EmblemHealth®

Technical Proposal

Health Maintenance Organizations Specifications for the New York State Health Insurance Program (NYSHIP)

July 27, 2020

Submitted to:

New York State Department of Civil Services
Attn: Brian Bopp, Assistant Director of Financial Administration
Office of Financial Administration, Floor 17
Agency Building 1, Empire State Plaza
Albany, New York 12239
Phone: (518) 473-2726
Email: DCSprocurement@cs.ny.gov

NEW YORK STATE

ORIGINAL
2021 HMO Submission

Disclaimer Information

EmblemHealth benefit plans are underwritten by Group Health Incorporated (GHI), Health Insurance Plan of Greater New York (HIP), and HIP Insurance Company of New York.

GHI, HIP, HIP Insurance Company of New York, and EmblemHealth Services Company, LLC are all EmblemHealth companies. EmblemHealth Services Company, LLC provides administrative services to EmblemHealth companies.

Corporate Headquarters

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EmblemHealth

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List of Exhibits

1. Plan Requirements

The Offeror must provide a copy of their current DOH Certificate of Authority to operate an HMO.

As required, please see the following page for a copy of our Article 44 License which serves as our Certificate to Operate. Our approved service area, by county, is provided on the certificate. This same information has also been provided in electronic form, labeled as *Attachment 1. HIP DOH License* on our USBs provided.

New York State Department of Health
Division of Health Plan Contracting and Oversight

Health Maintenance Organization Certificate of Authority

Health Insurance Plan of Greater New York
d/b/a EmblemHealth
55 Water Street
New York, New York 10041

Has been granted this certification of authority to operate
Pursuant to Article 44 of the New York State Public Health Law

December 1, 1978
Reissued
March 1, 1983
June 1, 1992
June 1, 1995
August 1, 1997
August 23, 2004
June 14, 2005
August 1, 1997
August 23, 2004
June 14, 2005
June 15, 2010
April 2, 2012
April 29, 2013
August 14, 2015
April 15, 2016
February 3, 2017
December 6, 2019

Conditions of Operations

- The Article 44 service area for Health Insurance Plan of Greater New York serving the commercial population shall be designated as Albany, Bronx, Broome, Columbia, Delaware, Dutchess, Fulton, Greene, Kings, Montgomery, Nassau, New York, Orange, Otsego, Putnam, Queens, Rensselaer, Richmond, Rockland, Saratoga, Schenectady, Schoharie, Suffolk, Sullivan, Ulster, Warren, Washington and Westchester Counties.
- The Article 44 service area for Health Insurance Plan of Greater New York serving the Medicaid and Child Health Plus populations shall be designated as Bronx, Kings, Nassau, New York, Queens, Richmond, Suffolk, and Westchester Counties. The provision of health care services in this service area is contingent upon the execution of Medicaid and Child Health Plus contracts.
- Health Insurance Plan of Greater New York is certified to offer Medicare Advantage in the following counties: Albany, Bronx, Broome, Columbia, Delaware, Dutchess, Greene, Kings, Nassau, New York, Orange, Putnam, Queens, Rensselaer, Richmond, Rockland, Saratoga, Schenectady, Suffolk, Sullivan, Ulster, Warren, Washington and Westchester. Health Insurance Plan of Greater New York will operate in accordance with all applicable State and Federal requirements. The Department of Health's approval is based upon information provided by the plan. A comprehensive review of the plan's policies and procedures associated with the operation of the Medicare Advantage Program was not conducted. All aspects of operation will be governed primarily by the Centers for Medicare and Medicaid Services (CMS), and operation is contingent upon securing a Medicare contract with the Federal government.
- Health Insurance Plan of Greater New York is approved as a Health and Recovery Plan (HARP) serving the HARP eligible Medicaid population in the counties of Bronx, Kings, Nassau, New York, Queens, Richmond, Suffolk, and Westchester. The provision of HARP services in these counties is contingent upon execution of the Medicaid contract with New York State.

[redacted]

Jonathan Bick, Director
Division of Health Plan
Contracting and Oversight

In addition, the Offeror must:

1. *Submit a copy of the draft NYSHIP Dependent Eligibility Rider that the organization will file with the DFS. A draft 2020 NYSHIP Dependent Eligibility Rider (Attachment 19) provides the NYSHIP dependent eligibility requirements. The HMO must include this Rider, approved by the DFS, as part of its proposed benefit package.*

   Please see the following pages for a copy of our draft 2020 NYSHIP Dependent Eligibility Rider which was filed with the DFS on July 9, 2020 and is awaiting approval. This identical information has also been provided in electronic format, labeled as *Attachment 2. Draft 2020 NYSHIP Dependent Eligibility Rider* on our USBs submitted.

(1)[Section XX]

Who is Covered

This Rider amends Your Certificate by deleting in its entirety "Section V – Who is Covered" and replacing with the following:

A. Definitions.
Terms used in this Rider are defined as follows. (Other defined terms can be found in the Definitions section of the Certificate).

1. **"Young Adult"** means an unmarried child, including adopted and stepchild through the age of 29 (until the Young Adult's 30th birthday) of an employee or member insured under NYSHIP, regardless of financial dependence, who is not insured by or eligible for coverage under any employee health benefit plan as an employee or member, whether insured or self-insured, and who lives, works or resides in New York State or the service area of the insurer and who is not covered under Medicare.

2. **"Young Adult Option"** means the right of a Young Adult who exceeds the age for dependent coverage under his or her parent's health insurance policy to independently purchase coverage through the parent's policy through the age of 29.

B. NYSHIP Eligibility.
The Subscriber, as a result of his or her relationship with the Group, is covered hereunder, and if such person has selected family coverage, the following family members of the Subscriber are also covered:

1. Your spouse, including a legally separated spouse, is eligible. If you are divorced or your marriage has been annulled, your former spouse is not eligible, even if a court orders you to maintain coverage.

2. Your Domestic Partner. You may cover your same or opposite sex domestic partner as your dependent under NYSHIP. A domestic partnership, for eligibility under NYSHIP, is one in which you and your partner are 18 years of age or older, unmarried and not related in a way that would bar marriage, living together, involved in an exclusive mutually committed relationship and financially interdependent. To enroll a domestic partner, you must have been in the partnership for six months and be able to provide proof of 6 months of cohabitation and 6 months of financial interdependence. There is a one year waiting period from the termination date of your previous partner's coverage before you may again enroll a domestic partner.

3. Your children under 26 years of age are eligible. This includes your natural children, legally adopted children, children in a waiting period prior to finalization of adoption, your stepchildren and children of your domestic partner who are covered without regard to financial dependence, residency with you, student status or employment. Other children who reside permanently with you in your household, who are chiefly dependent on you and for whom you have assumed legal responsibility, in place of the parent, also are eligible; you

must verify eligibility and provide documentation to your Employer upon enrollment and every two years thereafter. For "other children," legal responsibility by you must have commenced before the child reached 19.

4. For purposes of eligibility for health insurance coverage as a dependent, you may deduct from your dependent's age up to four years for service in a branch of the U.S. Military between the age of 19 and 25 for those dependents that return to school on a full-time basis, are unmarried and are otherwise not eligible for employer group coverage. You must be able to provide written documentation from the U.S. Military. Proof of full-time student status at an accredited secondary or preparatory school, college or other educational institution will be required by the HMO for verification.

5. Your unmarried dependent children 26 or over who are incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation as defined in the mental hygiene law, or physical handicap who became so incapable prior to attainment of the age at which dependent coverage would otherwise be terminated are eligible.

   The HMO will accept determinations of total disability under the above standards made by other group health plans provided that there has not been a break in coverage between plans.

6. Your unmarried children, including adopted and stepchildren through age twenty-nine ("Young Adult"), who live, work, or reside in New York State or the service area of the HMO's network-based NYSHIP policy and who:

   a) are not insured by or eligible for coverage through the Young Adult's own employer-sponsored health plan, whether insured or self-funded, provided that the health plan includes both hospital and medical benefits; and

   b) are not covered under Medicare;

   are eligible for coverage under the Young Adult Option.

   In addition:

   c) the Young Adult need not live with the parent, be financially dependent upon the parent, or be a student;

   d) the Young Adult's eligibility for health insurance coverage through a former employer under federal COBRA or State continuation coverage does not disqualify the Young Adult from electing the Young Adult Option under NYSHIP;

   e) the Young Adult's children are not eligible for coverage under the Young Adult Option, but may be eligible for health insurance coverage under other programs, such as the Child Health Plus program;

f) the parent need not have family coverage for the Young Adult to enroll in the Young Adult Option; and

g) the Young Adult need not have been previously covered under the parent's NYSHIP coverage.

The HMO must accept all NYSHIP determinations of eligibility for enrollment in this coverage. Coverage of a Young Adult as described in this paragraph shall consist of coverage which is identical to the coverage provided to a NYSHIP enrollee. If the parent is enrolled in the HMO, coverage is available for the Young Adult who lives, works or resides outside of the parent's HMO service area but within New York State. However, the parent of the Young Adult need not be enrolled in the HMO in order for the Young Adult to have NYSHIP coverage through the plan in which he/she is enrolling as long as the Young Adult lives, works or resides in that HMO's service area. The parent must only be a NYSHIP enrollee (including under COBRA).

Coverage shall terminate on the first of the following to occur:

a) the Young Adult voluntarily terminates coverage;

b) The Young Adult's parent no longer is enrolled in NYSHIP;

c) the Young Adult no longer meets the eligibility requirements for the Young Adult Option as outlined above;

d) the NYSHIP premium for the Young Adult is not paid in full within the 30-day grace period; or

e) the group contract is terminated and not replaced.

The dependent child does not have a separate federal COBRA or New York State continuation right at the time coverage through this option terminates.

A Young Adult and his/her parent have the following opportunities to enroll in the Young Adult Option:

1. When the Young Adult Would Otherwise Lose Coverage Due to Age

   Coverage may be elected within 60 days of the date that the Young Adult otherwise would lose eligibility for coverage as his/her parent's dependent due to age. Coverage is retroactive to the date that the Young Adult otherwise would have lost coverage due to age. This is the only circumstance in which the Young Adult Option will be effective on a retroactive basis.

2. When the Young Adult is Newly Qualified Due to a Change in Circumstances

   Coverage may be elected within 60 days of the date that the Young Adult newly meets the eligibility requirements for the Young Adult Option, such as due to loss of coverage through his/her employer; moves his/her residence into New York State; or gets divorced. It is possible for a Young Adult to elect coverage under this option on multiple occasions due to changes in the Young Adult's eligibility over time. Coverage will be effective prospectively, no later than 30 days after NYSHIP receives written notice of the election and payment of the first premium.

3. During the Young Adult Option Annual 30-Day Open Enrollment Period

   Coverage may be elected during the Young Adult Option's annual 30-day open enrollment period which is expected to coincide with NYSHIP's Annual Option Transfer Period. Coverage under this option will be effective prospectively.

C. Controlling Certificate.
All of the terms, conditions, limitations, and exclusions of Your Certificate to which this Rider is attached shall also apply to this rider except where specifically changed by this Rider.

HEALTH INSURANCE PLAN OF GREATER NEW YORK

(2)[Karen Ignagni
President and CEO**]**

2. *Indicate whether or not the HMO will be proposing a Medicare Advantage offering.*

Yes, EmblemHealth is proposing a Medicare Advantage offering. Currently, our Medicare Advantage offering is approved by NYSHIP for supporting members in Bronx, Kings, Nassau, New York, Queens, Richmond, Suffolk and Westchester counties only. However, since this is a new contract year, EmblemHealth is requesting additional approval for the following counties which we are already approved for by the New York State Department of Financial Services (DFS) and the Centers for Medicare and Medicaid Services (CMS):

- Albany, Columbia, Delaware, Dutchess, Greene, Orange, Putnam, Rensselaer, Saratoga, Schenectady, Sullivan, Ulster, Warren, and Washington counties

EmblemHealth offers Medicare Advantage in these counties today and is fully prepared to market to NYSHIP members in these additional counties, providing complete administrative and customer service support. Upon your approval, our new NYSHIP Service Area for Medicare Advantage will cover the following counties:

- Albany, Bronx, Columbia, Delaware, Dutchess, Greene, Kings, Nassau, New York, Orange, Putnam, Queens, Rensselaer, Richmond, Saratoga, Schenectady, Suffolk, Sullivan, Ulster, Warren, Washington, and Westchester counties

3. *Provide a list of Counties and associated rating region configuration for the HMO's proposed 2021 NYSHIP Service Area. Counties must be contiguous and listed for both Commercial Plan and Medicare Advantage Plan, if offered through NYSHIP. The Medicare Advantage Plan Service Area must be identical to the Commercial Plan and all counties must be CMS approved. However, additional participation in underserved counties is permissible during the term of the Contract. As of January 1, 2020, the Department, in consultation with the JLMC, considers Chemung, Schuyler, Rockland, Bronx, New York, Richmond, Queens, Kings, Nassau, and Suffolk counties in New York State to be underserved. The Department, in consultation with the JLMC currently defines an "underserved county" as a county in which, in addition to the Empire Plan, only one (1) NYSHIP HMO is offered. The definition of an "underserved county" is subject to change for any given plan year by the Department in consultation with the JLMC.*

Please see the following table for our list of counties per plan along with the associated rating region. As noted in our previous response, we are requesting expansion of our NYSHIP Service Area to include additional counties for which we offer Medicare Advantage today. Further, as required, EmblemHealth has ensured our service area is identical for both our Commercial and Medicare Advantage offerings.

Exhibit 1. 2021-2025 NYSHIP Service Area: HIP Prime & Medicare Advantage HMO Plans

HIP Commercial Service Area	HIP Medicare Service Area	Rating Region (same for both plans)
NYS Counties	NYS Counties	NYSHIP Code Number
Albany	Albany	220
Bronx	Bronx	050
Columbia	Columbia	220
Delaware	Delaware	350
Dutchess	Dutchess	350
Greene	Greene	220
Kings	Kings	050
Nassau	Nassau	050
New York	New York	050
Orange	Orange	350
Putnam	Putnam	350
Queens	Queens	050
Rensselaer	Rensselaer	220
Richmond	Richmond	050
Saratoga	Saratoga	220
Schenectady	Schenectady	220
Suffolk	Suffolk	050
Sullivan	Sullivan	350
Ulster	Ulster	350
Warren	Warren	220
Washington	Washington	220
Westchester	Westchester	050

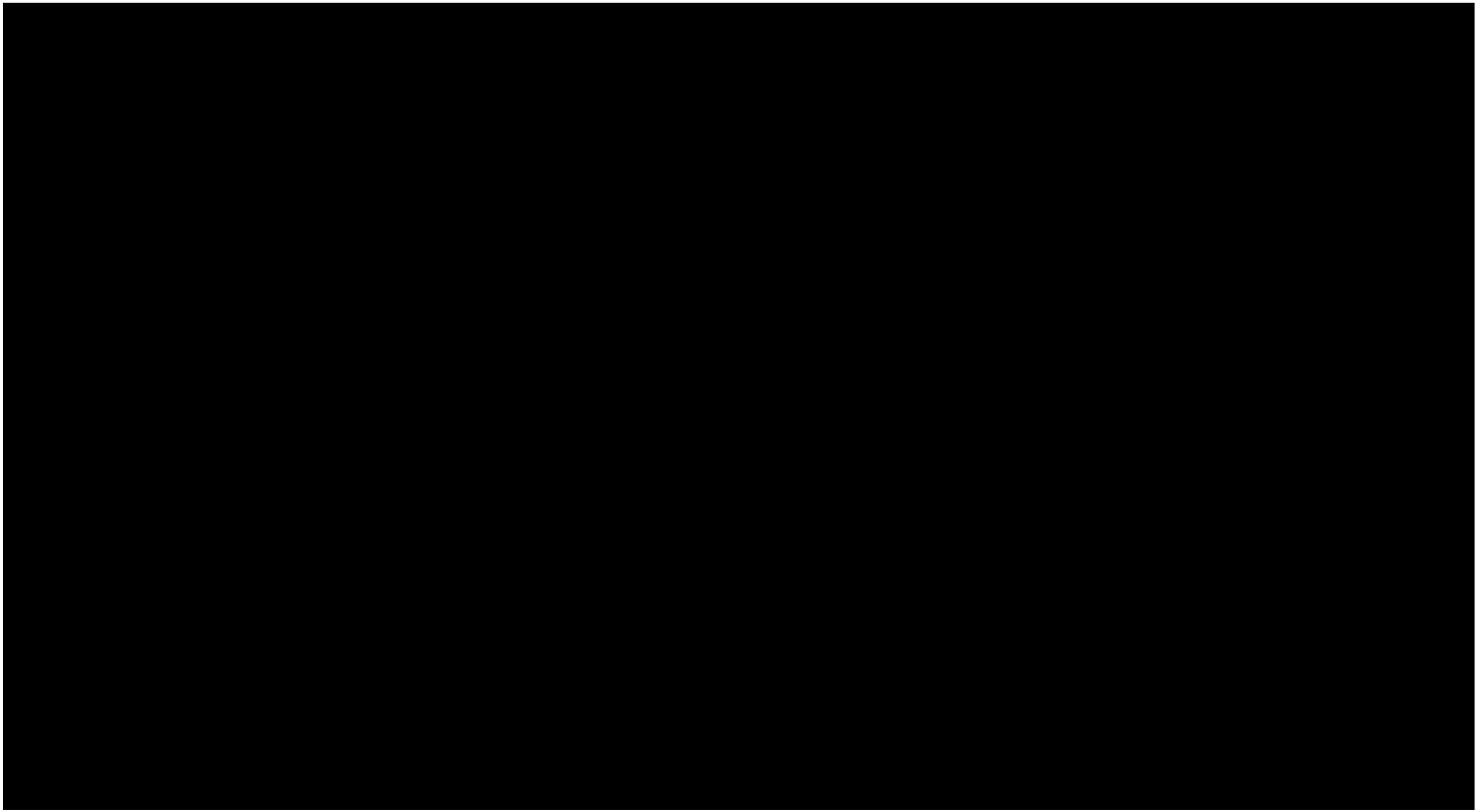
4. *Provide a copy of your organization's most recent annual filing of Schedule M (Complaints).*

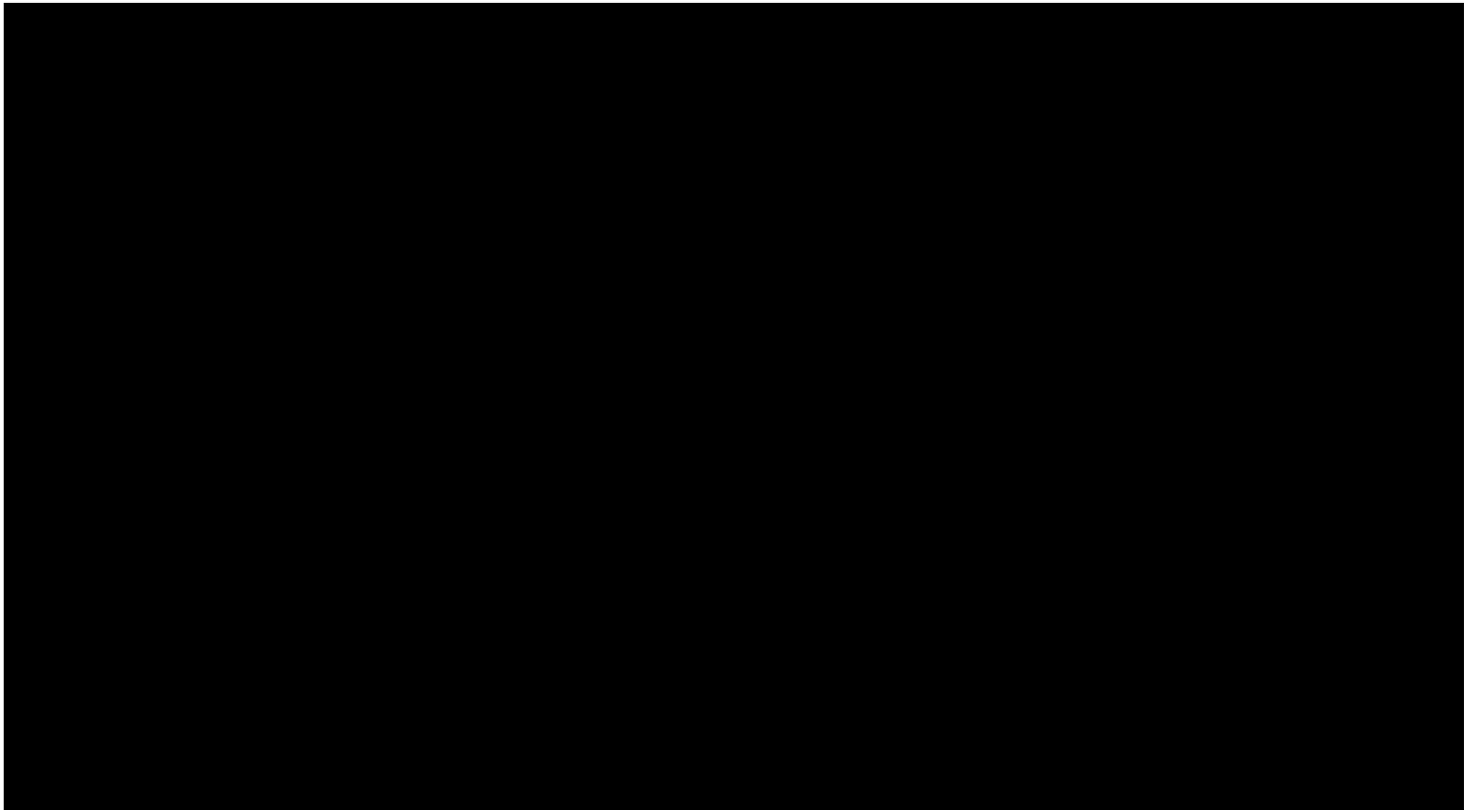
Please see EmblemHealth's *Schedule M* as provided in the following pages as part of our hardcopy and electronic response submission. This identical information has also been provided as a separate attachment on our USBs submitted, labeled as *Attachment 3. EmblemHealth's 2019 Schedule M*.

[redacted]

[redacted]

NY61





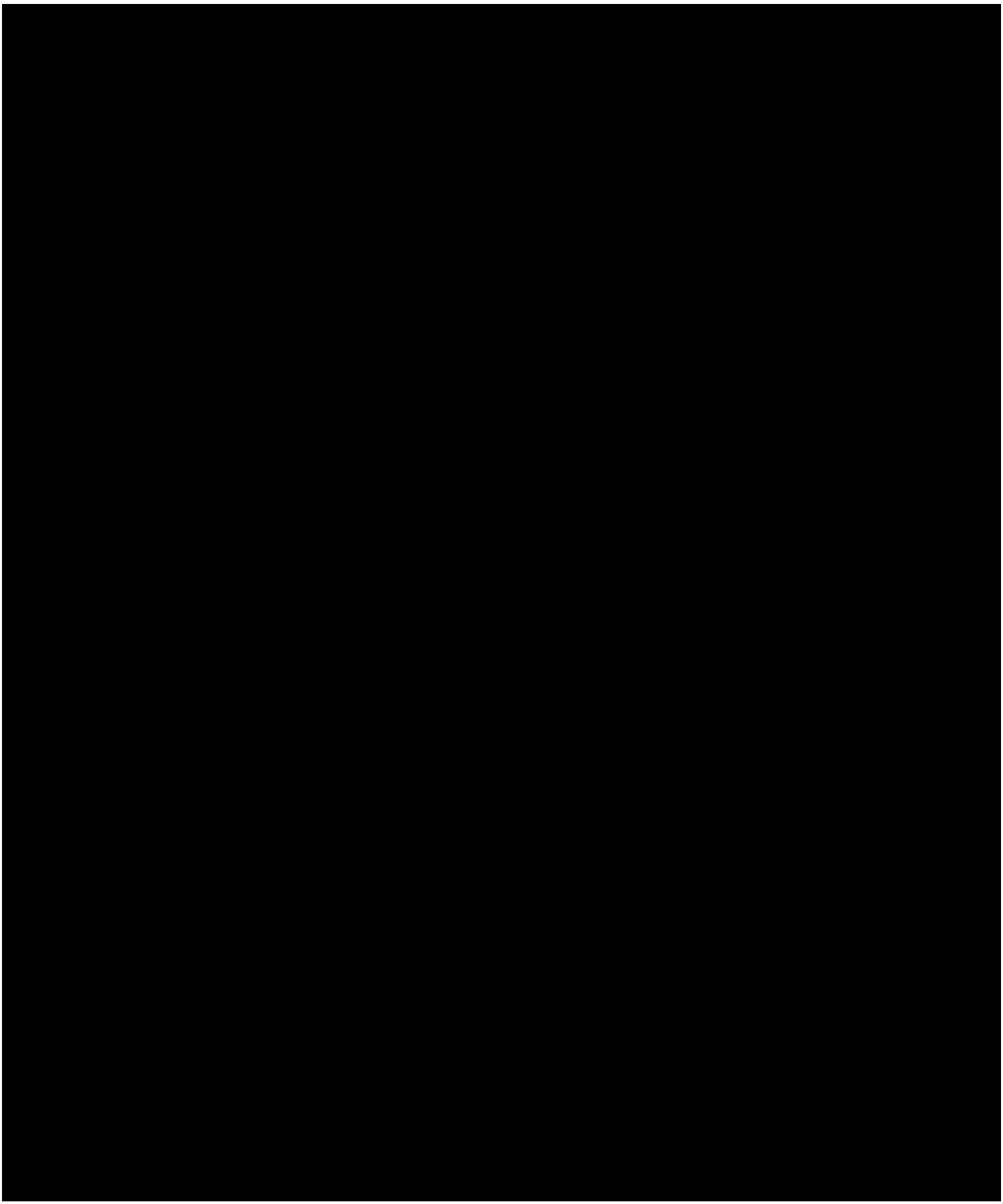
5. *Describe the method that the Offeror uses to determine that all Members have reasonable access to Network Providers. For example, access to primary care physicians (PCP) should be within a 5-mile radius in an urban setting and 15 miles in a rural area. Provide the minimum standards that the Offeror uses to measure access. Submit a measurement of network access based on a "snapshot" of the network taken on March 31, 2020.*

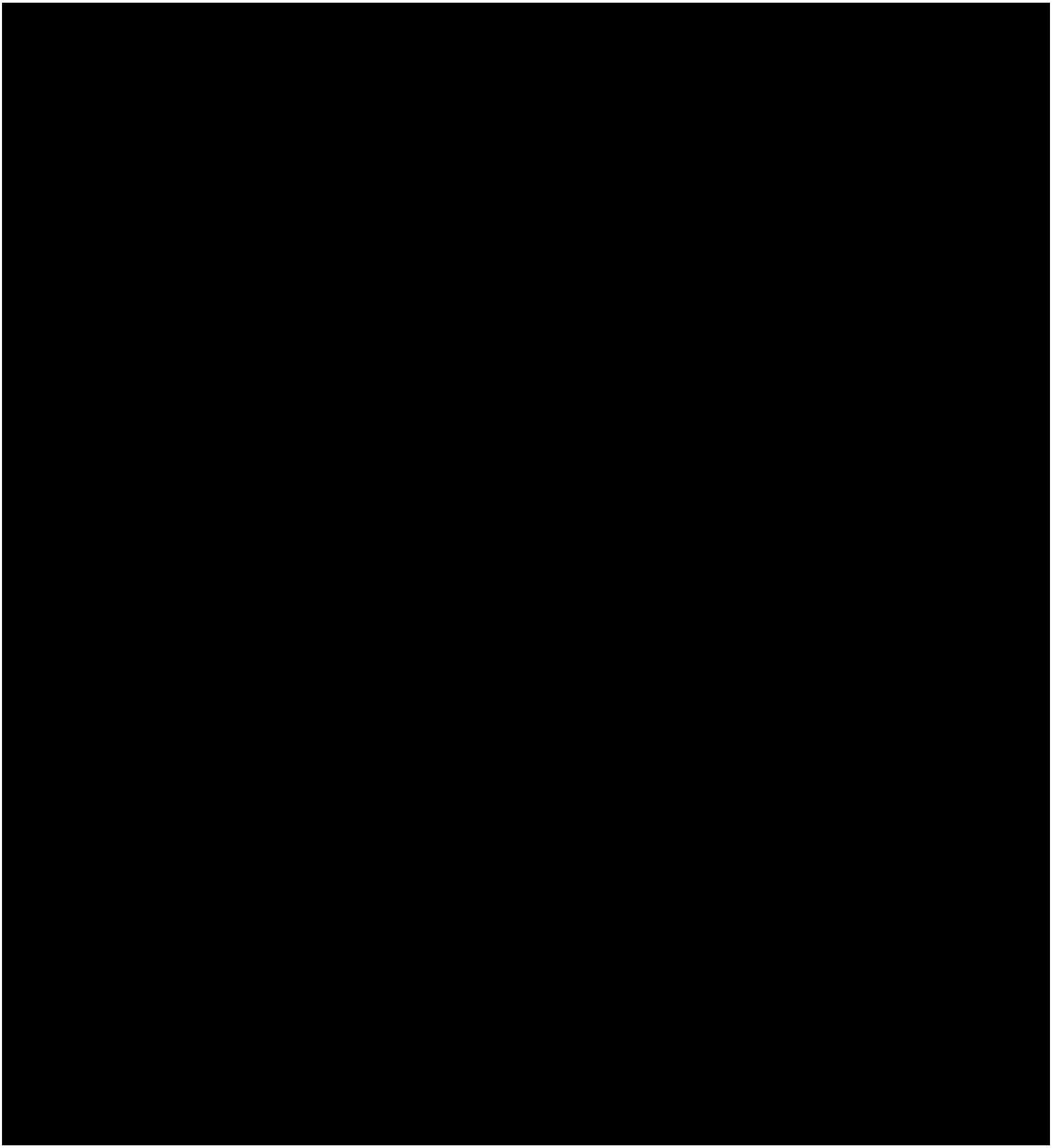
   EmblemHealth runs GeoAccess reports to ensure enrollees have sufficient access to providers in-network. Our access standards are provided in the following table.

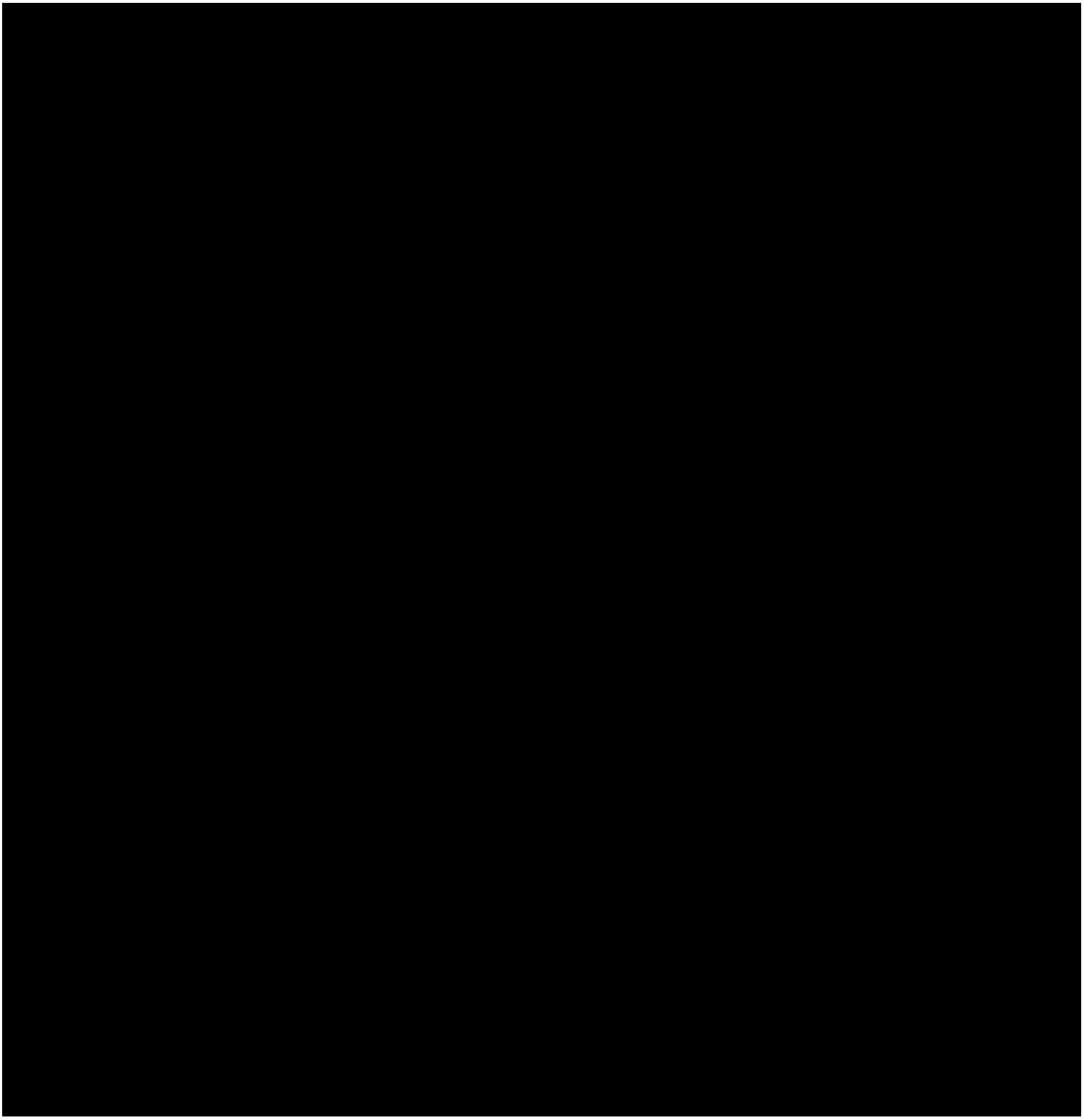
Exhibit 2. Access Standards

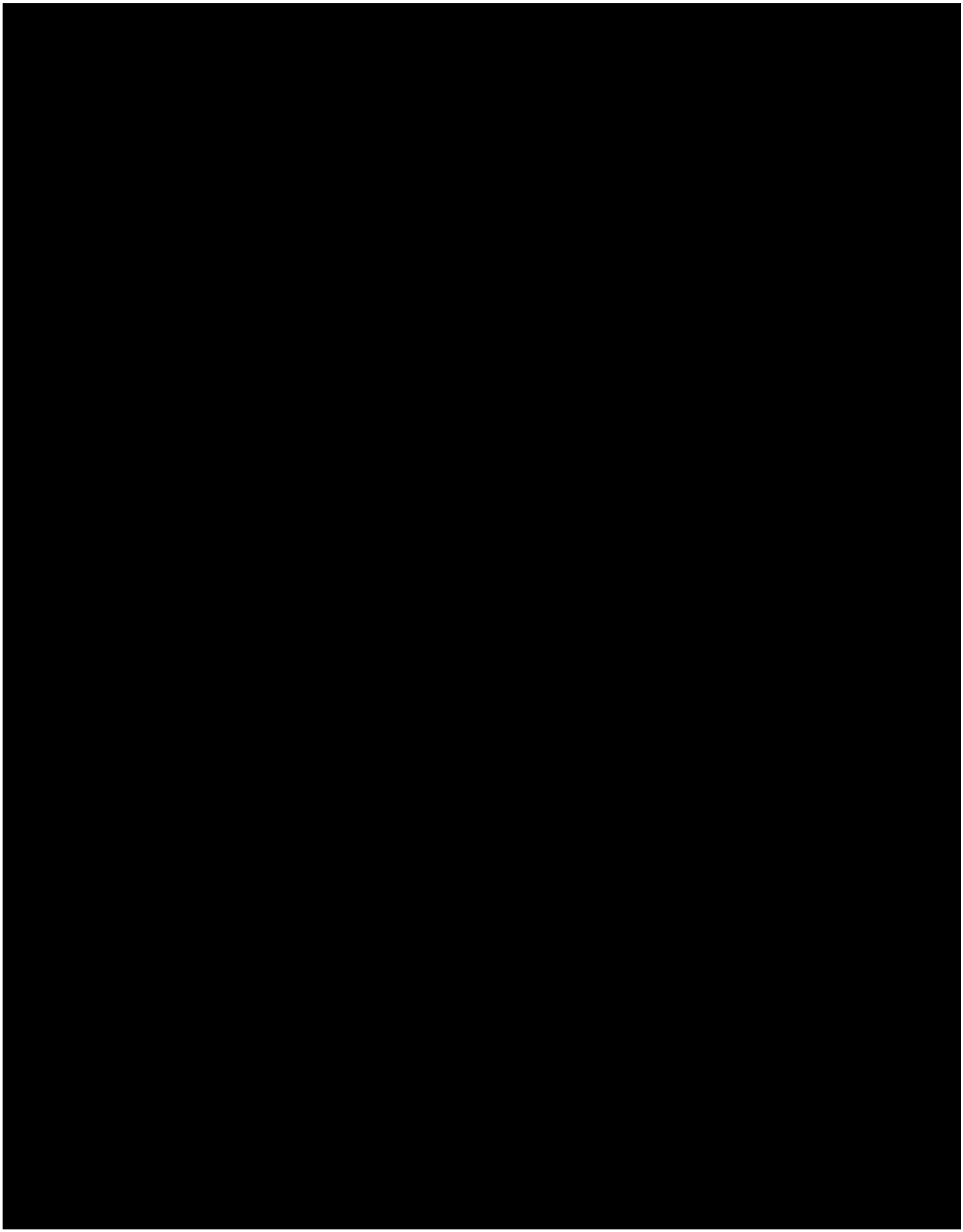
Access Standards		
Area	**Primary Care Physician**	**Specialist**
Urban	1 provider within 5 miles	2 providers within 10 miles
Suburban	1 provider within 10 miles	2 providers within 12 miles
Rural	1 provider within 15 miles	2 providers within 20 miles

In addition, we have included GeoAccess report tables as provided on the following tables which demonstrates access for both HIP Prime HMO Plan enrollees and Medicare Advantage HMO Plan enrollees.









