the plan that was just terminated.

If you do not receive prescription drugs through your union welfare fund, or you do not currently have the high option drug rider, you may purchase the prescription drug rider for the NYC Medicare Advantage Plus Plan. Per CMS regulations, if you choose not to take any Part D coverage, you may be subject to higher costs in the future.

(See page 29 for additional information.)

Drug plan scenarios and NYC Medicare Advantage Plus coverage

SCENARIO	SOLUTION
If you purchase the High Option Rider through the City of New York	No concerns — you can have both plans
If you have union-sponsored Part D drug coverage	
If you have union-sponsored commercial drug coverage	
If you have an Individual PDP plan	Under CMS guidelines, enrollment in the NYC Medicare Advantage Plus Plan will result in disenrollment from an individual Part D plan for prescription drugs. If you have coverage from your union welfare fund for prescription drugs, but that plan has limited coverage, you may also buy the GHI Enhanced Medicare Part D Prescription Drug Plan (sometimes called the High Option Rider) as supplemental coverage.

Online and mobile resources*

We offer two convenient ways to access your plan information.

1 The Empire consumer website

After you receive your membership card, register at **www.empireblue.com/nyc-ma-plus** and follow the menu options to:

- View details of your plan, including claims status and history, and all of your plan documents, like your *Evidence of Coverage (EOC)*.
- Find a doctor, hospital, lab and other health care providers in your plan.
- Access our library of preenrollment materials, educational content and more.

2 The Sydney Health mobile app

Want access to your plan information on the go? Sydney Health gives you a simple and connected experience through your iPhone or Android smartphone.

- View your membership card — wherever you are.
- Use your device's GPS to find nearby doctors, hospitals and urgent care centers.
- Check the status of recent medical claims.
- Use the chat feature to quickly find answers to health questions.
- Set health reminders and wellness goals.
- Store and share health records with My Family Health Record (myFHR), which gives you the ability to share your health information with doctors, family members and caregivers.

* Website tools are offered to Empire plan members as extra services. They are not part of the contract and can change or stop.

Prior authorization

What is it?

Some types of care require your provider to get an approval from us before you receive care. This is called prior authorization.

How does it work?

In-network providers who accept NYC Medicare Advantage Plus are required to ask for prior authorization before providing certain types of care, and once approved by Empire BlueCross BlueShield Retiree Solutions, the provider will only bill you for your applicable copay or coinsurance. If your provider doesn't ask for prior authorization when required, the claim will be denied. The provider CANNOT bill you for the treatment if they did not get prior authorization.

Out-of-network providers aren't required to ask for prior authorization. We encourage you to ask your provider to request it for you before you get care. Here's why:

- If the provider doesn't ask for prior authorization, Empire will review the claim after you've been treated.
- If the claim is determined to be medically necessary, we will process it according to the rules of your plan.
- If the claim is determined to not be medically necessary, we will deny the claim and let you know that you have the right to appeal the decision. The provider CAN bill you for the treatment.

Whether you see an in-network or out-of-network provider, if your provider does ask for prior authorization and it is denied:

- You will be notified. If you choose to continue with the treatment, you will be responsible for the cost.
- We will let you know that you have the right to appeal the decision.

The important thing to remember is that you are not responsible for asking for prior authorization when you see an in-network provider. If you see an out-of-network provider, you can ask them to request it for you.

Whose responsibility is it to receive prior authorization?

It is the provider's responsibility to ask for prior authorization from Empire BlueCross BlueShield Retiree Solutions. You aren't responsible for asking for it when you see a provider that accepts NYC Medicare Advantage Plus.

How do I know what services require prior authorization?

Please refer to the full benefits chart as part of the *Evidence of Coverage*, each service that requires prior authorization will have an asterisk (*). Below is a brief list of most common services that require prior authorization.

- Inpatient hospital admissions
- Skilled nursing facility
- Rehabilitation, including physical, occupational and speech therapy
- Complex radiology — MRI, CT and PET scans
- Prosthetics/orthotics
- Transplants

Summary of Benefits

The *Summary of Benefits* gives you details about the many medical benefits this plan offers, including:

- What we cover.
- Copay amounts, if any.
- Coinsurance amounts, if any.
- Out-of-pocket costs, if any.

Need help?

We're always happy to go over your *Summary of Benefits* with you! The **NYC Medicare Advantage Plus Welcome Team** is available at **1-833-325-1190**, TTY: **711**, Monday to Friday, 8 a.m. to 9 p.m. ET, except holidays.

Be in the know!

The *Summary of Benefits* starts on page 18.

Summary of Benefits

PLAN NAME: NYC Medicare Advantage Plus

PLAN YEAR: Plan Year 2022

Please note, to enroll in the NYC Medicare Advantage Plus Plan, you must be entitled to Medicare Part A and enrolled in Part B.

Covered services	What you must pay for these covered services
Monthly premium	**$0**[1] 1 Consolidated Omnibus Budget Reconciliation Act (COBRA) and full pay premium: $7.50
GHI Enhanced Medicare Part D prescription drug plan rider	**$125**
Deductible	**$253** combined in network and out of network
Maximum out of pocket	**$1,470** combined in network and out of network. All copays, coinsurance, and deductibles listed in this *Summary of Benefits* accrue toward the medical plan out-of-pocket maximum, with the exception of the routine hearing services and the foreign travel emergency and urgently needed care copay or coinsurance amounts. Part D prescription drug deductibles and copays do not apply to the medical plan out-of-pocket maximum.
Inpatient hospital coverage* for Medicare-covered hospital stays	**$300 copay** per admission. Deductible does not apply. The inpatient hospital out-of-pocket maximum is **$750** per year, combined with inpatient mental healthcare and combined in network and out of network. **$0 copay** for Medicare-covered physician services received while an inpatient during a Medicare-covered hospital stay. Deductible does not apply.

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Covered services	What you must pay for these covered services
Outpatient hospital coverage*	**Nonsurgical:** **$0 copay** for a visit to an in- or out-of-network primary care physician in an outpatient hospital setting/clinic or outpatient observation room for Medicare-covered nonsurgical services. **$15 copay** for a visit to an in-network or out-of-network specialist in an outpatient hospital setting/clinic for Medicare-covered nonsurgical services. **Surgical:** **$0 copay** for each Medicare-covered outpatient hospital facility or ambulatory surgical center, or outpatient observation room visit for surgery, in or out of network.
Doctor visits (primary care and specialists)	**$0 copay** for a visit to an in- or out-of-network primary care physician. **$15 copay** per visit to an in-network or out-of-network specialist for Medicare-covered services. No referral is needed.
Preventive care for abdominal aortic aneurysm screening, bone mass measurement, colorectal cancer screening/services, HIV screening, sexually transmitted disease (STI) screening, breast cancer screening, cervical/vaginal cancer screening, prostate cancer screening, cardiovascular disease risk reduction visit, cardiovascular disease testing, "Welcome to Medicare" preventive visit, Annual Wellness Visit, depression screening, diabetes screening, Medicare Diabetes Prevention Program (MDPP), obesity screening/therapy to promote sustained weight loss, screening/counseling to reduce alcohol misuse, lung cancer screening with low dose computed tomography (LDCT), medical nutrition therapy, and smoking/tobacco cessation	There is no coinsurance, copay, or deductible for Medicare-covered visits, tests, therapies, or benefits, in or out of network.

(Continued on next page)

Covered services	What you must pay for these covered services
Emergency care Services that are both: • Furnished by a provider qualified to furnish emergency services. • Needed to evaluate or stabilize an emergency medical condition.	**$50 copay** for each Medicare-covered emergency room visit worldwide, in or out of network. Limited to what is allowed under the Medicare fee schedule for the services performed/received outside of the United States (U.S.).
Urgently needed services	**$15 copay** for each Medicare-covered urgently needed care visit worldwide, in or out of network.
Diagnostic services/labs/imaging* X-rays; complex diagnostic tests and radiology services; radiation therapy; testing to confirm chronic obstructive pulmonary disease (COPD); surgical supplies, splints, casts, and other devices used to treat fractures and dislocations; laboratory tests; blood, including storage and administration; diagnostic tests; heart catheterizations; sleep studies; and CT, MRI/MRA, and PET scans	**$0 copay** for Medicare-covered testing to confirm COPD, Medicare-covered supplies, and each Medicare-covered pint of blood. **$0 copay** for supplies. **$15 copay** for each Medicare-covered X-ray visit and/or simple diagnostic test, complex diagnostic test, and/or radiology visit, radiation therapy treatment, and clinical/diagnostic lab tests.
Mental health services* Includes mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental healthcare professional, as allowed under applicable state laws	**Outpatient: $0 copay** for each Medicare-covered individual, group, partial hospitalization, and outpatient hospital facility visit. **Inpatient: $300** copay per admission. Deductible does not apply. The inpatient mental healthcare out-of-pocket maximum is **$750** per year, combined with inpatient hospital care and combined in network and out of network. No limit to the number of days covered by the plan. **$0 copay** for Medicare-covered physician services received while an inpatient during a Medicare-covered hospital stay. Deductible does not apply. **$15 copay** for each Medicare-covered professional individual therapy visit. Deductible applies.