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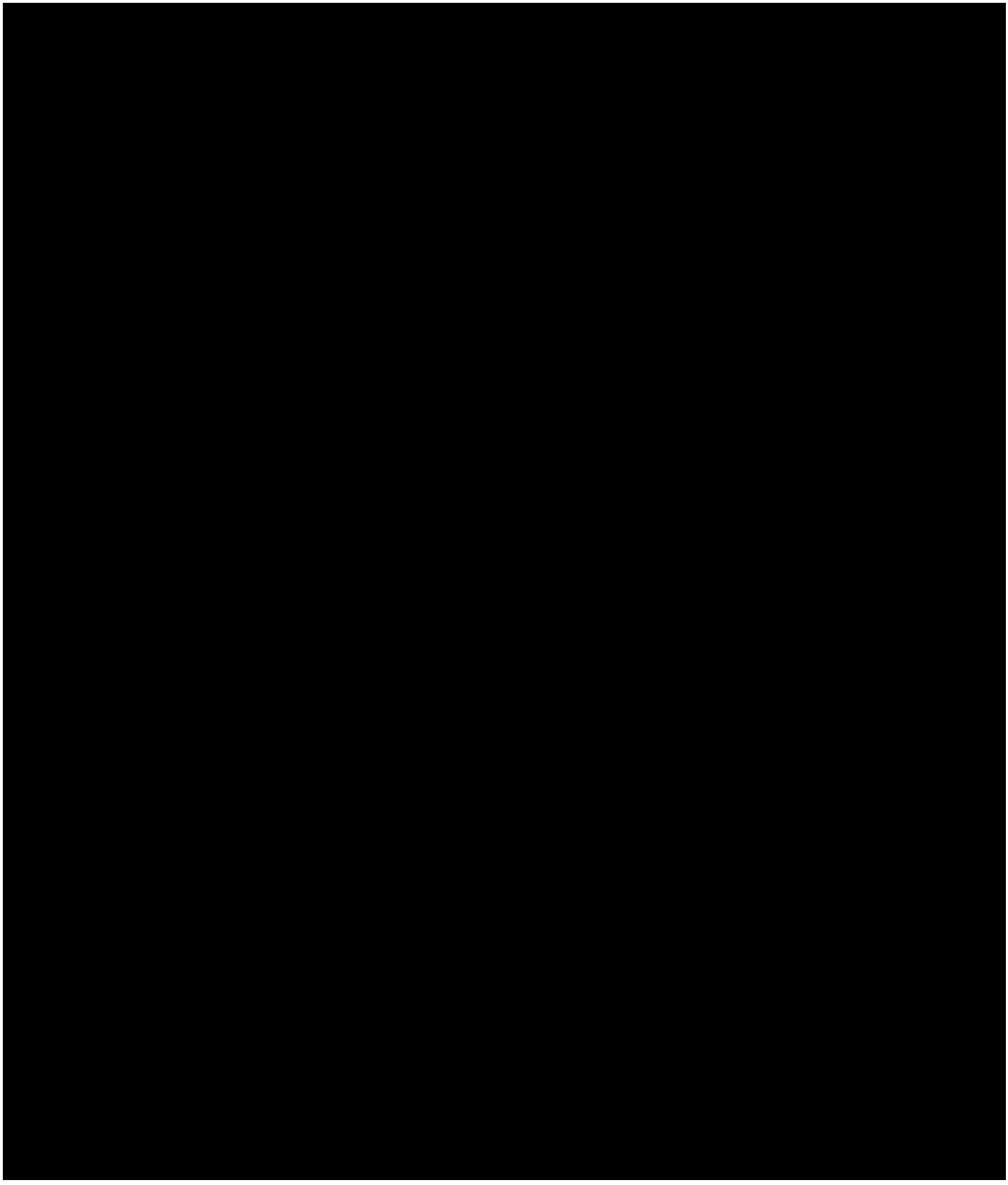