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Covered services	What you must pay for these covered services
Skilled nursing facility (SNF) care* Covered services include semiprivate room (or a private room if medically necessary); meals, including special diets; skilled nursing services; physical therapy, occupational therapy, and speech language therapy; drugs administered to you as part of your plan of care (this includes substances that are naturally present in the body, such as blood clotting factors); blood, including storage and administration; medical/surgical supplies; laboratory tests; X-rays and other radiology services; use of appliances such as wheelchairs ordinarily provided by SNFs; and physician/practitioner services	**$0 copay** for Medicare-covered SNF stays, for days 1-100 per benefit period, in or out of network. No prior hospital stay required.
Physical therapy* Part of outpatient rehabilitation services, which includes physical, occupational, and speech language therapy	**$15 copay** for Medicare-covered physical therapy, occupational therapy, and speech language therapy visits, in or out of network.
Ambulance services Your provider must get approval from the plan before you get ground, air, or water transportation that is not an emergency. This is called getting prior authorization. Covered ambulance services include fixed wing, rotary wing, water, and ground ambulance services to the nearest appropriate facility that can provide care only if the services are furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by the plan. Nonemergency transportation by ambulance is appropriate if it is documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required. Ambulance service is not covered for physician office visits.	**$0 copay** per one-way trip for Medicare-covered ambulance services, in or out of network.

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Covered services	What you must pay for these covered services
Medicare Part B immunizations Covered services include pneumonia vaccine; flu shots, including H1N1, once each flu season in the fall and winter, with additional flu shots if medically necessary; hepatitis B vaccine if you are at high or intermediate risk of getting hepatitis B; COVID-19 vaccine; and other vaccines if you are at risk and they meet Medicare Part B coverage rules. If you have Part D prescription drug coverage, some vaccines are covered under your Part D benefit (for example, the shingles vaccine). Please refer to your Part D prescription drug benefits.	There is no coinsurance, copay, or deductible for the pneumonia, influenza, hepatitis B, COVID-19, or other Medicare-covered vaccines when you are at risk and meet Medicare Part B rules, in or out of network.
Chiropractic services for manual manipulation of the spine to correct subluxation only	**$15 copay** for each Medicare-covered visit, in or out of network.
Acupuncture services for chronic low back pain* Covered services include: Up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as all of the following: • Lasting 12 weeks or longer • Nonspecific, in that it has no identifiable systemic cause (in other words, not associated with any disease of a metastatic, inflammatory, or infectious nature) • Not associated with surgery • Not associated with pregnancy An additional eight sessions will be covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually.	**$15 copay** per visit, limited to 20 visits per year, combined in or out of network.
Medicare Community Resource Support As a member, your plan provides the support of a community resource outreach team to help bridge the gap between your medical benefits and the resources available to you in your community. Our team will assist you by providing information and education about community-based services and support programs in your area. If you have questions about this benefit, call Member Services at the number listed on the back of your plan membership card.	**$0 copay** for Medicare Community Resource Support.

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The NYC Medicare Advantage Plus Plan also has benefits that cover dental and vision for specific medical services and situations. Please see descriptions and coverage below.	
Covered services	**What you must pay for these covered services**
Dental services Nonroutine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician)	**$0 copay** for Medicare-covered services of nonroutine dental care, in or out of network, when provided by a primary care physician. **$15 copay** for Medicare-covered services of nonroutine dental care, in or out of network, when provided by a specialist.
Vision services Includes outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration; one glaucoma screening each year for people who are at high risk; screening for diabetic retinopathy once per year for people with diabetes; and one pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens	**$0 copay** for nonroutine visits to a primary care physician, in or out of network, for Medicare-covered exams, glaucoma and retinopathy screening, and glasses/contacts following Medicare-covered cataract surgery. **$15 copay** for nonroutine visits to an in-network or out-of-network specialist for Medicare-covered exams to diagnose and treat diseases of the eye.
Home health agency care* Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but are not limited to: • Part-time or intermittent skilled nursing and home health aide services (to be covered under the home healthcare benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week). • Physical therapy, occupational therapy, and speech language therapy. • Medical and social services. • Medical equipment and supplies.	**$0 copay** for Medicare-covered home health visits. Deductible does not apply. Durable medical equipment (DME) copay or coinsurance, if any, may apply.

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Covered services	What you must pay for these covered services
Private duty nursing Private duty nursing is skilled nursing care provided to a recipient by a registered nurse (RN) or licensed practical nurse (LPN) in the home or in a hospital setting. Skilled care is defined as medically necessary services, when prescribed by a physician, that can only be rendered under state law or regulation by a licensed health professional such as a medical doctor, physician assistant, physical therapist, occupational therapist, speech therapist, certified clinical social worker, certified nurse midwife, LPN, or RN. Services are limited to the time such services are deemed medically necessary. Private duty nursing is limited to a maximum benefit of $2,500 per year, combined in network and out of network.	**20% coinsurance** for private duty nursing. Deductible applies. After the plan pays benefits for private duty nursing, you are responsible for any remaining cost.
Wellness rewards We have created a wellness rewards incentive program to help members like you stay healthy. With this voluntary program, you can earn up to a $200 annual incentive for completion of services. These services can include, but are not limited to, preventive screenings such as breast cancer screenings, colorectal cancer screenings, HbA1c testing/retinal screenings for comprehensive diabetes management, and bone health screenings. Screenings may be added or changed each year. Participation in the annual incentive program will require the completion of a Health Risk Assessment. Please contact Member Services for more information.	**$0 copay** for the wellness rewards program. Deductible does not apply.

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Additional benefits

Covered services	What you must pay for these covered services
Nonemergency transportation Routine nonemergency transportation covers up to 24 one-way trips each year. A trip is defined as a ride from one destination to another. A trip is limited to 30 miles. • Trips are covered within your local service area for plan covered services, such as medical visits, visits to SilverSneakers® locations, and visits to a pharmacy to pick up prescriptions. A stop at a pharmacy after a doctor's appointment to pick up prescriptions will not count as a separate trip. When you schedule a pick-up from the doctor's visit, tell the vendor that you need to go to the pharmacy. Ask the doctor/facility to call in the prescription so you have a shorter wait. • You must schedule trips two business days in advance. Whenscheduling your ride, let the vendor know if you are in a wheelchair, if you need help, or if someone will be coming with you. • Trips will not be covered for non-health-related services, such as going to buy groceries, personal errands, or other reasons. We have partnered with Access2Care to bring you these discounts and services. Please contact Member Services if you have questions about this benefit. Access2Care, an independent company, is providing routine transportation on behalf of our plan.	24 one-way trips each year, within 30 miles.
Routine hearing services	**$0 copay** for routine hearing exams. **$70** maximum benefit limited to one exam every 12 months, combined in network and out of network. **$0 copay** for hearing aids. **$500** maximum benefit toward hearing aids every 12 months.
Healthy Meals	Provides up to 14 meals to eligible members (post-inpatient discharge or chronic condition) per qualifying event. Allows up to four events each year (56 meals in total).

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Covered services	What you must pay for these covered services
Healthy Pantry	Eligible members receive a monthly nutritional counseling session via phone. A monthly delivery of nonperishable pantry items is sent directly to the home.
Health and fitness tracker	Coverage includes a fitness tracking device to track your physical activity and a member engagement website designed to provide guidance, encouragement, and motivation. Limit is one device every two years, provided through our contracted vendor.
SilverSneakers® membership SilverSneakers can help you live a healthier, more active life through fitness and social connection. You are covered for a fitness benefit through SilverSneakers at participating locations.[1] You have access to instructors who lead specially designed group exercise classes.[2] At participating locations nationwide,[1] you can take classes,[2] plus use exercise equipment and other amenities. Additionally, SilverSneakers FLEX® gives you options to get active outside of traditional gyms (like recreation centers, malls, and parks). SilverSneakers also connects you to a support network and virtual resources through SilverSneakers LIVE™, SilverSneakers On-Demand™, and our mobile app, SilverSneakers GO™. All you need to get started is your personal SilverSneakers ID number. Go to **www.silversneakers.com** to learn more about your benefit or call **1-855-741-4985** (TTY: **711**), Monday to Friday, 8 a.m.to 8 p.m. ET. Always talk with your doctor before starting an exercise program. 1 Participating locations ("PL") are not owned or operated by Tivity Health, Inc. or its affiliates. Use of PL facilities and amenities is limited to terms and conditions of PL basic membership. Facilities and amenities vary by PL. 2 Membership includes SilverSneakers instructor-led group fitness classes. Some locations offer members additional classes. Classes vary by location. SilverSneakers and SilverSneakers FLEX are registered trademarks of Tivity Health, Inc. SilverSneakers LIVE, SilverSneakers On-Demand and SilverSneakers GO are trademarks of Tivity Health, Inc. © 2021 Tivity Health, Inc. All rights reserved.	**$0 copay** for the SilverSneakers fitness benefit. Deductible does not apply.

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Covered services	What you must pay for these covered services
LiveHealth® Online LiveHealth Online lets you see board-certified doctors and licensed therapists, psychologists, and psychiatrists through live, two-way video on your smartphone, tablet, or computer. It's easy to get started. You can sign up at livehealthonline.com or download the free LiveHealth Online app and register. Make sure you have your plan membership card ready — you'll need it to answer some questions. **Sign up for free** You must enter your health insurance information during enrollment, so have your plan membership card ready when you sign up. **Benefits of a video doctor visit** • The visit is just like seeing your regular doctor face to face, but just by web camera. • It's a great option for medical care when your doctor can't see you. Board-certified doctors can help 24/7 for most types of care and common conditions like the flu, colds, pink eye, and more. • The doctor can send prescriptions to the pharmacy of your choice, if needed.[1] • If you're feeling stressed, worried, or having a tough time, you can make an appointment to talk to a licensed therapist or psychologist from your home or on the road. • In most cases, you can make an appointment and talk with a therapist[2] or make an appointment and talk with a psychiatrist[3] from the privacy of your home. Video doctor visits are intended to complement face-to-face visits with a board-certified physician and are available for most types of care. LiveHealth Online is the trade name of Health Management Corporation, a separate company, providing telehealth services on behalf of this plan. 1 Prescription is prescribed based on physician recommendations and state regulations (rules). 2 Appointments are typically scheduled within 14 days, but may vary based on therapist/psychologist availability. Video psychologists or therapists cannot prescribe medications. 3 Appointments are typically scheduled within 14 days, but may vary based on psychiatrist availability. Video psychiatrists cannot prescribe controlled substances.	**$0 copay** for video doctor visits using LiveHealth Online. Deductible does not apply.

Learn more about Medicare

If you're unclear on what Medicare is and how it works, refer to your current *Medicare & You* handbook. If you do not have a copy, you can view it online or download the booklet at **www.medicare.gov**, or you can order a printed copy by calling **1-800-MEDICARE** (**1-800-633-4227**), 24 hours a day, seven days a week. TTY users, call **1-877-486-2048**.

Service area: All 50 states, Washington, D.C., American Samoa, Guam, Northern Mariana Islands, U.S. Virgin Islands, and Puerto Rico.

Eligibility: You are eligible for the NYC Medicare Advantage Plus Plan if you are enrolled in both Medicare Parts A and B. Most people qualify for Medicare at age 65. If you, your spouse/domestic partner, or dependent has certain disabilities and/or has end-stage renal disease (ESRD), you may qualify for Medicare before age 65.

While the *Summary of Benefits* does not list every service, limitation, or exclusion, the *Evidence of Coverage (EOC)* does. If you have questions or would like to request a copy of the *EOC*, please call the **NYC Medicare Advantage Plus Welcome Team** at **1-833-325-1190**, TTY: **711**, Monday to Friday, 8 a.m. to 9 p.m. ET, except holidays.

* Some services that fall within this benefit category require prior authorization. Based on the service you are receiving, your provider will know if prior authorization is needed. This means an approval in advance is needed by your plan to get covered services. In the network portion of a preferred provider organization (PPO), some in-network medical services are covered only if your doctor or other in-network provider gets prior authorization from our plan. In a PPO, you do not need prior authorization to obtain out-of-network services. However, we recommend you ask for a pre-visit coverage decision to confirm that the services you are getting are covered and medically necessary. Benefit categories that include services that require prior authorization are marked with an asterisk in the Benefits Charts.

Out-of-network/noncontracted providers are under no obligation to treat plan members, except in emergency situations. Please call our Member Services number or see your *Evidence of Coverage* for more information, including cost sharing that applies to out-of-network services.

EmblemHealth Medicare Part D Pharmacy Coverage

GHI Enhanced Medicare Part D Prescription Drug Plan (High Option Rider)

If you currently purchase an individual, direct pay prescription drug plan (PDP), once you are enrolled in the NYC Medicare Advantage Plus Plan, you will be automatically disenrolled in that direct pay prescription drug plan. You will need to enroll in a new group prescription drug plan by <Effective Date - TBD> — through your union or in the GHI Enhanced Medicare Part D Prescription Drug Plan (High Option Rider) — if you want to keep prescription drug coverage.

The **GHI Enhanced Medicare Part D Prescription Drug Plan (High Option Rider)** is a group prescription drug plan that is available to you. It is affordable and includes a broad network of pharmacies to receive your covered drugs. It also provides convenient options, like 90-day refills through retail pharmacies or Express Scripts Pharmacy mail order.

Enrolling in a Part D Prescription Drug plan

To enroll in this **GHI Enhanced Medicare Part D Prescription Drug Plan (High Option Rider)**, you must opt in by completing the *City of New York Retiree Health Benefits Program Application Change Form (ERB)* and sending it to the Office of Labor Relations. If your union offers a group prescription drug plan, you must contact your union to enroll in the plan.

If you are currently enrolled with the optional rider, you do not need to take any action. You will automatically be enrolled into the **GHI Enhanced Medicare Part D Prescription Drug Plan**. If you have a group prescription drug plan through your union, you may remain in that group plan.

Prescription coverage overview

The **GHI Enhanced Medicare Part D Prescription Drug Plan (High Option Rider)** has three different periods of coverage. They include Initial Coverage, Coverage Gap and Catastrophic Coverage periods. As you spend money on covered drugs, you will move through these coverage periods and the plan will keep track of how much money you have spent out of pocket for covered drugs. Most people never meet their plan's Initial Coverage limit. Few enrolled in a Medicare drug plan will purchase formulary drugs with a high retail value that will push them into the Coverage Gap or maybe into Catastrophic Coverage.

(Prescription coverage rates appear on the following page.)

EmblemHealth Medicare Part D Pharmacy Coverage

Monthly cost: $125 per person, per month (deducted from your pension check)

Initial Coverage period	Until you reach your Initial Coverage Limit of $4,430 for drug purchases, you will pay: $0 deductible • Tier 1: preferred generics: 25% of the drug cost • Tier 2: preferred brand: 25% of the drug cost • Tier 3: nonpreferred drug: 25% of the drug cost • Tier 4: specialty: 25% of the drug cost
Coverage Gap period	Once the value of your drug purchases exceeds your Initial Coverage Limit of $4,430, you will pay: $0 deductible • Tier 1: preferred generics: 25% of the drug cost • Tier 2: preferred brand: 25% of the drug cost • Tier 3: nonpreferred drug: 25% of the drug cost • Tier 4: specialty: 25% of the drug cost
Catastrophic Coverage period	After you meet your true out-of-pocket (TrOOP) amount spending limit of $7,050, you will pay: • Tier 1: preferred generics: $3.95 or 5% of the drug cost, whichever is greater • Tier 2: preferred brand: $9.85 or 5% of the drug cost, whichever is greater • Tier 3: nonpreferred drug: $3.95 & $9.85, or 5% of the drug cost, whichever is greater • Tier 4: specialty: $3.95 & $9.85, or 5% of the drug cost, whichever is greater

Retiree Health Plan Rates

As of January 1, 2022

These rates will be reflected in your January 2022 pension check.
Please note that all rates are subject to change.
See OLR website at **www.nyc.gov/hbp** for non-Medicare rates.

MONTHLY MEDICARE			
Individual	**Aetna Medicare Advantage Plan PPO/ ESA (NY/NJ/PA)**	**Aetna Medicare Advantage Plan PPO/ ESA (All Other Areas)**	**CIGNA Healthspring (AZ)**
Basic	$0.00	$20.00	$290.05
Prescription Drugs	$108.00	$79.00	$0.00
Rider Other[1]	$0.00	$0.00	$0.00
Total (Basic + Rider)	**$108.00**	**$99.00**	**$290.05**
Individual	**DC37 Med-Team Senior Care[2]**	**Empire Medicare Related**	**Empire MediBlue Freedom (PPO)**
Basic	TBD	$306.48	$149.72
Prescription Drugs	TBD	$200.95	$127.79
Rider Other[1]	TBD	$0.00	$0.00
Total (Basic + Rider)	**TBD**	**$507.43**	**$277.51**
Individual	**GHI Senior Care**	**GHI HMO Medicare Senior Supplement**	**HIP VIP Premier (HMO)**
Basic	$191.57	$788.56	$0.00
Prescription Drugs	$125.00	$85.00	$177.59
Rider Other[1]	$2.83	$0.00	$0.00
Total (Basic + Rider)	**$319.40**	**$873.56**	**$177.59**

MONTHLY MEDICARE				
Individual	**Humana Gold Plus**	**United Healthcare Group Medicare Advantage Plan Horizons (NYC)**	**United Healthcare Group Medicare Advantage Plan Horizons (NJ)**	**NYC Medicare Advantage Plus**
Basic	$12.82	$311.63	$262.96	$0.00
Prescription Drugs	$50.40	$82.89	$109.38	$125.00
Rider Other[1]	$0.00	$0.00	$0.00	$0.00
Total (Basic + Rider)	**$63.22**	**$394.52**	**$372.34**	**$125.00**

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MONTHLY MEDICARE			
Family	**Aetna Medicare Advantage Plan PPO/ ESA (NY/NJ/PA)**	**Aetna Medicare Advantage Plan PPO/ ESA (All Other Areas)**	**CIGNA Healthspring (AZ)**
Basic	$0.00	$40.00	$580.10
Prescription Drugs	$216.00	$158.00	$0.00
Rider Other[1]	$0.00	$0.00	$0.00
Total (Basic + Rider)	**$216.00**	**$198.00**	**$580.10**
Family	**DC37 Med-Team Senior Care[2]**	**Empire Medicare Related**	**Empire MediBlue Freedom (PPO)**
Basic	TBD	$612.96	$299.44
Prescription Drugs	TBD	$401.90	$255.58
Rider Other[1]	TBD	$0.00	$0.00
Total (Basic + Rider)	**TBD**	**$1,014.86**	**$555.02**
Family	**GHI Senior Care**	**GHI HMO Medicare Senior Supplement**	**HIP VIP Premier (HMO)**
Basic	$383.14	$1,577.12	$0.00
Prescription Drugs	$250.00	$170.00	$355.18
Rider Other[1]	$5.66	$0.00	$0.00
Total (Basic + Rider)	**$638.80**	**$1,747.12**	**$355.18**

MONTHLY MEDICARE				
Family	**Humana Gold Plus**	**United Healthcare Group Medicare Advantage Plan Horizons (NYC)**	**United Healthcare Group Medicare Advantage Plan Horizons (NJ)**	**NYC Medicare Advantage Plus**
Basic	$25.64	$623.26	$525.92	$0.00
Prescription Drugs	$100.80	$165.78	$218.76	$250.00
Rider Other[1]	$0.00	$0.00	$0.00	$0.00
Total (Basic + Rider)	**$126.44**	**$789.04**	**$744.68**	**$250.00**

[1] For GHI Senior Care, "Rider Other" is for 365-Day Hospitalization.
[2] 2022 rate will be posted on the OLR website.
NOTE: AvMed, BC Health Options and ElderPlan are "zero" premium plans.