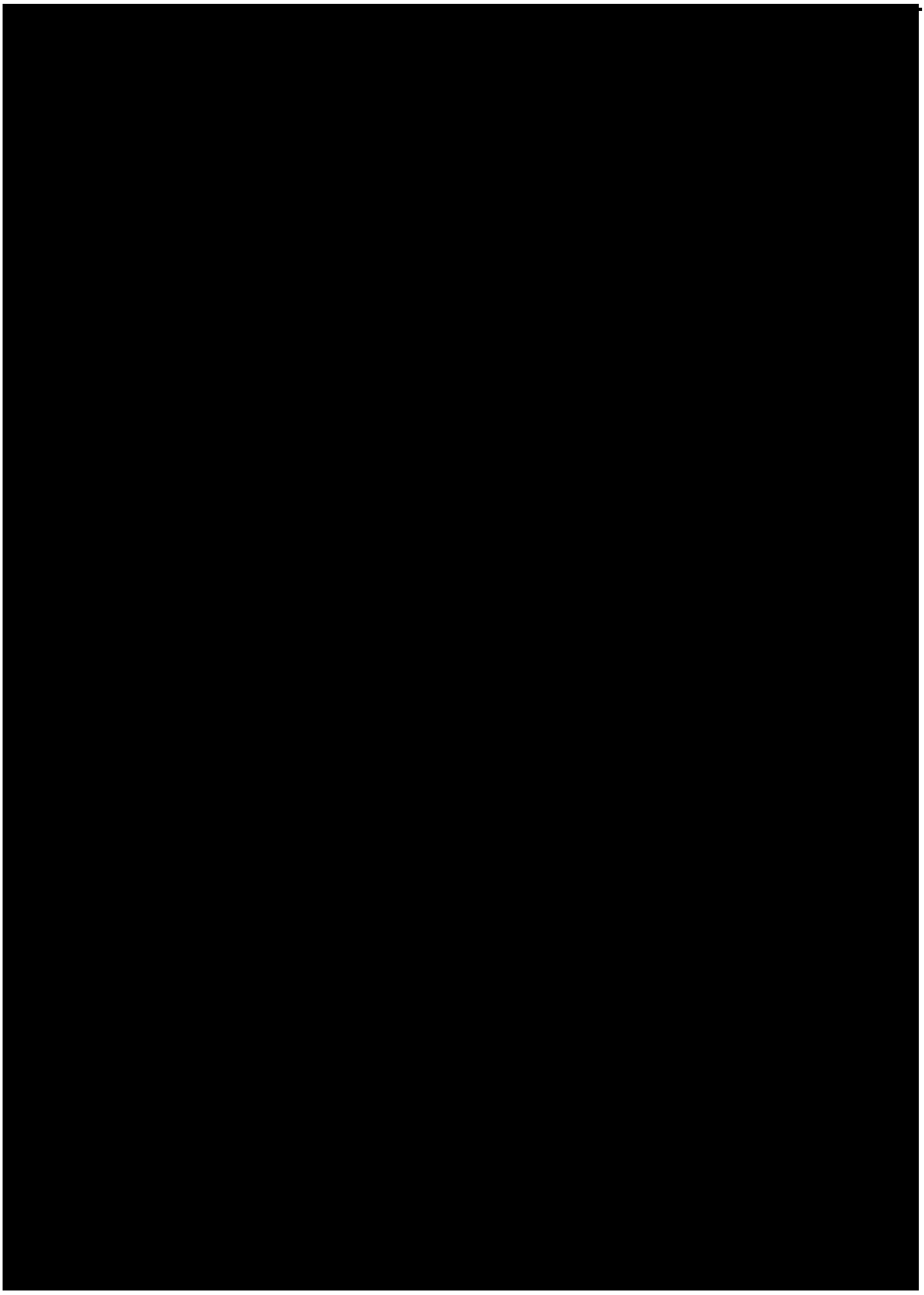

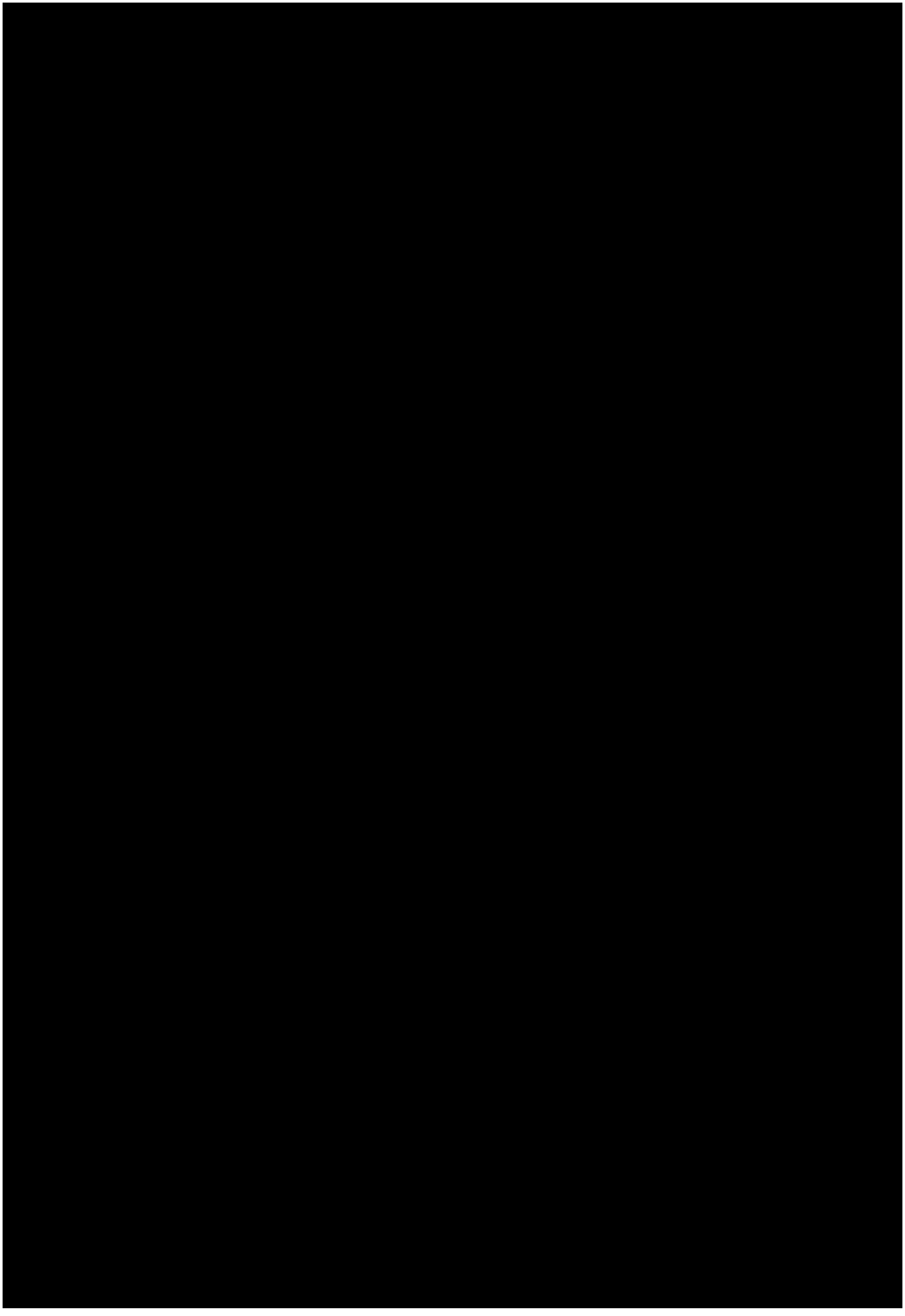

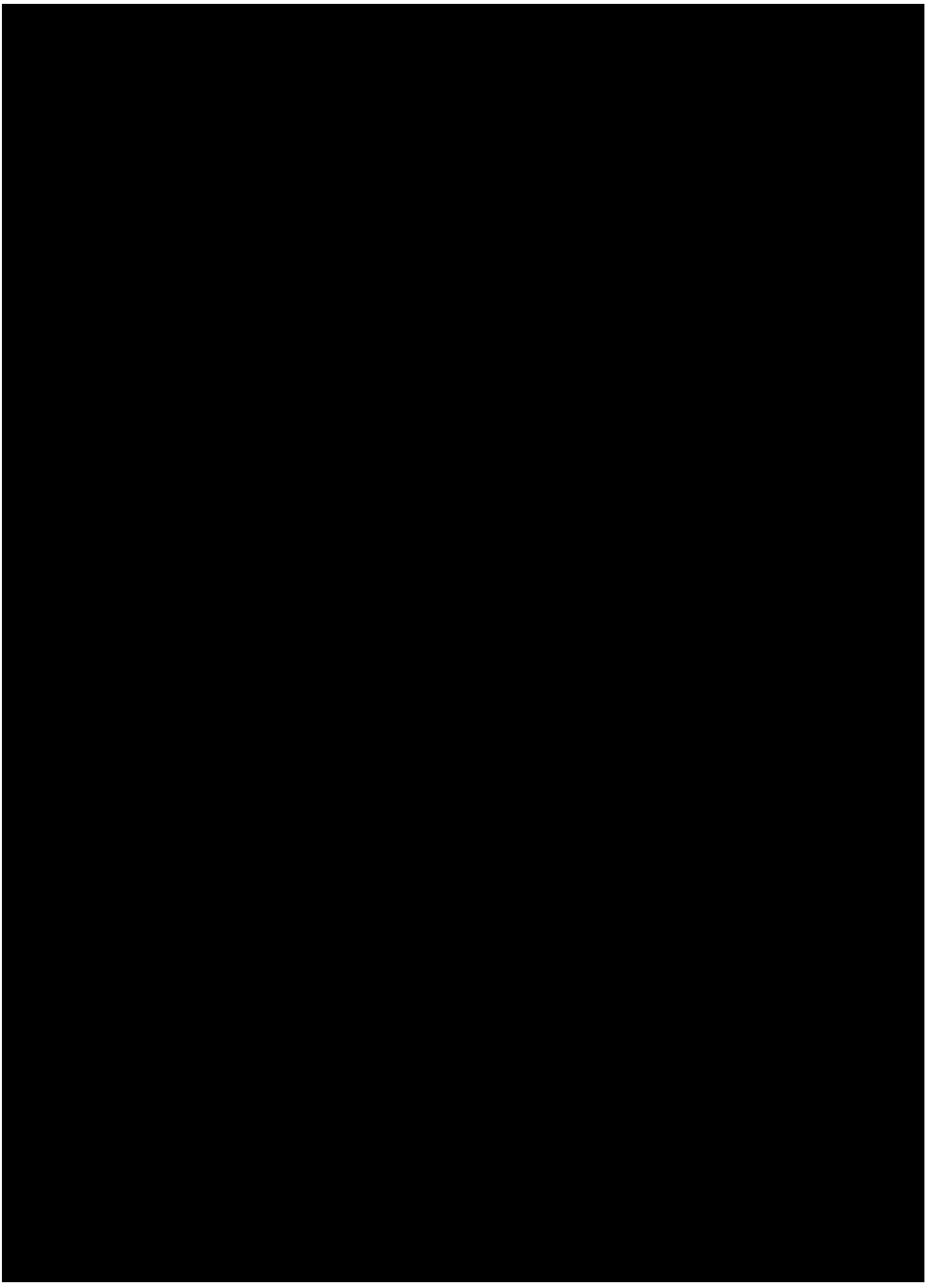

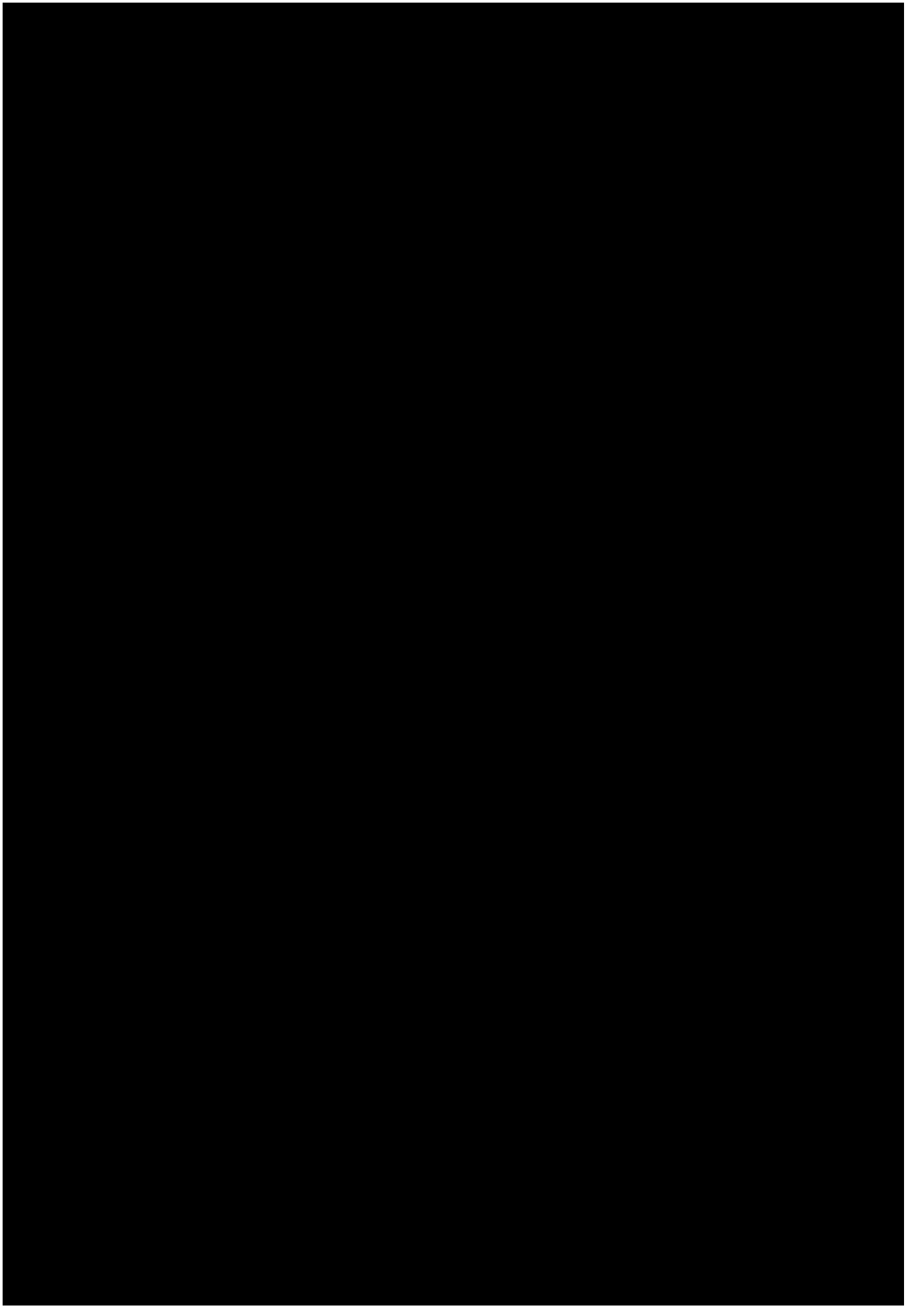

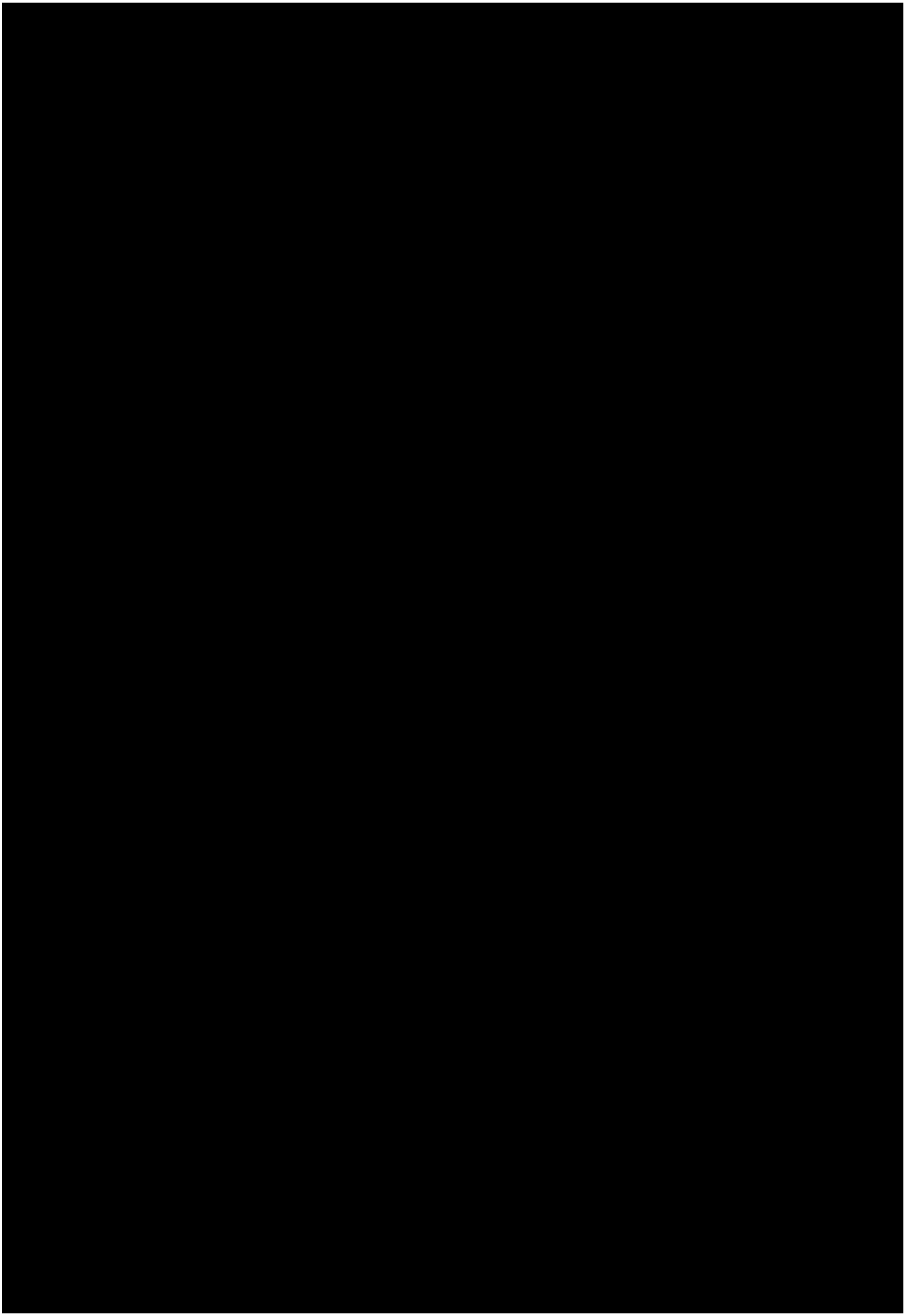

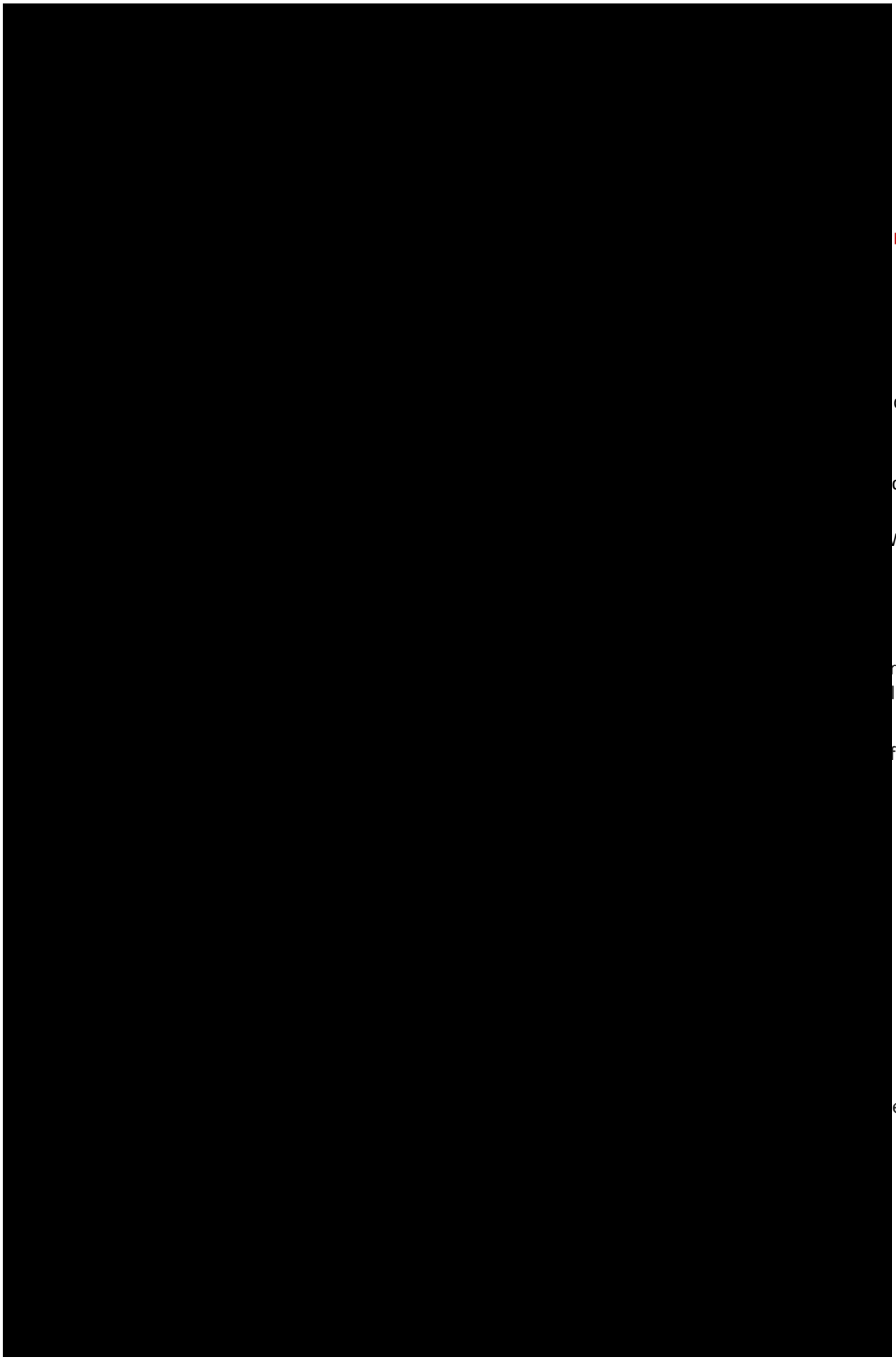

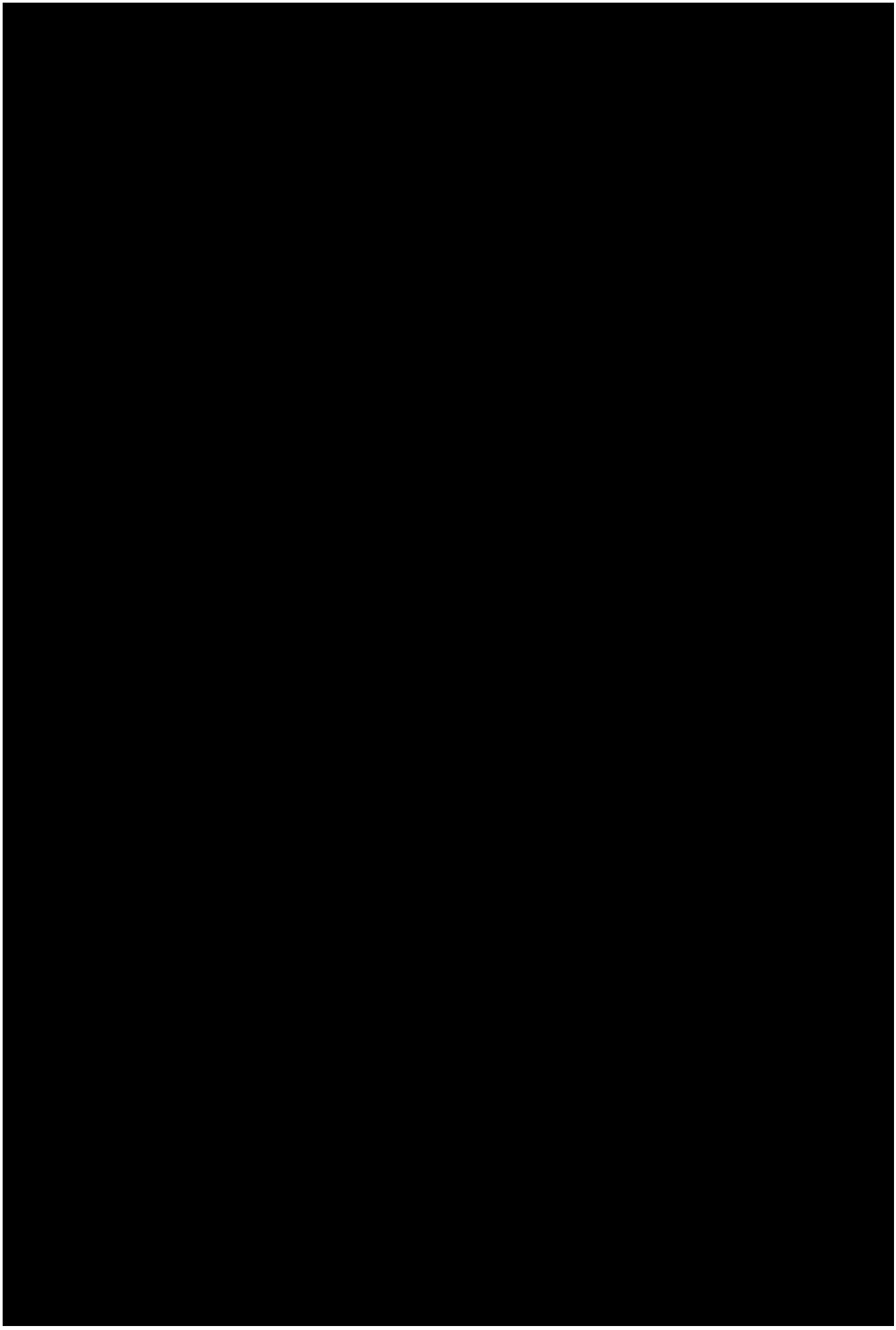

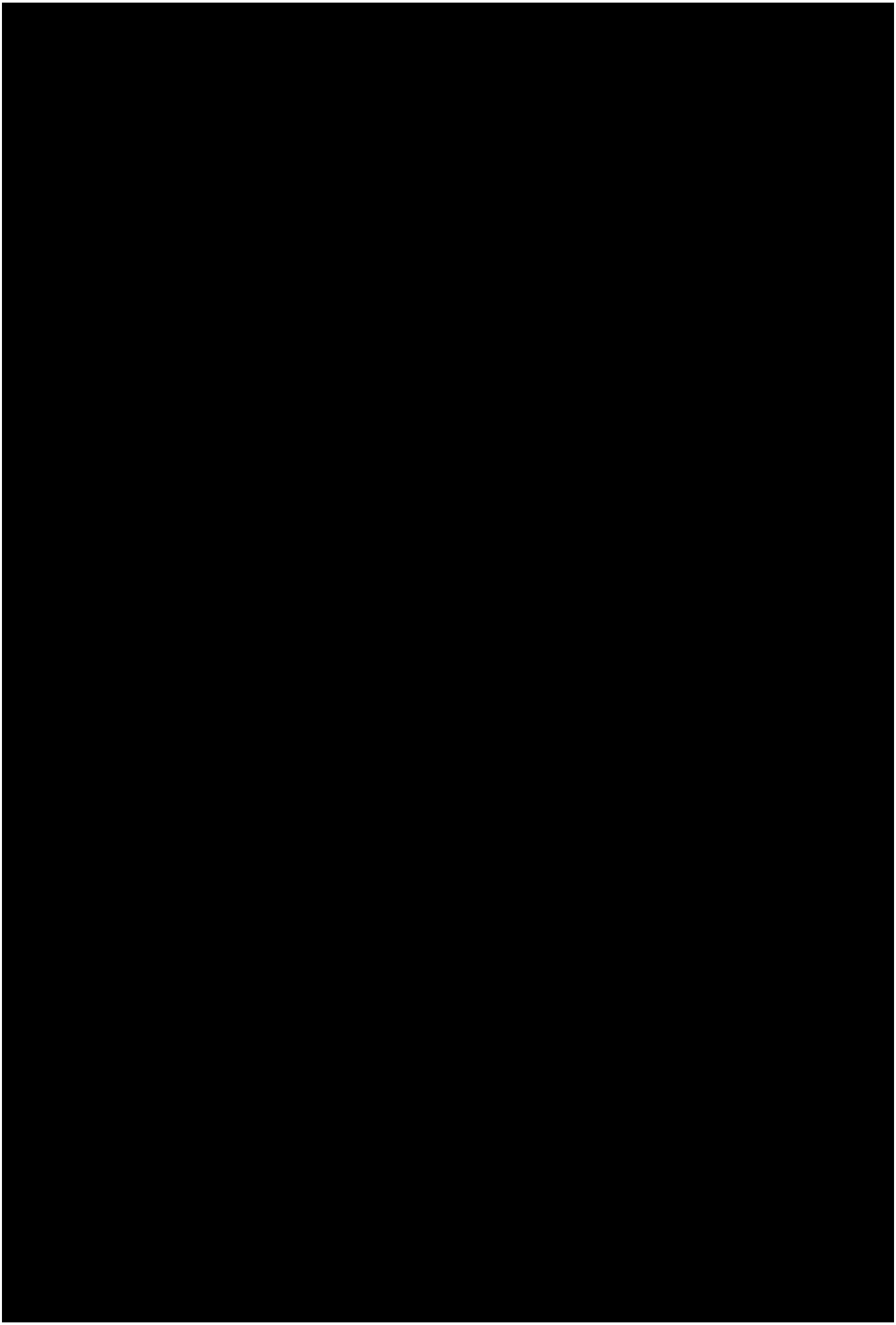

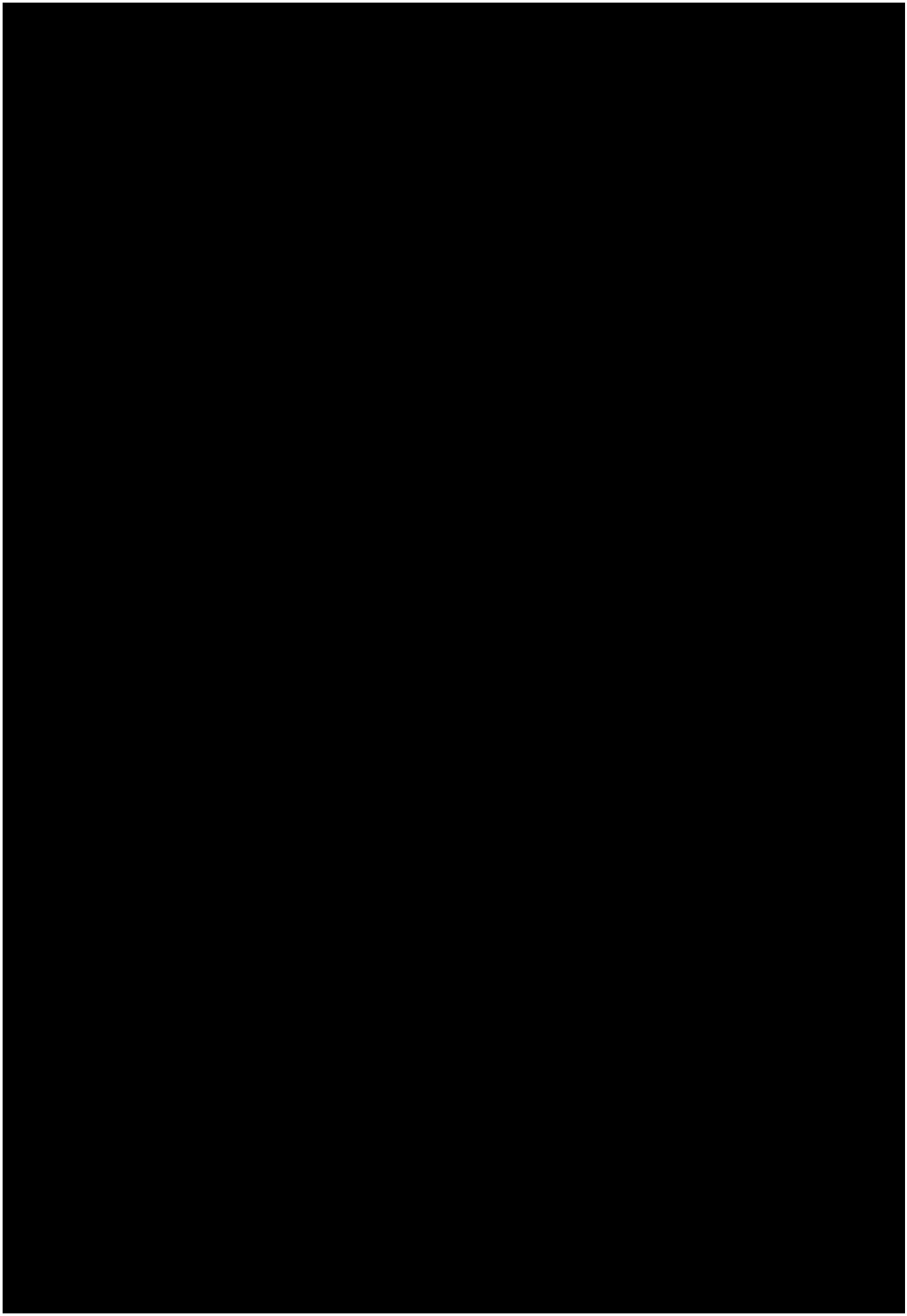

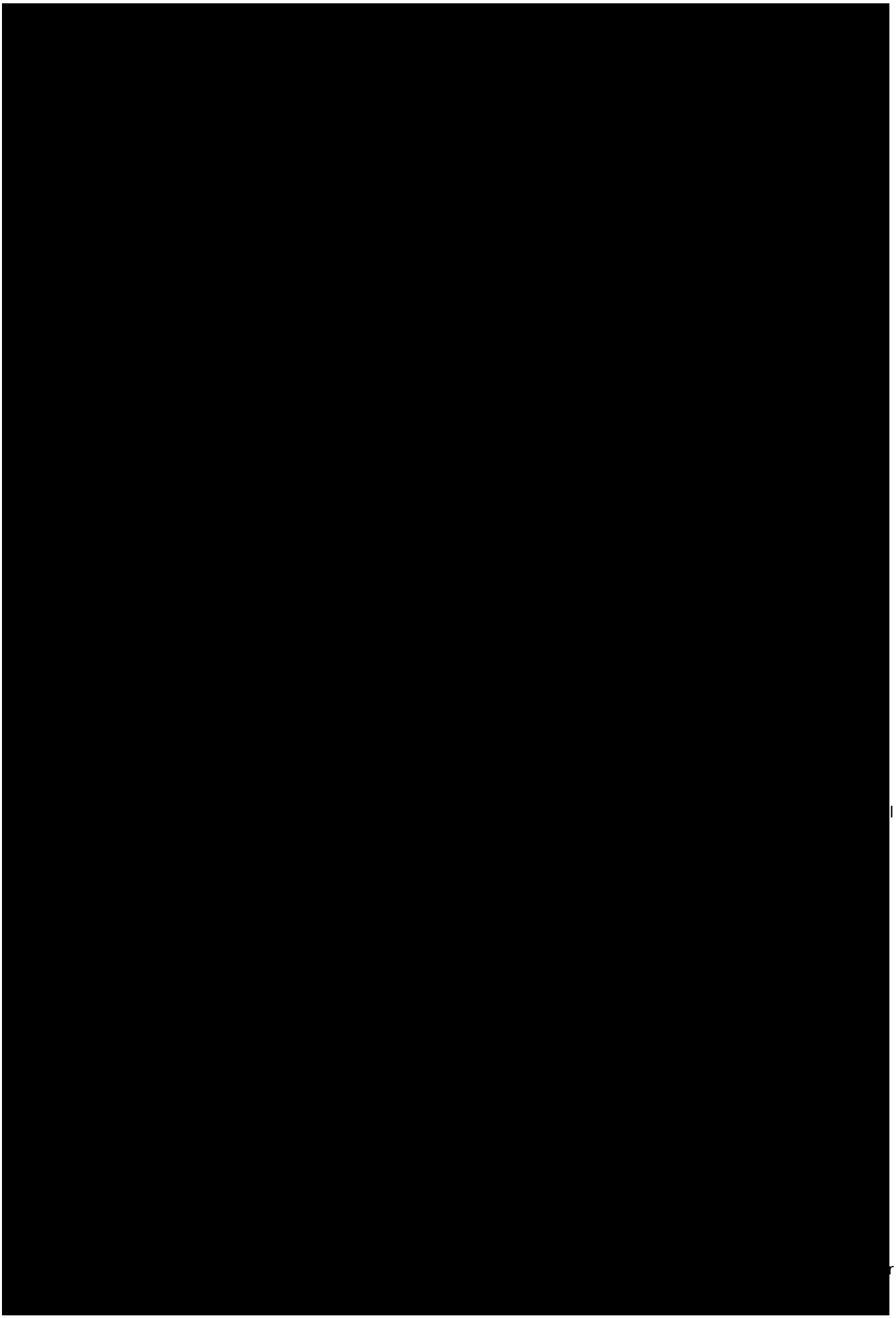

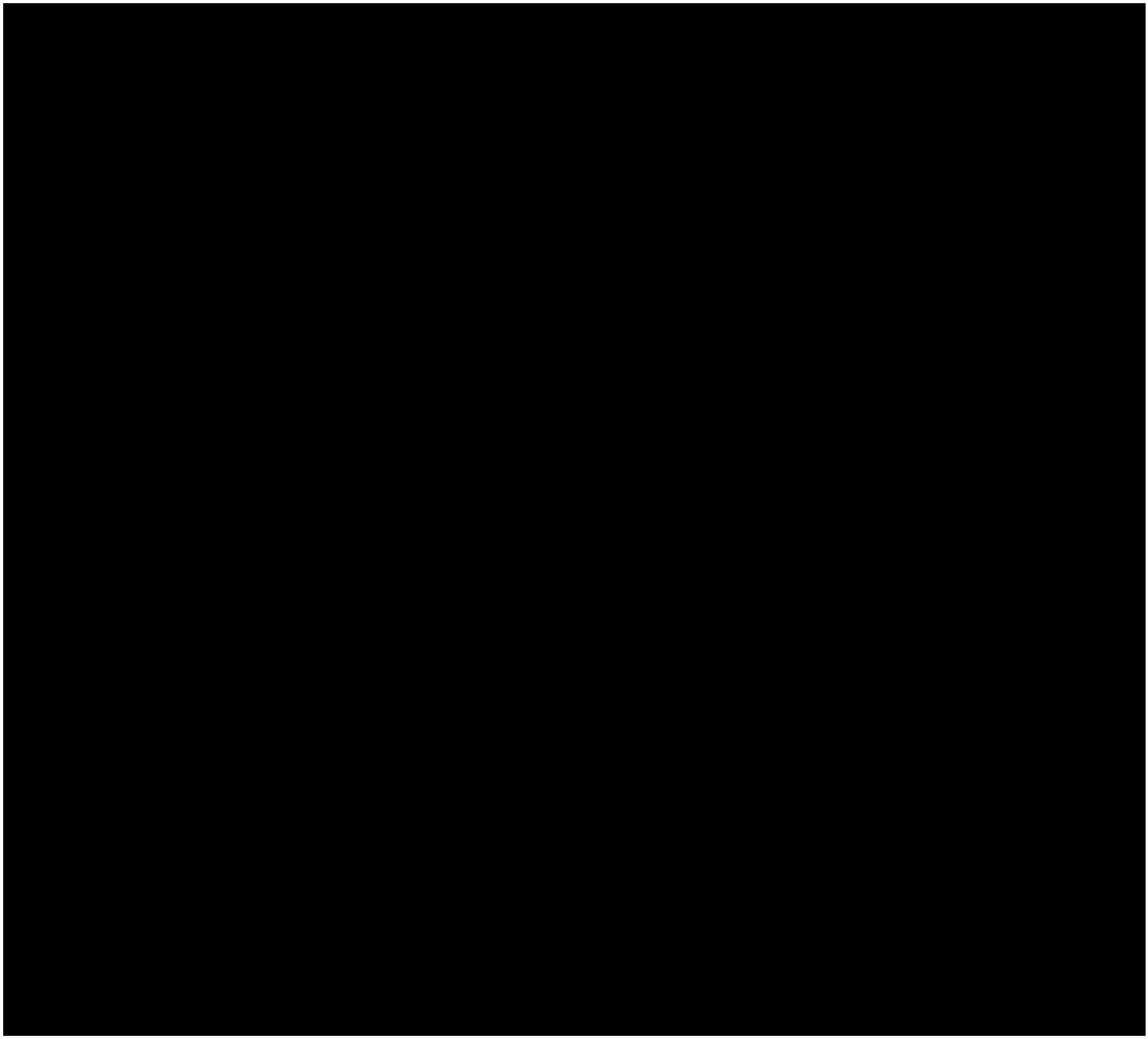

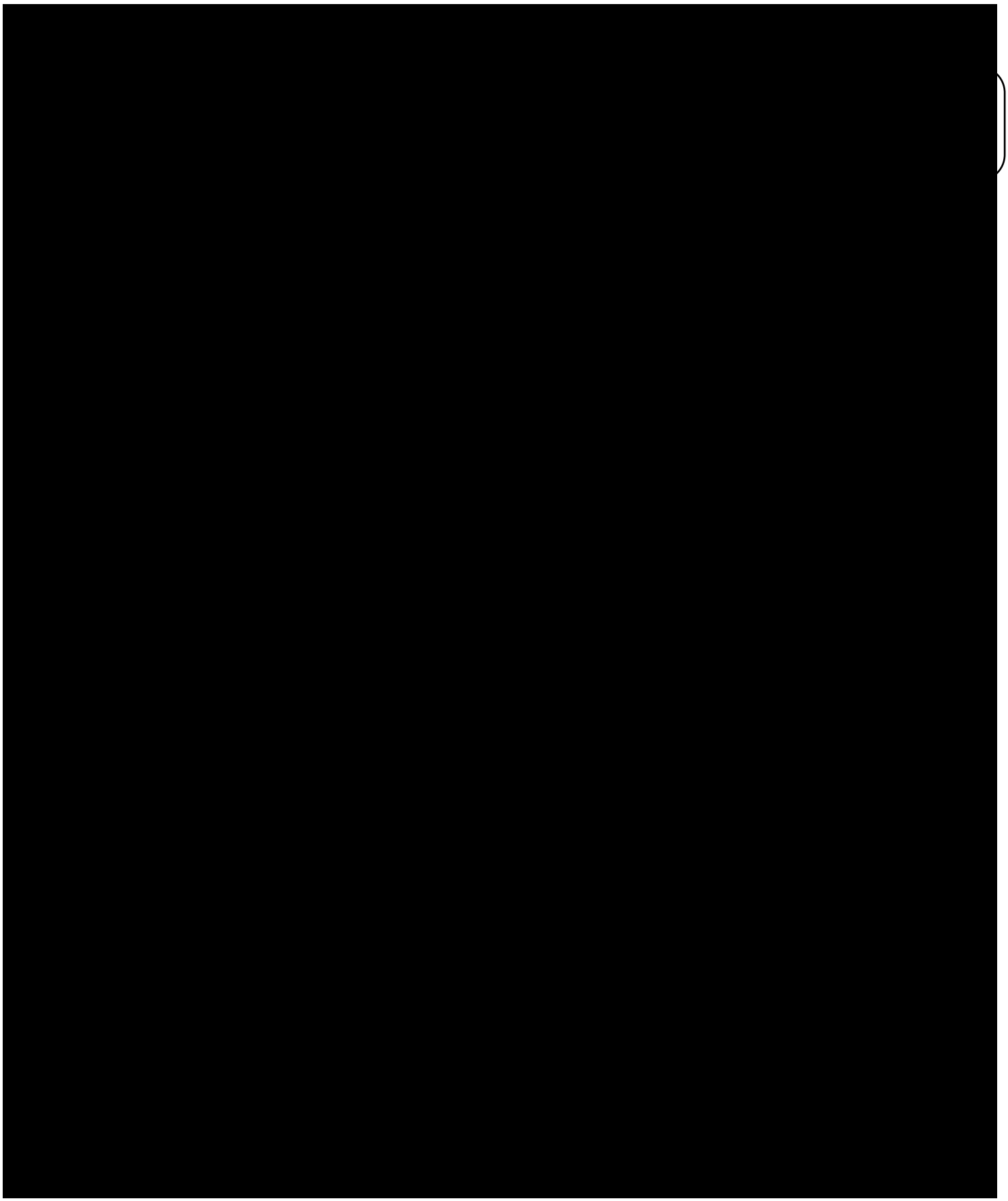

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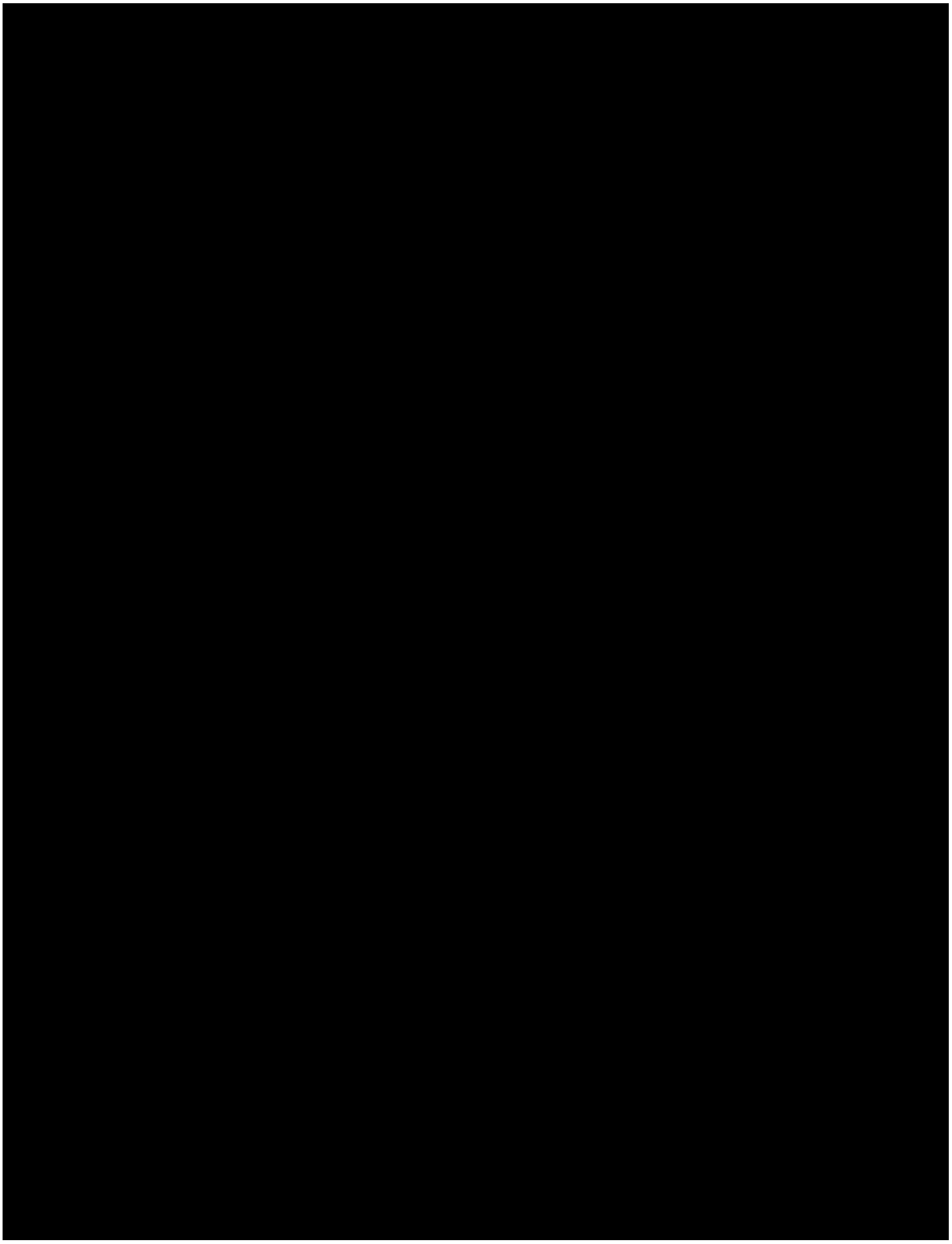

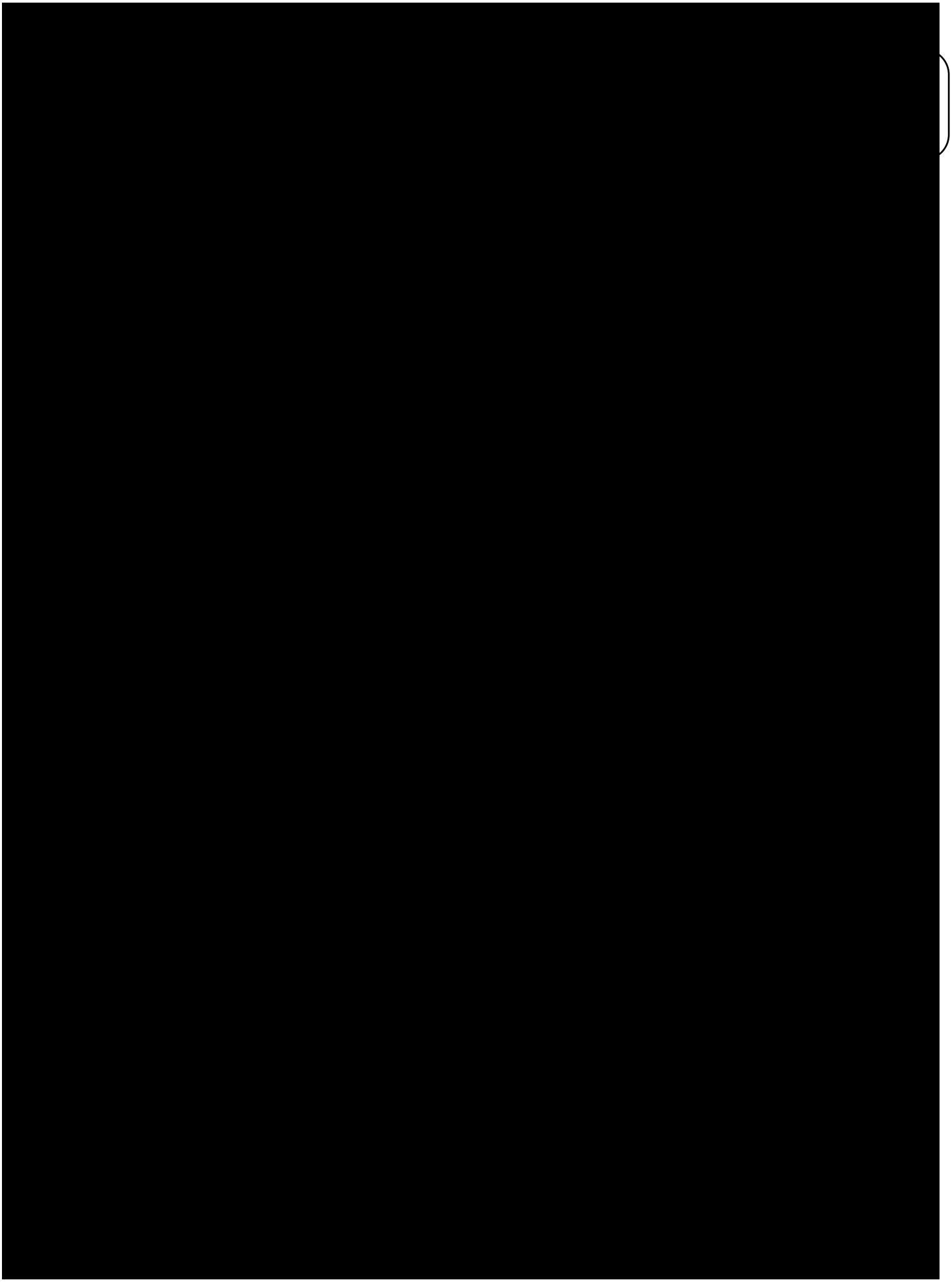

Commercial Certificate of Coverage – Filed Information

26. *Certificate of Coverage (for Commercial Plan) and coverage riders. The proposed standard contract and riders should be available with prescription drug coverage and without prescription drug coverage. If the Certificate of Coverage is the same but for the prescription drug coverage, please submit only one copy of the Certificate and separate out the prescription drug coverage provisions.*

As required, please see our Certificates of Coverage and associated information for our Commercial HIP Prime HMO Plan as provided on the following pages as part of our hardcopy response submission. Although our certificate files are essentially the same except for prescription drug coverage information, we have included both versions since there are minor differences, such as section numbers, that do change between versions. Overall, our attachments included in the following pages (in order) and on our USBs submitted are:

- *Attachment 10. Commercial Certificate of Coverage with Rx*
- *Attachment 11. Commercial Certificate of Coverage without Rx*
- *Attachment 12. Commercial Schedule of Benefits with Rx - DFS Approved Form*
- *Attachment 13. Commercial Schedule of Benefits without Rx - DFS Approved Form*
- *Attachment 14. Commercial Contract*
- *Attachment 15. Commercial Transplants Expenses Rider*
- *Attachment 16. Commercial Rx Rider for Certain Drugs*

Commercial Certificate of Coverage with Rx

Provided on the following pages is our Commercial Certificate of Coverage with prescription drug coverage included.

EmblemHealth

THIS IS YOUR

EMBLEMHEALTH HEALTH MAINTENANCE ORGANIZATION (HMO) CERTIFICATE OF COVERAGE

Issued by

HEALTH INSURANCE PLAN OF GREATER NEW YORK (hereinafter referred to as "HIP")

55 Water Street, New York, New York 10041

This Certificate of Coverage ("Certificate") explains the benefits available to You under a Group Contract between HIP (hereinafter referred to as "We", "Us" or "Our") and the Group listed in the Group Contract. This Certificate is not a contract between You and Us. Amendments, riders or endorsements may be delivered with the Certificate or added thereafter.

In-Network Benefits. This Certificate only covers in-network benefits. To receive in-network benefits You must receive care exclusively from Participating Providers in Our Prime network. Care Covered under this Certificate (including Hospitalization) must be provided, arranged or authorized in advance by Your Primary Care Physician and, when required, approved by Us. In order to receive the benefits under this Certificate, You must contact Your Primary Care Physician before You obtain the services, except for services to treat an Emergency or urgent Condition described in the Emergency Services and Urgent Care section of this Certificate. Except for care for an Emergency Condition described in the Emergency Services and Urgent Care section of this Certificate, You will be responsible for paying the cost of all care that is provided by Non-Participating Providers.

READ THIS ENTIRE CERTIFICATE CAREFULLY. IT DESCRIBES THE BENEFITS AVAILABLE UNDER THE GROUP CONTRACT. IT IS YOUR RESPONSIBILITY TO UNDERSTAND THE TERMS AND CONDITIONS IN THIS CERTIFICATE.

This Certificate is governed by the laws of New York State.

Signed for Health Insurance Plan of Greater New York

Karen Ignagni
President and CEO

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Section I

Definitions

Defined terms will appear capitalized throughout this Certificate.

Acute: The onset of disease or injury, or a change in the Member's condition that would require prompt medical attention.

Allowed Amount: The maximum amount on which Our payment is based for Covered Services. See the Cost-Sharing Expenses and Allowed Amount section of this Certificate for a description of how the Allowed Amount is calculated.

Ambulatory Surgical Center: A Facility currently licensed by the appropriate state regulatory agency for the provision of surgical and related medical services on an outpatient basis.

Appeal: A request for Us to review a Utilization Review decision or a Grievance again.

Balance Billing: When a Non-Participating Provider bills You for the difference between the Non-Participating Provider's charge and the Allowed Amount. A Participating Provider may not Balance Bill You for Covered Services.

Certificate: This Certificate issued by HIP, including the Schedule of Benefits and any attached riders.

Child, Children: The Subscriber's Children, including any natural, adopted or step-children, unmarried disabled Children, newborn Children, or any other Children as described in the Who is Covered section of this Certificate.

Coinsurance: Your share of the costs of a Covered Service, calculated as a percent of the Allowed Amount for the service that You are required to pay to a Provider. The amount can vary by the type of Covered Service.

Copayment: A fixed amount You pay directly to a Provider for a Covered Service when You receive the service. The amount can vary by the type of Covered Service.

Cost-Sharing: Amounts You must pay for Covered Services, expressed as Copayments, Deductibles and/or Coinsurance.

Cover, Covered or Covered Services: The Medically Necessary services paid for, arranged, or authorized for You by Us under the terms and conditions of this Certificate.

Deductible: The amount You owe before We begin to pay for Covered Services. The Deductible applies before any Copayments or Coinsurance are applied. The Deductible may not apply to all Covered Services. You may also have a Deductible that applies to a specific Covered Service (e.g., a Prescription Drug Deductible) that You owe before We begin to pay for a particular Covered Service.

Dependents: The Subscriber's Spouse and Children.

Durable Medical Equipment ("DME"): Equipment which is:

- Designed and intended for repeated use;
- Primarily and customarily used to serve a medical purpose;
- Generally not useful to a person in the absence of disease or injury; and
- Appropriate for use in the home.

Emergency Condition: A medical or behavioral condition that manifests itself by Acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;
- Serious impairment to such person's bodily functions;
- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of such person.

Emergency Department Care: Emergency Services You get in a Hospital emergency department.

Emergency Services: A medical screening examination which is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Condition; and within the capabilities of the staff and facilities available at the Hospital, such further medical examination and treatment as are required to stabilize the patient. "To stabilize" is to provide such medical treatment of an Emergency Condition as may be necessary to assure that, within reasonable medical probability, no material deterioration of the condition is likely to result from or occur during the transfer of the patient from a Facility, or to deliver a newborn child (including the placenta).

Exclusions: Health care services that We do not pay for or Cover.

External Appeal Agent: An entity that has been certified by the New York State Department of Financial Services to perform external appeals in accordance with New York law.

Facility: A Hospital; Ambulatory Surgical Center; birthing center; dialysis center; rehabilitation Facility; Skilled Nursing Facility; hospice; Home Health Agency or home care services agency certified or licensed under Article 36 of the New York Public Health Law; a comprehensive care center for eating disorders pursuant to Article 27-J of the New York Public Health Law; and a Facility defined in New York Mental Hygiene Law Sections 1.03(10) and (33), certified by the New York State Office of Alcoholism and Substance Abuse Services, or certified under Article 28 of the New York Public Health Law (or, in other states, a similarly licensed or certified Facility). If You receive treatment for substance use disorder outside of New York State, a Facility also includes one which is accredited by the Joint Commission to provide a substance use disorder treatment program.

Grievance: A complaint that You communicate to Us that does not involve a Utilization Review determination.

Group: The employer or party that has entered into an agreement with Us as a contractholder.

Habilitation Services: Health care services that help a person keep, learn or improve skills and functioning for daily living. Habilitative Services include the management of limitations and disabilities, including services or programs that help maintain or prevent deterioration in physical, cognitive, or behavioral function. These services consist of physical therapy, occupational therapy and speech therapy.

Health Care Professional: An appropriately licensed, registered or certified Physician; dentist; optometrist; chiropractor; psychologist; social worker; podiatrist; physical therapist; occupational therapist; midwife; speech-language pathologist; audiologist; pharmacist; behavior analyst; or any other licensed, registered or certified Health Care Professional under Title 8 of the New York Education Law (or other comparable state law, if applicable) that the New York Insurance Law requires to be recognized who charges and bills patients for Covered Services. The Health Care Professional's services must be rendered within the lawful scope of practice for that type of Provider in order to be covered under this Certificate.

Home Health Agency: An organization currently certified or licensed by the State of New York or the state in which it operates and renders home health care services.

Hospice Care: Care to provide comfort and support for persons in the last stages of a terminal illness and their families that are provided by a hospice organization certified pursuant to Article 40 of the New York Public Health Law or under a similar certification process required by the state in which the hospice organization is located.

Hospital: A short term, acute, general Hospital, which:

- Is primarily engaged in providing, by or under the continuous supervision of Physicians, to patients, diagnostic services and therapeutic services for diagnosis, treatment and care of injured or sick persons;
- Has organized departments of medicine and major surgery;
- Has a requirement that every patient must be under the care of a Physician or dentist;
- Provides 24-hour nursing service by or under the supervision of a registered professional nurse (R.N.);
- If located in New York State, has in effect a Hospitalization review plan applicable to all patients which meets at least the standards set forth in 42 U.S.C. Section 1395x(k);
- Is duly licensed by the agency responsible for licensing such Hospitals; and
- Is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial, educational, or rehabilitory care.

Hospital does not mean health resorts, spas, or infirmaries at schools or camps.

Hospitalization: Care in a Hospital that requires admission as an inpatient and usually requires an overnight stay.

Hospital Outpatient Care: Care in a Hospital that usually does not require an overnight stay.

Medically Necessary: See the How Your Coverage Works section of this Certificate for the definition.

Medicare: Title XVIII of the Social Security Act, as amended.

Member: The Subscriber or a covered Dependent for whom required Premiums have been paid. Whenever a Member is required to provide a notice pursuant to a Grievance or emergency department visit or admission, "Member" also means the Member's designee.

Non-Participating Provider: A Provider who does not have a contract with Us to provide services to You. The services of Non-Participating Providers are Covered only for Emergency Services or when authorized by Us.

Out-of-Pocket Limit: The most You pay during a Plan Year in Cost-Sharing before We begin to pay 100% of the Allowed Amount for Covered Services. This limit never includes Your Premium, Balance Billing charges or the cost of health care services We do not Cover.

Participating Provider: A Provider who has a contract with Us to provide services to You. A list of Participating Providers and their locations is available on Our website at www.emblemhealth.com or upon Your request to Us. The list will be revised from time to time by Us.

Physician or Physician Services: Health care services a licensed medical Physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan Year: The twelve (12)-month period beginning on the effective date of the Group Policy or any anniversary date thereafter, during which this Certificate is in effect.

Preauthorization: A decision by Us prior to Your receipt of a Covered Service, procedure, treatment plan, device, or Prescription Drug that the Covered Service, procedure, treatment plan, device or Prescription Drug is Medically Necessary. We indicate which Covered Services require Preauthorization in the Schedule of Benefits section of this Certificate.

Premium: The amount that must be paid for Your health insurance coverage.

Prescription Drugs: A medication, product or device that has been approved by the Food and Drug Administration ("FDA") and that can, under federal or state law, be dispensed only pursuant to a prescription order or refill and is on Our formulary. A Prescription Drug includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver.

Primary Care Physician ("PCP"): A participating nurse practitioner or Physician who typically is an internal medicine, family practice or pediatric Physician and who directly provides or coordinates a range of health care services for You.

Provider: A Physician, Health Care Professional, or Facility licensed, registered, certified or accredited as required by state law. A Provider also includes a vendor or dispenser of diabetic equipment and supplies, durable medical equipment, medical supplies, or any other equipment or supplies that are Covered under this Certificate that is licensed, registered, certified or accredited as required by state law.

Referral: An authorization given to one Participating Provider from another Participating Provider (usually from a PCP to a participating Specialist) in order to arrange for additional care for a Member. A Referral can be transmitted electronically or by Your Provider completing a paper Referral form. Except as provided in the Access to Care and Transitional Care section of this Certificate or as otherwise authorized by Us, a Referral will not be made to a Non-Participating Provider.

Rehabilitation Services: Health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services consist of physical therapy, occupational therapy, and speech therapy in an inpatient and/or outpatient setting.

Schedule of Benefits: The section of this Certificate that describes the Copayments, Deductibles, Coinsurance, Out-of-Pocket Limits, Preauthorization requirements, Referral requirements, and other limits on Covered Services.

Service Area: The geographical area, designated by Us and approved by the State of New York, in which We provide coverage. Our Service Area consists of: Bronx, Kings, Manhattan, Queens, Richmond, Rockland, Nassau, Suffolk, Westchester, Broome, Otsego, Albany, Columbia, Fulton, Greene, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, Washington, Delaware, Dutchess, Orange, Putnam, Sullivan and Ulster counties.

Skilled Nursing Facility: An institution or a distinct part of an institution that is currently licensed or approved under state or local law; primarily engaged in providing skilled nursing care and related services as a Skilled Nursing Facility, extended care Facility, or nursing care Facility approved by the Joint Commission, or the Bureau of Hospitals of the American Osteopathic Association, or as a Skilled Nursing Facility under Medicare; or as otherwise determined by Us to meet the standards of any of these authorities.

Specialist: A Physician who focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.

Spouse: The person to whom the Subscriber is legally married, including a same sex Spouse.

Subscriber: The person to whom this Certificate is issued.

UCR (Usual, Customary and Reasonable): The cost of a medical service in a geographic area based on what Providers in the area usually charge for the same or similar medical service.

Urgent Care: Medical care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require Emergency Department Care. Urgent Care may be rendered in a participating Physician's office or Urgent Care Center.

Urgent Care Center: A licensed Facility (other than a Hospital) that provides Urgent Care.

Us, We, Our: Health Insurance Plan of Greater New York ("HIP") and anyone to whom We legally delegate performance, on Our behalf, under this Certificate.

Utilization Review: The review to determine whether services are or were Medically Necessary or experimental or investigational (i.e., treatment for a rare disease or a clinical trial).

You, Your: The Member.

Section II

How Your Coverage Works

A. Your Coverage Under this Certificate.

Your employer (referred to as the "Group") has purchased a Group HMO Contract from Us. We will provide the benefits described in this Certificate to covered Members of the Group, that is, to employees of the Group and their covered Dependents. However, this Certificate is not a contract between You and Us. You should keep this Certificate with Your other important papers so that it is available for Your future reference.

B. Covered Services.

You will receive Covered Services under the terms and conditions of this Certificate only when the Covered Service is:

- Medically Necessary;
- Provided by a Participating Provider;
- Listed as a Covered Service;
- Not in excess of any benefit limitations described in the Schedule of Benefits section of this Certificate; and
- Received while Your Certificate is in force.

When You are outside Our Service Area, coverage is limited to Emergency Services, Pre-Hospital Emergency Medical Services and ambulance services to treat Your Emergency Condition.

C. Participating Providers.

To find out if a Provider is a Participating Provider, and for details about licensure and training:

- Check Our Provider directory, available at Your request;
- Call the number on Your ID card; or
- Visit Our website at www.emblemhealth.com.

D. The Role of Primary Care Physicians.

This Certificate has a gatekeeper, usually known as a Primary Care Physician ("PCP"). This Certificate requires that You select a PCP. You need a written Referral from a PCP before receiving Specialist care from a Participating Provider.

You may select any participating PCP who is available from the list of PCPs in the HIP Prime Network. Each Member may select a different PCP. Children covered under this Certificate may designate a participating PCP who specializes in pediatric care. In certain circumstances, You may designate a Specialist as Your PCP. See the Access to Care and Transitional Care section of this Certificate for more information about designating a Specialist. To select a PCP, visit Our website at www.emblemhealth.com. If You do not select a PCP, We will assign one to You.

For purposes of Cost-Sharing, if You seek services from a PCP (or a Physician covering for a PCP) who has a primary or secondary specialty other than general practice, family practice, internal medicine, pediatrics and OB/GYN, You must pay the specialty office visit Cost-Sharing in the Schedule of Benefits section of this Certificate when the services provided are related to specialty care.