APPENDIX

How to qualify and enroll in the NYC Medicare Advantage Plus Plan

How you qualify for this plan

To qualify for the NYC Medicare Advantage Plus Plan, you must meet all of these conditions:

- You are a United States (U.S.) citizen or are lawfully present in the U.S.
- You live in the plan's service area.
- You are now entitled to Medicare Part A and enrolled in Part B.
- You keep paying your Medicare Part B premiums, unless they are paid by Medicaid or through another third party.
  - —The City of New York will continue to reimburse you for your Medicare Part B premiums.
  - —The City of New York will continue to reimburse you for your income-related monthly adjustment amount (IRMAA).
- You qualify for coverage under your or your spouse's group-sponsored health plan.

For more information on enrollment, call the **NYC Medicare Advantage Plus Welcome Team** at **1-833-325-1190**, TTY: **711**, Monday to Friday, 8 a.m. to 9 p.m. ET, except holidays. You can also visit **www.medicare.gov** to learn more about when you can sign up for a plan.

How to enroll

Effective <Effective Date - TBD>, you will be automatically enrolled, at no cost to you, in the NYC Medicare Advantage Plus (PPO) Plan.

Important: If you enroll in the NYC Medicare Advantage Plus Plan, all non-Medicare eligible dependents will automatically be enrolled in the GHI/EBCBS CBP plan.

If you want to opt out of this coverage, please follow the instructions below based on which plan you want to select:

- Retirees can only opt out of the NYC Medicare Advantage Plus Plan in order to remain in their current retiree health plan. The opt-out period for the NYC Medicare Advantage Plus Plan is extended until further notice. By opting out of the NYC Medicare Advantage Plus Plan, you will be responsible for your plan's cost. To remain enrolled in your current plan, complete the electronic opt-out form at **www.empireblue.com/nyc-ma-plus** and select the option to remain in your current health plan or complete the opt-out form on the following page and follow the instructions on the form.
- If you wish to waive your City of New York retiree coverage, complete the NYC Retiree *Health Benefits Application/Change Form* available on the Office of Labor Relations (OLR) website at **www1.nyc.gov/site/olr/health/retiree/health-retiree-forms-and-downloads.page**. If you drop your medical coverage, you may be able to reenroll during the next open enrollment period.

Note: Waiver of Retiree Health Benefits results in loss of eligibility for Medicare Part B reimbursement.

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NYC Medicare Advantage Plus Plan Opt-Out Form

Effective <Effective Date - TBD>, City of New York is automatically enrolling Medicare-eligible retirees, along with their eligible dependents, into a premium-free plan: The NYC Medicare Advantage Plus Plan.

Important information for those who choose not to be enrolled in the NYC Medicare Advantage Plus Plan

You acknowledge that:

- You can only opt out of the NYC Medicare Advantage Plus Plan in order to remain in your current retiree health plan.

Retirees can only opt out of the NYC Medicare Advantage Plus Plan in order to remain in their current retiree health plan. The opt-out period for the NYC Medicare Advantage Plus Plan is extended until further notice.

To opt out of the NYC Medicare Advantage Plus Plan and remain in your current health plan, please complete and sign the form on the next page and return it via mail, fax or email. Each Medicare-eligible participant (i.e., retiree, spouse or dependent) must complete a separate opt-out form.

DO NOT complete this opt-out form if you would like to be enrolled in the NYC Medicare Advantage Plus Plan. No action is required by you. You will automatically be enrolled in the NYC Medicare Advantage Plus Plan effective <Effective Date - TBD>.

By your signature on the next page, you acknowledge that you **do not** wish to participate in the NYC Medicare Advantage Plus Plan and hereby elect to continue participation in your current health plan option.

If you wish to waive your City of New York retiree health coverage, complete the NYC Retiree *Health Benefits Application/Change Form* available on the Health Benefits Program website at: **https://www1.nyc.gov/site/olr/health/retiree/health-retiree-forms-and-downloads.page**.

You may reenroll in City retiree health benefits during the next Transfer Period, or experience a qualifying event. During the Transfer Period, you may add the 365-Day Rider under GHI Senior Care if your union provides prescription drug coverage. If you currently have the High Option Rider, the 365-Day Rider is already included.

NYC Medicare Advantage Plus Plan Opt-Out Form

Complete this form if you wish to opt out of the NYC Medicare Advantage Plus Plan.

This section should be completed by the Medicare-eligible participant (each Medicare-eligible participant [i.e., retiree, spouse, or dependent] must complete a separate opt-out form):

First Name: _____ Last Name: _____

Address: _____

City, State and ZIP: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Medicare Number: _____

Social Security Number: _____

Date of Birth: _____

Complete this section with the City Retiree's information:

Retiree's First Name: _____ Retiree's Last Name: _____

Retiree's Medicare Number: _____

Retiree's Social Security Number: _____

Date of Birth: _____

City Agency from which the City employee retired: _____

By signing below, I elect to continue participation in my current health plan.

_____

Signature of Participant Opting Out Date

Return this form at your earliest convenience via one of the following methods:

Complete electronically at: **www.empireblue.com/nyc-ma-plus**

Mail to: **NYC Medicare Advantage Plus Plan, PO Box 1620 New York, NY 10008-1620**

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Required information for 2022

Your rights, protections and Medicare options

As a Medicare beneficiary, you have many rights and options put in place to protect you as a consumer.

You have choices. As a Medicare beneficiary, you can choose between:

- The Original (Fee-for-Service) Medicare plan.
- A Medicare health plan like the one offered in this guide.

You may have other options, too

The important thing to remember is that the choice is yours, keeping in mind that you may be able to join or leave a plan only at certain times. Please note that if you do not take your retiree benefits, it may affect other retiree benefits your group sponsor offers. No matter what you decide, you may still be eligible for the Original Medicare program.

Geographic service areas covered by this plan

This plan offers coverage in our Centers for Medicare & Medicaid Services (CMS) defined geographic service area of all 50 states, Washington, D.C., and all United States territories.

Your Medicare protections

The plan must offer Medicare benefits to you for a full calendar year at a time, although benefits and cost sharing may change from year to year. The plan provider can decide each year whether to keep offering Medicare Advantage plans, or whether or not to continue offering plans in specific geographic areas like yours.

Also, Medicare may decide to end our contract. But rest assured, even if this happens or if your plan is discontinued, you will not lose coverage.

If for some reason this plan is discontinued, we will send you a letter at least 90 days before your coverage ends explaining your options for Medicare coverage in your area.

For more information on the options and rights you have as a Medicare Advantage member with this plan, please contact our **NYC Medicare Advantage Plus Welcome Team** and ask for a copy of the *Evidence of Coverage (EOC)*.

Required information for 2022

Information about Medicare

To help you make more informed health care decisions, we are providing this important information about Medicare to use as a resource. If you have any questions, please contact our **NYC Medicare Advantage Plus Welcome Team**.

Pay your Medicare Part B premiums

Once you enroll in this plan, you must still pay your Medicare Part B premiums. If you don't, Medicare will terminate your coverage and then you may have to pay a late enrollment penalty if you decide to reenroll.

- The City of New York will continue to reimburse you for your Medicare Part B premiums.
- The City of New York will continue to reimburse you for your income-related monthly adjustment amount (IRMAA).

Enrolling in other plans

If you decide to enroll in other plans, you will be disenrolled from your current plan. You can only be enrolled in one Medicare Advantage plan. If your spouse has Medicare Advantage coverage through their former employer, determine what plan best fits your needs.

Notifying your group sponsor

To ensure a smooth enrollment, make sure your group sponsor has your most up-to-date information and that it matches your Medicare beneficiary information.

Matching Medicare Advantage (medical) coverage and Part D (prescription drug) coverage for members in group plans

If you are enrolled in a group Medicare Advantage plan, your Part D coverage must also be a group Part D plan. This is important because enrolling in a non-group Part D plan could result in termination of your enrollment in your group Medicare Advantage plan.

About IRMAA and your income level

If your modified adjusted gross income on your IRS tax return from two years ago is above a certain limit, you must pay an income-related monthly adjustment amount (IRMAA) in addition to your monthly plan premium.

The Social Security Administration will contact you if you have to pay an IRMAA, which you must pay to them, not us.

High-income surcharges

If you must pay a high-income surcharge on your Medicare Part B premium to the Social Security Administration, please be sure to do so to avoid a mandatory disenrollment.

Required information for 2022

Information about Medicare

Our plan has free language interpreter services available to answer questions from non-English speaking members. Please call the **NYC Medicare Advantage Plus Welcome Team** at the number listed in this guide to request interpreter services.

Out-of-network/non-contracted providers are under no obligation to treat NYC Medicare Advantage Plus members, except in emergency situations. Please call our **NYC Medicare Advantage Plus Welcome Team** at **1-833-325-1190**, TTY: **711**, Monday to Friday, 8 a.m. to 9 p.m. ET, except holidays, for more information.

This information is not a complete description of benefits. Contact the plan for more information. Every year, Medicare evaluates plans based on a 5-star rating system.

This guide is intended to be a brief outline of coverage and is not intended to be a legal contract. The entire provisions of benefits and exclusions are contained in the Benefits Chart and *Evidence of Coverage (EOC)*, which are received upon enrollment. In the event of a conflict between the Benefits Chart/*EOC* and this guide, the terms of the Benefits Chart and *EOC* will prevail.

Aspire Health is a separate company providing coordination of care through home-based visits and telehealth services on behalf of this plan.

LiveHealth Online is the trade name of Health Management Corporation, a separate company, providing telehealth services on behalf of Empire BlueCross BlueShield Retiree Solutions.

The SilverSneakers fitness program is provided by Tivity Health, an independent company. SilverSneakers and the SilverSneakers shoe logotype are registered trademarks of Tivity Health, Inc. SilverSneakers On-Demand and SilverSneakers GO are trademarks of Tivity Health, Inc. © 2019 Tivity Health, Inc. All rights reserved.

The NYC Medicare Advantage Plus Plan is offered through an alliance between Empire BlueCross BlueShield Retiree Solutions and EmblemHealth.

Empire BlueCross BlueShield Retiree Solutions is an LPPO plan with a Medicare contract. Enrollment in Empire BlueCross BlueShield Retiree Solutions depends on contract renewal. Empire BlueCross BlueShield Retiree Solutions is the trade name of Anthem Insurance Companies, Inc. Independent licensee of the Blue Cross Blue Shield Association.

EmblemHealth insurance plans are underwritten by EmblemHealth Plan, Inc., EmblemHealth Insurance Company, and Health Insurance Plan of Greater New York (HIP). EmblemHealth Services Company, LLC provides administrative services to EmblemHealth companies.

The EmblemHealth companies are separate companies from Empire BlueCross BlueShield.

Empire and EmblemHealth have come together to create a new, customized, fully insured Group Medicare Advantage program for the City of New York.

Required information for 2022

It is important we treat you fairly

That is why we follow Federal civil rights laws in our health programs and activities. We do not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language is not English, we offer free language assistance services through interpreters. Interested in these services? Call the **NYC Medicare Advantage Plus Welcome Team** for help (TTY: **711**).

If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, 4361 Irwin Simpson Rd, Mailstop: OH0205-A537; Mason, Ohio 45040-9498. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling **1-800-368-1019** (TTY: **1-800-537-7697**) or online at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**. Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

Find help in your language

Separate from our language assistance program, we make documents available in alternate formats. If you need a copy of this document in an alternate format, please call the **NYC Medicare Advantage Plus Welcome Team**.

English: You have the right to get this information and help in your language for free. Call the **NYC Medicare Advantage Plus Welcome Team** for help. (TTY: **711**)

Spanish: Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda. (TTY: **711**)

Arabic:
يحق لك الحصول على هذه المعلومات والمساعدة بلغتك مجانًا. اتصل برقم خدمات الأعضاء الموجود على بطاقة التعريف الخاصة بك للمساعدة (TTY: **711**).

Armenian: Դուք իրավունք ունեք Ձեր լեզվով անվճար ստանալ այս տեղեկատվությունը և ցանկացած օգնություն: Օգնություն ստանալու համար զանգահարեք Անդամների սպասարկման կենտրոն՝ Ձեր ID քարտի վրա նշված համարով: (TTY: **711**)

Chinese: 您有權使用您的語言免費獲得該資訊和協助。請撥打您的 ID 卡上的成員服務號碼尋求協助。 (TTY: **711**)

Farsi:
شما این حق را دارید که این اطلاعات و کمکها را به صورت رایگان به زبان خودتان دریافت کنید. برای دریافت کمک به شماره مرکز خدمات اعضاء که بر روی کارت شناسایی‌تان درج شده است، تماس بگیرید (TTY: **711**).

French: Vous avez le droit d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour cela, veuillez appeler le numéro des Services destinés aux membres qui figure sur votre carte d'identification. (TTY: **711**)

Haitian: Ou gen dwa pou resevwa enfòmasyon sa a ak asistans nan lang ou pou gratis. Rele nimewo Manm Sèvis la ki sou kat idantifikasyon ou a pou jwenn èd. (TTY: **711**)

Italian: Ha il diritto di ricevere queste informazioni ed eventuale assistenza nella sua lingua senza alcun costo aggiuntivo. Per assistenza, chiami il numero dedicato ai Servizi per i membri riportato sul suo libretto. (TTY: **711**)

Japanese: この情報と支援を希望する言語で無料で受けることができます。支援を受けるには、IDカードに記載されているメンバーサービス番号に電話してください。(TTY: **711**)

Korean: 귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가 있습니다. 도움을 얻으려면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오. (TTY: **711**)

Polish: Masz prawo do bezpłatnego otrzymania niniejszych informacji oraz uzyskania pomocy w swoim języku. W tym celu skontaktuj się z Działem Obsługi Klienta pod numerem telefonu podanym na karcie identyfikacyjnej. (TTY: **711**)

Portuguese-Europe: Tem o direito de receber gratuitamente estas informações e ajuda no seu idioma. Ligue para o número dos Serviços para Membros indicado no seu cartão de identificação para obter ajuda. (TTY: **711**)

Russian: Вы имеете право получить данную информацию и помощь на вашем языке бесплатно. Для получения помощи звоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. (TTY: **711**)

Tagalog: May karapatan kayong makuha ang impormasyon at tulong na ito sa ginagamit ninyong wika nang walang bayad. Tumawag sa numero ng **NYC Medicare Advantage Plus Welcome Team** na nasa inyong Membership Card para sa tulong. (TTY: **711**)

Vietnamese: Quý vị có quyền nhận miễn phí thông tin này và sự trợ giúp bằng ngôn ngữ của quý vị. Hãy gọi cho số Dịch Vụ Thành Viên trên thẻ ID của quý vị để được giúp đỡ. (TTY: **711**)

Empire BlueCross BlueShield Retiree Solutions – H4036

2021 Medicare Star Ratings

Every year, Medicare evaluates plans based on a 5-star rating system. Medicare Star Ratings help you know how good a job our plan is doing. You can use these Star Ratings to compare our plan's performance to other plans. The two main types of Star Ratings are:

1. An Overall Star Rating that combines all of our plan's scores.
2. Summary Star Ratings that focus on our medical or our prescription drug services.

Some of the areas Medicare reviews for these ratings include:

- How our members rate our plan's services and care;
- How well our doctors detect illnesses and keep members healthy;
- How well our plan helps our members use recommended and safe prescription medications.

For 2021, Empire BlueCross BlueShield Retiree Solutions received the following Overall Star Rating from Medicare:

★★★★
4 Stars

We received the following Summary Star Ratings for Empire BlueCross BlueShield Retiree Solutions' health/drug plan services:

Health Plan Services: ★★★★
4 Stars

Drug Plan Services: ★★★½
3.5 Stars

The number of stars shows how well our plan performs.

★★★★★	5 stars – excellent
★★★★	4 stars – above average
★★★	3 stars – average
★★	2 stars – below average
★	1 star – poor

Learn more about our plan and how we are different from other plans at **www.medicare.gov**.

You may also contact us Monday to Friday, 8 a.m. to 9 p.m. ET, at **1-833-325-1190** (toll-free) or **711** (TTY).

Current members please call **1-833-325-1190** (toll-free) or **711** (TTY).

Star Ratings are based on 5 Stars. Star Ratings are assessed each year and may change from one year to the next.

Empire BlueCross BlueShield Retiree Solutions is an LPPO plan with a Medicare contract. Enrollment in Empire BlueCross BlueShield Retiree Solutions depends on contract renewal.

Medicare Advantage

Important information regarding your plan

I understand that the effective date of coverage is when I can begin using the plan services, and the Medicare Advantage plan will send me written notification of the effective date of my enrollment in the plan. I understand that this Medicare Advantage plan is offered under a contract with the Centers for Medicare & Medicaid Services (CMS) and CMS' review of its benefits. I understand that my coverage will come into effect only if this enrollment is approved by the plan and CMS.

I understand that I need to keep my Medicare Parts A & B. I must maintain my Medicare Part B insurance by continuing to pay the Part B premium, if applicable.

I understand that by enrolling in this Medicare Advantage plan, I will automatically be disenrolled by CMS from any other Medicare Advantage plan of which I am currently a member. **I can only be in one Medicare Advantage plan at a time.** It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. I understand that if I enroll in a Medicare Part D prescription drug plan, it also must be a group sponsored plan. If I enroll in an individual Medicare Part D prescription drug plan, it will disenroll me from this group-sponsored Medicare Advantage plan.

I understand that when my City Medicare Advantage Plus coverage begins, I must receive all of my medical benefits from Empire BlueCross BlueShield. Benefits and services authorized by Empire BlueCross BlueShield and contained in my City Medicare Advantage Plus *Evidence of Coverage* document (also known as a member contract or subscriber agreement) will be covered. **Without authorization, neither Medicare nor Empire BlueCross BlueShield will pay for benefits or services.**

I understand that people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the United States border.

I understand that as a member of this plan, I have the right to ask about the plan's decision about payments or coverage for services I receive. I also have the right to appeal plan decisions about payment or services if I disagree.

Release of information: By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment, and healthcare operations.

The information on this enrollment election form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.