E. Services Not Requiring a Referral from Your PCP.
Your PCP is responsible for determining the most appropriate treatment for Your health care needs. You do not need a Referral from Your PCP to a Participating Provider for the following services:

- Primary and preventive obstetric and gynecologic services including annual examinations, care resulting from such annual examinations, treatment of Acute gynecologic conditions, or for any care related to a pregnancy from a qualified Participating Provider of such services;
- Emergency Services;
- Pre-Hospital Emergency Medical Services and emergency ambulance transportation;
- Maternal depression screening;
- Urgent Care;
- Chiropractic services;
- Outpatient mental health care;
- Outpatient substance use services;
- Refractive eye exams from an optometrist; and
- Diabetic eye exams from an ophthalmologist.

However, the Participating Provider must discuss the services and treatment plan with Your PCP; agree to follow Our policies and procedures including any procedures regarding Referrals or Preauthorization for services other than obstetric and gynecologic services rendered by such Participating Provider; and agree to provide services pursuant to a treatment plan (if any) approved by Us. See the Schedule of Benefits section of this Certificate for the services that require a Referral.

F. Access to Providers and Changing Providers.
Sometimes Providers in Our Provider directory are not available. Prior to notifying Us of the PCP You selected, You should call the PCP to make sure he or she is a Participating Provider and is accepting new patients.

To see a Provider, call his or her office and tell the Provider that You are a HIP Member, and explain the reason for Your visit. Have Your ID card available. The Provider's office may ask You for Your Group or Member ID number. When You go to the Provider's office, bring Your ID card with You.

You may change Your PCP by accessing Our website at www.emblemhealth.com, or by calling Customer Service. This can be done at any time through website access, or through Customer Service, Monday through Friday between 8 am and 6 pm.

You may change Your Specialist by contacting Your PCP to obtain a Referral. This can be done at any time during Your PCP's office hours.

If We do not have a Participating Provider for certain provider types in the county in which You live or in a bordering county that is within approved time and distance standards, We will approve a Referral to a specific Non-Participating Provider until You no longer need the care or We have a Participating Provider in Our network that meets the time and distance standards and Your care has been transitioned to that Participating Provider. Covered Services rendered by the Non-Participating Provider will be paid as if they were provided by a Participating Provider. You will be responsible only for any applicable in-network Cost-Sharing.

G. Services Subject to Preauthorization.
Our Preauthorization is required before You receive certain Covered Services. Your PCP is responsible for requesting Preauthorization for in-network services.

H. Preauthorization / Notification Procedure.
If You seek coverage for services that require Preauthorization or notification, Your Provider must call Us or Our vendor at the number on Your ID card.

Your Provider must contact Us to request Preauthorization as follows:

- At least two (2) weeks prior to a planned admission or surgery when Your Provider recommends inpatient Hospitalization. If that is not possible, then as soon as reasonably possible during regular business hours prior to the admission.
- At least two (2) weeks prior to ambulatory surgery or any ambulatory care procedure when Your Provider recommends the surgery or procedure be performed in an ambulatory surgical unit of a Hospital or in an Ambulatory Surgical Center. If that is not possible, then as soon as reasonably possible during regular business hours prior to the surgery or procedure.
- Within the first three (3) months of a pregnancy, or as soon as reasonably possible and again within forty-eight (48) hours after the actual delivery date if Your Hospital stay is expected to extend beyond forty-eight (48) hours for a vaginal birth or ninety-six (96) hours for cesarean birth.
- Before air ambulance services are rendered for a non-Emergency Condition.

You must contact Us to provide notification as follows:

- As soon as reasonably possible when air ambulance services are rendered for an Emergency Condition.
- If You are hospitalized in cases of an Emergency Condition, You must call Us within forty-eight (48) hours after Your admission or as soon thereafter as reasonably possible.

After receiving a request for approval, We will review the reasons for Your planned treatment and determine if benefits are available. Criteria will be based on multiple sources which may include medical policy, clinical guidelines, and pharmacy and therapeutic guidelines.

I. Medical Management.
The benefits available to You under this Certificate are subject to pre-service, concurrent and retrospective reviews to determine when services should be Covered by Us. The purpose of these reviews is to promote the delivery of cost-effective medical care by reviewing the use of procedures and, where appropriate, the setting or place the services are performed. Covered Services must be Medically Necessary for benefits to be provided.

J. Medical Necessity.
We Cover benefits described in this Certificate as long as the health care service, procedure, treatment, test, device, Prescription Drug or supply (collectively, "service") is Medically Necessary. The fact that a Provider has furnished, prescribed, ordered, recommended, or approved the service does not make it Medically Necessary or mean that We have to Cover it.

We may base Our decision on a review of:

- Your medical records;
- Our medical policies and clinical guidelines;
- Medical opinions of a professional society, peer review committee or other groups of Physicians;
- Reports in peer-reviewed medical literature;
- Reports and guidelines published by nationally-recognized health care organizations that include supporting scientific data;
- Professional standards of safety and effectiveness, which are generally-recognized in the United States for diagnosis, care, or treatment;
- The opinion of Health Care Professionals in the generally-recognized health specialty involved;
- The opinion of the attending Providers, which have credence but do not overrule contrary opinions.

Services will be deemed Medically Necessary only if:

- They are clinically appropriate in terms of type, frequency, extent, site, and duration, and considered effective for Your illness, injury, or disease;
- They are required for the direct care and treatment or management of that condition;
- Your condition would be adversely affected if the services were not provided;
- They are provided in accordance with generally-accepted standards of medical practice;
- They are not primarily for the convenience of You, Your family, or Your Provider;
- They are not more costly than an alternative service or sequence of services, that is at least as likely to produce equivalent therapeutic or diagnostic results;
- When setting or place of service is part of the review, services that can be safely provided to You in a lower cost setting will not be Medically Necessary if they are performed in a higher cost setting. For example, We will not provide coverage for an inpatient admission for surgery if the surgery could have been performed on an outpatient basis or an infusion or injection of a specialty drug provided in the outpatient department of a Hospital if the drug could be provided in a Physician's office or the home setting.

See the Utilization Review and External Appeal sections of this Certificate for Your right to an internal Appeal and external appeal of Our determination that a service is not Medically Necessary.

K. Protection from Surprise Bills.

1. A surprise bill is a bill You receive for Covered Services in the following circumstances:

- For services performed by a non-participating Physician at a participating Hospital or Ambulatory Surgical Center, when:
  - A participating Physician is unavailable at the time the health care services are performed;
  - A non-participating Physician performs services without Your knowledge; or
  - Unforeseen medical issues or services arise at the time the health care services are performed.

A surprise bill does not include a bill for health care services when a participating Physician is available and You elected to receive services from a non-participating Physician.

- You were referred by a participating Physician to a Non-Participating Provider without

Your explicit written consent acknowledging that the Referral is to a Non-Participating Provider and it may result in costs not covered by Us. For a surprise bill, a Referral to a Non-Participating Provider means:

- Covered Services are performed by a Non-Participating Provider in the participating Physician's office or practice during the same visit;
- The participating Physician sends a specimen taken from You in the participating Physician's office to a non-participating laboratory or pathologist; or
- For any other Covered Services performed by a Non-Participating Provider at the participating Physician's request, when Referrals are required under Your Certificate.

You will be held harmless for any Non-Participating Provider charges for the surprise bill that exceed Your Copayment, Deductible or Coinsurance if You assign benefits to the Non-Participating Provider in writing. In such cases, the Non-Participating Provider may only bill You for Your Copayment, Deductible or Coinsurance.

The assignment of benefits form for surprise bills is available at www.dfs.ny.gov or You can visit Our website at www.emblemhealth.com for a copy of the form. You need to mail a copy of the assignment of benefits form to Us at the address on Your ID card and to Your Provider.

2. **Independent Dispute Resolution Process.** Either We or a Provider may submit a dispute involving a surprise bill to an independent dispute resolution entity ("IDRE") assigned by the state. Disputes are submitted by completing the IDRE application form, which can be found at www.dfs.ny.gov. The IDRE will determine whether Our payment or the Provider's charge is reasonable within thirty (30) days of receiving the dispute.

L. Delivery of Covered Services Using Telehealth.

If Your Participating Provider offers Covered Services using telehealth, We will not deny the Covered Services because they are delivered using telehealth. Covered Services delivered using telehealth may be subject to utilization review and quality assurance requirements and other terms and conditions of the Certificate that are at least as favorable as those requirements for the same service when not delivered using telehealth. "Telehealth" means the use of electronic information and communication technologies by a Participating Provider to deliver Covered Services to You while Your location is different than Your Provider's location.

M. Early Intervention Program Services.

We will not exclude Covered Services solely because they are Early Intervention Program services for infants and toddlers under three (3) years of age who have a confirmed disability or an established developmental delay. Additionally, if Early Intervention Program services are otherwise covered under this Certificate, coverage for Early Intervention Program services will not be applied against any maximum annual or lifetime dollar limits if applicable. Visit limits and other terms and conditions will continue to apply to coverage for Early Intervention Program services. However, any visits used for Early Intervention Program services will not reduce the number of visits otherwise available under this Certificate.

N. Case Management.

Case management helps coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions. Our programs coordinate benefits and educate Members

who agree to take part in the case management program to help meet their health-related needs.

Our case management programs are confidential and voluntary. These programs are given at no extra cost to You and do not change Covered Services. If You meet program criteria and agree to take part, We will help You meet Your identified health care needs. This is reached through contact and team work with You and/or Your authorized representative, treating Physician(s), and other Providers. In addition, We may assist in coordinating care with existing community-based programs and services to meet Your needs, which may include giving You information about external agencies and community-based programs and services.

In certain cases of severe or chronic illness or injury, We may provide benefits for alternate care through Our case management program that is not listed as a Covered Service. We may also extend Covered Services beyond the benefit maximums of this Certificate. We will make Our decision on a case-by-case basis if We determine the alternate or extended benefit is in the best interest of You and Us.

Nothing in this provision shall prevent You from appealing Our decision. A decision to provide extended benefits or approve alternate care in one case does not obligate Us to provide the same benefits again to You or to any other Member. We reserve the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, We will notify You or Your representative in writing.

O. Important Telephone Numbers and Addresses.

- CLAIMS
  Submit claim forms to this address:
  Medical Claims: P.O. Box 2845, New York, NY 10116-2845
  Hospital Claims: P.O. Box 2803, New York, NY 10116-2803

  Submit electronic claim forms to this email address:
  EmblemHealthClaimSubmission@emblemhealth.com

- COMPLAINTS, GRIEVANCES AND UTILIZATION REVIEW APPEALS
  Members may call 1-800-447-8255

  Submit written Complaints and Grievances to this address:
  EmblemHealth Grievance and Appeals Department
  JAF Station
  P.O. Box 2844
  New York, NY 10016-2844

- ASSIGNMENT OF BENEFITS FORM
  Submit assignment of benefits forms for surprise bills to the address on Your ID card.

- CUSTOMER SERVICE
  1-800-447-8255
  (Customer Services Representatives are available Monday – Friday, 8:00 a.m. – 6:00p.m.)

- PREAUTHORIZATION
  1-800-447-8255

- BEHAVIORAL HEALTH SERVICES
  Call the number on Your ID card

- OUR WEBSITE
  www.emblemhealth.com

Section III

Access to Care and Transitional Care

A. Referral to a Non-Participating Provider.
If We determine that We do not have a Participating Provider that has the appropriate training and experience to treat Your condition, We will approve a Referral to an appropriate Non-Participating Provider. Your Participating Provider must request prior approval of the Referral to a specific Non-Participating Provider. Approvals of Referrals to Non-Participating Providers will not be made for the convenience of You or another treating Provider and may not necessarily be to the specific Non-Participating Provider You requested. If We approve the Referral, all services performed by the Non-Participating Provider are subject to a treatment plan approved by Us in consultation with Your PCP, the Non-Participating Provider and You. Covered Services rendered by the Non-Participating Provider will be Covered as if they were provided by a Participating Provider. You will be responsible only for any applicable in-network Cost-Sharing. In the event a Referral is not approved, any services rendered by a Non-Participating Provider will not be Covered.

B. When a Specialist Can Be Your Primary Care Physician.
If You have a life-threatening condition or disease or a degenerative and disabling condition or disease that requires specialty care over a long period of time, You may ask that a Specialist who is a Participating Provider be Your PCP. We will consult with the Specialist and Your PCP and decide whether the Specialist should be Your PCP. Any Referral will be pursuant to a treatment plan approved by Us in consultation with Your PCP, the Specialist and You. We will not approve a non-participating Specialist unless We determine that We do not have an appropriate Provider in Our network. If We approve a non-participating Specialist, Covered Services rendered by the non-participating Specialist pursuant to the approved treatment plan will be paid as if they were provided by a Participating Provider. You will only be responsible for any applicable in-network Cost-Sharing.

C. Standing Referral to a Participating Specialist.
If You need ongoing specialty care, You may receive a standing Referral to a Specialist who is a Participating Provider. This means that You will not need a new Referral from Your PCP every time You need to see that Specialist. We will consult with the Specialist and Your PCP and decide whether You should have a standing Referral. Any Referral will be pursuant to a treatment plan approved by Us in consultation with Your PCP, the Specialist and You. The treatment plan may limit the number of visits, or the period during which the visits are authorized and may require the Specialist to provide Your PCP with regular updates on the specialty care provided as well as all necessary medical information. We will not approve a standing Referral to a non-participating Specialist unless We determine that We do not have an appropriate Provider in Our network. If We approve a standing Referral to a non-participating Specialist, Covered Services rendered by the non-participating Specialist pursuant to the approved treatment plan will be paid as if they were provided by a Participating Provider. You will be responsible only for any applicable in-network Cost-Sharing.

D. Specialty Care Center.
If You have a life-threatening condition or disease or a degenerative and disabling condition or disease that requires specialty care over a long period of time, You may request a Referral to a specialty care center with expertise in treating Your condition or disease. A specialty care center is a center that has an accreditation or designation from a state agency, the federal government or a national health organization as having special expertise to treat Your disease or condition. We will consult with Your PCP, Your Specialist, and the specialty care center to decide whether to approve such a Referral. Any Referral will be pursuant to a treatment plan developed by the specialty care center, and approved by Us in consultation with Your PCP or Specialist and You. We will not approve a Referral to a non-participating specialty care center unless We determine that We do not have an appropriate specialty care center in Our network. If We approve a Referral to a non-participating specialty care center, Covered Services rendered by the non-participating specialty care center pursuant to the approved treatment plan will be paid as if they were provided by a participating specialty care center. You will be responsible only for any applicable in-network Cost-Sharing.

E. When Your Provider Leaves the Network.
If You are in an ongoing course of treatment when Your Provider leaves Our network, then You may be able to continue to receive Covered Services for the ongoing treatment from the former Participating Provider for up to ninety (90) days from the date Your Provider's contractual obligation to provide services to You terminates. If You are pregnant and in Your second or third trimester, You may be able to continue care with a former Participating Provider through delivery and any postpartum care directly related to the delivery.

In order for You to continue to receive Covered Services for up to ninety (90) days or through a pregnancy with a former Participating Provider, the Provider must agree to accept as payment the negotiated fee that was in effect just prior to the termination of Our relationship with the Provider. The Provider must also agree to provide Us necessary medical information related to Your care and adhere to Our policies and procedures, including those for assuring quality of care, obtaining Preauthorization, Referrals, and a treatment plan approved by Us. If the Provider agrees to these conditions, You will receive the Covered Services as if they were being provided by a Participating Provider. You will be responsible only for any applicable in-network Cost-Sharing. Please note that if the Provider was terminated by Us due to fraud, imminent harm to patients or final disciplinary action by a state board or agency that impairs the Provider's ability to practice, continued treatment with that Provider is not available.

F. New Members In a Course of Treatment.
If You are in an ongoing course of treatment with a Non-Participating Provider when Your coverage under this Certificate becomes effective, You may be able to receive Covered Services for the ongoing treatment from the Non-Participating Provider for up to sixty (60) days from the effective date of Your coverage under this Certificate. This course of treatment must be for a life-threatening disease or condition or a degenerative and disabling condition or disease. You may also continue care with a Non-Participating Provider if You are in the second or third trimester of a pregnancy when Your coverage under this Certificate becomes effective. You may continue care through delivery and any post-partum services directly related to the delivery.

In order for You to continue to receive Covered Services for up to sixty (60) days or through pregnancy, the Non-Participating Provider must agree to accept as payment Our fees for such services. The

Provider must also agree to provide Us necessary medical information related to Your care and to adhere to Our policies and procedures including those for assuring quality of care, obtaining Preauthorization, Referrals, and a treatment plan approved by Us. If the Provider agrees to these conditions, You will receive the Covered Services as if they were being provided by a Participating Provider. You will be responsible only for any applicable in-network Cost-Sharing.

Section IV

Cost-Sharing Expenses and Allowed Amount

A. Deductible.
There is no Deductible for Covered Services under this Certificate during each Plan Year.

B. Copayments.
Except where stated otherwise, You must pay the Copayments, or fixed amounts, in the Schedule of Benefits section of this Certificate for Covered Services. However, when the Allowed Amount for a service is less than the Copayment, You are responsible for the lesser amount.

C. Coinsurance.
Except where stated otherwise, You must pay a percentage of the Allowed Amount for Covered Services. We will pay the remaining percentage of the Allowed Amount as Your benefit as shown in the Schedule of Benefits section of this Certificate.

D. Out-of-Pocket Limit.
When You have met Your Out-of-Pocket Limit in payment of Copayments, Deductibles and Coinsurance for a Plan Year in the Schedule of Benefits section of this Certificate, We will provide coverage for 100% of the Allowed Amount for Covered Services for the remainder of that Plan Year. If You have other than individual coverage, once a person within a family meets the individual Out-of-Pocket Limit in the Schedule of Benefits section of this Certificate, We will provide coverage for 100% of the Allowed Amount for the rest of that Plan Year for that person. If other than individual coverage applies, when persons in the same family covered under this Certificate have collectively met the family Out-of-Pocket Limit in payment of Copayments, Deductibles and Coinsurance for a Plan Year in the Schedule of Benefits section of this Certificate, We will provide coverage for 100% of the Allowed Amount for the rest of that Plan Year for the entire family.

Cost-Sharing for out-of-network services, except for Emergency Services, out-of-network services approved by Us as an in-network exception and out-of-network dialysis does not apply toward Your Out-of-Pocket Limit.

E. Allowed Amount.
"Allowed Amount" means the maximum amount We will pay for the services or supplies Covered under this Certificate, before any applicable Copayment, Deductible and Coinsurance amounts are subtracted. We determine Our Allowed Amount as follows:

The Allowed Amount for Participating Providers will be the amount We have negotiated with the Participating Provider, or the Participating Provider's charge, if less.

See the Emergency Services and Urgent Care section of this Certificate for the Allowed Amount for Emergency Services rendered by Non-Participating Providers. See the Ambulance and Pre-Hospital Emergency Medical Services section of this Certificate for the Allowed Amount for Pre-Hospital Emergency Medical Services rendered by Non-Participating Providers.

Section V

Who is Covered

A. Who is Covered Under this Certificate.
You, the Subscriber to whom this Certificate is issued, are covered under this Certificate. You must live, work, or reside in Our Service Area to be covered under this Certificate. Members of Your family may also be covered depending on the type of coverage You selected.

B. Types of Coverage.
We offer the following types of coverage:

1. **Individual.** If You selected individual coverage, then You are covered.

2. **Individual and Spouse.** If You selected individual and Spouse coverage, then You and Your Spouse are covered.

3. **Parent and Child/Children.** If You selected parent and child/children coverage, then You and Your Child or Children, as described below, are covered.

4. **Family.** If You selected family coverage, then You and Your Spouse and Your Child or Children, as described below, are covered.

C. Children Covered Under this Certificate.
If You selected parent and child/children or family coverage, Children covered under this Certificate include Your natural Children, legally adopted Children, step Children, and Children for whom You are the proposed adoptive parent without regard to financial dependence, residency with You, student status or employment. A proposed adopted Child is eligible for coverage on the same basis as a natural Child during any waiting period prior to the finalization of the Child's adoption. Coverage lasts until the end of the month in which the Child turns twenty-six (26) years of age. Coverage also includes Children for whom You are a permanent legal guardian if the Children are chiefly dependent upon You for support and You have been appointed the legal guardian by a court order. Foster Children and grandchildren are not covered.

Any unmarried dependent Child, regardless of age, who is incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation (as defined in the New York Mental Hygiene Law), or physical handicap and who became so incapable prior to attainment of the age at which the Child's coverage would otherwise terminate and who is chiefly dependent upon You for support and maintenance, will remain covered while Your insurance remains in force and Your Child remains in such condition. You have thirty-one (31) days from the date of Your Child's attainment of the termination age to submit an application to request that the Child be included in Your coverage and proof of the Child's incapacity. We have the right to check whether a Child is and continues to qualify under this section.

We have the right to request and be furnished with such proof as may be needed to determine eligibility status of a prospective or covered Subscriber and all other prospective or covered Members in relation to

eligibility for coverage under this Certificate at any time.

D. When Coverage Begins.

Coverage under this Certificate will begin as follows:

1. If You, the Subscriber, elect coverage before becoming eligible, or within thirty (30) days of becoming eligible for other than a special enrollment period, coverage begins on the date You become eligible, or on the date determined by Your Group. Groups cannot impose waiting periods that exceed ninety (90) days.
2. If You, the Subscriber, do not elect coverage upon becoming eligible or within thirty (30) days of becoming eligible for other than a special enrollment period, You must wait until the Group's next open enrollment period to enroll, except as provided below.
3. If You, the Subscriber, marry while covered, and We receive notice of such marriage and any Premium payment within thirty (30) days thereafter, coverage for Your Spouse and Child starts on the date of the marriage. If We do not receive notice within thirty (30) days of the marriage, You must wait until the Group's next open enrollment period to add Your Spouse or Child.
4. If You, the Subscriber, have a newborn or adopted newborn Child and We receive notice of such birth within thirty (30) days thereafter, coverage for Your newborn starts at the moment of birth; otherwise, coverage begins on the date on which We receive notice. Your adopted newborn Child will be covered from the moment of birth if You take physical custody of the infant as soon as the infant is released from the Hospital after birth and You file a petition pursuant to Section 115-c of the New York Domestic Relations Law within thirty (30) days of the infant's birth; and provided further that no notice of revocation to the adoption has been filed pursuant to Section 115-b of the New York Domestic Relations Law, and consent to the adoption has not been revoked. However, We will not provide Hospital benefits for the adopted newborn's initial Hospital stay if one of the infant's natural parents has coverage for the newborn's initial Hospital stay. If You have individual or individual and Spouse coverage, You must also notify Us of Your desire to switch to parent and child/children or family coverage and pay any additional Premium within thirty (30) days of the birth or adoption in order for coverage to start at the moment of birth. Otherwise, coverage begins on the date on which We receive notice, provided that You pay any additional Premium when due.

E. Special Enrollment Periods.

You, Your Spouse or Child can also enroll for coverage within thirty (30) days of the loss of coverage in another group health plan if coverage was terminated because You, Your Spouse or Child are no longer eligible for coverage under the other group health plan due to:

1. Termination of employment;
2. Termination of the other group health plan;
3. Death of the Spouse;
4. Legal separation, divorce or annulment;
5. Reduction of hours of employment;
6. Employer contributions toward the group health plan were terminated for You or Your Dependents' coverage; or
7. A Child no longer qualifies for coverage as a Child under the other group health plan.

You, Your Spouse or Child can also enroll thirty (30) days from exhaustion of Your COBRA or continuation coverage or if You gain a Dependent or become a Dependent through marriage, birth, adoption, or placement for adoption.

We must receive notice and Premium payment within thirty (30) days of one (1) of these events. Your coverage will begin on the first day of the following month after We receive Your application. If You gain a Dependent or become a Dependent due to a birth, adoption, or placement for adoption, Your coverage will begin on the date of the birth, adoption or placement for adoption.

In addition, You, Your Spouse or Child, can also enroll for coverage within sixty (60) days of the occurrence of one of the following events:

1. You or Your Spouse or Child loses eligibility for Medicaid or Child Health Plus; or
2. You or Your Spouse or Child becomes eligible for Medicaid or Child Health Plus.

We must receive notice and Premium payment within sixty (60) days of one of these events. Your coverage will begin on the first day of the following month after We receive Your application.

Section VI

Preventive Care

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

Preventive Care.
We Cover the following services for the purpose of promoting good health and early detection of disease. Preventive services are not subject to Cost-Sharing (Copayments, Deductibles or Coinsurance) when performed by a Participating Provider and provided in accordance with the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA"), or if the items or services have an "A" or "B" rating from the United States Preventive Services Task Force ("USPSTF"), or if the immunizations are recommended by the Advisory Committee on Immunization Practices ("ACIP"). However, Cost-Sharing may apply to services provided during the same visit as the preventive services. Also, if a preventive service is provided during an office visit wherein the preventive service is not the primary purpose of the visit, the Cost-Sharing amount that would otherwise apply to the office visit will still apply. You may contact Us at 1-800-447-8255 or visit Our website at www.emblemhealth.com for a copy of the comprehensive guidelines supported by HRSA, items or services with an "A" or "B" rating from USPSTF, and immunizations recommended by ACIP.

A. Well-Baby and Well-Child Care. We Cover well-baby and well-child care which consists of routine physical examinations including vision screenings and hearing screenings, developmental assessment, anticipatory guidance, and laboratory tests ordered at the time of the visit as recommended by the American Academy of Pediatrics. We also Cover preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF. If the schedule of well-child visits referenced above permits one (1) well-child visit per Plan Year, We will not deny a well-child visit if three hundred sixty-five (365) days have not passed since the previous well-child visit. Immunizations and boosters as recommended by ACIP are also Covered. This benefit is provided to Members from birth through attainment of age nineteen (19) and is not subject to Copayments, Deductibles or Coinsurance when provided by a Participating Provider.

B. Adult Annual Physical Examinations. We Cover adult annual physical examinations and preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF.

Examples of items or services with an "A" or "B" rating from USPSTF include, but are not limited to, blood pressure screening for adults, lung cancer screening, colorectal cancer screening, alcohol misuse screening, depression screening, and diabetes screening. A complete list of the Covered preventive Services is available on Our website at www.emblemhealth.com, or will be mailed to You upon request.

You are eligible for a physical examination once every Plan Year, regardless of whether or not three hundred sixty-five (365) days have passed since the previous physical examination visit. Vision screenings do not include refractions.

This benefit is not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF and when provided by a Participating Provider.

C. Adult Immunizations. We Cover adult immunizations as recommended by ACIP. This benefit is not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the recommendations of ACIP and when provided by a Participating Provider.

D. Well-Woman Examinations. We Cover well-woman examinations which consist of a routine gynecological examination, breast examination and annual screening for cervical cancer, including laboratory and diagnostic services in connection with evaluating cervical cancer screening tests. We also Cover preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF. A complete list of the Covered preventive Services is available on Our website at www.emblemhealth.com, or will be mailed to You upon request. This benefit is not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF, which may be less frequent than described above, and when provided by a Participating Provider.

E. Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer. We Cover mammograms, which may be provided by breast tomosynthesis (i.e., 3D mammograms), for the screening of breast cancer as follows:

- One (1) baseline screening mammogram for Members age thirty-five (35) through thirty-nine (39);
- Upon the recommendation of the Member's Provider, an annual screening mammogram for Members age thirty-five (35) through thirty-nine (39) if Medically Necessary; and
- One (1) screening mammogram annually for Members age forty (40) and over.

If a Member of any age has a history of breast cancer or a first degree relative has a history of breast cancer, We Cover mammograms as recommended by the Member's Provider. However, in no event will more than one (1) preventive screening per Plan Year be Covered.

Mammograms for the screening of breast cancer are not subject to Copayments, Deductibles or Coinsurance when provided by a Participating Provider.

We also Cover additional screening and diagnostic imaging for the detection of breast cancer, including diagnostic mammograms, breast ultrasounds and MRIs. Screening and diagnostic imaging for the detection of breast cancer, including diagnostic mammograms, breast ultrasounds and MRIs are not subject to Copayments, Deductibles or Coinsurance when provided by a Participating Provider.

F. Family Planning and Reproductive Health Services. We Cover family planning services which consist of: FDA-approved contraceptive methods prescribed by a Provider not otherwise Covered under the Prescription Drug Coverage section of this Certificate; patient education and counseling on use of contraceptives and related topics; follow-up services related to contraceptive methods, including management of side effects, counseling for continued

adherence, and device insertion and removal; and sterilization procedures for women. Such services are not subject to Copayments, Deductibles or Coinsurance when provided by a Participating Provider.

We also Cover vasectomies subject to Copayments, Deductibles or Coinsurance.

We do not Cover services related to the reversal of elective sterilizations.

G. Bone Mineral Density Measurements or Testing. We Cover bone mineral density measurements or tests, and Prescription Drugs and devices approved by the FDA or generic equivalents as approved substitutes. Coverage of Prescription Drugs is subject to the Prescription Drug Coverage section of this Certificate. Bone mineral density measurements or tests, drugs or devices shall include those covered for individuals meeting the criteria under the federal Medicare program and those in accordance with the criteria of the National Institutes of Health. You will also qualify for coverage of bone mineral density measurements and testing if You meet any of the following:

- Previously diagnosed as having osteoporosis or having a family history of osteoporosis;
- With symptoms or conditions indicative of the presence or significant risk of osteoporosis;
- On a prescribed drug regimen posing a significant risk of osteoporosis;
- With lifestyle factors to a degree as posing a significant risk of osteoporosis; or
- With such age, gender, and/or other physiological characteristics which pose a significant risk for osteoporosis.

We also Cover bone mineral density measurements or tests, and Prescription Drugs and devices as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF.

This benefit is not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF, which may not include all of the above services such as drugs and devices and when provided by a Participating Provider.

H. Screening for Prostate Cancer. We Cover an annual standard diagnostic examination including, but not limited to, a digital rectal examination and a prostate specific antigen test for men age fifty (50) and over who are asymptomatic and for men age forty (40) and over with a family history of prostate cancer or other prostate cancer risk factors. We also Cover standard diagnostic testing including, but not limited to, a digital rectal examination and a prostate-specific antigen test, at any age for men having a prior history of prostate cancer.

This benefit is not subject to Copayments, Deductibles or Coinsurance when provided by a Participating Provider.

Section VII

Ambulance and Pre-Hospital Emergency Medical Services

Please refer to the Schedule of Benefits section of this Certificate for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits. Pre-Hospital Emergency Medical Services and ambulance services for the treatment of an Emergency Condition do not require Preauthorization.

A. Emergency Ambulance Transportation.

1. Pre-Hospital Emergency Medical Services. We Cover Pre-Hospital Emergency Medical Services worldwide for the treatment of an Emergency Condition when such services are provided by an ambulance service.

"Pre-Hospital Emergency Medical Services" means the prompt evaluation and treatment of an Emergency Condition and/or non-airborne transportation to a Hospital. The services must be provided by an ambulance service issued a certificate under the New York Public Health Law. We will, however, only Cover transportation to a Hospital provided by such an ambulance service when a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in:

- Placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;
- Serious impairment to such person's bodily functions;
- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of such person.

An ambulance service must hold You harmless and may not charge or seek reimbursement from You for Pre-Hospital Emergency Medical Services except for the collection of any applicable Copayment, Deductible or Coinsurance.

In the absence of negotiated rates, We will pay a Non-Participating Provider the usual and customary charge for Pre-Hospital Emergency Medical Services, which shall not be excessive or unreasonable. The usual and customary charge for Pre-Hospital Emergency Medical Services is the FAIR Health rate at the 80th percentile.

2. Emergency Ambulance Transportation. In addition to Pre-Hospital Emergency Medical Services, We also Cover emergency ambulance transportation worldwide by a licensed ambulance service (either ground, water or air ambulance) to the nearest Hospital where Emergency Services can be performed. This coverage includes emergency ambulance transportation to a Hospital when the originating Facility does not have the ability to treat Your Emergency Condition.

B. Non-Emergency Ambulance Transportation.

We Cover non-emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as appropriate) between Facilities when the transport is any of the following:

- From a non-participating Hospital to a participating Hospital;

- To a Hospital that provides a higher level of care that was not available at the original Hospital;
- To a more cost-effective Acute care Facility; or
- From an Acute care Facility to a sub-Acute setting.

C. Limitations/Terms of Coverage.

- We do not Cover travel or transportation expenses, unless connected to an Emergency Condition or due to a Facility transfer approved by Us, even though prescribed by a Physician.
- We do not Cover non-ambulance transportation such as ambulette, van or taxi cab.
- Coverage for air ambulance related to an Emergency Condition or air ambulance related to non-emergency transportation is provided when Your medical condition is such that transportation by land ambulance is not appropriate; and Your medical condition requires immediate and rapid ambulance transportation that cannot be provided by land ambulance; and one (1) of the following is met:
    - The point of pick-up is inaccessible by land vehicle; or
    - Great distances or other obstacles (e.g., heavy traffic) prevent Your timely transfer to the nearest Hospital with appropriate facilities.

Section VIII

Emergency Services and Urgent Care

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

A. Emergency Services.
We Cover Emergency Services for the treatment of an Emergency Condition in a Hospital.

We define an **"Emergency Condition"** to mean: A medical or behavioral condition that manifests itself by Acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;
- Serious impairment to such person's bodily functions;
- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of such person.

For example, an Emergency Condition may include, but is not limited to, the following conditions:

- Severe chest pain
- Severe or multiple injuries
- Severe shortness of breath
- Sudden change in mental status (e.g., disorientation)
- Severe bleeding
- Acute pain or conditions requiring immediate attention such as suspected heart attack or appendicitis
- Poisonings
- Convulsions

Coverage of Emergency Services for treatment of Your Emergency Condition will be provided regardless of whether the Provider is a Participating Provider. We will also Cover Emergency Services to treat Your Emergency Condition worldwide. However, We will Cover only those Emergency Services and supplies that are Medically Necessary and are performed to treat or stabilize Your Emergency Condition in a Hospital.

Please follow the instructions listed below regardless of whether or not You are in Our Service Area at the time Your Emergency Condition occurs:

1. **Hospital Emergency Department Visits.** In the event that You require treatment for an Emergency Condition, seek immediate care at the nearest Hospital emergency department or call 911. Emergency Department Care does not require Preauthorization. **However, only Emergency Services for the treatment of an Emergency Condition are Covered in an emergency department**.

We do not Cover follow-up care or routine care provided in a Hospital emergency department. You should contact Us to make sure You receive the appropriate follow-up care.

2. **Emergency Hospital Admissions.** In the event that You are **admitted** to the Hospital, You or someone on Your behalf must notify Us at the number listed in this Certificate and on Your ID card within forty-eight (48) hours of Your admission, or as soon as is reasonably possible.

   We Cover inpatient Hospital services at a non-participating Hospital at the in-network Cost-Sharing for as long as Your medical condition prevents Your transfer to a participating Hospital, unless We authorize continued treatment at the non-participating Hospital. If Your medical condition permits Your transfer to a participating Hospital, We will notify You and arrange the transfer. Any inpatient Hospital services received from a non-participating Hospital after We have notified You and arranged for a transfer to a participating Hospital will not be Covered.

3. **Payments Relating to Emergency Services Rendered.** The amount We pay a Non-Participating Provider for Emergency Services will be the greater of: 1) the amount We have negotiated with Participating Providers for the Emergency Service (and if more than one amount is negotiated, the median of the amounts); 2) 100% of the Allowed Amount for services provided by a Non-Participating Provider (i.e., the amount We would pay in the absence of any Cost-Sharing that would otherwise apply for services of Non-Participating Providers); or 3) the amount that would be paid under Medicare. The amounts described above exclude any Copayment or Coinsurance that applies to Emergency Services provided by a Participating Provider.

   If a dispute involving a payment for physician or Hospital services is submitted to an independent dispute resolution entity ("IDRE"), We will pay the amount, if any, determined by the IDRE for physician or Hospital services.

   You are responsible for any Copayment, Deductible or Coinsurance. You will be held harmless for any Non-Participating Provider charges that exceed Your Copayment, Deductible or Coinsurance.

B. Urgent Care.

Urgent Care is medical care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require Emergency Department Care. **Urgent Care is Covered in Our Service Area**.

1. **In-Network.** We Cover Urgent Care from a participating Physician or a participating Urgent Care Center. You do not need to contact Us prior to or after Your visit.

2. **Out-of-Network.** We do not Cover Urgent Care from non-participating Urgent Care Centers or Physicians in Our Service Area.

If Urgent Care results in an emergency admission, please follow the instructions for emergency Hospital admissions described above.