Empire
BlueCross BlueShield
An Anthem Company
The Whole Health Company


The City of New York


EmblemHealth

EXHIBIT D

TRUST

**It’s what you have with your current doctors.
And we’re keeping it that way.**

**With the new NYC Medicare Advantage Plus plan,
you can see all the trusted doctors you’ve seen before.**

**If your doctors accept Medicare today then you can continue seeing them with NYC Medicare Advantage Plus.
In fact, you can see over 850,000 Medicare participating doctors nationwide. That’s our promise to you.**

For 85 years Empire BlueCross BlueShield and Emblem Health have been taking care of the health needs of the workers of the City of New York. The new NYC Medicare Advantage Plus (PPO) plan is managed through an alliance of these two trusted insurance companies. This new plan delivers many custom benefits designed to meet your needs and keep you healthy.

Benefit	GHI/EBCBS Senior Care Plan	NYC Medicare Advantage Plus Plan
Annual Maximum Out-of-Pocket	No limit/No protection on amount	$1,470 combined in-network and out-of-network
Foreign Travel Outpatient Emergency Care (Outside the US)	Minimal coverage is provided outside the U.S.	Coverage provided with a $50 copay. Copay waived if admitted within 72 hours
Primary Care Physician (PCP) Visits	$15 copay	$0 copay
Nonemergency transportation	Not Included	Included; 24 one-way trips each year, within 30 miles
Healthy Meals	Not Included	Included
Wellness Rewards	Not Included	$0 copay
Health and Fitness Tracker	Not Included	Included
Care Coordination and Care Management	Not Included	Included
Fitness Program	Not Included	SilverSneakers included, at no cost

EmpireBlue.com/nyc-ma-plus

EmblemHealth®

Empire BlueCross BlueShield
An Anthem Company

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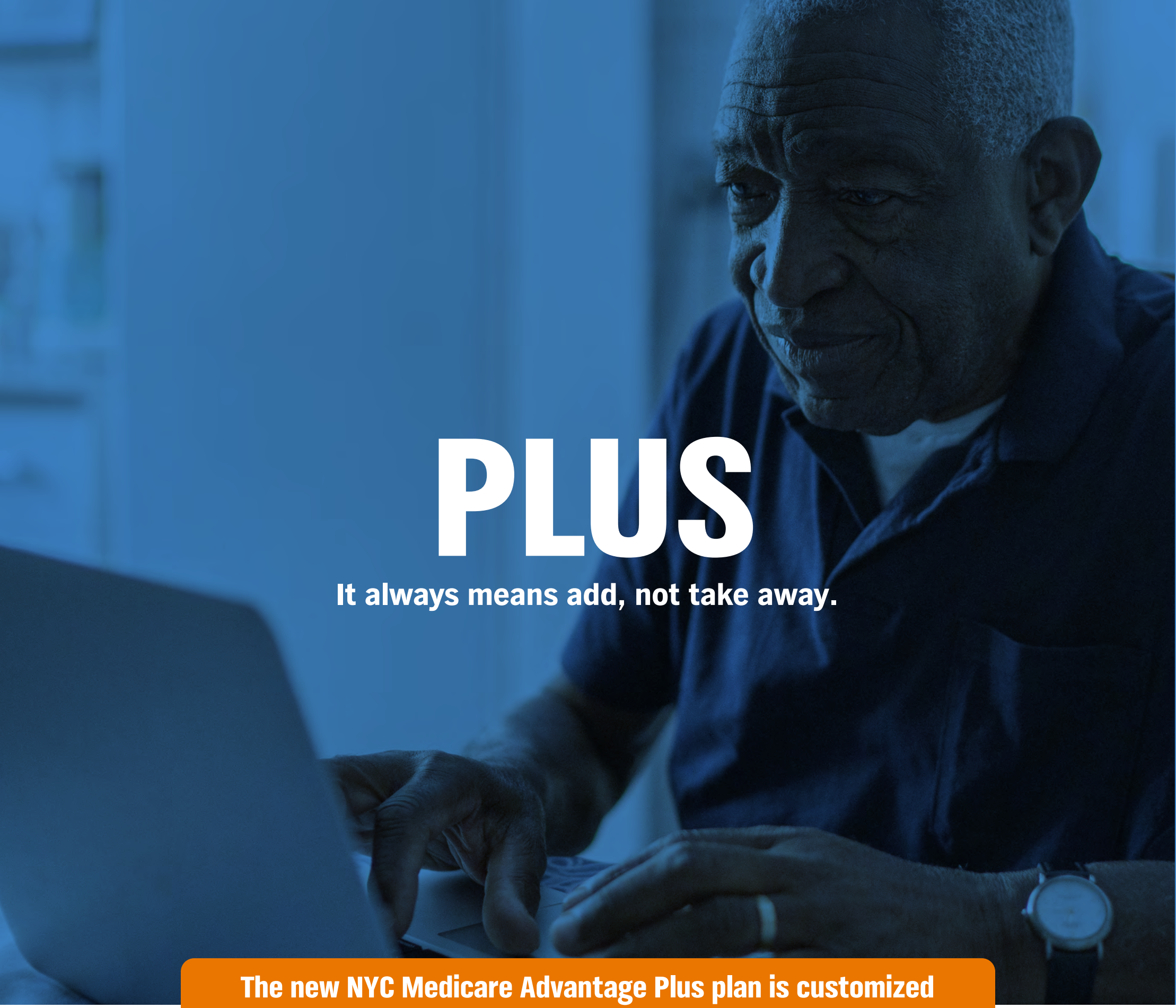

PLUS

It always means add, not take away.

The new NYC Medicare Advantage Plus plan is customized with added benefits exclusively for NYC retirees.

With the new NYC Medicare Advantage Plus plan, you get all the health care benefits and services previously covered by the GHI/EBCBS Senior Care Plan plus many new benefits not covered before. All without any added premium cost. That's our promise to you.

For 85 years Empire BlueCross BlueShield and EmblemHealth have been taking care of the health needs of the City of New York workers. The new NYC Medicare Advantage Plus (PPO) plan is managed through an alliance of these two trusted insurance companies. This new plan delivers many custom benefits designed to meet your needs and keep you healthy.

Benefit	GHI/EBCBS Senior Care Plan	NYC Medicare Advantage Plus Plan
Annual Maximum Out-of-Pocket	No limit/No protection on amount	$1,470 combined in-network and out-of-network
Foreign Travel Outpatient Emergency Care (Outside the US)	Minimal coverage is provided outside the U.S.	Coverage provided with a $50 copay. Copay waived if admitted within 72 hours
Primary Care Physician (PCP) Visits	$15 copay	$0 copay
Nonemergency transportation	Not Included	Included; 24 one-way trips each year, within 30 miles
Healthy Meals	Not Included	Included
Wellness Rewards	Not Included	$0 copay
Health and Fitness Tracker	Not Included	Included
Care Coordination and Care Management	Not Included	Included
Fitness Program	Not Included	SilverSneakers included, at no cost

EmpireBlue.com/nyc-ma-plus

EmblemHealth®

Empire BlueCross BlueShield
An Anthem Company

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EXHIBIT E

Empire BlueCross BlueShield
An Anthem Company

EmblemHealth

Information for medical providers: NYC Medicare Advantage Plus Plan Offered by The Alliance

Effective January 1, 2022, nearly 250,000 Medicare-eligible City of New York retirees are eligible to be transferred to the **NYC Medicare Advantage Plus** plan. The **NYC Medicare Advantage Plus** plan is a Medicare Advantage PPO group retiree offering through The Alliance, an alliance between Empire BlueCross BlueShield (Empire) and EmblemHealth. The plan allows retirees to visit any doctor nationally that accepts Medicare, while ensuring the provider gets paid their negotiated contractual rate or 100% of the Medicare Allowed rate if non-contracted (less any member copay).

Are you in-network? If you are contracted with any of the following networks, you are already an in-network provider participating in this plan. You should continue to see your City of New York retiree patients and submit claims to Empire or your local BlueCross BlueShield plan:

- EmblemHealth's Medicare Choice PPO
- Empire MediBlue PPO
- BlueCross BlueShield (BCBS) Medicare Advantage PPO Network

Are you out-of-network? No problem, you can see City of New York retirees and will still get paid 100% of the Medicare Allowed rate. No contract required.

- You can continue seeing our members as long as you are eligible to receive payments from Medicare.
- Your reimbursement is the same as under Original Medicare.
- Our members are not required to obtain a referral before they see a provider.

What are the benefits of NYC Medicare Advantage Plus Plan? Easier administration with one integrated plan. You no longer need to submit claims to both Original Medicare and the Medicare Supplemental plan, and you will receive one payment for both Medicare covered and supplemental services.

How to submit claims: You should submit all claims to Empire or your local Blue Cross/Blue Shield plan for processing. Please include the amount the member paid when you submit a claim. The member's copay amount will be noted on their ID card for commonly used services:

1. **By mail:** Submit paper claims to your local Blue Cross/Blue Shield plan. Include the 3-digit alpha prefix **N6Y** that precedes the member ID number listed on the front of their card.
2. **By electronic submission:** Submit electronically using the electronic payer ID, or by submitting a UB-04 or *CMS-1500* form, to the Blue Cross/Blue Shield plan in your state. You can also submit claims online at www.availity.com.

Please visit our provider portal for more information:
https://www.empireblue.com/provider/medicare-advantage

If you would like to join the EmblemHealth Medicare Choice PPO network or Empire MediBlue network, please use the following links to get started with the application process:

- **https://www.emblemhealth.com/providers/resources/join-our-network**
- **https://www.empireblue.com/provider/enrollment**

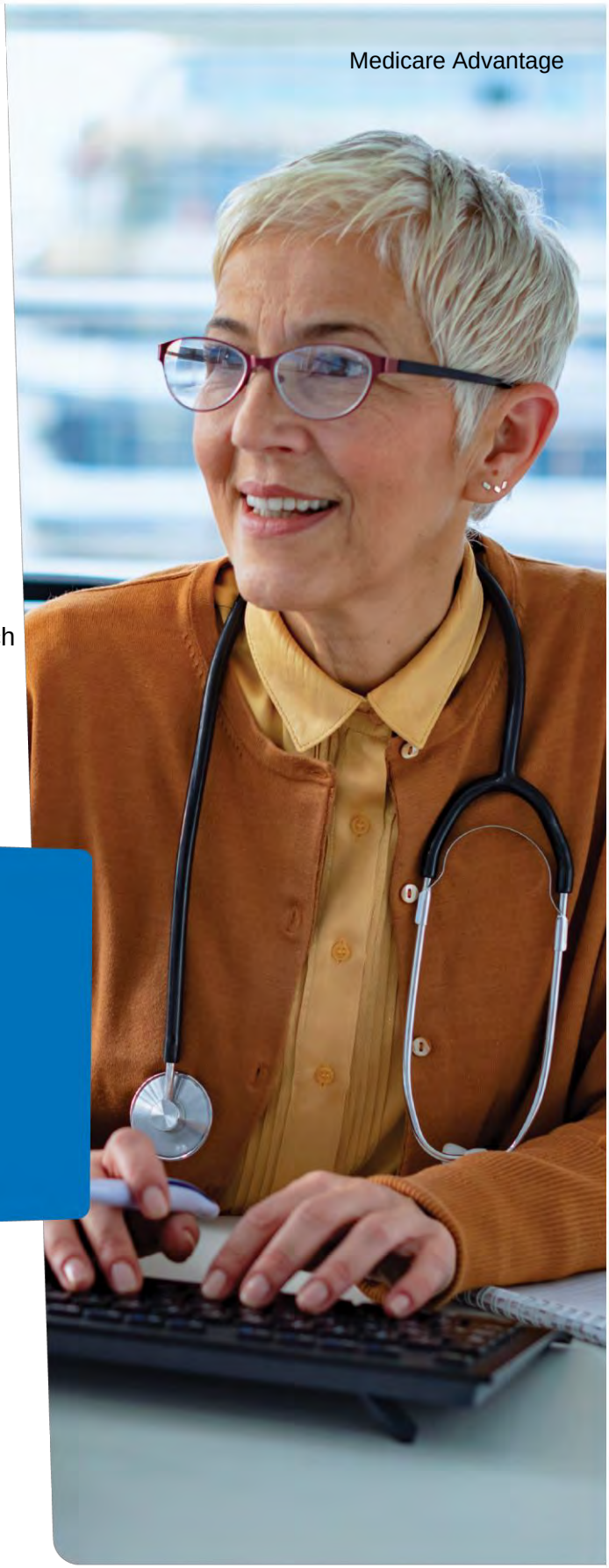
EBSCARE-0708-21 October 2021

EXHIBIT F

Empire BlueCross BlueShield

An Anthem Company

Medicare Advantage



You are invited!

City of New York retirees transition to Medicare Advantage Webinar

We are offering provider webinars to help providers understand the upcoming changes for City of New York retirees transitioning to the NYC Medicare Advantage Plus Plan. The webinars will review key operational processes such as determining eligibility and benefits, prior authorizations requirements, and claims submissions to assist you in continuing to provide care for City of New York retirees.

Registration is required. Please register for the session you would like to attend by selecting your desired date and time via the link below:

https://anthem.webex.com/anthem/onstage/g.php?PRID=ddb0dacedc3d2fade3b01cde286dfce1

You will receive a reminder email before the webinar. A link to the webinar session and the dial-in information will be included in the reminder email.

https://www.empireblue.com/medicareprovider

EBSCARE-1086-21 December 2021

Provider Bulletin
December 2021

Webinars for City of New York retirees transitioning to new Medicare Advantage plan

We are offering webinars to help you understand the upcoming changes for City of New York retirees transitioning to the NYC Medicare Advantage Plus Plan. The webinars will review key operational processes such as determining eligibility and benefits, prior authorization requirements, and claims submissions to assist you in continuing to provide care for City of New York retirees. Please access the following invitation link to register for an upcoming webinar: **https://empireblue.com/da/inline/pdf/ebscare-1086-21.pdf**.

EBSCRNU-0200-21 December 2021

Provider Bulletin
Updated December 2021

City of New York offers Medicare Advantage option in 2022

The City of New York has awarded their group retiree business to the Alliance, an alliance between Empire BlueCross BlueShield (Empire) and EmblemHealth. Approximately 240,000 Medicare-eligible City of New York retirees will transition to the Alliance's NYC Medicare Advantage Plus Plan. The transition is currently anticipated to begin in Q1 2022.

The NYC Medicare Advantage Plus Plan is a Medicare Advantage PPO plan that allows retirees to receive services from both in-network and out-of-network providers. Out-of-network providers must be eligible to receive Medicare payment. Under this new plan, City of New York retirees will have no difference in cost share for both in-network and out-of-network services. NYC Medicare Advantage Plus offers the same hospital and medical benefits Medicare covers, as well as additional benefits Medicare does not provide, such as an annual routine physical exam, hearing exams, health and fitness tracker, LiveHealth Online,* and SilverSneakers.*

In the coming months, provider education materials and training opportunities specific to the NYC Medicare Advantage Plus Plan will be made available to all providers in both Empire's and EmblemHealth's Medicare Advantage networks.

We look forward to furthering our mission to materially and measurably improve the health of all New Yorkers through this opportunity, in partnership with the City of New York and EmblemHealth.

* LiveHealth Online is the trade name of Health Management Corporation, an independent company, providing telehealth services on behalf of Empire BlueCross BlueShield and EmblemHealth. Tivity Health, Inc. is an independent company providing the SilverSneakers fitness program on behalf of Empire BlueCross BlueShield and EmblemHealth.

EBSCARE-0654-21 December 2021

Provider Bulletin
December 2021

City of New York GRS Alliance Program

Anticipated to begin Q1 2022, The City of New York Retirees (GRS) will transition to an integrated Medicare Advantage PPO plan via an alliance between Empire BlueCross BlueShield (Empire) and EmblemHealth (the 'Alliance'), which follows Medicare rules and is a national program. The Alliance program provides comprehensive health coverage to retirees, inclusive of all benefits provided by original Medicare, plus additional benefits. The Alliance plan name is **NYC Medicare Advantage Plus** and is easily identified as plan members have one insurance card displaying an alpha prefix of **N6Y** and a unique Medicare Advantage PPO suitcase logo.

Empire and EmblemHealth network arrangement is applicable in the following 13 downstate New York counties: New York, Bronx, Kings, Queens, Richmond, Nassau, Suffolk, Westchester, Orange, Rockland, Putnam, Dutchess, and Sullivan. Medicare Advantage PPO professional and facility providers outside of the counties listed above will be considered participating. NYC Medicare Advantage Plus members have access to Medicare Advantage PPO providers contracted with Blue Cross Blue Shield Association plans across the nation.

Members do not need referrals for any providers, specialists, or hospitals in or out of the network. Actual benefit payments are subject to eligibility and coverage limitations at the time services are rendered. Claims should be submitted electronically using payer ID **CONY1** or paper submission (via *UB-04* or *CMS-1500* form) to Empire (the local Blue plan).

The following grid illustrates which insurer has claims rate responsibility for NYC Medicare Advantage Plus Plan benefits. Notably, **all claims for NYC Medicare Advantage Plus Plan members must be submitted to Empire** (the local Blue plan) for both the hospital (facility) and medical (professional) benefits, regardless of services rendered or health plan claims rate responsibility, to ensure a seamless claims process and experience for providers and facilities alike.

Under no circumstances should claims be submitted directly to EmblemHealth for NYC Medicare Advantage Plus Plan members.

Empire (the local Blue plan) will process and adjudicate all claims for NYC Medicare Advantage Plus Plan benefits.

Empire rate applies to facility-based services, including but not limited to those listed below, in all geographies, including within the 13 downstate New York counties. **All claims must be submitted to Empire (the local Blue plan)**:

- Acupuncture
- Air/ground ambulance
- Ambulatory infusions
- Audiology (hearing aids)
- Behavioral health (professional/facility)
- Dialysis
- Diabetic supplies
- Durable medical equipment
- Emergency care
- **Facility hospitals**
- Home health
- Home infusion therapy
- Nutrition (registered dietitians)
- Orthotics and prosthetics
- Pathology
- Pharmacy (Part B drugs covered under medical plan)
- Private duty nursing
- Reference labs
- Skilled nursing facilities (SNFs)
- Urgent care

EmblemHealth rate applies to directly contracted professional/traditional services, including but not limited to those listed below, only within the 13 downstate New York counties. **All claims must be submitted to Empire (the local Blue plan):**

- **Professional and specialist providers**
- Chiropractic
- Occupational therapy
- Physical therapy
- Speech therapy

EBSCRNU-0213-21 December 2021

Provider Bulletin
December 2021

FAQ: NYC Medicare Advantage Plus

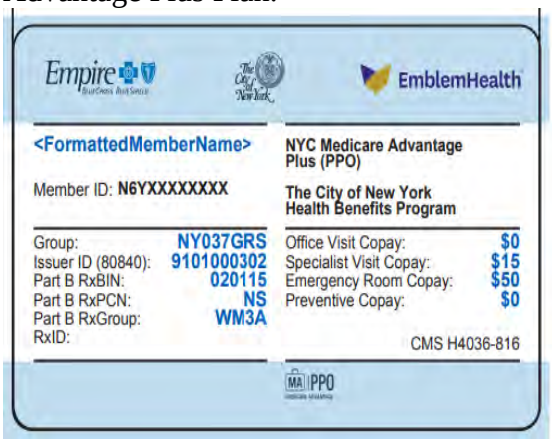
Q: What is NYC Medicare Advantage Plus?