Section IX

Outpatient and Professional Services

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

A. Advanced Imaging Services.
We Cover PET scans, MRI, nuclear medicine, and CAT scans.

B. Allergy Testing and Treatment.
We Cover testing and evaluations including injections, and scratch and prick tests to determine the existence of an allergy. We also Cover allergy treatment, including desensitization treatments, routine allergy injections and serums.

C. Ambulatory Surgical Center Services.
We Cover surgical procedures performed at Ambulatory Surgical Centers including services and supplies provided by the center the day the surgery is performed.

D. Chemotherapy.
We Cover chemotherapy in an outpatient Facility or in a Health Care Professional's office. Chemotherapy may be administered by injection or infusion. Orally-administered anti-cancer drugs are Covered under the Prescription Drug Coverage section of this Certificate.

E. Chiropractic Services.
We Cover chiropractic care when performed by a Doctor of Chiropractic ("chiropractor") in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for the purpose of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of the vertebral column. This includes assessment, manipulation and any modalities. Any laboratory tests will be Covered in accordance with the terms and conditions of this Certificate.

F. Clinical Trials.
We Cover the routine patient costs for Your participation in an approved clinical trial and such coverage shall not be subject to Utilization Review if You are:

- Eligible to participate in an approved clinical trial to treat either cancer or other life-threatening disease or condition; and
- Referred by a Participating Provider who has concluded that Your participation in the approved clinical trial would be appropriate.

All other clinical trials, including when You do not have cancer or other life-threatening disease or condition, may be subject to the Utilization Review and External Appeal sections of this Certificate.

We do not Cover: the costs of the investigational drugs or devices; the costs of non-health services required for You to receive the treatment; the costs of managing the research; or costs that would not be covered under this Certificate for non-investigational treatments provided in the clinical trial.

An "approved clinical trial" means a phase I, II, III, or IV clinical trial that is:

- A federally funded or approved trial;
- Conducted under an investigational drug application reviewed by the federal Food and Drug Administration; or
- A drug trial that is exempt from having to make an investigational new drug application.

G. Dialysis.
We Cover dialysis treatments of an Acute or chronic kidney ailment.

We also Cover dialysis treatments provided by a Non-Participating Provider subject to all the following conditions:

- The Non-Participating Provider is duly licensed to practice and authorized to provide such treatment.
- The Non-Participating Provider is located outside Our Service Area.
- The Participating Provider who is treating You has issued a written order indicating that dialysis treatment by the Non-Participating Provider is necessary.
- You notify Us in writing at least thirty (30) days in advance of the proposed treatment date(s) and include the written order referred to above. The thirty (30)-day advance notice period may be shortened when You need to travel on sudden notice due to a family or other emergency, provided that We have a reasonable opportunity to review Your travel and treatment plans.
- We have the right to Preauthorize the dialysis treatment and schedule.
- We will provide benefits for no more than ten (10) dialysis treatments by a Non-Participating Provider per Member per calendar year.
- Benefits for services of a Non-Participating Provider are Covered when all the above conditions are met and are subject to any applicable Cost-Sharing that applies to dialysis treatments by a Participating Provider. However, You are also responsible for paying any difference between the amount We would have paid had the service been provided by a Participating Provider and the Non-Participating Provider's charge.

H. Habilitation Services.
We Cover Habilitation Services consisting of physical therapy, speech therapy and occupational therapy in the outpatient department of a Facility or in a Health Care Professional's office for up to ninety (90) visits per Plan Year. The visit limit applies to all therapies combined.

I. Home Health Care.
We Cover care provided in Your home by a Home Health Agency certified or licensed by the appropriate state agency. The care must be provided pursuant to Your Physician's written treatment plan and must be in lieu of Hospitalization or confinement in a Skilled Nursing Facility. Home care includes:

- Part-time or intermittent nursing care by or under the supervision of a registered professional nurse;
- Part-time or intermittent services of a home health aide;
- Physical, occupational or speech therapy provided by the Home Health Agency; and

- Medical supplies, Prescription Drugs and medications prescribed by a Physician, and laboratory services by or on behalf of the Home Health Agency to the extent such items would have been Covered during a Hospitalization or confinement in a Skilled Nursing Facility.

Home Health Care is limited to two hundred (200) visits per Plan Year. Each visit by a member of the Home Health Agency is considered one (1) visit. Each visit of up to four (4) hours by a home health aide is considered one (1) visit. Any Rehabilitation or Habilitation Services received under this benefit will not reduce the amount of services available under the Rehabilitation or Habilitation Services benefits.

J. Infertility Treatment.

We Cover services for the diagnosis and treatment (surgical and medical) of infertility. "Infertility" is a disease or condition characterized by the incapacity to impregnate another person or to conceive, defined by the failure to establish a clinical pregnancy after twelve (12) months of regular, unprotected sexual intercourse or therapeutic donor insemination, or after six (6) months of regular, unprotected sexual intercourse or therapeutic donor insemination for a female thirty-five (35) years of age or older. Earlier evaluation and treatment may be warranted based on a Member's medical history or physical findings.

Such coverage is available as follows:

1. **Basic Infertility Services.** Basic infertility services will be provided to a Member who is an appropriate candidate for infertility treatment. In order to determine eligibility, We will use guidelines established by the American College of Obstetricians and Gynecologists, the American Society for Reproductive Medicine, and the State of New York.

   Basic infertility services include:
   - Initial evaluation;
   - Semen analysis;
   - Laboratory evaluation;
   - Evaluation of ovulatory function;
   - Postcoital test;
   - Endometrial biopsy;
   - Pelvic ultra sound;
   - Hysterosalpingogram;
   - Sono-hystogram;
   - Testis biopsy;
   - Blood tests; and
   - Medically appropriate treatment of ovulatory dysfunction.

   Additional tests may be Covered if the tests are determined to be Medically Necessary.

2. **Comprehensive Infertility Services.** If the basic infertility services do not result in increased fertility, We Cover comprehensive infertility services.

   Comprehensive infertility services include:
   - Ovulation induction and monitoring;

- Pelvic ultra sound;
- Artificial insemination;
- Hysteroscopy;
- Laparoscopy; and
- Laparotomy.

3. **Advanced Infertility Services.** We Cover the following advanced infertility services:
   - Three (3) cycles per lifetime of in vitro fertilization;
   - Sperm storage costs in connection with in vitro fertilization; and
   - Cryopreservation and storage of embryos in connection with in vitro fertilization.

   A "cycle" is all treatment that starts when: preparatory medications are administered for ovarian stimulation for oocyte retrieval with the intent of undergoing in vitro fertilization using a fresh embryo transfer, or medications are administered for endometrial preparation with the intent of undergoing in vitro fertilization using a frozen embryo transfer.

4. **Fertility Preservation Services.** We Cover standard fertility preservation services when a medical treatment will directly or indirectly lead to iatrogenic infertility. Standard fertility preservation services include the collecting, preserving, and storing of ova and sperm. "Iatrogenic infertility" means an impairment of Your fertility by surgery, radiation, chemotherapy or other medical treatment affecting reproductive organs or processes.

5. **Exclusions and Limitations.** We do not Cover:
   - Gamete intrafallopian tube transfers or zygote intrafallopian tube transfers;
   - Costs for an ovum donor or donor sperm;
   - Ovulation predictor kits;
   - Reversal of tubal ligations;
   - Reversal of vasectomies;
   - Costs for and relating to surrogate motherhood (maternity services are Covered for Members acting as surrogate mothers);
   - Cloning; or
   - Medical and surgical procedures that are experimental or investigational, unless Our denial is overturned by an External Appeal Agent.

   All services must be provided by Providers who are qualified to provide such services in accordance with the guidelines established and adopted by the American Society for Reproductive Medicine. We will not discriminate based on Your expected length of life, present or predicted disability, degree of medical dependency, perceived quality of life, other health conditions, or based on personal characteristics including age, sex, sexual orientation, marital status or gender identity, when determining coverage under this benefit.

K. Infusion Therapy.

We Cover infusion therapy which is the administration of drugs using specialized delivery systems. Drugs or nutrients administered directly into the veins are considered infusion therapy. Drugs taken by mouth or self-injected are not considered infusion therapy. The services must be ordered by a Physician or other authorized Health Care Professional and provided in an office or by an agency licensed or

certified to provide infusion therapy.

L. Interruption of Pregnancy.
We Cover medically necessary abortions including abortions in cases of rape, incest or fetal malformation. We Cover elective abortions for one (1) procedure per Member, per Plan Year.

M. Laboratory Procedures, Diagnostic Testing and Radiology Services.
We Cover x-ray, laboratory procedures and diagnostic testing, services and materials, including diagnostic x-rays, x-ray therapy, fluoroscopy, electrocardiograms, electroencephalograms, laboratory tests, and therapeutic radiology services.

N. Maternity and Newborn Care.
We Cover services for maternity care provided by a Physician or midwife, nurse practitioner, Hospital or birthing center. We Cover prenatal care (including one (1) visit for genetic testing), postnatal care, delivery, and complications of pregnancy. In order for services of a midwife to be Covered, the midwife must be licensed pursuant to Article 140 of the New York Education Law, practicing consistent with Section 6951 of the New York Education Law and affiliated or practicing in conjunction with a Facility licensed pursuant to Article 28 of the New York Public Health Law. We will not pay for duplicative routine services provided by both a midwife and a Physician. See the Inpatient Services section of this Certificate for coverage of inpatient maternity care.

We Cover breastfeeding support, counseling and supplies, including the cost of renting one (1) breast pump per pregnancy for the duration of breast feeding from a Participating Provider or designated vendor.

O. Office Visits.
We Cover office visits for the diagnosis and treatment of injury, disease and medical conditions. Office visits may include house calls.

P. Outpatient Hospital Services.
We Cover Hospital services and supplies as described in the Inpatient Services section of this Certificate that can be provided to You while being treated in an outpatient Facility. For example, Covered Services include but are not limited to inhalation therapy, pulmonary rehabilitation, infusion therapy and cardiac rehabilitation. Unless You are receiving preadmission testing, Hospitals are not Participating Providers for outpatient laboratory procedures and tests.

Q. Preadmission Testing.
We Cover preadmission testing ordered by Your Physician and performed in Hospital outpatient Facilities prior to a scheduled surgery in the same Hospital provided that:

- The tests are necessary for and consistent with the diagnosis and treatment of the condition for which the surgery is to be performed;
- Reservations for a Hospital bed and operating room were made prior to the performance of the tests;
- Surgery takes place within seven (7) days of the tests; and
- The patient is physically present at the Hospital for the tests.

R. Prescription Drugs for Use in the Office.
We Cover Prescription Drugs (excluding self-injectable drugs) used by Your Provider in the Provider's office for preventive and therapeutic purposes. This benefit applies when Your Provider orders the Prescription Drug and administers it to You. When Prescription Drugs are Covered under this benefit, they will not be Covered under the Prescription Drug Coverage section of this Certificate.

S. Rehabilitation Services.
We Cover Rehabilitation Services consisting of physical therapy, speech therapy, occupational therapy and pulmonary rehabilitation in the outpatient department of a Facility or in a Health Care Professional's office for up to ninety (90) visits per Plan Year. The visit limit applies to all therapies combined.

We Cover speech and physical therapy only when:
- Such therapy is related to the treatment or diagnosis of Your illness or injury (in the case of a covered Child, this includes a medically diagnosed congenital defect); and
- The therapy is ordered by a Physician.

Covered Rehabilitation Services must begin within six (6) months of the later to occur:
- The date of the injury or illness that caused the need for the therapy;
- The date You are discharged from a Hospital where surgical treatment was rendered; or
- The date outpatient surgical care is rendered.

In no event will the therapy continue beyond three hundred sixty-five (365) days after such event.

We also Cover Cardiac Rehabilitation for thirty-two (32) visits when performed in a Specialist Office or Outpatient Hospital Services.

T. Second Opinions.
1. **Second Cancer Opinion.** We Cover a second medical opinion by an appropriate Specialist, including but not limited to a Specialist affiliated with a specialty care center, in the event of a positive or negative diagnosis of cancer or a recurrence of cancer or a recommendation of a course of treatment for cancer. You may obtain a second opinion from a Non-Participating Provider on an in-network basis when Your attending Physician provides a written Referral to a non-participating Specialist.

2. **Second Surgical Opinion.** We Cover a second surgical opinion by a qualified Physician on the need for surgery.

3. **Required Second Surgical Opinion.** We may require a second opinion before We preauthorize a surgical procedure. There is no cost to You when We request a second opinion.
    - The second opinion must be given by a board-certified Specialist who personally examines You.
    - If the first and second opinions do not agree, You may obtain a third opinion.
    - The second and third surgical opinion consultants may not perform the surgery on You.

4. **Second Opinions in Other Cases.** There may be other instances when You will disagree with a Provider's recommended course of treatment. In such cases, You may request that We designate

another Provider to render a second opinion. If the first and second opinions do not agree, We will designate another Provider to render a third opinion. After completion of the second opinion process, We will preauthorize Covered Services supported by a majority of the Providers reviewing Your case.

U. Surgical Services.
We Cover Physicians' services for surgical procedures, including operating and cutting procedures for the treatment of a sickness or injury, and closed reduction of fractures and dislocations of bones, endoscopies, incisions, or punctures of the skin on an inpatient and outpatient basis, including the services of the surgeon or Specialist, assistant (including a Physician's assistant or a nurse practitioner), and anesthetist or anesthesiologist, together with preoperative and post-operative care. Benefits are not available for anesthesia services provided as part of a surgical procedure when rendered by the surgeon or the surgeon's assistant.

If Covered multiple surgical procedures are performed during the same operative session through the same or different incisions, We will pay:

- For the procedure with the highest Allowed Amount; and
- 50% of the amount We would otherwise pay for the other procedures.

V. Oral Surgery.
We Cover the following limited dental and oral surgical procedures:

- Oral surgical procedures for jaw bones or surrounding tissue and dental services for the repair or replacement of sound natural teeth that are required due to accidental injury. Replacement is Covered only when repair is not possible. Dental services must be obtained within twelve (12) months of the injury.
- Oral surgical procedures for jaw bones or surrounding tissue and dental services necessary due to congenital disease or anomaly.
- Oral surgical procedures required for the correction of a non-dental physiological condition which has resulted in a severe functional impairment.
- Removal of tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth. Cysts related to teeth are not Covered.
- Surgical/nonsurgical medical procedures for temporomandibular joint disorders and orthognathic surgery.

W. Reconstructive Breast Surgery.
We Cover breast reconstruction surgery after a mastectomy or partial mastectomy. Coverage includes: all stages of reconstruction of the breast on which the mastectomy or partial mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and physical complications of the mastectomy or partial mastectomy, including lymphedemas, in a manner determined by You and Your attending Physician to be appropriate. We also Cover implanted breast prostheses following a mastectomy or partial mastectomy.

X. Other Reconstructive and Corrective Surgery.
We Cover reconstructive and corrective surgery other than reconstructive breast surgery only when it is:

- Performed to correct a congenital birth defect of a covered Child which has resulted in a functional defect;

- Incidental to surgery or follows surgery that was necessitated by trauma, infection or disease of the involved part; or
- Otherwise Medically Necessary.

Y. Transplants.
We Cover only those transplants determined to be non-experimental and non-investigational. Covered transplants include but are not limited to: kidney, corneal, liver, heart, and heart/lung transplants; and bone marrow transplants for aplastic anemia, leukemia, severe combined immunodeficiency disease and Wiskott-Aldrich Syndrome.

All transplants must be prescribed by Your Specialist(s). Additionally, all transplants must be performed at Hospitals that We have specifically approved and designated to perform these procedures.

We Cover the Hospital and medical expenses, including donor search fees, of the Member-recipient. We Cover transplant services required by You when You serve as an organ donor only if the recipient is a Member. We do not Cover the medical expenses of a non-Member acting as a donor for You if the non-Member's expenses will be Covered under another health plan or program.

Section X

Additional Benefits, Equipment and Devices

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

A. Autism Spectrum Disorder.
We Cover the following services when such services are prescribed or ordered by a licensed Physician or a licensed psychologist and are determined by Us to be Medically Necessary for the screening, diagnosis, and treatment of autism spectrum disorder. For purposes of this benefit, "autism spectrum disorder" means any pervasive developmental disorder defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders at the time services are rendered.

1. **Screening and Diagnosis.** We Cover assessments, evaluations, and tests to determine whether someone has autism spectrum disorder.

2. **Assistive Communication Devices.** We Cover a formal evaluation by a speech-language pathologist to determine the need for an assistive communication device. Based on the formal evaluation, We Cover the rental or purchase of assistive communication devices when ordered or prescribed by a licensed Physician or a licensed psychologist if You are unable to communicate through normal means (i.e., speech or writing) when the evaluation indicates that an assistive communication device is likely to provide You with improved communication. Examples of assistive communication devices include communication boards and speech-generating devices. Coverage is limited to dedicated devices. We will only Cover devices that generally are not useful to a person in the absence of a communication impairment. We do not Cover items, such as, but not limited to, laptop, desktop or tablet computers. We Cover software and/or applications that enable a laptop, desktop or tablet computer to function as a speech-generating device. Installation of the program and/or technical support is not separately reimbursable. We will determine whether the device should be purchased or rented.

   We Cover repair, replacement fitting and adjustments of such devices when made necessary by normal wear and tear or significant change in Your physical condition. We do not Cover the cost of repair or replacement made necessary because of loss or damage caused by misuse, mistreatment, or theft; however, We Cover one (1) repair or replacement per device type that is necessary due to behavioral issues. Coverage will be provided for the device most appropriate to Your current functional level. We do not Cover delivery or service charges or routine maintenance.

3. **Behavioral Health Treatment.** We Cover counseling and treatment programs that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual. We will provide such coverage when provided by a licensed Provider. We Cover applied behavior analysis when provided by a licensed or certified applied behavior analysis Health Care Professional. "Applied behavior analysis" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct

observation, measurement, and functional analysis of the relationship between environment and behavior. The treatment program must describe measurable goals that address the condition and functional impairments for which the intervention is to be applied and include goals from an initial assessment and subsequent interim assessments over the duration of the intervention in objective and measurable terms.

4. **Psychiatric and Psychological Care.** We Cover direct or consultative services provided by a psychiatrist, psychologist or a licensed clinical social worker with the experience required by the New York Insurance Law, licensed in the state in which they are practicing.

5. **Therapeutic Care.** We Cover therapeutic services necessary to develop, maintain, or restore, to the greatest extent practicable, functioning of the individual when such services are provided by licensed or certified speech therapists, occupational therapists, physical therapists and social workers to treat autism spectrum disorder and when the services provided by such Providers are otherwise Covered under this Certificate. Except as otherwise prohibited by law, services provided under this paragraph shall be included in any visit maximums applicable to services of such therapists or social workers under this Certificate.

6. **Pharmacy Care.** We Cover Prescription Drugs to treat autism spectrum disorder that are prescribed by a Provider legally authorized to prescribe under Title 8 of the New York Education Law. Coverage of such Prescription Drugs is subject to all the terms, provisions, and limitations that apply to Prescription Drug benefits under this Certificate.

7. **Limitations.** We do not Cover any services or treatment set forth above when such services or treatment are provided pursuant to an individualized education plan under the New York Education Law. The provision of services pursuant to an individualized family service plan under Section 2545 of the New York Public Health Law, an individualized education plan under Article 89 of the New York Education Law, or an individualized service plan pursuant to regulations of the New York State Office for People With Developmental Disabilities shall not affect coverage under this Certificate for services provided on a supplemental basis outside of an educational setting if such services are prescribed by a licensed Physician or licensed psychologist.

   You are responsible for any applicable Copayment, Deductible or Coinsurance provisions under this Certificate for similar services. For example, any Copayment, Deductible or Coinsurance that applies to physical therapy visits will generally also apply to physical therapy services Covered under this benefit; and any Copayment, Deductible or Coinsurance for Prescription Drugs will generally also apply to Prescription Drugs Covered under this benefit. See the Schedule of Benefits section of this Certificate for the Cost-Sharing requirements that apply to applied behavior analysis services and assistive communication devices.

   Nothing in this Certificate shall be construed to affect any obligation to provide coverage for otherwise Covered Services solely on the basis that the services constitute early intervention program services pursuant to Section 3235-a of the New York Insurance Law or an individualized service plan pursuant to regulations of the New York State Office for People With Developmental Disabilities.

B. Diabetic Equipment, Supplies and Self-Management Education.
We Cover diabetic equipment, supplies, and self-management education if recommended or prescribed by a Physician or other licensed Health Care Professional legally authorized to prescribe under Title 8 of the New York Education Law as described below:

1. **Equipment and Supplies.**
   We Cover the following equipment and related supplies for the treatment of diabetes when prescribed by Your Physician or other Provider legally authorized to prescribe:
   - Acetone reagent strips
   - Acetone reagent tablets
   - Alcohol or peroxide by the pint
   - Alcohol wipes
   - All insulin preparations
   - Automatic blood lance kit
   - Blood glucose kit
   - Blood glucose strips (test or reagent)
   - Blood glucose monitor with or without special features for visually impaired, control solutions, and strips for home blood glucose monitor
   - Cartridges for the visually impaired
   - Diabetes data management systems
   - Disposable insulin and pen cartridges
   - Drawing-up devices for the visually impaired
   - Equipment for use of the pump
   - Glucagon for injection to increase blood glucose concentration
   - Glucose acetone reagent strips
   - Glucose reagent strips
   - Glucose reagent tape
   - Injection aides
   - Injector (Busher) Automatic
   - Insulin
   - Insulin cartridge delivery
   - Insulin infusion devices
   - Insulin pump
   - Lancets
   - Oral agents such as glucose tablets and gels
   - Oral anti-diabetic agents used to reduce blood sugar levels
   - Syringe with needle; sterile 1 cc box
   - Urine testing products for glucose and ketones
   - Additional supplies, as the New York State Commissioner of Health shall designate by regulation as appropriate for the treatment of diabetes.

   Diabetic equipment and supplies are Covered only when obtained from a designated diabetic equipment or supply manufacturer which has an agreement with Us to provide all diabetic equipment or supplies required by law for Members through participating pharmacies. If You require a certain item not available from Our designated diabetic equipment or supply manufacturer, You or Your Provider must submit a request for a medical exception by calling the number on Your ID card. Our medical director will make all medical exception determinations.

Diabetic equipment and supplies are limited to a thirty (30)-day supply up to a maximum of a ninety (90)-day supply when purchased at a pharmacy.

2. Self-Management Education.
Diabetes self-management education is designed to educate persons with diabetes as to the proper self-management and treatment of their diabetic condition, including information on proper diets. We Cover education on self-management and nutrition when: diabetes is initially diagnosed; a Physician diagnoses a significant change in Your symptoms or condition which necessitates a change in Your self-management education; or when a refresher course is necessary. It must be provided in accordance with the following:

- By a Physician, other health care Provider authorized to prescribe under Title 8 of the New York Education Law, or their staff during an office visit;
- Upon the Referral of Your Physician or other health care Provider authorized to prescribe under Title 8 of the New York Education Law to the following non-Physician, medical educators: certified diabetes nurse educators; certified nutritionists; certified dietitians; and registered dietitians in a group setting when practicable; and
- Education will also be provided in Your home when Medically Necessary.

3. Limitations.
The items will only be provided in amounts that are in accordance with the treatment plan developed by the Physician for You. We Cover only basic models of blood glucose monitors unless You have special needs relating to poor vision or blindness or as otherwise Medically Necessary.

Step Therapy for Diabetes Equipment and Supplies. Step therapy is a program that requires You to try one (1) type of diabetic Prescription Drug, supply or equipment unless another Prescription Drug, supply or equipment is Medically Necessary. The diabetic Prescription Drugs, supplies and equipment that are subject to step therapy include:

- Diabetic glucose meters and test strips;
- Diabetic supplies (including but not limited to syringes, lancets, needles, pens);
- Insulin;
- Injectable anti-diabetic agents; and
- Oral anti-diabetic agents.

These items also require Preauthorization and will be reviewed for Medical Necessity. For diabetic Prescription Drugs, refer to the step therapy provisions in the Prescription Drug section and the Step Therapy Protocol Override Determination provisions in the Utilization Review section of this Certificate.

C. Durable Medical Equipment and Braces.
We Cover the rental or purchase of durable medical equipment and braces.

1. Durable Medical Equipment.
Durable Medical Equipment is equipment which is:

- Designed and intended for repeated use;
- Primarily and customarily used to serve a medical purpose;

- Generally not useful to a person in the absence of disease or injury; and
- Appropriate for use in the home.

Coverage is for standard equipment only. We Cover the cost of repair or replacement when made necessary by normal wear and tear. We do not Cover the cost of repair or replacement that is the result of misuse or abuse by You. We will determine whether to rent or purchase such equipment. We do not Cover over-the-counter durable medical equipment.

We do not Cover equipment designed for Your comfort or convenience (e.g., pools, hot tubs, air conditioners, saunas, humidifiers, dehumidifiers, exercise equipment), as it does not meet the definition of durable medical equipment.

2. Braces.
We Cover braces, including orthotic braces, that are worn externally and that temporarily or permanently assist all or part of an external body part function that has been lost or damaged because of an injury, disease or defect. Coverage is for standard equipment only. We Cover replacements when growth or a change in Your medical condition make replacement necessary. We do not Cover the cost of repair or replacement that is the result of misuse or abuse by You.

D. Hearing Aids.
Cochlear Implants.
We Cover bone anchored hearing aids (i.e., cochlear implants) when they are Medically Necessary to correct a hearing impairment. Examples of when bone anchored hearing aids are Medically Necessary include the following:

- Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or
- Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

Coverage is provided for one (1) hearing aid per ear during the entire period of time that You are enrolled under this Certificate. We Cover repair and/or replacement of a bone anchored hearing aid only for malfunctions.

E. Hospice.
Hospice Care is available if Your primary attending Physician has certified that You have six (6) months or less to live. We Cover inpatient Hospice Care in a Hospital or hospice and home care and outpatient services provided by the hospice, including drugs and medical supplies. Coverage is provided for two hundred ten (210) days of Hospice Care. We also Cover five (5) visits for supportive care and guidance for the purpose of helping You and Your immediate family cope with the emotional and social issues related to Your death, either before or after Your death.

We Cover Hospice Care only when provided as part of a Hospice Care program certified pursuant to Article 40 of the New York Public Health Law. If care is provided outside New York State, the hospice must be certified under a similar certification process required by the state in which the hospice is located. We do not Cover: funeral arrangements; pastoral, financial, or legal counseling; or homemaker, caretaker, or respite care.

F. Medical Supplies.

We Cover medical supplies that are required for the treatment of a disease or injury which is Covered under this Certificate. We also Cover maintenance supplies (e.g., ostomy supplies) for conditions Covered under this Certificate. All such supplies must be in the appropriate amount for the treatment or maintenance program in progress. We do not Cover over-the-counter medical supplies. See the Diabetic Equipment, Supplies, and Self-Management Education section above for a description of diabetic supply coverage.

G. Prosthetics.

1. External Prosthetic Devices.

We Cover prosthetic devices (including wigs) that are worn externally and that temporarily or permanently replace all or part of an external body part that has been lost or damaged because of an injury or disease. We Cover wigs only when You have severe hair loss due to injury or disease or as a side effect of the treatment of a disease (e.g., chemotherapy). We do not Cover wigs made from human hair unless You are allergic to all synthetic wig materials.

We do not Cover dentures or other devices used in connection with the teeth unless required due to an accidental injury to sound natural teeth or necessary due to congenital disease or anomaly.

Eyeglasses and contact lenses are not Covered under this section of the Certificate and are only Covered under the Vision Care section of this Certificate.

We Cover external breast prostheses following a mastectomy, which are not subject to any lifetime limit.

Coverage is for standard equipment only.

We Cover the cost of one (1) prosthetic device, per limb, per lifetime. We also Cover the cost of repair and replacement of the prosthetic device and its parts. We do not Cover the cost of repair or replacement covered under warranty or if the repair or replacement is the result of misuse or abuse by You.

2. Internal Prosthetic Devices.

We Cover surgically implanted prosthetic devices and special appliances if they improve or restore the function of an internal body part which has been removed or damaged due to disease or injury. This includes implanted breast prostheses following a mastectomy or partial mastectomy in a manner determined by You and Your attending Physician to be appropriate.

Coverage also includes repair and replacement due to normal growth or normal wear and tear.

Coverage is for standard equipment only.

H. Shoe Inserts.

We Cover shoe inserts that are necessary to: support, restore or protect body function; redirect, eliminate or restrict motion of an impaired body part; or relieve or correct a condition caused by an injury or illness. We Cover replacements: due to a change in Your condition; when required repairs would

exceed the cost of a replacement device or parts that need to be replaced; or when there has been an irreparable change in the condition of the device due to normal wear and tear. We do not Cover the cost of repair or replacement that is the result of misuse or abuse by You.

Section XI

Inpatient Services

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

A. Hospital Services.
We Cover inpatient Hospital services for Acute care or treatment given or ordered by a Health Care Professional for an illness, injury or disease of a severity that must be treated on an inpatient basis, including:

- Semiprivate room and board;
- General, special and critical nursing care;
- Meals and special diets;
- The use of operating, recovery and cystoscopic rooms and equipment;
- The use of intensive care, special care or cardiac care units and equipment;
- Diagnostic and therapeutic items, such as drugs and medications, sera, biologicals and vaccines, intravenous preparations and visualizing dyes and administration, but not including those which are not commercially available for purchase and readily obtainable by the Hospital;
- Dressings and casts;
- Supplies and the use of equipment in connection with oxygen, anesthesia, physiotherapy, chemotherapy, electrocardiographs, electroencephalographs, x-ray examinations and radiation therapy, laboratory and pathological examinations;
- Blood and blood products except when participation in a volunteer blood replacement program is available to You;
- Radiation therapy, inhalation therapy, chemotherapy, pulmonary rehabilitation, infusion therapy and cardiac rehabilitation;
- Short-term physical, speech and occupational therapy; and
- Any additional medical services and supplies which are provided while You are a registered bed patient and which are billed by the Hospital.

The Cost-Sharing requirements in the Schedule of Benefits section of this Certificate apply to a continuous Hospital confinement, which is consecutive days of in-Hospital service received as an inpatient or successive confinements when discharge from and readmission to the Hospital occur within a period of not more than ninety (90) days for the same or related causes.

B. Observation Services.
We Cover observation services in a Hospital. Observation services are Hospital outpatient services provided to help a Physician decide whether to admit or discharge You. These services include use of a bed and periodic monitoring by nursing or other licensed staff.

C. Inpatient Medical Services.
We Cover medical visits by a Health Care Professional on any day of inpatient care Covered under this Certificate.

D. Inpatient Stay for Maternity Care.
We Cover inpatient maternity care in a Hospital for the mother, and inpatient newborn care in a Hospital for the infant, for at least forty-eight (48) hours following a normal delivery and at least ninety-six (96) hours following a caesarean section delivery, regardless of whether such care is Medically Necessary. The care provided shall include parent education, assistance, and training in breast or bottle-feeding, and the performance of any necessary maternal and newborn clinical assessments. We will also Cover any additional days of such care that We determine are Medically Necessary. In the event the mother elects to leave the Hospital and requests a home care visit before the end of the forty-eight (48)-hour or ninety-six (96)-hour minimum coverage period, We will Cover a home care visit. The home care visit will be provided within twenty-four (24) hours after the mother's discharge, or at the time of the mother's request, whichever is later. Our coverage of this home care visit shall be in addition to home health care visits under this Certificate and shall not be subject to any Cost-Sharing amounts in the Schedule of Benefits section of this Certificate that apply to home care benefits.

We also Cover the inpatient use of pasteurized donor human milk, which may include fortifiers as Medically Necessary, for which a Health Care Professional has issued an order for an infant who is medically or physically unable to receive maternal breast milk, participate in breast feeding, or whose mother is medically or physically unable to produce maternal breast milk at all or in sufficient quantities or participate in breast feeding despite optimal lactation support. Such infant must have a documented birth weight of less than one thousand five hundred (1,500) grams, or a congenital or acquired condition that places the infant at a high risk for development of necrotizing enterocolitis.

E. Inpatient Stay for Mastectomy Care.
We Cover inpatient services for Members undergoing a lymph node dissection, lumpectomy, mastectomy or partial mastectomy for the treatment of breast cancer and any physical complications arising from the mastectomy, including lymphedema, for a period of time determined to be medically appropriate by You and Your attending Physician.

F. Autologous Blood Banking Services.
We Cover autologous blood banking services only when they are being provided in connection with a scheduled, Covered inpatient procedure for the treatment of a disease or injury. In such instances, We Cover storage fees for a reasonable storage period that is appropriate for having the blood available when it is needed.

G. Habilitation Services.
We Cover inpatient Habilitation Services consisting of physical therapy, speech therapy and occupational therapy for thirty (30) days per Plan Year. The visit limit applies to all therapies combined.

H. Rehabilitation Services.
We Cover inpatient Rehabilitation Services consisting of physical therapy, speech therapy and occupational therapy for thirty (30) days per Plan Year. The visit limit applies to all therapies combined.

We Cover speech and physical therapy only when:
1. Such therapy is related to the treatment or diagnosis of Your illness or injury (in the case of a covered Child, this includes a medically diagnosed congenital defect); and

2. The therapy is ordered by a Physician.

Covered Rehabilitation Services must begin within six (6) months of the later to occur:
1. The date of the injury or illness that caused the need for the therapy;
2. The date You are discharged from a Hospital where surgical treatment was rendered; or
3. The date outpatient surgical care is rendered.

I. Skilled Nursing Facility.
We Cover services provided in a Skilled Nursing Facility, including care and treatment in a semi-private room, as described in "Hospital Services" above. Custodial, convalescent or domiciliary care is not Covered (see the Exclusions and Limitations section of this Certificate). An admission to a Skilled Nursing Facility must be supported by a treatment plan prepared by Your Provider and approved by Us. We Cover up to unlimited days per Plan Year for non-custodial care.

J. End of Life Care.
If You are diagnosed with advanced cancer and You have fewer than sixty (60) days to live, We will Cover Acute care provided in a licensed Article 28 Facility or Acute care Facility that specializes in the care of terminally ill patients. Your attending Physician and the Facility's medical director must agree that Your care will be appropriately provided at the Facility. If We disagree with Your admission to the Facility, We have the right to initiate an expedited external appeal to an External Appeal Agent. We will Cover and reimburse the Facility for Your care, subject to any applicable limitations in this Certificate until the External Appeal Agent renders a decision in Our favor.

We will reimburse Non-Participating Providers for this end of life care as follows:
1. We will reimburse a rate that has been negotiated between Us and the Provider.
2. If there is no negotiated rate, We will reimburse Acute care at the Facility's current Medicare Acute care rate.
3. If it is an alternate level of care, We will reimburse at 75% of the appropriate Medicare Acute care rate.

K. Centers of Excellence.
Centers of Excellence are Hospitals that We have approved and designated for certain services. We Cover a range of services when performed at Centers of Excellence.

Our network of facilities includes designated Centers of Excellence. We closely monitor the quality of Our provider network, assuring a high level of board certification. In addition, EmblemHealth looks to contract with providers who have achieved National Committee for Quality Assurance ("NCQA") medical home designation, offer electronic medical records, and facilities that have been designated as a Center of Excellence by the Centers for Medicare and Medicaid Services ("CMS").

We provide case management for Members undergoing transplants and for those awaiting organ transplant, Members are listed in a minimum of two regions. Through Our vendor relationships for in-network access to designated transplant centers, We provide Members access to a nationally recognized network of transplant providers for the following services:

- Bone marrow transplant
- Heart transplant

- Liver transplant
- Lung transplant
- Pancreas transplant
- Kidney transplant
- Bone marrow/stem cell transplant

We also provide Members a link to the CMS designated Centers of Excellence for Obesity on Our website and encourage Members to access services through these centers for gastric bypass surgery and pre- and post-surgery support.

L. Limitations/Terms of Coverage.

1. When You are receiving inpatient care in a Facility, We will not Cover additional charges for special duty nurses, charges for private rooms (unless a private room is Medically Necessary), or medications and supplies You take home from the Facility. If You occupy a private room, and the private room is not Medically Necessary, Our coverage will be based on the Facility's maximum semi-private room charge. You will have to pay the difference between that charge and the private room charge.
2. We do not Cover radio, telephone or television expenses, or beauty or barber services.
3. We do not Cover any charges incurred after the day We advise You it is no longer Medically Necessary for You to receive inpatient care, unless Our denial is overturned by an External Appeal Agent.