A: NYC Medicare Advantage Plus is the group retiree offering for City of New York Medicare eligible retirees. NYC Medicare Advantage Plus is a Medicare Advantage PPO plan. Under this new plan, City of New York retirees will have no difference in cost share for both in-network and out-of-network services. NYC Medicare Advantage Plus offers the same hospital and medical benefits traditional Medicare covers as well as additional benefits traditional Medicare does not provide, such as an annual routine physical exam, hearing exam, health and fitness tracker, LiveHealth Online,* and SilverSneakers.*

This plan is offered through an alliance between Empire BlueCross BlueShield (Empire) and EmblemHealth. The transition to NYC Medicare Advantage Plus is anticipated to begin in Q1 2022.

Q: What is changing for City of New York retirees transitioning to NYC Medicare Advantage Plus?

A: Prior to City of New York retirees transitioning to NYC Medicare Advantage Plus, City of New York retirees received Part A (Hospital) and Part B (Professional) services through traditional Medicare and supplemental Part A benefits through Empire and supplemental Part B benefits through EmblemHealth. Under the NYC Medicare Advantage Plus Plan, City of New York retirees will have a Medicare Advantage PPO plan instead of using traditional Medicare and supplemental insurance. Each member will receive a new ID card (sample below), cobranded with Empire and EmblemHealth logos, to access their new NYC Medicare Advantage Plus Plan.



* LiveHealth Online is the trade name of Health Management Corporation, an independent company, providing telehealth services on behalf of Empire BlueCross BlueShield. Tivity Health, Inc. is an independent company providing the SilverSneakers fitness program on behalf of Empire BlueCross BlueShield. Availity, LLC is an independent company providing administrative support services on behalf of Empire BlueCross BlueShield. AIM Specialty Health is an independent company providing some utilization review services on behalf of Empire BlueCross BlueShield. MyNexus is an independent company providing post-acute benefits management services on behalf of Empire BlueCross BlueShield.

EBSCRNU-0204-21 December 2021

Q: What is the member prefix for NYC Medicare Advantage Plus?
A: The prefix is N6Y.

Q: Are NYC Medicare Advantage Plus members required to select a primary care physician (PCP)?
A: No, NYC Medicare Advantage Plus members are not required to select a PCP. However, members are encouraged to choose a PCP as a healthcare advocate and first point of contact for health concerns.

Q: Does a provider have to be a participating provider with Empire or EmblemHealth to provide care to NYC Medicare Advantage Plus members?
A: No, the NYC Medicare Advantage Plus Plan is a PPO plan that allows members to get care from both participating and nonparticipating providers. NYC Medicare Advantage Plus members can see any Medicare healthcare provider.

Q: Do NYC Medicare Advantage Plus members need a referral to see a specialist?
A: No, referrals are not needed to provide care to NYC Medicare Advantage Plus members.

Q: Is there a specific network arrangement because of the Retiree Health Alliance?
A: Yes, 13 counties in downstate New York will use EmblemHealth professional providers and Empire facility providers as the contracted network:

- Bronx
- Duchess
- Kings
- Nassau
- New York
- Orange
- Putnam
- Queens
- Richmond
- Rockland
- Suffolk
- Sullivan
- Westchester

Q: Is a provider considered participating with NYC Medicare Advantage Plus if the provider is currently contracted with Empire or EmblemHealth?
A: It depends. If a professional provider has an existing contract with EmblemHealth, then the provider is participating.

Facility and ancillary providers with an existing Empire contract are participating, according to the network arrangement outlined above. Professional providers in the 13 downstate counties must have a contract with EmblemHealth to be considered participating.

Professional and facility providers in other Empire counties outside of the 13 downstate counties with an existing Empire contract are participating for NYC Medicare Advantage Plus, regardless of provider type as the network arrangement is not applicable outside of these 13 downstate counties.

Q: If a professional provider in the 13 downstate counties has a contract with both EmblemHealth and Empire, which contract is considered for participation in the network?
A: The EmblemHealth contract will be considered the participating contract for professional providers including chiropractors, physical therapists, occupational therapists, and speech therapists in the 13 downstate counties.

Q: In the 13 downstate counties, are there any exceptions for certain professional specialties that would utilize their Empire contract?

A: Yes, behavioral health professional specialties, both professional and facility, will be considered participating under their Empire contract.

Q: In the 13 downstate counties, if a professional provider is not contracted with EmblemHealth but does have a contract with Empire, is the provider considered nonparticipating?

A: Yes, the provider will be considered non-participating and will be reimbursed according to the local Medicare fee schedule allowable when seeing NYC Medicare Advantage Plus members.

Q: How are contracted providers reimbursed?

A: Reimbursement is based on your contracted rate. For details, contracted providers should review their contract:

- Professional providers excluding behavioral health specialists in the 13 downstate counties will be reimbursed per their contract with EmblemHealth.
- Professional providers in all other Empire counties will be reimbursed per their contract with Empire.
- Behavioral health specialists will be reimbursed per their contract with Empire.
- Facility and ancillary providers will be reimbursed per their contract with Empire.
- All provider types outside of the Empire service area will be reimbursed per their contract with their local Blue plan.

Q: How are noncontracted providers reimbursed?

A: Noncontracted providers are reimbursed according to the local traditional Medicare fee schedule less the NYC Medicare Advantage Plus member's cost share.

Q: What is the claims submission process for NYC Medicare Advantage Plus?

A: Under the NYC Medicare Advantage Plus Plan, providers will change billing processes as follows:

- Providers will submit all claims (facility, professional, and ancillary) to Empire.
- Providers will ***not*** submit any claims to traditional Medicare or EmblemHealth.
- Claims can be submitted electronically (preferred) or by paper (*UB-04* or *CMS-1500* forms).
- Inpatient admissions before the effective date of the NYC Medicare Advantage Plus Plan will follow previous billing procedures, regardless of the date of discharge.
- Payer ID: *CONY1*
- If a vendor or clearinghouse needs additional time to add the new payer ID, providers may use existing Empire payer IDs:
    - 00803 — Professional claims
    - 00303 — Institutional claims

Q: How can member eligibility and benefits be verified?

A: Member eligibility and benefits can be verified online or via phone:

- **Online:** Eligibility, benefits, claims, commonly used forms, and remit information are all available through the Availity Portal* at **availity.com**. If you do not have an Availity account, we encourage you to register at your earliest convenience.
- **Phone:** Call the Provider Service number on the back of the member's ID card.

Q: Is prior authorization required?

A: Some services will require a prior authorization. Providers may use Availity to determine if a prior authorization is required:

- Contracted providers must request prior authorization.
- All providers will follow Empire authorization guidelines.
- Noncontracted providers are not required to submit prior authorizations, but requesting prior authorization is highly encouraged. Requesting prior authorization will confirm services are covered and are medically necessary.

Q: How can a provider request prior authorization?

A: Providers are encouraged to use Availity to request prior authorization but may request by fax and phone as well:

- **Online: availity.com** (Preferred and most efficient)
- **Phone:** Call the Provider Services number on the back of the member's ID card and follow the prompts

In some instances, prior authorization is delegated for specific services:

- AIM Specialty Health®* — Radiology, cardiology, genetic testing, sleep, msk, radiation oncology, and medical oncology
- myNexus* — Home health

Q: Does the plan follow Medicare guidelines detailed in the national coverage determinations (NCDs) and local coverage determinations (LCDs)?

A: Yes, NCDs and LCDs will be applied in accordance with federal regulation and CMS guidance for both contracted and noncontracted providers.

Q: Does the NYC Medicare Advantage Plus Plan require advance patient notification for services not covered under this plan?

A: Providers are encouraged to contact the plan for a formal determination of coverage if the provider thinks a service may not be covered.

If a contracted provider performs a service that may not be covered and the plan has not issued a *Notice of Denial of Medical Coverage*, also known as the *Integrated Denial Notice*, a determination that the service is noncovered, the provider can only collect the cost share that would apply for the service as if the service were actually coverable. The provider must not balance bill an NYC Medicare Advantage Plus member for a noncovered service if the plan has not issued the member an *Integrated Denial Notice* that the service will not be covered.

For more information, see ***Chapter 4, Section 160,* of the *Medicare Managed Care Manual***.

Q: Can providers collect cost share amounts up front from NYC Medicare Advantage Plus members?

A: Yes, providers may request the member's cost share at the time of service.

Q: Can NYC Medicare Advantage Plus members be balance billed?

A: No, NYC Medicare Advantage Plus members may only be billed the applicable member cost share as indicated on the provider remittance.

Q: Will there be any additional way to learn more about the NYC Medicare Advantage Plus Plan for providers?

A: Yes, please join a provider education session. There will be a variety of date and time options and will be for any provider type.

Registration link: **https://bit.ly/2Y9DrBj**