Section XII

Mental Health Care and Substance Use Services

Please refer to the Schedule of Benefits section of this Certificate for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits which are no more restrictive than those that apply to medical and surgical benefits in accordance with the federal Mental Health Parity and Addiction Equity Act of 2008.

A. Mental Health Care Services. We Cover the following mental health care services to treat a mental health condition. For purposes of this benefit, "mental health condition" means any mental health disorder as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.

1. **Inpatient Services.** We Cover inpatient mental health care services relating to the diagnosis and treatment of mental health conditions comparable to other similar Hospital, medical and surgical coverage provided under this Certificate. Coverage for inpatient services for mental health care is limited to Facilities defined in New York Mental Hygiene Law Section 1.03(10), such as:
    - A psychiatric center or inpatient Facility under the jurisdiction of the New York State Office of Mental Health;
    - A state or local government run psychiatric inpatient Facility;
    - A part of a Hospital providing inpatient mental health care services under an operating certificate issued by the New York State Commissioner of Mental Health;
    - A comprehensive psychiatric emergency program or other Facility providing inpatient mental health care that has been issued an operating certificate by the New York State Commissioner of Mental Health;

    and, in other states, to similarly licensed or certified Facilities. In the absence of a similarly licensed or certified Facility, the Facility must be accredited by the Joint Commission on Accreditation of Health Care Organizations or a national accreditation organization recognized by Us.

    We also Cover inpatient mental health care services relating to the diagnosis and treatment of mental health conditions received at Facilities that provide residential treatment, including room and board charges. Coverage for residential treatment services is limited to Facilities defined in New York Mental Hygiene Law Section 1.03(33) and to residential treatment facilities that are part of a comprehensive care center for eating disorders identified pursuant to Article 27-J of the New York Public Health Law; and, in other states, to Facilities that are licensed or certified to provide the same level of treatment. In the absence of a licensed or certified Facility that provides the same level of treatment, the Facility must be accredited by the Joint Commission on Accreditation of Health Care Organizations or a national accreditation organization recognized by Us.

2. **Outpatient Services.** We Cover outpatient mental health care services, including but not limited to partial hospitalization program services and intensive outpatient program services, relating to the diagnosis and treatment of mental health conditions. Coverage for outpatient services for

mental health care includes Facilities that have been issued an operating certificate pursuant to Article 31 of the New York Mental Hygiene Law or are operated by the New York State Office of Mental Health and, in other states, to similarly licensed or certified Facilities; and services provided by a licensed psychiatrist or psychologist; a licensed clinical social worker; a nurse practitioner; a licensed mental health counselor; a licensed marriage and family therapist; a licensed psychoanalyst; or a professional corporation or a university faculty practice corporation thereof. In the absence of a similarly licensed or certified Facility, the Facility must be accredited by the Joint Commission on Accreditation of Health Care Organizations or a national accreditation organization recognized by Us.

B. Substance Use Services. We Cover the following substance use services to treat a substance use disorder. For purposes of this benefit, "substance use disorder" means any substance use disorder as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.

1. **Inpatient Services.** We Cover inpatient substance use services relating to the diagnosis and treatment of substance use disorders. This includes coverage for detoxification and rehabilitation services for substance use disorders. Inpatient substance use services are limited to Facilities in New York State which are licensed, certified or otherwise authorized by the Office of Alcoholism and Substance Abuse Services ("OASAS"); and, in other states, to those Facilities that are licensed, certified or otherwise authorized by a similar state agency and accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs.

   We also Cover inpatient substance use services relating to the diagnosis and treatment of substance use disorders received at Facilities that provide residential treatment, including room and board charges. Coverage for residential treatment services is limited to Facilities that are licensed, certified or otherwise authorized by OASAS; and, in other states, to those Facilities that are licensed, certified or otherwise authorized by a similar state agency and accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs to provide the same level of treatment.

2. **Outpatient Services.** We Cover outpatient substance use services relating to the diagnosis and treatment of substance use disorders, including but not limited to partial hospitalization program services, intensive outpatient program services, counseling, and medication-assisted treatment. Such coverage is limited to Facilities in New York State that are licensed, certified or otherwise authorized by OASAS to provide outpatient substance use disorder services and, in other states, to those that are licensed, certified or otherwise authorized by a similar state agency and accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs. Coverage in an OASAS-certified Facility includes services relating to the diagnosis and treatment of a substance use disorder provided by an OASAS credentialed Provider. Coverage is also available in a professional office setting for outpatient substance use disorder services relating to the diagnosis and treatment of alcoholism, substance use and dependency or by Physicians who have been granted a waiver pursuant to the federal Drug Addiction Treatment Act of 2000 to prescribe Schedule III, IV and V narcotic medications for the treatment of opioid addiction during the Acute detoxification stage of treatment or during stages of rehabilitation.

Additional Family Counseling. We also Cover outpatient visits per Plan Year for family counseling. A family member will be deemed to be covered, for the purposes of this provision, so long as that family member: 1) identifies himself or herself as a family member of a person suffering from a substance use disorder; and 2) is covered under the same family Certificate that covers the person receiving, or in need of, treatment for a substance use disorder. Our payment for a family member therapy session will be the same amount, regardless of the number of family members who attend the family therapy session.

Section XIII

Prescription Drug Coverage

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

A. Covered Prescription Drugs.
We Cover Medically Necessary Prescription Drugs that, except as specifically provided otherwise, can be dispensed only pursuant to a prescription and are:

- Required by law to bear the legend "Caution – Federal Law prohibits dispensing without a prescription";
- FDA approved;
- Ordered by a Provider authorized to prescribe and within the Provider's scope of practice;
- Prescribed within the approved FDA administration and dosing guidelines;
- On Our Formulary; and
- Dispensed by a licensed pharmacy.

Covered Prescription Drugs include, but are not limited to:

- Self-injectable/administered Prescription Drugs.
- Inhalers (with spacers).
- Topical dental preparations.
- Pre-natal vitamins, vitamins with fluoride, and single entity vitamins.
- Osteoporosis drugs and devices approved by the FDA, or generic equivalents as approved substitutes, for the treatment of osteoporosis and consistent with the criteria of the federal Medicare program or the National Institutes of Health.
- Nutritional formulas for the treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria.
- Prescription or non-prescription enteral formulas for home use, whether administered orally or via tube feeding, for which a Physician or other licensed Provider has issued a written order. The written order must state that the enteral formula is Medically Necessary and has been proven effective as a disease-specific treatment regimen. Specific diseases and disorders include but are not limited to: inherited diseases of amino acid or organic acid metabolism; Crohn's disease; gastroesophageal reflux; gastroesophageal motility such as chronic intestinal pseudo-obstruction; and multiple severe food allergies. Multiple food allergies include, but are not limited to: immunoglobulin E and nonimmunoglobulin E-mediated allergies to multiple food proteins; severe food protein induced enterocolitis syndrome; eosinophilic disorders and impaired absorption of nutrients caused by disorders affecting the absorptive surface, function, length, and motility of the gastrointestinal tract.
- Modified solid food products that are low in protein, contain modified protein, or are amino acid based to treat certain inherited diseases of amino acid and organic acid metabolism and severe protein allergic conditions.
- Prescription Drugs prescribed in conjunction with treatment or services Covered under the infertility treatment benefit in the Outpatient and Professional Services section of this Certificate.

- Off-label cancer drugs, so long as the Prescription Drug is recognized for the treatment of the specific type of cancer for which it has been prescribed in one (1) of the following reference compendia: the American Hospital Formulary Service-Drug Information; National Comprehensive Cancer Networks Drugs and Biologics Compendium; Thomson Micromedex DrugDex; Elsevier Gold Standard's Clinical Pharmacology; or other authoritative compendia as identified by the Federal Secretary of Health and Human Services or the Centers for Medicare and Medicaid Services; or recommended by review article or editorial comment in a major peer reviewed professional journal.
- Orally administered anticancer medication used to kill or slow the growth of cancerous cells.
- Smoking cessation drugs, including over-the-counter drugs for which there is a written order and Prescription Drugs prescribed by a Provider.
- Prescription Drugs for the treatment of mental health and substance use disorders, including drugs for detoxification, maintenance and overdose reversal.
- Contraceptive drugs, devices and other products, including over-the-counter contraceptive drugs, devices and other products, approved by the FDA and as prescribed or otherwise authorized under State or Federal law. "Over-the-counter contraceptive products" means those products provided for in comprehensive guidelines supported by HRSA. Coverage also includes emergency contraception when provided pursuant to a prescription or order or when lawfully provided over-the-counter. You may request coverage for an alternative version of a contraceptive drug, device and other product if the Covered contraceptive drug, device and other product is not available or is deemed medically inadvisable, as determined by Your attending Health Care Provider.

You may request a copy of Our Formulary. Our Formulary is also available on Our website at www.emblemhealth.com. You may inquire if a specific drug is Covered under this Certificate by contacting Us at 1-855-283-2150.

B. Refills.

We Cover Refills of Prescription Drugs only when dispensed at a retail, mail order or Designated Pharmacy as ordered by an authorized Provider. Benefits for Refills will not be provided beyond one (1) year from the original prescription date. For prescription eye drop medication, We allow for the limited refilling of the prescription prior to the last day of the approved dosage period without regard to any coverage restrictions on early Refill of renewals. To the extent practicable, the quantity of eye drops in the early Refill will be limited to the amount remaining on the dosage that was initially dispensed. Your Cost-Sharing for the limited Refill is the amount that applies to each prescription or Refill as set forth in the Schedule of Benefits section of this Certificate.

C. Benefit and Payment Information.

1. **Cost-Sharing Expenses.** You are responsible for paying the costs outlined in the Schedule of Benefits section of this Certificate when Covered Prescription Drugs are obtained from a retail, mail order or Designated Pharmacy.

   You have a two (2) tier plan design, which means that You will have lower out-of-pocket expenses for tier 1 drugs and higher out-of-pocket expenses for tier 2 drugs.

   For most Prescription Drugs, You pay only the Cost-Sharing in the Schedule of Benefits. An

additional charge, called an "ancillary charge," may apply to some Prescription Drugs when a Prescription Drug on a higher tier is dispensed at Your or Your Provider's request and Our Formulary includes a chemically equivalent Prescription Drug on a lower tier. You will pay the difference between the full cost of the Prescription Drug on the higher tier and the cost of the Prescription Drug on the lower tier. The cost difference is not Covered and must be paid by You in addition to the lower tier Cost-Sharing. If Your Provider thinks that a chemically equivalent Prescription Drug on a lower tier is not clinically appropriate, You, Your designee or Your Provider may request that We approve coverage at the higher tier Cost-Sharing. If approved, You will pay the higher tier Cost-Sharing only. If We do not approve coverage at the higher tier Cost-Sharing, You are entitled to an Appeal as outlined in the Utilization Review and External Appeal sections of this Certificate. The request for an approval should include a statement from Your Provider that the Prescription Drug at the lower tier is not clinically appropriate (e.g., it will be or has been ineffective or would have adverse effects.) We may also request clinical documentation to support this statement. If We do not approve coverage for the Prescription Drug on the higher tier, the ancillary charge will not apply toward Your Out-of-Pocket Limit.

You are responsible for paying the full cost (the amount the pharmacy charges You) for any non-Covered Prescription Drug, and Our contracted rates (Our Prescription Drug Cost) will not be available to You.

2. **Participating Pharmacies.** For Prescription Drugs purchased at a retail, mail order or Designated Participating Pharmacy, You are responsible for paying the lower of:
   - The applicable Cost-Sharing; or
   - The Prescription Drug Cost for that Prescription Drug.

   (Your Cost-Sharing will never exceed the Usual and Customary Charge of the Prescription Drug.)

   In the event that Our Participating Pharmacies are unable to provide the Covered Prescription Drug, and cannot order the Prescription Drug within a reasonable time, You may, with Our prior written approval, go to a Non-Participating Pharmacy that is able to provide the Prescription Drug. We will pay You the Prescription Drug Cost for such approved Prescription Drug less Your required in-network Cost-Sharing upon receipt of a complete Prescription Drug claim form. Contact Us at 1-855-283-2150 or visit Our website at www.emblemhealth.com to request approval.

3. **Non-Participating Pharmacies.** We will not pay for any Prescription Drugs that You purchase at a Non-Participating retail or mail order Pharmacy other than as described above.

4. **Designated Pharmacies.** If You require certain Prescription Drugs including, but not limited to specialty Prescription Drugs, We may direct You to a Designated Pharmacy with whom We have an arrangement to provide those Prescription Drugs.

   Generally, specialty Prescription Drugs are Prescription Drugs that are more complex to administer and monitor in comparison to traditional drugs and are approved to treat limited patient populations or conditions; are normally injected, infused or require close monitoring by a Provider; involves special storage, handling and/or administration; entails a narrow therapeutic

range; or have limited availability, special dispensing and delivery requirements and/or require additional patient supports.

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

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

- Anti-Emetics;
- Biologics;
- Biosimilars;
- Bisphosphonates;
- Contraceptives;
- Cardiovascular;
- CSF;
- Cystic fibrosis;
- ESA;
- Fertility;
- Gaucher's disease;
- Growth hormone;
- Hemophilia;
- Hepatitis medications;
- Hereditary angioedema;
- HIV/AIDS;
- Immunomodulators;
- Intravitreal injections;
- Iron overload;
- Iron toxicity;
- IVIG;
- Multiple sclerosis;
- Neuromuscular blockers;
- Oncology medication;
- Orphan drugs;
- Osteoarthritis;
- Pulmonary arterial hypertension;
- RSV prevention;
- Transplant;
- Vaccines.

5. **Designated Retail Pharmacy for Maintenance Drugs.** You may also fill Your Prescription Order for Maintenance Drugs for up to a ninety (90)-day supply at a Designated retail Pharmacy. See the Supply Limits paragraph below for information regarding supply limits for contraceptive drugs and devices. You are responsible for paying the lower of:
    - The applicable Cost-Sharing; or
    - The Prescription Drug Cost for that Prescription Drug.

(Your Cost-Sharing will never exceed the Usual and Customary Charge of the Prescription Drug.)

To maximize Your benefit, ask Your Provider to write Your Prescription Order or Refill for a ninety (90)-day supply, with Refills when appropriate (not a thirty (30)-day supply with three (3) Refills).

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

- Asthma;
- Behavioral Health;
- Blood pressure;
- Contraceptives;
- Diabetes;
- High cholesterol.

You or Your Provider may obtain a copy of the list of Prescription Drugs available through a Designated retail Pharmacy by visiting Our website at www.emblemhealth.com or by calling 1-855-283-2150. The Maintenance Drug list is updated periodically. Visit Our website at www.emblemhealth.com or call 1-855-283-2150 to find out if a particular Prescription Drug is on the maintenance list.

6. **Mail Order.** Certain Prescription Drugs may be ordered through Our mail order pharmacy. You are responsible for paying the lower of:
   - The applicable Cost-Sharing; or
   - The Prescription Drug Cost for that Prescription Drug.

   (Your Cost-Sharing will never exceed the Usual and Customary Charge of the Prescription Drug.)

   To maximize Your benefit, ask Your Provider to write Your Prescription Order or Refill for a ninety (90)-day supply, with Refills when appropriate (not a thirty (30)-day supply with three (3) Refills). You will be charged the mail order Cost-Sharing for any Prescription Orders or Refills sent to the mail order pharmacy regardless of the number of days supply written on the Prescription Order or Refill.

   Prescription Drugs purchased through mail order will be delivered directly to Your home or office.

   We will provide benefits that apply to drugs dispensed by a mail order pharmacy to drugs that are purchased from a retail pharmacy when that retail pharmacy has a participation agreement with Us or Our vendor in which it agrees to be bound by the same terms and conditions as a participating mail order pharmacy.

   You or Your Provider may obtain a copy of the list of Prescription Drugs available through mail order by visiting Our website at www.emblemhealth.com or by calling 1-855-283-2150.

7. **Tier Status.** The tier status of a Prescription Drug may change periodically, but no more than four (4) times per calendar year, or when a Brand-Name Drug becomes available as a Generic Drug as described below, based on Our tiering decisions. These changes may occur without prior notice to You. However, if You have a prescription for a drug that is being moved to a higher tier or is being removed from Our Formulary, We will notify You at least thirty (30) days before the change is effective. When such changes occur, Your Cost-Sharing may change. You may also request a Formulary exception for a Prescription Drug that is no longer on the Formulary as outlined below and in the External Appeal section of this Certificate. You may access the most up to date tier status on Our website at www.emblemhealth.com or by calling 1-855-283-2150.

8. **When a Brand-Name Drug Becomes Available as a Generic Drug.** When a Brand-Name Drug becomes available as a Generic Drug, the tier placement of the Brand-Name Prescription Drug may change. If this happens, You will pay the Cost-Sharing applicable to the tier to which the Prescription Drug is assigned or the Brand-Name Drug will be removed from the Formulary and You no longer have benefits for that particular Brand-Name Drug. Please note, if You are taking a Brand-Name Drug that is being excluded or placed on a higher tier due to a Generic Drug becoming available, You will receive thirty (30) days' advance written notice of the change before it is effective. You may request a Formulary exception for a Prescription Drug that is no longer on the Formulary as outlined below and in the External Appeal section of this Certificate.

9. **Formulary Exception Process.** If a Prescription Drug is not on Our Formulary, You, Your designee or Your prescribing Health Care Professional may request a Formulary exception for a clinically-appropriate Prescription Drug in writing, electronically or telephonically. The request should include a statement from Your prescribing Health Care Professional that all Formulary drugs will be or have been ineffective, would not be as effective as the non-Formulary drug, or would have adverse effects. If coverage is denied under Our standard or expedited Formulary exception process, You are entitled to an external appeal as outlined in the External Appeal section of this Certificate. Visit Our website at www.emblemhealth.com or call 1-855-283-2150 to find out more about this process.

   Standard Review of a Formulary Exception. We will make a decision and notify You or Your designee and the prescribing Health Care Professional by telephone no later than seventy-two (72) hours after Our receipt of Your request. We will notify You in writing within three (3) business days of receipt of Your request. If We approve the request, We will Cover the Prescription Drug while You are taking the Prescription Drug, including any refills.

   Expedited Review of a Formulary Exception. If You are suffering from a health condition that may seriously jeopardize Your health, life or ability to regain maximum function or if You are undergoing a current course of treatment using a non-Formulary Prescription Drug, You may request an expedited review of a Formulary exception. The request should include a statement from Your prescribing Health Care Professional that harm could reasonably come to You if the requested drug is not provided within the timeframes for Our standard Formulary exception process. We will make a decision and notify You or Your designee and the prescribing Health Care Professional by telephone no later than twenty-four (24) hours after Our receipt of Your request. We will notify You in writing within three (3) business days of receipt of Your request. If We approve the request, We will Cover the Prescription Drug while You suffer from the

health condition that may seriously jeopardize Your health, life or ability to regain maximum function or for the duration of Your current course of treatment using the non-Formulary Prescription Drug.

10. **Supply Limits.** Except for contraceptive drugs, devices, or products, We will pay for no more than a ninety (90)-day supply of a Prescription Drug purchased at a retail pharmacy. You are responsible for one (1) Cost-Sharing amount for up to a thirty (30)-day supply. However, for Maintenance Drugs We will pay for up to a ninety (90)-day supply of a drug purchased at a retail pharmacy. You are responsible for up to three (3) Cost-Sharing amounts for a ninety (90)-day supply at a retail pharmacy.

    You may have the entire supply (of up to twelve (12) months) of the contraceptive drug, device, or product dispensed at the same time. Contraceptive drugs, devices, or products are not subject to Cost-Sharing when provided by a Participating Pharmacy.

    Benefits will be provided for Prescription Drugs dispensed by a mail order pharmacy in a quantity of up to a ninety (90)-day supply. You are responsible for one (1) Cost-Sharing amount for a thirty (30)-day supply up to a maximum of three (3) Cost-Sharing amounts for a ninety (90)-day supply.

    Some Prescription Drugs may be subject to quantity limits based on criteria that We have developed, subject to Our periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply. You can determine whether a Prescription Drug has been assigned a maximum quantity level for dispensing by accessing Our website at www.emblemhealth.com or by calling 1-855-283-2150. If We deny a request to Cover an amount that exceeds Our quantity level, You are entitled to an Appeal pursuant to the Utilization Review and External Appeal sections of this Certificate.

11. **Initial Limited Supply of Prescription Opioid Drugs.** If You receive an initial limited prescription for a seven (7) day supply or less of any schedule II, III, or IV opioid prescribed for Acute pain, and You have a Copayment, Your Copayment will be the same Copayment that would apply to a thirty (30)-day supply of the Prescription Drug. If You receive an additional supply of the Prescription Drug within the same thirty (30)-day period in which You received the seven (7) day supply, You will not be responsible for an additional Copayment for the remaining thirty (30)-day supply of that Prescription Drug.

12. **Cost-Sharing for Orally-Administered Anti-Cancer Drugs.** Your Cost-Sharing for orally-administered anti-cancer drugs is at least as favorable to You as the Cost-Sharing amount, if any, that applies to intravenous or injected anti-cancer medications Covered under the Outpatient and Professional Services section of this Certificate.

13. **Split Fill Dispensing Program.** The split fill dispensing program is designed to prevent wasted Prescription Drugs if Your Prescription Drug or dose changes or if We contact You and You confirm that You have leftover Prescription Drugs from a previous fill. The Prescription Drugs that are included under this program have been identified as requiring more frequent follow up to monitor response to treatment and reactions. You will initially get a fifteen (15)-day supply of Your Prescription Order for certain drugs filled at a pharmacy instead of the full Prescription

Order. You initially pay half the thirty (30)-day Cost-Sharing. The therapeutic classes of Prescription Drugs that are included in this program are: Antivirals/Anti-infectives, Multiple Sclerosis, and Oncology. This program applies for the first sixty (60) days when You start a new Prescription Drug. This program will not apply upon You or Your Provider's request. You or Your Provider can opt out by visiting Our website at www.emblemhealth.com or by calling 1-855-283-2150.

D. Medical Management.

This Certificate includes certain features to determine when Prescription Drugs should be Covered, which are described below. As part of these features, Your prescribing Provider may be asked to give more details before We can decide if the Prescription Drug is Medically Necessary.

1. **Preauthorization.** Preauthorization may be needed for certain Prescription Drugs to make sure proper use and guidelines for Prescription Drug coverage are followed. When appropriate, Your Provider will be responsible for obtaining Preauthorization for the Prescription Drug. Preauthorization is not required for Covered medications to treat a substance use disorder, including opioid overdose reversal medications prescribed or dispensed to You.

   Preauthorization and utilization review is required to obtain certain Prescription Drugs, which include migraine medications, anti-nausea medications, anti-fungal agents, anti-inflammatory agents, appetite suppressants, asthma/COPD medications, smoking deterrents, eczema medications, vitamin A-based medications for treatment of cystic acne and other drugs and drug classes listed in this section.

   If Your prescription is for a drug that is subject to Preauthorization, Your physician should contact EmblemHealth's Pharmacy Benefits Services Department (PBSD). Our PBSD staff and Your physician will decide, based upon Our clinical guidelines, whether the prescription is Medically Necessary for Your treatment or condition. Our PBSD staff and Your physician will also decide, based upon the guidelines, whether the quantity or duration of the prescription is medically appropriate. Our PBSD staff will then notify You and Your physician of its decision(s).

   If the prescription request is approved, then the pharmacist will fill Your prescription and We will cover the prescription. If the prescription request is not approved, then We will not cover the prescription. If the prescription request is approved, but at a reduced quantity or duration, then We will cover only the reduced quantity or duration of the drug.

   Our PBSD staff will make its decision(s) in the time periods and in accordance with the other requirements that apply to utilization review decisions. If You disagree with the PBSD staff's decision(s), You may file an appeal. (Please refer to the section entitled Utilization Review of this Certificate for information about timeframes and how to file an appeal).

   The individual prescription drugs listed below require Preauthorization. The drug list below shows each drug by its brand name and generic name.

   - Enbrel / etanercept
   - Humira / adalimumab

- Kineret / anakinra
- Provigil / modafinil
- Regranex / becaplermin
- Zyvox / linezolid
- Tazorac / tazarotene
- Lidoderm / lidocaine patch
- Orencia / abatacept
- Sutent / sunitinib malate
- Nexavar / sorafenib tosylate
- Xeloda / capecitabine

Prescription Drugs in the drug classes listed below are also subject to Preauthorization. Examples of common drugs in the class are listed with each class.

- **Anti-Nausea Medications**, such as: Anzemet and Zofran.

- **Anti-Depressant Medications**, such as: Prozac; Paxil/Paxil CR; Celexa; Lexpro; Sarafem; Fluvoxamine ER, Pexeva; Zoloft; Effexor/Effexor XR; and Cymbalta.

- **Anti-Fungal Agents**, such as: Diflucan; Lamisil; Sporanox; and Vfend.

- **Anti-inflammatory Agents**, such as: Ponstel; Arthrotec; and Mobic.

- **Appetite Suppressants**, such as: Xenical; Benzphetamine hydrochloride; and Phentermine hydrochloride.

- **Blood Pressure Medications**, such as: Lotensin; Vasotec; Prinivil; Accupril; Altace; Vaseretic; Prinzide, Zestoretic; Lotrel; Avapro; Cozaar; Diovan HCT; Avalide; and Hyzaar.

- **Cholesterol Lowering Medications**, such as: Mevacor; Zocor; Lipitor; Crestor; and Lescol.

- **Diabetic Medications**, such as: Trulicity; Tradjenta; Jentadueto/Jentadueto XR; Steglatro; Steglujan; Segluromet; Alogliptin; Alogliptin-metformin; Alogliptin-pioglitazone; Nesina; Kazano; and Oseni.

- **Eczema Medications**, such as: Elidel; and Protopic.

- **Fertility Medications**, such as: Clomiphene citrate; Leuprolide 2-wk kit; Gonal F; Chorionic gonadotropin; Follistim AQ; Ovidrel; Novarel; Pregnyl; Ganirelix; Bravelle; Menopur; and Cetrotide.

- **GI Medications that Block Acid Secretion**, such as: Prevacid; Prilosec; Nexium; Protonix; and Aciphex.

- **Growth Hormones**, such as: Norditropin; Genotropin; Humatrope; Nutropin; and Serostim.

- **Hepatitis C Medications**, such as: Pegasys; Peg-Intron; Daklinza; Harvoni; Epclusa; Vosevi; Zepatier; Sovaldi; Viekira Pak; Mavyret; and Ribavirin.

- **Leukotriene Blocker Asthma Medications**, such as: Singulair; and Accolate.

- **Migraine Medications**, such as: Imitrex; Axert; Relpax; Maxalt; and Zomig.

- **Narcotics/Opiods**, such as: Fentora; Opana; Opana ER; OxyContin; Kadian; Exalgo; Avinza; and Actiq.

- **Osteo-Arthritis/Anti-Inflammatory Medication**, such as: Celebrex.

- **Vitamin A Based Medications for Treatment of Cystic Acne**, such as: Retin-A; Retin-A micro; and Avita.

For a list of Prescription Drugs that need Preauthorization, please visit Our website at www.emblemhealth.com or call 1-855-283-2150. The list will be reviewed and updated from time to time. We also reserve the right to require Preauthorization for any new Prescription Drug on the market or for any currently available Prescription Drug which undergoes a change in prescribing protocols and/or indications regardless of the therapeutic classification, including if a Prescription Drug or related item on the list is not Covered under Your Certificate. Your Provider may check with Us to find out which Prescription Drugs are Covered.

2. **Step Therapy.** Step therapy is a process in which You may need to use one (1) or more types of Prescription Drugs before We will Cover another as Medically Necessary. A "step therapy protocol" means Our policy, protocol or program that establishes the sequence in which We approve Prescription Drugs for Your medical condition. When establishing a step therapy protocol, We will use recognized evidence-based and peer reviewed clinical review criteria that also takes into account the needs of atypical patient populations and diagnoses. We check certain Prescription Drugs to make sure that proper prescribing guidelines are followed. These guidelines help You get high quality and cost-effective Prescription Drugs. The Prescription Drugs that require Preauthorization under the step therapy program are also included on the Preauthorization drug list. If a step therapy protocol is applicable to Your request for coverage of a Prescription Drug, You, Your designee, or Your Health Care Professional can request a step therapy override determination as outlined in the Utilization Review section of this Certificate.

E. Limitations/Terms of Coverage.

1. We reserve the right to limit quantities, day supply, early Refill access and/or duration of therapy for certain medications based on Medical Necessity including acceptable medical standards and/or FDA recommended guidelines.

2. If We determine that You may be using a Prescription Drug in a harmful or abusive manner, or with harmful frequency, Your selection of Participating Pharmacies may be limited. If this happens, We may require You to select a single Participating Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if You use the selected single

Participating Pharmacy. If You do not make a selection within thirty-one (31) days of the date We notify You, We will select a single Participating Pharmacy for You.

3. Compounded Prescription Drugs will be Covered only when the primary ingredient is a Covered legend Prescription Drug, they are not essentially the same as a Prescription Drug from a manufacturer and are obtained from a pharmacy that is approved for compounding. All compounded Prescription Drugs require Your Provider to obtain Preauthorization.

4. Various specific and/or generalized "use management" protocols will be used from time to time in order to ensure appropriate utilization of medications. Such protocols will be consistent with standard medical/drug treatment guidelines. The primary goal of the protocols is to provide Our Members with a quality-focused Prescription Drug benefit. In the event a use management protocol is implemented, and You are taking the drug(s) affected by the protocol, You will be notified in advance.

5. Injectable drugs (other than self-administered injectable drugs) and diabetic insulin, oral hypoglycemics, and diabetic supplies and equipment are not Covered under this section but are Covered under other sections of this Certificate.

6. We do not Cover charges for the administration or injection of any Prescription Drug. Prescription Drugs given or administered in a Physician's office are Covered under the Outpatient and Professional Services section of this Certificate.

7. We do not Cover drugs that do not by law require a prescription, except for smoking cessation drugs, over-the-counter preventive drugs or devices provided in accordance with the comprehensive guidelines supported by HRSA or with an "A" or "B" rating from USPSTF, or as otherwise provided in this Certificate. We do not Cover Prescription Drugs that have over-the-counter non-prescription equivalents, except if specifically designated as Covered in the drug Formulary. Non-prescription equivalents are drugs available without a prescription that have the same name/chemical entity as their prescription counterparts. We do not Cover repackaged products such as therapeutic kits or convenience packs that contain a Covered Prescription Drug unless the Prescription Drug is only available as part of a therapeutic kit or convenience pack. Therapeutic kits or convenience packs contain one (1) or more Prescription Drug(s) and may be packaged with over-the-counter items, such as gloves, finger cots, hygienic wipes or topical emollients.

8. We do not Cover Prescription Drugs to replace those that may have been lost or stolen.

9. We do not Cover Prescription Drugs dispensed to You while in a Hospital, nursing home, other institution, Facility, or if You are a home care patient, except in those cases where the basis of payment by or on behalf of You to the Hospital, nursing home, Home Health Agency or home care services agency, or other institution, does not include services for drugs.

10. We reserve the right to deny benefits as not Medically Necessary or experimental or investigational for any drug prescribed or dispensed in a manner contrary to standard medical practice. If coverage is denied, You are entitled to an Appeal as described in the Utilization Review and External Appeal sections of this Certificate.

11. A pharmacy need not dispense a Prescription Order that, in the pharmacist's professional judgment, should not be filled.

F. General Conditions.

1. You must show Your ID card to a retail pharmacy at the time You obtain Your Prescription Drug or You must provide the pharmacy with identifying information that can be verified by Us during regular business hours. You must include Your identification number on the forms provided by the mail order pharmacy from which You make a purchase.

2. Drug Utilization, Cost Management and Rebates. We conduct various utilization management activities designed to ensure appropriate Prescription Drug usage, to avoid inappropriate usage, and to encourage the use of cost-effective drugs. Through these efforts, You benefit by obtaining appropriate Prescription Drugs in a cost-effective manner. The cost savings resulting from these activities are reflected in the Premiums for Your coverage.

We may also, from time to time, enter into agreements that result in Us receiving rebates or other funds ("rebates") directly or indirectly from Prescription Drug manufacturers, Prescription Drug distributors or others. Any rebates are based upon utilization of Prescription Drugs across all of Our business and not solely on any one Member's utilization of Prescription Drugs. Any rebates received by Us may or may not be applied, in whole or part, to reduce premiums either through an adjustment to claims costs or as an adjustment to the administrative expenses component of Our Prescription Drug premiums. Any such rebates may be retained by Us, in whole or part, in order to fund such activities as new utilization management activities, community benefit activities and increasing reserves for the protection of Members. Rebates will not change or reduce the amount of any Copayment or Coinsurance applicable under Our Prescription Drug coverage.

G. Definitions.

Terms used in this section are defined as follows. (Other defined terms can be found in the Definitions section of this Certificate).

1. Brand-Name Drug: A Prescription Drug that: 1) is manufactured and marketed under a trademark or name by a specific drug manufacturer; or 2) We identify as a Brand-Name Prescription Drug, based on available data resources. All Prescription Drugs identified as "brand name" by the manufacturer, pharmacy, or Your Physician may not be classified as a Brand-Name Drug by Us.

2. Designated Pharmacy: A pharmacy that has entered into an agreement with Us or with an organization contracting on Our behalf, to provide specific Prescription Drugs, including but not limited to, specialty Prescription Drugs. The fact that a pharmacy is a Participating Pharmacy does not mean that it is a Designated Pharmacy.

3. Formulary: The list that identifies those Prescription Drugs for which coverage may be available under this Certificate. This list is subject to Our periodic review and modification (no more than four (4) times per calendar year or when a Brand-Name Drug becomes available as a

Generic Drug). To determine which tier a particular Prescription Drug has been assigned, visit Our website at www.emblemhealth.com or call 1-855-283-2150.

4. **Generic Drug:** A Prescription Drug that: 1) is chemically equivalent to a Brand-Name Drug; or 2) We identify as a Generic Prescription Drug based on available data resources. All Prescription Drugs identified as "generic" by the manufacturer, pharmacy or Your Physician may not be classified as a Generic Drug by Us.

5. **Maintenance Drug:** A Prescription Drug used to treat a condition that is considered chronic or long-term and which usually requires daily use of Prescription Drugs.

6. **Non-Participating Pharmacy:** A pharmacy that has not entered into an agreement with Us to provide Prescription Drugs to Members. We will not make any payment for prescriptions or Refills filled at a Non-Participating Pharmacy other than as described above.

7. **Participating Pharmacy:** A pharmacy that has:
   - Entered into an agreement with Us or Our designee to provide Prescription Drugs to Members;
   - Agreed to accept specified reimbursement rates for dispensing Prescription Drugs; and
   - Been designated by Us as a Participating Pharmacy.

   A Participating Pharmacy can be either a retail or mail-order pharmacy.

8. **Prescription Drug:** A medication, product or device that has been approved by the FDA and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill and is on Our Formulary. A Prescription Drug includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver.

9. **Prescription Drug Cost:** The amount, including a dispensing fee and any sales tax, We have agreed to pay Our Participating Pharmacies for a Covered Prescription Drug dispensed at a Participating Pharmacy. If Your Certificate includes coverage at Non-Participating Pharmacies, the Prescription Drug Cost for a Prescription Drug dispensed at a Non-Participating Pharmacy is calculated using the Prescription Drug Cost that applies for that particular Prescription Drug at most Participating Pharmacies.

10. **Prescription Order or Refill:** The directive to dispense a Prescription Drug issued by a duly licensed Health Care Professional who is acting within the scope of his or her practice.

11. **Usual and Customary Charge:** The usual fee that a pharmacy charges individuals for a Prescription Drug without reference to reimbursement to the pharmacy by third parties as required by Section 6826-a of the New York Education Law.

Section XIV

Wellness Benefits

A. The ExerciseRewards™ Program.
The ExerciseRewards Program will reward the Subscriber and each covered Dependent for meeting the activity requirements at qualified fitness centers which maintain equipment and programs that promote cardiovascular wellness.

Activity in tennis clubs, country clubs, weight loss clinics, spas or any other similar facilities will not be eligible for rewards. Reward activity is limited to actual workout visits. We will not provide reimbursement for equipment, clothing, vitamins or other services that may be offered by the fitness center (e.g., massages, etc.).

In order to be eligible for Your reward, You must:
- Be an active member of the fitness center, and
- Work out at least fifty (50) times each six (6) month calendar year period.

You can track Your exercise in the following four (4) ways:
- The ExerciseRewards CheckIn!® app – an app to check in and out at thousands of fitness centers nationwide.
- The Active&Fit Direct™ Program – an optional program that provides discounts at thousands of participating fitness centers to eligible Members and will submit visits on Your behalf.
- Auto-Reporting – work out at participating fitness center that submit Your visits on Your behalf.
- Paper Log – track Your fitness center visits manually to earn rewards.

Subscribers are eligible to receive a $200 reward and covered Dependents are eligible to receive $100 each six (6) month calendar year period. Once ExerciseRewards receives confirmation of activity that meets the requirement of fifty (50) visits, You will receive an email to redeem Your reward. Rewards will be issued fourteen (14) days after You have redeemed Your reward on the ExerciseRewards website or forty-five (45) days from the end of Your reward period if You do not redeem Your reward. We encourage You to use the reward for a product or service that promotes good health, such as healthy cookbooks, over-the-counter vitamins or exercise equipment.

The ExerciseRewards and Active&Fit Direct programs are provided by American Specialty Health Fitness, Inc., a subsidiary of American Specialty Health Incorporated (ASH). ExerciseRewards, ExerciseRewards CheckIn! and Active&Fit Direct are trademarks of ASH and used with permission herein.

B. Wellness Program.

1. Purpose.
The purpose of this wellness program is to encourage You to take a more active role in managing Your health and well-being.

2. Description.
We provide benefits in connection with the use of or participation in any of the following wellness and health promotion actions and activities:

DISCOUNT PROGRAMS
The Healthy Discount programs are available to all EmblemHealth Members but are not a covered benefit under Your plan. The offerings include:

- **Acupuncture, Massage Therapy and Nutrition Counseling** — Members can save up to 25 percent on acupuncture, therapeutic massage and nutrition counseling. Call **1-877-327-2746** to get more information.
- **Jenny Craig** — Join Jenny Craig and receive a free three (3)-month program (food not included) with up to $120 in food savings (purchase required) or save 50% off our premium programs (food not included). Visit www.jennycraig.com/emblem for details. You can register at www.jennycraig.com/emblem to receive Your discount. Print Your personalized registration coupon. Call **1-877-JENNY70 (1-877-536-6970)** to speak to Your closest Jenny Craig Center or Jenny Craig anywhere. Please be sure to take Your registration coupon to Your free consultation and be sure to mention that You are an EmblemHealth member when getting started.
- **NutriSystem** — Members receive $30 off all Select, Basic, Silver, Diabetic and Vegetarian program orders, plus all the benefits found at www.nutrisystem.com. Members can sign up online at www.nutrisystem.com/emblem or call **1-877-690-6534** to enroll.
- **Vision Discount Program** — You are eligible to access vision care, including examinations, eyewear, contact lenses and laser vision correction, at discounted rates through a network of vision providers. To locate discount program participating vision providers, go online at www.eyemed.com or call **1-844-790-3878**. To access the discount vision program services, contact a participating vision provider to schedule an appointment, identify yourself as Our Member and present Your ID card at the appointment. You must pay the full, discounted cost of the services that You receive under this program directly to the participating provider. Services may vary by provider.

If Your Certificate includes coverage for certain vision care services or if such services are covered under an insurance plan that You have with another insurer, You should generally use Your insured vision benefit to access Covered Services, and only use this discount program to access non-covered services.

- **Hearing Care Discount Programs** — You are eligible to access discounts from the following selected vendors:

  HearUSA/Hearx — Offers discounts of up to 20% on hearing aid purchases and up to 10% on listening products and hearing aid accessories. To identify participating locations where discounts apply, go online at www.hearusa.com/centers/search_criteria.asp?m=1&type=corporate&switch=no, or call **1-800-442-8231**. TTD users can call **1-888-300-3277**. To access the discounts for listening products and hearing aid accessories go to www.hearingshop.com. To receive the discount, view Your shopping cart and enter coupon code Emblem.

  Amplifon — Take control of Your hearing and improve Your quality of life with a low-price

guarantee on hearing aids, free batteries, follow-up care and screenings. Amplifon offers a 60-day trial period with a 100% money-back guarantee. Call **1-888-534-4427** or visit www.amplifonusa.com/emblem to schedule Your evaluation today.

If Your Certificate includes coverage for hearing aids and/or listening products and hearing aid accessories or if these items are covered under another insurance plan if You are covered under more than one health plan, You should generally use Your insured hearing aid benefit, and only use this discount program to access non-covered hearing aid purchases.

- **Medical Equipment and Services Discount Program** — You may save up to 50% on comprehensive health care services and products – including prescription medications, dental care, medical supplies, home nursing care and more. Register online at www.careexpresshealth.com/Emblem, or call **1-866-635-9532**. (Membership fee is required to access discounts.)

If Your Certificate includes coverage for prescription drugs, dental care, medical supplies, home nursing care, and other discount services available under this program, or if these services are covered under an insurance plan that You have with another insurer if You are covered under more than one health plan, You should use Your insured benefits to access covered services, and only use this discount program to access non-covered services.

To read more about these and other discount programs, visit www.emblemhealth.com/goodhealth.

CARE MANAGEMENT PROGRAMS

We offer programs designed to help Members with chronic conditions improve their health and well-being. To accomplish this goal, You can receive support and education from a specially trained nurse or other health care professional.

Care Management programs includes:

1. **Emergency Department (ED) Utilization** – A program designed to increase alignment of the care delivery system for Our high-need Members who have preventable ED visits. The goal of the program is to provide clinical oversight to reduce avoidable ED visits, engage Members in their primary care system, provide education to disease process and management and assist in care coordination to improve health outcomes. To find out more or to enroll, call 800-447-0768, Monday to Friday, 9 a.m. to 5 p.m.

2. **Transitions of Care** – A program designed to prevent hospital readmissions through a comprehensive clinical program that provides Member education, ensuring post-discharge doctors' appointments, obtaining needed medications and understanding their usage, times of administration and signs and symptoms of concern to report, navigation for appropriate resources and assist in care coordination to meet health care needs. To find out more or to enroll, call 800-447-0768, Monday to Friday, 9 a.m. to 5 p.m.

3. **Complex Case Management** – A clinical oversight program designed to support Members with complex comorbid chronic medical conditions. This program provides high-level of outreach

with one-on-one intervention, advocacy for their health care, coordinates healthcare services and communications between the health care providers, Member and their families at a time when help is most needed. To find out more or to enroll, call 800-447-0768, Monday to Friday, 9 a.m. to 5 p.m.

4. **Transplant Program** – A program designed for Members who are in the process of receiving or being evaluated for transplant services. This includes collaboration with facilities and providers to ensure that Members obtain the best care while navigating through the transplant medical process. To find out more or to enroll, call 800-447-0768, Monday to Friday, 9 a.m. to 5 p.m.

5. **HIV Program** – A program designed to provide support to Members with home life, medical care, and psychological issues. The program aids with finding community resources and supports the Member in navigating the medical system. To find out more or to enroll, call 800-447-0768, Monday to Friday, 9 a.m. to 5 p.m.

6. **Neonatal Intensive Care Unit (NICU) Program** – A program designed to address the needs of compromised newborns through one (1) year of age with collaboration with the facility NICU nurses and social workers to assess neonates at the time of discharge for continuing care needs. To find out more or to enroll, call 800-447-0768, Monday to Friday, 9 a.m. to 5 p.m.

7. **Disease Management** – A program designed for Members with Chronic Kidney Disease ("CKD") and End Stage Renal Disease ("ESRD"). The CKD portion of this program is designed to delay progression to dialysis and avoid co-morbidities. If dialysis is unavoidable, Members are assisted selecting the type of dialysis and provider that best meets their individual needs. To find out more or to enroll, call 866-561-7518, Monday to Friday, 9 a.m. to 5 p.m.

WELLNESS PROGRAMS

1. **Diabetes Prevention Program** – A program designed to teach Members at risk for diabetes the habits and techniques necessary to avoid or delay the onset of diabetes and lead healthier lives. To find out more or to enroll, call 866-447-8080, Monday to Friday, 9 a.m. to 5 p.m.

2. **Tobacco Free Quit-Smoking Program** – A program designed to offer a telephonic-based behavior modification to Members that are eighteen (18) years old and older who want to stop smoking. The program consists of a comprehensive educational kit and support calls from a smoking cessation specialist. New York residents call **866-NY-QUITS** (866-697-8487), non-New York residents, call 877-500-2393 Monday to Friday, 8 a.m. to 9 p.m., Saturday, 9 a.m. to 7 p.m. and Sunday, 9 a.m. to 5 p.m. (**TTY: 711**).

3. **24-Hour Nurse Health Information Line** – A program designed to provide a 24-hour toll-free health information line that is staffed by highly-trained registered nurses and is available 7 days a week. Nurses trained in telephone triaging gives eligible Members access to immediate clinical support for everyday health issues and guide callers in making informed decisions about a multitude of health conditions and how best to handle a medical concern. To find out more, call 877-444-7988.

4. **Healthy Beginnings Pregnancy Program** – A prenatal program designed to provide expectant

mothers with important information about having a healthy pregnancy. The program conducts Obstetrical Risk Assessments. Members identified as high risk are referred to a complex care manager for further evaluation and intervention. To find out more, call 888-447-0337, Monday to Friday, 9 a.m. to 5 p.m.

We also provide the following preventive health screening reminders and health management tools for Your convenience:

- **Preventive Health Screening Reminders** — You may receive mail, email and/or telephone reminders from Us to schedule important health screenings for breast, cervical and colorectal cancer, as well as other preventive health care messages.
- **Health Management Tools** — Interactive online tools are available to You to help manage Your health and wellness at www.emblemhealth.com/en/Health-and-Wellness/Stay-Healthy/Health-Manager-Tools.aspx.
    - **A health risk assessment tool; Health Assessment (HA):** The Health Assessment includes approximately 40 questions, based on individual risks and status, and takes Members approximately 10 to 15 minutes to complete. The assessment establishes a baseline of consumer risks and provides a Health Score for the Member by collecting only essential data. The questions included in the HA have been validated through rigorous third-party research, evaluates Members' physical health as well as their social health, mental health and work-life balance – the key components in maintaining optimal wellness. Immediately following completion of the assessment, Members are provided a summary report of their health status, including a personalized Health Score indicating their potential for improvement and related health improvement opportunities. After completing the HA, each Member receives a recommended digital coaching program to improve unhealthy behavior, impacting their quality of life and health status.

      Personal Health Record (PHR) — Your health records are among Your most important documents. When you visit Our website at www.emblemhealth.com and sign in as a Member, You will be connected to myEmblemHealth, which provides resources to help You manage Your membership and Your health, including accessing Your health records and keeping them well organized and at Your fingertips. You can also retain a concise record of Your medications, medical history, tests, health care contacts and more in Your personal health record, as well as elect to have Your prescription records automatically added to Your PHR. You can even print out copies of Your PHR to share with Your doctor(s).

3. Eligibility.
You, the Subscriber, and each covered Dependent can participate in the wellness program.

4. Participation.
The preferred method for accessing the wellness program is through Our website at http://www.emblemhealth.com/en/Health-and-Wellness.aspx. You need to have access to a computer

with internet access in order to participate in the website program. However, if You do not have access to a computer, please call Us at the number on Your ID card and We will provide You with information regarding how to participate without internet access.

5. Rewards.

If You have one (1) or more chronic conditions or suspected chronic conditions, You may be eligible to earn a $50 reward card for participating in a free, convenient in-home or mobile clinic preventive health visit with a nurse practitioner. We will determine Your eligibility for this opportunity based on Your claims data. You may be eligible if You have or may be at risk for certain chronic conditions, such as diabetes, certain cancers, certain metabolic or endocrine disorders, certain mental health and substance use disorders, immune system disorders, congenital anomalies, liver diseases and/or certain other types of conditions. If We determine that You are eligible, You will receive a letter from Our vendor inviting You to schedule the free preventive care visit. The visit will take about an hour. After Your visit, You will receive a Personal Health Summary in the mail detailing Your health information. We will also share the information We learn from Your visit with Your doctor. You will receive the reward card by mail within two to three weeks after You complete the visit. We suggest that You use the reward card for products or services that promote Your good health, such as healthy cook books, over-the-counter vitamins or exercise equipment.

The in-home or mobile clinic visit is not intended to replace regular visits with Your doctor. The in-home or mobile preventive examination visit is free. Additional services may be subject to Cost-Sharing as set forth in this Certificate.

Section XV

Vision Care

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

A. Vision Care.

We Cover emergency, preventive and routine vision care.

B. Vision Examinations.

We Cover vision examinations for the purpose of determining the need for corrective lenses, and if needed, to provide a prescription for corrective lenses. We Cover a vision examination one (1) time in any twelve (12)-month period, unless more frequent examinations are Medically Necessary as evidenced by appropriate documentation. The vision examination may include, but is not limited to:

- Case history;
- External examination of the eye or internal examination of the eye;
- Ophthalmoscopic exam;
- Determination of refractive status;
- Binocular distance;
- Tonometry tests for glaucoma;
- Gross visual fields and color vision testing; and
- Summary findings and recommendation for corrective lenses.

C. Prescribed Lenses and Frames.

We Cover standard prescription lenses and will pay the dollar allowance shown in the Schedule of Benefits section of this Certificate one (1) time in any twenty-four (24)-month period, unless it is Medically Necessary for You to have new lenses more frequently, as evidenced by appropriate documentation. Prescription lenses may be constructed of either glass or plastic. We also Cover standard frames adequate to hold lenses one (1) time in any twenty-four (24)-month period, unless it is Medically Necessary for You to have new frames more frequently, as evidenced by appropriate documentation. You must choose the frames and lenses from a Participating Provider.

Section XVI

Exclusions and Limitations

No coverage is available under this Certificate for the following:

A. Aviation.
We do not Cover services arising out of aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline.

B. Convalescent and Custodial Care.
We do not Cover services related to rest cures, custodial care or transportation. "Custodial care" means help in transferring, eating, dressing, bathing, toileting and other such related activities. Custodial care does not include Covered Services determined to be Medically Necessary.

C. Conversion Therapy.
We do not Cover conversion therapy. Conversion therapy is any practice by a mental health professional that seeks to change the sexual orientation or gender identity of a Member under eighteen (18) years of age, including efforts to change behaviors, gender expressions, or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same sex. Conversion therapy does not include counseling or therapy for an individual who is seeking to undergo a gender transition or who is in the process of undergoing a gender transition, that provides acceptance, support, and understanding of an individual or the facilitation of an individual's coping, social support, and identity exploration and development, including sexual orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices, provided that the counseling or therapy does not seek to change sexual orientation or gender identity.

D. Cosmetic Services.
We do not Cover cosmetic services, Prescription Drugs, or surgery, unless otherwise specified, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered Child which has resulted in a functional defect. We also Cover services in connection with reconstructive surgery following a mastectomy, as provided elsewhere in this Certificate. Cosmetic surgery does not include surgery determined to be Medically Necessary. If a claim for a procedure listed in 11 NYCRR 56 (e.g., certain plastic surgery and dermatology procedures) is submitted retrospectively and without medical information, any denial will not be subject to the Utilization Review process in the Utilization Review and External Appeal sections of this Certificate unless medical information is submitted.

E. Coverage Outside of the United States, Canada or Mexico.
We do not Cover care or treatment provided outside of the United States, its possessions, Canada or Mexico except for Emergency Services, Pre-Hospital Emergency Medical Services and ambulance services to treat Your Emergency Condition.

F. Dental Services.
We do not Cover dental services except for: care or treatment due to accidental injury to sound natural

teeth within twelve (12) months of the accident; dental care or treatment necessary due to congenital disease or anomaly; or dental care or treatment specifically stated in the Outpatient and Professional Services section of this Certificate.

G. Experimental or Investigational Treatment.
We do not Cover any health care service, procedure, treatment, device or Prescription Drug that is experimental or investigational. However, We will Cover experimental or investigational treatments, including treatment for Your rare disease or patient costs for Your participation in a clinical trial as described in the Outpatient and Professional Services section of this Certificate, when Our denial of services is overturned by an External Appeal Agent certified by the State. However, for clinical trials, We will not Cover the costs of any investigational drugs or devices, non-health services required for You to receive the treatment, the costs of managing the research, or costs that would not be Covered under this Certificate for non-investigational treatments. See the Utilization Review and External Appeal sections of this Certificate for a further explanation of Your Appeal rights.

H. Felony Participation.
We do not Cover any illness, treatment or medical condition due to Your participation in a felony, riot or insurrection. This exclusion does not apply to coverage for services involving injuries suffered by a victim of an act of domestic violence or for services as a result of Your medical condition (including both physical and mental health conditions).

I. Foot Care.
We do not Cover routine foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet. However, We will Cover foot care when You have a specific medical condition or disease resulting in circulatory deficits or areas of decreased sensation in Your legs or feet.

J. Government Facility.
We do not Cover care or treatment provided in a Hospital that is owned or operated by any federal, state or other governmental entity, except as otherwise required by law unless You are taken to the Hospital because it is close to the place where You were injured or became ill and Emergency Services are provided to treat Your Emergency Condition.

K. Medically Necessary.
In general, We will not Cover any health care service, procedure, treatment, test, device or Prescription Drug that We determine is not Medically Necessary. If an External Appeal Agent certified by the State overturns Our denial, however, We will Cover the service, procedure, treatment, test, device or Prescription Drug for which coverage has been denied, to the extent that such service, procedure, treatment, test, device or Prescription Drug is otherwise Covered under the terms of this Certificate.

L. Medicare or Other Governmental Program.
We do not Cover services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid).

M. Military Service.
We do not Cover an illness, treatment or medical condition due to service in the Armed Forces or

auxiliary units.

N. No-Fault Automobile Insurance.
We do not Cover any benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable. This exclusion applies even if You do not make a proper or timely claim for the benefits available to You under a mandatory no-fault policy.

O. Services Not Listed.
We do not Cover services that are not listed in this Certificate as being Covered.

P. Services Provided by a Family Member.
We do not Cover services performed by a member of the covered person's immediate family. "Immediate family" shall mean a child, spouse, mother, father, sister or brother of You or Your Spouse.

Q. Services Separately Billed by Hospital Employees.
We do not Cover services rendered and separately billed by employees of Hospitals, laboratories or other institutions.

R. Services with No Charge.
We do not Cover services for which no charge is normally made.

S. Vision Services.
We do not Cover the examination or fitting of eyeglasses or contact lenses, except as specifically stated in the Vision Care section of this Certificate.

T. War.
We do not Cover an illness, treatment or medical condition due to war, declared or undeclared.

U. Workers' Compensation.
We do not Cover services if benefits for such services are provided under any state or federal Workers' Compensation, employers' liability or occupational disease law.

Section XVII

Claim Determinations

A. Claims.
A claim is a request that benefits or services be provided or paid according to the terms of this Certificate. When You receive services from a Participating Provider, You will not need to submit a claim form. However, if You receive services from a Non-Participating Provider either You or the Provider must file a claim form with Us. If the Non-Participating Provider is not willing to file the claim form, You will need to file it with Us. See the Coordination of Benefits section of this Certificate for information on how We coordinate benefit payments when You also have group health coverage with another plan.

B. Notice of Claim.
Claims for services must include all information designated by Us as necessary to process the claim, including, but not limited to: Member identification number; name; date of birth; date of service; type of service; the charge for each service; procedure code for the service as applicable; diagnosis code; name and address of the Provider making the charge; and supporting medical records, when necessary. A claim that fails to contain all necessary information will not be accepted and must be resubmitted with all necessary information. Claim forms are available from Us by calling the number on Your ID card or visiting Our website at www.emblemhealth.com. Completed claim forms should be sent to the address in the How Your Coverage Works section of this Certificate. You may also submit a claim to Us electronically by sending it to the e-mail address in the How Your Coverage Works section of this Certificate.

C. Timeframe for Filing Claims.
Claims for services must be submitted to Us for payment within one hundred eighty (180) days after You receive the services for which payment is being requested. If it is not reasonably possible to submit a claim within the one hundred eighty (180) day period, You must submit it as soon as reasonably possible.

D. Claims for Prohibited Referrals.
We are not required to pay any claim, bill or other demand or request by a Provider for clinical laboratory services, pharmacy services, radiation therapy services, physical therapy services or x-ray or imaging services furnished pursuant to a referral prohibited by Section 238-a(1) of the New York Public Health Law.

E. Claim Determinations.
Our claim determination procedure applies to all claims that do not relate to a medical necessity or experimental or investigational determination. For example, Our claim determination procedure applies to contractual benefit denials and Referrals. If You disagree with Our claim determination, You may submit a Grievance pursuant to the Grievance Procedures section of this Certificate.

For a description of the Utilization Review procedures and Appeal process for medical necessity or experimental or investigational determinations, see the Utilization Review and External Appeal sections of this Certificate.

F. Pre-Service Claim Determinations.

1. A pre-service claim is a request that a service or treatment be approved before it has been received. If We have all the information necessary to make a determination regarding a pre-service claim (e.g., a covered benefit determination or Referral), We will make a determination and provide notice to You (or Your designee) within fifteen (15) days from receipt of the claim.

   If We need additional information, We will request it within fifteen (15) days from receipt of the claim. You will have forty-five (45) calendar days to submit the information. If We receive the information within forty-five (45) days, We will make a determination and provide notice to You (or Your designee) in writing, within fifteen (15) days of Our receipt of the information. If all necessary information is not received within forty-five (45) days, We will make a determination within fifteen (15) calendar days of the end of the forty-five (45)-day period.

2. **Urgent Pre-Service Reviews.** With respect to urgent pre-service requests, if We have all information necessary to make a determination, We will make a determination and provide notice to You (or Your designee) by telephone, within seventy-two (72) hours of receipt of the request. Written notice will follow within three (3) calendar days of the decision. If We need additional information, We will request it within twenty-four (24) hours. You will then have forty-eight (48) hours to submit the information. We will make a determination and provide notice to You (or Your designee) by telephone within forty-eight (48) hours of the earlier of Our receipt of the information or the end of the forty-eight (48)-hour period. Written notice will follow within three (3) calendar days of the decision.

G. Post-Service Claim Determinations.

A post-service claim is a request for a service or treatment that You have already received. If We have all information necessary to make a determination regarding a post-service claim, We will make a determination and notify You (or Your designee) within thirty (30) calendar days of the receipt of the claim if We deny the claim in whole or in part. If We need additional information, We will request it within thirty (30) calendar days. You will then have forty-five (45) calendar days to provide the information. We will make a determination and provide notice to You (or Your designee) in writing within fifteen (15) calendar days of the earlier of Our receipt of the information or the end of the forty-five (45)-day period if We deny the claim in whole or in part.

H. Payment of Claims.

Where Our obligation to pay a claim is reasonably clear, We will pay the claim within thirty (30) days of receipt of the claim (when submitted through the internet or e-mail) and forty-five (45) days of receipt of the claim (when submitted through other means, including paper or fax). If We request additional information, We will pay the claim within thirty (30) days (for claims submitted through the internet or e-mail) or forty-five (45) days (for claims submitted through other means, including paper or fax) of receipt of the information.

Section XVIII

Grievance Procedures

A. Grievances.
Our Grievance procedure applies to any issue not relating to a Medical Necessity or experimental or investigational determination by Us. For example, it applies to contractual benefit denials or issues or concerns You have regarding Our administrative policies or access to Providers.

B. Filing a Grievance.
You can contact Us by phone at 1-800-447-8255, in person, or in writing to file a Grievance. You may submit an oral Grievance in connection with a denial of a Referral or a covered benefit determination. We may require that You sign a written acknowledgement of Your oral Grievance, prepared by Us. You or Your designee has up to one hundred eighty (180) calendar days from when You received the decision You are asking Us to review to file the Grievance.

When We receive Your Grievance, We will mail an acknowledgment letter within fifteen (15) business days. The acknowledgment letter will include the name, address, and telephone number of the person handling Your Grievance, and indicate what additional information, if any, must be provided.

We keep all requests and discussions confidential and We will take no discriminatory action because of Your issue. We have a process for both standard and expedited Grievances, depending on the nature of Your inquiry.

C. Grievance Determination.
Qualified personnel will review Your Grievance, or if it is a clinical matter, a licensed, certified or registered Health Care Professional will look into it. We will decide the Grievance and notify You within the following timeframes:

Expedited/Urgent Grievances:	By phone, within the earlier of forty-eight (48) hours of receipt of all necessary information or seventy-two (72) hours of receipt of Your Grievance. Written notice will be provided within seventy-two (72) hours of receipt of Your Grievance.
Pre-Service Grievances: (A request for a service or treatment that has not yet been provided.)	In writing, within fifteen (15) calendar days of receipt of Your Grievance.
Post-Service Grievances: (A claim for a service or treatment that has already been provided.)	In writing, within thirty (30) calendar days of receipt of Your Grievance.

All Other Grievances: (That are not in relation to a claim or request for a service or treatment.)	In writing, within forty-five (45) calendar days of receipt of all necessary information.

D. Grievance Appeals.
If You are not satisfied with the resolution of Your Grievance, You or Your designee may file an Appeal by phone at 1-800-447-8255, in person, or in writing. However, Urgent Appeals may be filed by phone. You have up to sixty (60) business days from receipt of the Grievance determination to file an Appeal.

When We receive Your Appeal, We will mail an acknowledgment letter within fifteen (15) business days. The acknowledgement letter will include the name, address, and telephone number of the person handling Your Appeal and indicate what additional information, if any, must be provided.

One or more qualified personnel at a higher level than the personnel that rendered the Grievance determination will review it, or if it is a clinical matter, a clinical peer reviewer will look into it. We will decide the Appeal and notify You in writing within the following timeframes:

Expedited/Urgent Grievances:	The earlier of two (2) business days of receipt of all necessary information or seventy-two (72) hours of receipt of Your Appeal.
Pre-Service Grievances: (A request for a service or treatment that has not yet been provided.)	Fifteen (15) calendar days of receipt of Your Appeal.
Post-Service Grievances: (A claim for a service or treatment that has already been provided.)	Thirty (30) calendar days of receipt of Your Appeal.
All Other Grievances: (That are not in relation to a claim or request for a service or treatment.)	Thirty (30) business days of receipt of all necessary information to make a determination.

E. Assistance.
If You remain dissatisfied with Our Appeal determination, or at any other time You are dissatisfied, You may:

Call the New York State Department of Health at 1-800-206-8125 or write them at:
New York State Department of Health
Office of Health Insurance Programs
Bureau of Consumer Services – Complaint Unit
Corning Tower – OCP Room 1609
Albany, NY 12237
Email: managedcarecomplaint@health.ny.gov
Website: www.health.ny.gov

If You need assistance filing a Grievance or Appeal, You may also contact the state independent Consumer Assistance Program at:
Community Health Advocates
633 Third Avenue, 10th Floor
New York, NY 10017
Or call toll free: 1-888-614-5400, or e-mail cha@cssny.org
Website: www.communityhealthadvocates.org

Section XIX

Utilization Review

A. Utilization Review.

We review health services to determine whether the services are or were Medically Necessary or experimental or investigational ("Medically Necessary"). This process is called Utilization Review. Utilization Review includes all review activities, whether they take place prior to the service being performed (Preauthorization); when the service is being performed (concurrent); or after the service is performed (retrospective). If You have any questions about the Utilization Review process, please call the number on Your ID card; or, for mental health and substance use disorder services, also call the number on Your ID card. The toll-free telephone number is available at least forty (40) hours a week with an after-hours answering machine.

All determinations that services are not Medically Necessary will be made by: 1) licensed Physicians; or 2) licensed, certified, registered or credentialed Health Care Professionals who are in the same profession and same or similar specialty as the Provider who typically manages Your medical condition or disease or provides the health care service under review; or 3) with respect to mental health or substance use disorder treatment, licensed Physicians or licensed, certified, registered or credentialed Health Care Professionals who specialize in behavioral health and have experience in the delivery of mental health or substance use disorder courses of treatment. We do not compensate or provide financial incentives to Our employees or reviewers for determining that services are not Medically Necessary.

We have developed guidelines and protocols to assist Us in this process. For substance use disorder treatment, We will use evidence-based and peer reviewed clinical review tools designated by OASAS that are appropriate to the age of the patient. Specific guidelines and protocols are available for Your review upon request. For more information, call the number on Your ID card or visit Our website at www.emblemhealth.com.

B. Preauthorization Reviews.

1. **Non-Urgent Preauthorization Reviews.** If We have all the information necessary to make a determination regarding a Preauthorization review, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within three (3) business days of receipt of the request.

   If We need additional information, We will request it within three (3) business days. You or Your Provider will then have forty-five (45) calendar days to submit the information. If We receive the requested information within forty-five (45) days, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within three (3) business days of Our receipt of the information. If all necessary information is not received within forty-five (45) days, We will make a determination within fifteen (15) calendar days of the earlier of the receipt of part of the requested information or the end of the forty-five (45)-day period.

2. **Urgent Preauthorization Reviews.** With respect to urgent Preauthorization requests, if We have all information necessary to make a determination, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone, within seventy-two (72) hours of receipt of the request. Written notice will be provided within three (3) business days of receipt of the request. If We need additional information, We will request it within twenty-four (24) hours. You or Your Provider will then have forty-eight (48) hours to submit the information. We will make a determination and provide notice to You (or Your designee) and Your Provider by telephone within forty-eight (48) hours of the earlier of Our receipt of the information or the end of the forty-eight (48)-hour period. Written notification will be provided within the earlier of three (3) business days of Our receipt of the information or three (3) calendar days after the verbal notification.

3. **Court Ordered Treatment.** With respect to requests for mental health and/or substance use disorder services that have not yet been provided, if You (or Your designee) certify, in a format prescribed by the Superintendent of Financial Services, that You will be appearing, or have appeared, before a court of competent jurisdiction and may be subject to a court order requiring such services, We will make a determination and provide notice to You (or Your designee) and Your Provider by telephone within seventy-two (72) hours of receipt of the request. Written notification will be provided within three (3) business days of Our receipt of the request. Where feasible, the telephonic and written notification will also be provided to the court.

C. Concurrent Reviews.

1. **Non-Urgent Concurrent Reviews.** Utilization Review decisions for services during the course of care (concurrent reviews) will be made, and notice provided to You (or Your designee) and Your Provider, by telephone and in writing, within one (1) business day of receipt of all necessary information. If We need additional information, We will request it within one (1) business day. You or Your Provider will then have forty-five (45) calendar days to submit the information. We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within one (1) business day of Our receipt of the information or, if We do not receive the information, within the earlier of fifteen (15) calendar days of the receipt of part of the requested information or fifteen (15) calendar days of the end of the forty-five (45)-day period.

2. **Urgent Concurrent Reviews.** For concurrent reviews that involve an extension of urgent care, if the request for coverage is made at least twenty-four (24) hours prior to the expiration of a previously approved treatment, We will make a determination and provide notice to You (or Your designee) and Your Provider by telephone within twenty-four (24) hours of receipt of the request. Written notice will be provided within one (1) business day of receipt of the request.

   If the request for coverage is not made at least twenty-four (24) hours prior to the expiration of a previously approved treatment and We have all the information necessary to make a determination, We will make a determination and provide written notice to You (or Your designee) and Your Provider within the earlier of seventy-two (72) hours or one (1) business day of receipt of the request. If We need additional information, We will request it within twenty-four (24) hours. You or Your Provider will then have forty-eight (48) hours to submit the information. We will make a determination and provide written notice to You (or Your designee) and Your Provider within the earlier of one (1) business day or forty-eight (48) hours

of Our receipt of the information or, if We do not receive the information, within forty-eight (48) hours of the end of the forty-eight (48)-hour period.

3. **Home Health Care Reviews.** After receiving a request for coverage of home care services following an inpatient Hospital admission, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within one (1) business day of receipt of the necessary information. If the day following the request falls on a weekend or holiday, We will make a determination and provide notice to You (or Your designee) and Your Provider within seventy-two (72) hours of receipt of the necessary information. When We receive a request for home care services and all necessary information prior to Your discharge from an inpatient hospital admission, We will not deny coverage for home care services while Our decision on the request is pending.

4. **Inpatient Substance Use Disorder Treatment Reviews.** If a request for inpatient substance use disorder treatment is submitted to Us at least twenty-four (24) hours prior to discharge from an inpatient substance use disorder treatment admission, We will make a determination within twenty-four (24) hours of receipt of the request and We will provide coverage for the inpatient substance use disorder treatment while Our determination is pending.

5. **Inpatient Mental Health Treatment for Members under eighteen (18) at Participating Hospitals Licensed by the Office of Mental Health (OMH).** Coverage for inpatient mental health treatment at a participating OMH-licensed Hospital is not subject to Preauthorization. Coverage will not be subject to concurrent review for the first fourteen (14) days of the inpatient admission if the OMH-licensed Hospital notifies Us of both the admission and the initial treatment plan within two (2) business days of the admission. After the first fourteen (14) days of the inpatient admission, We may review the entire stay to determine whether it is Medically Necessary, and We will use clinical review tools approved by OMH. If any portion of the stay is denied as not Medically Necessary, You are only responsible for the in-network Cost-Sharing that would otherwise apply to Your inpatient admission.

6. **Inpatient Substance Use Disorder Treatment at Participating OASAS-Certified Facilities.** Coverage for inpatient substance use disorder treatment at a participating OASAS-certified Facility is not subject to Preauthorization. Coverage will not be subject to concurrent review for the first twenty-eight (28) days of the inpatient admission if the OASAS-certified Facility notifies Us of both the admission and the initial treatment plan within two (2) business days of the admission. After the first twenty-eight (28) days of the inpatient admission, We may review the entire stay to determine whether it is Medically Necessary and We will use clinical review tools designated by OASAS. If any portion of the stay is denied as not Medically Necessary, You are only responsible for the in-network Cost-Sharing that would otherwise apply to Your inpatient admission.

7. **Outpatient Substance Use Disorder Treatment at Participating OASAS-Certified Facilities.** Coverage for outpatient, intensive outpatient, outpatient rehabilitation and opioid treatment at a participating OASAS-certified Facility is not subject to Preauthorization. Coverage will not be subject to concurrent review for the first four (4) weeks of continuous treatment, not to exceed twenty-eight (28) visits, if the OASAS-certified Facility notifies Us of both the start of treatment and the initial treatment plan within two (2) business days. After the first four (4) weeks of

continuous treatment, not to exceed twenty-eight (28) visits, We may review the entire outpatient treatment to determine whether it is Medically Necessary and We will use clinical review tools designated by OASAS. If any portion of the outpatient treatment is denied as not Medically Necessary, You are only responsible for the in-network Cost-Sharing that would otherwise apply to Your outpatient treatment.

D. Retrospective Reviews.

If We have all information necessary to make a determination regarding a retrospective claim, We will make a determination and notify You and Your Provider within thirty (30) calendar days of the receipt of the request. If We need additional information, We will request it within thirty (30) calendar days. You or Your Provider will then have forty-five (45) calendar days to provide the information. We will make a determination and provide notice to You and Your Provider in writing within fifteen (15) calendar days of the earlier of Our receipt of all or part of the requested information or the end of the forty-five (45)-day period.

Once We have all the information to make a decision, Our failure to make a Utilization Review determination within the applicable time frames set forth above will be deemed an adverse determination subject to an internal Appeal.

E. Retrospective Review of Preauthorized Services.

We may only reverse a preauthorized treatment, service or procedure on retrospective review when:

- The relevant medical information presented to Us upon retrospective review is materially different from the information presented during the Preauthorization review;
- The relevant medical information presented to Us upon retrospective review existed at the time of the Preauthorization but was withheld or not made available to Us;
- We were not aware of the existence of such information at the time of the Preauthorization review; and
- Had We been aware of such information, the treatment, service or procedure being requested would not have been authorized. The determination is made using the same specific standards, criteria or procedures as used during the Preauthorization review.

F. Step Therapy Override Determinations.

You, Your designee, or Your Health Care Professional may request a step therapy protocol override determination for coverage of a Prescription Drug selected by Your Health Care Professional. When conducting Utilization Review for a step therapy protocol override determination, We will use recognized evidence-based and peer reviewed clinical review criteria that is appropriate for You and Your medical condition.

1. **Supporting Rationale and Documentation.** A step therapy protocol override determination request must include supporting rationale and documentation from a Health Care Professional, demonstrating that:
   - The required Prescription Drug(s) is contraindicated or will likely cause an adverse reaction or physical or mental harm to You;
   - The required Prescription Drug(s) is expected to be ineffective based on Your known clinical history, condition, and Prescription Drug regimen;

- You have tried the required Prescription Drug(s) while covered by Us or under Your previous health insurance coverage, or another Prescription Drug in the same pharmacologic class or with the same mechanism of action, and that Prescription Drug(s) was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event;
- You are stable on a Prescription Drug(s) selected by Your Health Care Professional for Your medical condition, provided this does not prevent Us from requiring You to try an AB-rated generic equivalent; or
- The required Prescription Drug(s) is not in Your best interest because it will likely cause a significant barrier to Your adherence to or compliance with Your plan of care, will likely worsen a comorbid condition, or will likely decrease Your ability to achieve or maintain reasonable functional ability in performing daily activities.

2. **Standard Review.** We will make a step therapy protocol override determination and provide notification to You (or Your designee) and where appropriate, Your Health Care Professional, within seventy-two (72) hours of receipt of the supporting rationale and documentation.

3. **Expedited Review.** If You have a medical condition that places Your health in serious jeopardy without the Prescription Drug prescribed by Your Health Care Professional, We will make a step therapy protocol override determination and provide notification to You (or Your designee) and Your Health Care Professional within twenty-four (24) hours of receipt of the supporting rationale and documentation.

If the required supporting rationale and documentation are not submitted with a step therapy protocol override determination request, We will request the information within seventy-two (72) hours for Preauthorization and retrospective reviews, the lesser of seventy-two (72) hours or one (1) business day for concurrent reviews, and twenty-four (24) hours for expedited reviews. You or Your Health Care Professional will have forty-five (45) calendar days to submit the information for Preauthorization, concurrent and retrospective reviews, and forty-eight (48) hours for expedited reviews. For Preauthorization reviews, We will make a determination and provide notification to You (or Your designee) and Your Health Care Professional within the earlier of seventy-two (72) hours of Our receipt of the information or fifteen (15) calendar days of the end of the forty-five (45)-day period if the information is not received. For concurrent reviews, We will make a determination and provide notification to You (or Your designee) and Your Health Care Professional within the earlier of seventy-two (72) hours or one (1) business day of Our receipt of the information or fifteen (15) calendar days of the end of the forty-five (45)-day period if the information is not received. For retrospective reviews, We will make a determination and provide notification to You (or Your designee) and Your Health Care Professional within the earlier of seventy-two (72) hours of Our receipt of the information or fifteen (15) calendar days of the end of the forty-five (45)-day period if the information is not received. For expedited reviews, We will make a determination and provide notification to You (or Your designee) and Your Health Care Professional within the earlier of twenty-four (24) hours of Our receipt of the information or forty-eight (48) hours of the end of the forty-eight (48)-hour period if the information is not received.

If We do not make a determination within seventy-two (72) hours (or twenty-four (24) hours for expedited reviews) of receipt of the supporting rationale and documentation, the step therapy protocol override request will be approved.

If We determine that the step therapy protocol should be overridden, We will authorize immediate coverage for the Prescription Drug prescribed by Your treating Health Care Professional. An adverse step therapy override determination is eligible for an Appeal.

G. Reconsideration.
If We did not attempt to consult with Your Provider who recommended the Covered Service before making an adverse determination, the Provider may request reconsideration by the same clinical peer reviewer who made the adverse determination or a designated clinical peer reviewer if the original clinical peer reviewer is unavailable. For Preauthorization and concurrent reviews, the reconsideration will take place within one (1) business day of the request for reconsideration. If the adverse determination is upheld, a notice of adverse determination will be given to You and Your Provider, by telephone and in writing.

H. Utilization Review Internal Appeals.
You, Your designee, and, in retrospective review cases, Your Provider, may request an internal Appeal of an adverse determination, either by phone, in person, or in writing.

You have up to one hundred eighty (180) calendar days after You receive notice of the adverse determination to file an Appeal. We will acknowledge Your request for an internal Appeal within fifteen (15) calendar days of receipt. This acknowledgment will include the name, address, and phone number of the person handling Your Appeal and, if necessary, inform You of any additional information needed before a decision can be made. The Appeal will be decided by a clinical peer reviewer who is not subordinate to the clinical peer reviewer who made the initial adverse determination and who is 1) a Physician or 2) a Health Care Professional in the same or similar specialty as the Provider who typically manages the disease or condition at issue.

1. **Out-of-Network Service Denial.** You also have the right to Appeal the denial of a Preauthorization request for an out-of-network health service when We determine that the out-of-network health service is not materially different from an available in-network health service. A denial of an out-of-network health service is a service provided by a Non-Participating Provider, but only when the service is not available from a Participating Provider. For a Utilization Review Appeal of denial of an out-of-network health service, You or Your designee must submit:
   - A written statement from Your attending Physician, who must be a licensed, board-certified or board-eligible Physician qualified to practice in the specialty area of practice appropriate to treat Your condition, that the requested out-of-network health service is materially different from the alternate health service available from a Participating Provider that We approved to treat Your condition; and
   - Two (2) documents from the available medical and scientific evidence that the out-of-network service: 1) is likely to be more clinically beneficial to You than the alternate in-network service; and 2) that the adverse risk of the out-of-network service would likely not be substantially increased over the in-network health service.

2. **Out-of-Network Referral Denial.** You also have the right to Appeal the denial of a request for a Referral to a Non-Participating Provider when We determine that We have a Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service. For a Utilization Review Appeal of an

out-of-network Referral denial, You or Your designee must submit a written statement from Your attending Physician, who must be a licensed, board-certified or board-eligible Physician qualified to practice in the specialty area of practice appropriate to treat Your condition:

- That the Participating Provider recommended by Us does not have the appropriate training and experience to meet Your particular health care needs for the health care service; and
- Recommending a Non-Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service.

I. Standard Appeal.

1. **Preauthorization Appeal.** If Your Appeal relates to a Preauthorization request, We will decide the Appeal within thirty (30) calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee), and where appropriate, Your Provider, within two (2) business days after the determination is made, but no later than thirty (30) calendar days after receipt of the Appeal request.

2. **Retrospective Appeal.** If Your Appeal relates to a retrospective claim, We will decide the Appeal within sixty (60) calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee), and where appropriate, Your Provider, within two (2) business days after the determination is made, but no later than sixty (60) calendar days after receipt of the Appeal request.

3. **Expedited Appeal.** An Appeal of a review of continued or extended health care services, additional services rendered in the course of continued treatment, home health care services following discharge from an inpatient Hospital admission, services in which a Provider requests an immediate review, mental health and/or substance use disorder services that may be subject to a court order, or any other urgent matter will be handled on an expedited basis. An expedited Appeal is not available for retrospective reviews. For an expedited Appeal, Your Provider will have reasonable access to the clinical peer reviewer assigned to the Appeal within one (1) business day of receipt of the request for an Appeal. Your Provider and a clinical peer reviewer may exchange information by telephone or fax. An expedited Appeal will be determined within the earlier of seventy-two (72) hours of receipt of the Appeal or two (2) business days of receipt of the information necessary to conduct the Appeal. Written notice of the determination will be provided to You (or Your designee) within twenty-four (24) hours after the determination is made, but no later than seventy-two (72) hours after receipt of the Appeal request.

   If You are not satisfied with the resolution of Your expedited Appeal, You may file a standard internal Appeal or an external appeal.

   Our failure to render a determination of Your Appeal within sixty (60) calendar days of receipt of the necessary information for a standard Appeal or within two (2) business days of receipt of the necessary information for an expedited Appeal will be deemed a reversal of the initial adverse determination.

4. **Substance Use Appeal.** If We deny a request for inpatient substance use disorder treatment that was submitted at least twenty-four (24) hours prior to discharge from an inpatient admission, and You or Your Provider file an expedited internal Appeal of Our adverse determination, We will

decide the Appeal within twenty-four (24) hours of receipt of the Appeal request. If You or Your Provider file the expedited internal Appeal and an expedited external appeal within twenty-four (24) hours of receipt of Our adverse determination, We will also provide coverage for the inpatient substance use disorder treatment while a determination on the internal Appeal and external appeal is pending.

J. Full and Fair Review of an Appeal.

We will provide You, free of charge, with any new or additional evidence considered, relied upon, or generated by Us or any new or additional rationale in connection with Your Appeal. The evidence or rationale will be provided as soon as possible and sufficiently in advance of the date on which the notice of final adverse determination is required to be provided to give You a reasonable opportunity to respond prior to that date.

K. Appeal Assistance.

If You need assistance filing an Appeal, You may contact the state independent Consumer Assistance Program at:
Community Health Advocates
633 Third Avenue, 10th Floor
New York, NY 10017
Or call toll free: 1-888-614-5400, or e-mail cha@cssny.org
Website: www.communityhealthadvocates.org

Section XX

External Appeal

A. Your Right to an External Appeal.
In some cases, You have a right to an external appeal of a denial of coverage. If We have denied coverage on the basis that a service is not Medically Necessary (including appropriateness, health care setting, level of care or effectiveness of a Covered benefit); or is an experimental or investigational treatment (including clinical trials and treatments for rare diseases); or is an out-of-network treatment, You or Your representative may appeal that decision to an External Appeal Agent, an independent third party certified by the State to conduct these appeals.

In order for You to be eligible for an external appeal You must meet the following two (2) requirements:

- The service, procedure, or treatment must otherwise be a Covered Service under this Certificate; and
- In general, You must have received a final adverse determination through Our internal Appeal process. But, You can file an external appeal even though You have not received a final adverse determination through Our internal Appeal process if:
    - We agree in writing to waive the internal Appeal. We are not required to agree to Your request to waive the internal Appeal; or
    - You file an external appeal at the same time as You apply for an expedited internal Appeal; or
    - We fail to adhere to Utilization Review claim processing requirements (other than a minor violation that is not likely to cause prejudice or harm to You, and We demonstrate that the violation was for good cause or due to matters beyond Our control and the violation occurred during an ongoing, good faith exchange of information between You and Us).

B. Your Right to Appeal a Determination that a Service is Not Medically Necessary.
If We have denied coverage on the basis that the service is not Medically Necessary, You may appeal to an External Appeal Agent if You meet the requirements for an external appeal in paragraph "A" above.

C. Your Right to Appeal a Determination that a Service is Experimental or Investigational.
If We have denied coverage on the basis that the service is an experimental or investigational treatment (including clinical trials and treatments for rare diseases), You must satisfy the two (2) requirements for an external appeal in paragraph "A" above and Your attending Physician must certify that Your condition or disease is one for which:

1. Standard health services are ineffective or medically inappropriate; or
2. There does not exist a more beneficial standard service or procedure Covered by Us; or
3. There exists a clinical trial or rare disease treatment (as defined by law).

In addition, Your attending Physician must have recommended one (1) of the following:

1. A service, procedure or treatment that two (2) documents from available medical and scientific evidence indicate is likely to be more beneficial to You than any standard Covered Service (only certain documents will be considered in support of this recommendation – Your attending

Physician should contact the State for current information as to what documents will be considered or acceptable); or

2. A clinical trial for which You are eligible (only certain clinical trials can be considered); or
3. A rare disease treatment for which Your attending Physician certifies that there is no standard treatment that is likely to be more clinically beneficial to You than the requested service, the requested service is likely to benefit You in the treatment of Your rare disease, and such benefit outweighs the risk of the service. In addition, Your attending Physician must certify that Your condition is a rare disease that is currently or was previously subject to a research study by the National Institutes of Health Rare Disease Clinical Research Network or that it affects fewer than 200,000 U.S. residents per year.

For purposes of this section, Your attending Physician must be a licensed, board-certified or board eligible Physician qualified to practice in the area appropriate to treat Your condition or disease. In addition, for a rare disease treatment, the attending Physician may not be Your treating Physician.

D. Your Right to Appeal a Determination that a Service is Out-of-Network.
If We have denied coverage of an out-of-network treatment because it is not materially different than the health service available in-network, You may appeal to an External Appeal Agent if You meet the two (2) requirements for an external appeal in paragraph "A" above, and You have requested Preauthorization for the out-of-network treatment.

In addition, Your attending Physician must certify that the out-of-network service is materially different from the alternate recommended in-network health service, and based on two (2) documents from available medical and scientific evidence, is likely to be more clinically beneficial than the alternate in-network treatment and that the adverse risk of the requested health service would likely not be substantially increased over the alternate in-network health service.

For purposes of this section, Your attending Physician must be a licensed, board-certified or board-eligible Physician qualified to practice in the specialty area appropriate to treat You for the health service.

E. Your Right to Appeal an Out-of-Network Referral Denial to a Non-Participating Provider.
If We have denied coverage of a request for a Referral to a Non-Participating Provider because We determine We have a Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service, You may appeal to an External Appeal Agent if You meet the two (2) requirements for an external appeal in paragraph "A" above.

In addition, Your attending Physician must: 1) certify that the Participating Provider recommended by Us does not have the appropriate training and experience to meet Your particular health care needs; and 2) recommend a Non-Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service.

For purposes of this section, Your attending Physician must be a licensed, board-certified or board-eligible Physician qualified to practice in the specialty area appropriate to treat You for the health service.

F. Your Right to Appeal a Formulary Exception Denial.
If We have denied Your request for coverage of a non-formulary Prescription Drug through Our formulary exception process, You, Your designee or the prescribing Health Care Professional may appeal the formulary exception denial to an External Appeal Agent. See the Prescription Drug Coverage section of this Certificate for more information on the formulary exception process.

G. The External Appeal Process.
You have four (4) months from receipt of a final adverse determination or from receipt of a waiver of the internal Appeal process to file a written request for an external appeal. If You are filing an external appeal based on Our failure to adhere to claim processing requirements, You have four (4) months from such failure to file a written request for an external appeal.

We will provide an external appeal application with the final adverse determination issued through the first level of Our internal Appeal process or Our written waiver of an internal Appeal. You may also request an external appeal application from the New York State Department of Financial Services at 1-800-400-8882. Submit the completed application to the Department of Financial Services at the address indicated on the application. If You meet the criteria for an external appeal, the State will forward the request to a certified External Appeal Agent.

You can submit additional documentation with Your external appeal request. If the External Appeal Agent determines that the information You submit represents a material change from the information on which We based Our denial, the External Appeal Agent will share this information with Us in order for Us to exercise Our right to reconsider Our decision. If We choose to exercise this right, We will have three (3) business days to amend or confirm Our decision. Please note that in the case of an expedited external appeal (described below), We do not have a right to reconsider Our decision.

In general, the External Appeal Agent must make a decision within thirty (30) days of receipt of Your completed application. The External Appeal Agent may request additional information from You, Your Physician, or Us. If the External Appeal Agent requests additional information, it will have five (5) additional business days to make its decision. The External Appeal Agent must notify You in writing of its decision within two (2) business days.

If Your attending Physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to Your health; or if Your attending Physician certifies that the standard external appeal time frame would seriously jeopardize Your life, health or ability to regain maximum function; or if You received Emergency Services and have not been discharged from a Facility and the denial concerns an admission, availability of care or continued stay, You may request an expedited external appeal. In that case, the External Appeal Agent must make a decision within seventy-two (72) hours of receipt of Your completed application. Immediately after reaching a decision, the External Appeal Agent must notify You and Us by telephone or facsimile of that decision. The External Appeal Agent must also notify You in writing of its decision.

If Your internal Formulary exception request received a standard review through Our Formulary exception process, the External Appeal Agent must make a decision on Your external appeal and notify You or Your designee and the prescribing Health Care Professional by telephone within seventy-two (72) hours of receipt of Your completed application. The External Appeal Agent will notify You or Your designee and the prescribing Health Care Professional in writing within two (2) business days of

making a determination. If the External Appeal Agent overturns Our denial, We will Cover the Prescription Drug while You are taking the Prescription Drug, including any refills.

If Your internal Formulary exception request received an expedited review through Our Formulary exception process, the External Appeal Agent must make a decision on Your external appeal and notify You or Your designee and the prescribing Health Care Professional by telephone within twenty-four (24) hours of receipt of Your completed application. The External Appeal Agent will notify You or Your designee and the prescribing Health Care Professional in writing within seventy-two (72) hours of receipt of Your completed application. If the External Appeal Agent overturns Our denial, We will Cover the Prescription Drug while You suffer from the health condition that may seriously jeopardize Your health, life or ability to regain maximum function or for the duration of Your current course of treatment using the non-Formulary Prescription Drug.

If the External Appeal Agent overturns Our decision that a service is not Medically Necessary or approves coverage of an experimental or investigational treatment or an out-of-network treatment, We will provide coverage subject to the other terms and conditions of this Certificate. Please note that if the External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, We will only Cover the cost of services required to provide treatment to You according to the design of the trial. We will not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing the research, or costs that would not be Covered under this Certificate for non-investigational treatments provided in the clinical trial.

The External Appeal Agent's decision is binding on both You and Us. The External Appeal Agent's decision is admissible in any court proceeding.

We will charge You a fee of twenty-five dollars ($25) for each external appeal, not to exceed seventy-five dollars ($75) in a single Plan Year. The external appeal application will explain how to submit the fee. We will waive the fee if We determine that paying the fee would be a hardship to You. If the External Appeal Agent overturns the denial of coverage, the fee will be refunded to You.

H. Your Responsibilities.

It is Your responsibility to start the external appeal process. You may start the external appeal process by filing a completed application with the New York State Department of Financial Services. You may appoint a representative to assist You with Your application; however, the Department of Financial Services may contact You and request that You confirm in writing that You have appointed the representative.

Under New York State law, Your completed request for external appeal must be filed within four (4) months of either the date upon which You receive a final adverse determination, or the date upon which You receive a written waiver of any internal Appeal, or Our failure to adhere to claim processing requirements. We have no authority to extend this deadline.

Section XXI

Coordination of Benefits

This section applies when You also have group health coverage with another plan. When You receive a Covered Service, We will coordinate benefit payments with any payment made by another plan. The primary plan will pay its full benefits and the other plan may pay secondary benefits, if necessary, to cover some or all of the remaining expenses. This coordination prevents duplicate payments and overpayments.

A. Definitions.

1. **"Allowable expense"** is the necessary, reasonable, and customary item of expense for health care, when the item is covered at least in part under any of the plans involved, except where a statute requires a different definition. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered as both an allowable expense and a benefit paid.

2. **"Plan"** is other group health coverage with which We will coordinate benefits. The term "plan" includes:
   - Group health benefits and group blanket or group remittance health benefits coverage, whether insured, self-insured, or self-funded. This includes group HMO and other prepaid group coverage, but does not include blanket school accident coverage or coverages issued to a substantially similar group (e.g., Girl Scouts, Boy Scouts) where the school or organization pays the premiums.
   - Medical benefits coverage, in group and individual automobile "no-fault" and traditional liability "fault" type contracts.
   - Hospital, medical, and surgical benefits coverage of Medicare or a governmental plan offered, required, or provided by law, except Medicaid or any other plan whose benefits are by law excess to any private insurance coverage.

3. **"Primary plan"** is one whose benefits must be determined without taking the existence of any other plan into consideration. A plan is primary if either: 1) the plan has no order of benefits rules or its rules differ from those required by regulation; or 2) all plans which cover the person use the order of benefits rules required by regulation and under those rules the plan determines its benefits first. More than one plan may be a primary plan (for example, two plans which have no order of benefit determination rules).

4. **"Secondary plan"** is one which is not a primary plan. If a person is covered by more than one secondary plan, the order of benefit determination rules decide the order in which their benefits are determined in relation to each other.

B. Rules to Determine Order of Payment.

The first of the rules listed below in paragraphs 1-6 that applies will determine which plan will be primary:

1. If the other plan does not have a provision similar to this one, then the other plan will be primary.

2. If the person receiving benefits is the Subscriber and is only covered as a Dependent under the other plan, this Certificate will be primary.

3. If a child is covered under the plans of both parents and the parents are not separated or divorced, the plan of the parent whose birthday falls earlier in the year will be primary. If both parents have the same birthday, the plan which covered the parent longer will be primary. To determine whose birthday falls earlier in the year, only the month and day are considered. However, if the other plan does not have this birthday rule, but instead has a rule based on the sex of the parent and as a result the plans do not agree on which is primary, then the rule in the other plan will determine which plan is primary.

4. If a child is covered by both parents' plans, the parents are separated or divorced, and there is no court decree between the parents that establishes financial responsibility for the child's health care expenses:
    - The plan of the parent who has custody will be primary;
    - If the parent with custody has remarried, and the child is also covered as a child under the step-parent's plan, the plan of the parent with custody will pay first, the step-parent's plan will pay second, and the plan of the parent without custody will pay third; and
    - If a court decree between the parents says which parent is responsible for the child's health care expenses, then that parent's plan will be primary if that plan has actual knowledge of the decree.

5. If the person receiving services is covered under one plan as an active employee or member (i.e., not laid-off or retired), or as the spouse or child of such an active employee, and is also covered under another plan as a laid-off or retired employee or as the spouse or child of such a laid-off or retired employee, the plan that covers such person as an active employee or spouse or child of an active employee will be primary. If the other plan does not have this rule, and as a result the plans do not agree on which will be primary, this rule will be ignored.

6. If none of the above rules determine which plan is primary, the plan that covered the person receiving services longer will be primary.

C. Effects of Coordination.
When this plan is secondary, its benefits will be reduced so that the total benefits paid by the primary plan and this plan during a claim determination period will not exceed Our maximum available benefit for each Covered Service. Also, the amount We pay will not be more than the amount We would pay if We were primary. As each claim is submitted, We will determine Our obligation to pay for allowable expenses based upon all claims that have been submitted up to that point in time during the claim determination period.

D. Right to Receive and Release Necessary Information.
We may release or receive information that We need to coordinate benefits. We do not need to tell anyone or receive consent to do this. We are not responsible to anyone for releasing or obtaining this information. You must give Us any needed information for coordination purposes, in the time frame requested.

E. Our Right to Recover Overpayment.
If We made a payment as a primary plan, You agree to pay Us any amount by which We should have reduced Our payment. Also, We may recover any overpayment from the primary plan or the Provider receiving payment and You agree to sign all documents necessary to help Us recover any overpayment.

F. Coordination with "Always Excess," "Always Secondary," or "Non-Complying" Plans.
Except as described below, We will coordinate benefits with plans, whether insured or self-insured, that provide benefits that are stated to be always excess or always secondary or use order of benefit determination rules that are inconsistent with the rules described above in the following manner:

1. If this Certificate is primary, as defined in this section, We will pay benefits first.

2. If this Certificate is secondary, as defined in this section, We will pay only the amount We would pay as the secondary insurer.

3. If We request information from a non-complying plan and do not receive it within thirty (30) days, We will calculate the amount We should pay on the assumption that the non-complying plan and this Certificate provide identical benefits. When the information is received, We will make any necessary adjustments.

If a blanket accident insurance policy issued in accordance with Section 1015.11 of the General Business Law contains a provision that its benefits are excess or always secondary, then this Certificate is primary.

Section XXII

Termination of Coverage

Coverage under this Certificate will automatically be terminated on the first of the following to apply:

1. The Group and/or Subscriber has failed to pay Premiums within thirty (30) days of when Premiums are due. Coverage will terminate as of the last day for which Premiums were paid.

2. The end of the month in which the Subscriber ceases to meet the eligibility requirements as defined by the Group.

3. Upon the Subscriber's death, coverage will terminate unless the Subscriber has coverage for Dependents. If the Subscriber has coverage for Dependents, then coverage will terminate as of the last day of the month for which the Premium had been paid.

4. For Spouses in cases of divorce, the date of the divorce.

5. For Children, until the end of the month in which the Child turns twenty-six (26) years of age.

6. For all other Dependents, the end of the month in which the Dependent ceases to be eligible.

7. The end of the month during which the Group or Subscriber provides written notice to Us requesting termination of coverage, or on such later date requested for such termination by the notice.

8. If the Subscriber or the Subscriber's Dependent has performed an act that constitutes fraud or the Subscriber has made an intentional misrepresentation of material fact in writing on his or her enrollment application, or in order to obtain coverage for a service, coverage will terminate immediately upon written notice of termination delivered by Us to the Subscriber and/or the Subscriber's Dependent, as applicable. However, if the Subscriber makes an intentional misrepresentation of material fact in writing on his or her enrollment application, We will rescind coverage if the facts misrepresented would have led Us to refuse to issue the coverage. Rescission means that the termination of Your coverage will have a retroactive effect of up to Your enrollment under the Certificate. If termination is a result of the Subscriber's action, coverage will terminate for the Subscriber and any Dependents. If termination is a result of the Dependent's action, coverage will terminate for the Dependent.

9. The date that the Group Contract is terminated. If We decide to stop offering a particular class of group contracts, without regard to claims experience or health related status, to which this Certificate belongs, We will provide the Group and Subscribers at least ninety (90) days' prior written notice.

10. If We decide to stop offering all hospital, surgical and medical expense coverage in the large group market in this state, We will provide written notice to the Group and Subscriber at least one hundred eighty (180) days prior to when the coverage will cease.

11. The Group has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.

12. The Group ceases to meet the statutory requirements to be defined as a group for the purposes of obtaining coverage. We will provide written notice to the Group and Subscriber at least thirty (30) days prior to when the coverage will cease.

13. The date there is no longer any Subscriber who lives, resides, or works in Our Service Area.

No termination shall prejudice the right to a claim for benefits which arose prior to such termination.

See the Continuation of Coverage section of this Certificate for Your right to continuation of this coverage. See the Conversion Right to a New Contract after Termination section of this Certificate for Your right to conversion to an individual Contract.

Section XXIII

Extension of Benefits

When Your coverage under this Certificate ends, benefits stop. But, if You are totally disabled on the date the Group Contract terminates, or on the date Your coverage under this Certificate terminates, continued benefits may be available for the treatment of the injury or sickness that is the cause of the total disability.

For purposes of this section, "total disability" means You are prevented because of injury or disease from engaging in any work or other gainful activity. Total disability for a minor means that the minor is prevented because of injury or disease from engaging in substantially all of the normal activities of a person of like age and sex who is in good health.

A. When You May Continue Benefits.
When Your coverage under this Certificate ends, We will provide benefits during a period of total disability for a Hospital stay commencing, or surgery performed, within thirty-one (31) days from the date Your coverage ends. The Hospital stay or surgery must be for the treatment of the injury, sickness, or pregnancy causing the total disability.

If Your coverage ends because You are no longer employed, We will provide benefits during a period of total disability for up to twelve (12) months from the date Your coverage ends for Covered Services to treat the injury, sickness, or pregnancy that caused the total disability, unless these services are covered under another group health plan.

B. Termination of Extension of Benefits.
Extended benefits will end on the earliest of the following:

- The date You are no longer totally disabled;
- The date the contractual benefit has been exhausted;
- Twelve (12) months from the date extended benefits began (if Your benefits are extended based on termination of employment); or
- With respect to the twelve (12) month extension of coverage, the date You become eligible for benefits under any group policy providing medical benefits.

C. Limits on Extended Benefits.
We will not pay extended benefits:

- For any Member who is not totally disabled on the date coverage under this Certificate ends; or
- Beyond the extent to which We would have paid benefits under this Certificate if coverage had not ended.

Section XXIV

Continuation of Coverage

Under the continuation of coverage provisions of the federal Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), most employer-sponsored group health plans must offer employees and their families the opportunity for a temporary continuation of health insurance coverage when their coverage would otherwise end. If You are not entitled to temporary continuation of coverage under COBRA, You may be entitled to temporary continuation coverage under the New York Insurance Law as described below. Call or write Your employer to find out if You are entitled to temporary continuation of coverage under COBRA or under the New York Insurance Law. Any period of continuation of coverage will terminate automatically at the end of the period of continuation provided under COBRA or the New York Insurance Law.

A. Qualifying Events.
Pursuant to federal COBRA and state continuation coverage laws, You, the Subscriber, Your Spouse and Your Children may be able to temporarily continue coverage under this Certificate in certain situations when You would otherwise lose coverage, known as qualifying events.

1. If Your coverage ends due to voluntary or involuntary termination of employment or a change in Your employee class (e.g., a reduction in the number of hours of employment), You may continue coverage. Coverage may be continued for You, Your Spouse and any of Your covered Children.

2. If You are a covered Spouse, You may continue coverage if Your coverage ends due to:
    - Voluntary or involuntary termination of the Subscriber's employment;
    - Reduction in the hours worked by the Subscriber or other change in the Subscriber's class;
    - Divorce or legal separation from the Subscriber; or
    - Death of the Subscriber.

3. If You are a covered Child, You may continue coverage if Your coverage ends due to:
    - Voluntary or involuntary termination of the Subscriber's employment;
    - Reduction in the hours worked by the Subscriber or other change in the Subscriber's class;
    - Loss of covered Child status under the plan rules; or
    - Death of the Subscriber.

If You want to continue coverage, You must request continuation from the Group in writing and make the first Premium payment within the sixty (60)-day period following the later of:
1. The date coverage would otherwise terminate; or
2. The date You are sent notice by first class mail of the right of continuation by the Group.

The Group may charge up to 102% of the Group Premium for continued coverage.

Continued coverage under this section will terminate at the earliest of the following:

1. The date thirty-six (36) months after the Subscriber's coverage would have terminated because of termination of employment;
2. If You are a covered Spouse or Child, the date thirty-six (36) months after coverage would have terminated due to the death of the Subscriber, divorce or legal separation, the Subscriber's eligibility for Medicare, or the failure to qualify under the definition of "Children";
3. The date You become covered by an insured or uninsured arrangement that provides group hospital, surgical or medical coverage;
4. The date You become entitled to Medicare;
5. The date to which Premiums are paid if You fail to make a timely payment; or
6. The date the Group Contract terminates. However, if the Group Contract is replaced with similar coverage, You have the right to become covered under the new Group Contract for the balance of the period remaining for Your continued coverage.

When Your continuation of coverage ends, You may have a right to conversion. See the Conversion Right to a New Contract after Termination section of this Certificate.

B. Supplementary Continuation, Conversion, and Temporary Suspension Rights During Active Duty.

If You, the Subscriber are a member of a reserve component of the armed forces of the United States, including the National Guard, You have the right to continuation, conversion, or a temporary suspension of coverage during active duty and reinstatement of coverage at the end of active duty if Your Group does not voluntarily maintain Your coverage and if:

1. Your active duty is extended during a period when the president is authorized to order units of the reserve to active duty, provided that such additional active duty is at the request and for the convenience of the federal government; and
2. You serve no more than four (4) years of active duty.

When Your Group does not voluntarily maintain Your coverage during active duty, coverage under this Certificate will be suspended unless You elect to continue coverage in writing within sixty (60) days of being ordered to active duty and You pay the Group the required Premium payment but not more frequently than on a monthly basis in advance. This right of continuation extends to You and Your eligible Dependents. Continuation of coverage is not available for any person who is eligible to be covered under Medicare; or any person who is covered as an employee, member or dependent under any other insured or uninsured arrangement which provides group hospital, surgical or medical coverage, except for coverage available to active duty members of the uniformed services and their family members.

Upon completion of active duty:

1. Your coverage under this Certificate may be resumed as long as You are reemployed or restored to participation in the Group upon return to civilian status. The right of resumption extends to coverage for Your covered Dependents. For coverage that was suspended while on active duty, coverage under the Group plan will be retroactive to the date on which active duty terminated.
2. If You are not reemployed or restored to participation in Your Group upon return to civilian status, You will be eligible for continuation and conversion as long as You apply to Us for coverage within thirty-one (31) days of the termination of active duty or discharge from a Hospitalization resulting from active duty as long as the Hospitalization was not in excess of one (1) year.

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

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

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

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

The Subscriber's Child may elect this coverage:

1. Within sixty (60) days of the date that his or her coverage would otherwise end due to reaching the maximum age for Dependent coverage, in which case coverage will be retroactive to the date that coverage would otherwise have terminated;
2. Within sixty (60) days of newly meeting the eligibility requirements, in which case coverage will be prospective and start within thirty (30) days of when the Group or the Group's designee receives notice and We receive Premium payment; or
3. During an annual thirty (30)-day open enrollment period, in which case coverage will be prospective and will start within thirty (30) days of when the Group or the Group's designee receives notice of election and We receive Premium payment.

The Subscriber or Subscriber's Child must pay the Premium rate that applies to individual coverage. Coverage will be the same as the coverage provided under this Certificate. The Child's children are not eligible for coverage under this option.

Section XXV

Conversion Right to a New Contract after Termination

A. Circumstances Giving Rise to Right to Conversion.
You have the right to convert to a new Contract if coverage under this Certificate terminates under the circumstances described below.

1. **Termination of the Group Contract.** If the Group Contract between Us and the Group is terminated as set forth in the Termination of Coverage section of this Certificate, and the Group has not replaced the coverage with similar and continuous health care coverage, whether insured or self-insured, You are entitled to purchase a new Contract as a direct payment member.

2. **If You Are No Longer Covered in a Group.** If Your coverage terminates under the Termination of Coverage section of this Certificate because You are no longer a member of a Group, You are entitled to purchase a new Contract as a direct payment member.

3. **On the Death of the Subscriber.** If coverage terminates under the Termination of Coverage section of this Certificate because of the death of the Subscriber, the Subscriber's Dependents are entitled to purchase a new Contract as direct payment members.

4. **Termination of Your Marriage.** If a Spouse's coverage terminates under the Termination of Coverage section of this Certificate because the Spouse becomes divorced from the Subscriber or the marriage is annulled, that former Spouse is entitled to purchase a new Contract as a direct payment member.

5. **Termination of Coverage of a Child.** If a Child's coverage terminates under the Termination of Coverage section of this Certificate because the Child no longer qualifies as a Child, the Child is entitled to purchase a new Contract as a direct payment member.

6. **Termination of Your Temporary Continuation of Coverage.** If coverage terminates under the Termination of Coverage section of this Certificate because You are no longer eligible for continuation of coverage, You are entitled to purchase a new Contract as a direct payment member.

7. **Termination of Your Young Adult Coverage.** If a Child's young adult coverage terminates under the Termination of Coverage section of this Certificate, the Child is entitled to purchase a new Contract as a direct payment member.

B. When to Apply for the New Contract.
If You are entitled to purchase a new Contract as described above, You must apply to Us for the new Contract within sixty (60) days after termination of coverage under this Certificate. You must also pay the first Premium of the new Contract at the time You apply for coverage.

C. The New Contract.
We will offer You an individual direct payment Contract at each level of coverage (i.e., bronze, silver, gold or platinum) that Covers all benefits required by state and federal law. You may choose among any of the four (4) Contracts offered by Us. The coverage may not be the same as Your current coverage.

Section XXVI

General Provisions

1. Agreements Between Us and Participating Providers.
Any agreement between Us and Participating Providers may only be terminated by Us or the Providers. This Certificate does not require any Provider to accept a Member as a patient. We do not guarantee a Member's admission to any Participating Provider or any health benefits program.

2. Assignment.
You cannot assign any benefits under this Certificate or legal claims based on a denial of benefits or request for plan documents to any person, corporation or other organization. You cannot assign any monies due under this Certificate to any person, corporation or other organization unless it is an assignment to Your Provider for a surprise bill or to a Hospital for Emergency Services, including inpatient services following Emergency Department Care. See the How Your Coverage Works section of this Certificate for more information about surprise bills. Any assignment of benefits or legal claims based on a denial of benefits or request for plan documents by You other than for monies due for a surprise bill or an assignment of monies due to a Hospital for Emergency Services, including inpatient services following Emergency Department Care, will be void and unenforceable. Assignment means the transfer to another person, corporation or other organization of Your right to the services provided under this Certificate or Your right to collect money from Us for those services or Your right to sue based on a denial of benefits or request for plan documents. Nothing in this paragraph shall affect Your right to appoint a designee or representative as otherwise permitted by applicable law.

3. Changes in this Certificate.
We may unilaterally change this Certificate upon renewal, if We give the Group thirty (30) days' prior written notice.

4. Choice of Law.
This Certificate shall be governed by the laws of the State of New York.

5. Clerical Error.
Clerical error, whether by the Group or Us, with respect to this Certificate, or any other documentation issued by Us in connection with this Certificate, or in keeping any record pertaining to the coverage hereunder, will not modify or invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated.

6. Conformity with Law.
Any term of this Certificate which is in conflict with New York State law or with any applicable federal law that imposes additional requirements from what is required under New York State law will be amended to conform with the minimum requirements of such law.

7. Continuation of Benefit Limitations.
Some of the benefits in this Certificate may be limited to a specific number of visits, and/or subject to a Deductible. You will not be entitled to any additional benefits if Your coverage status should change during the year. For example, if Your coverage status changes from covered family member to

Subscriber, all benefits previously utilized when You were a covered family member will be applied toward Your new status as a Subscriber.

8. Enrollment ERISA.
The Group will develop and maintain complete and accurate payroll records, as well as any other records of the names, addresses, ages, and social security numbers of all Group Members covered under this Certificate, and any other information required to confirm their eligibility for coverage.

The Group will provide Us with this information upon request. The Group may also have additional responsibilities as the "plan administrator" as defined by the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended. The "plan administrator" is the Group, or a third party appointed by the Group. We are not the ERISA plan administrator.

9. Entire Agreement.
This Certificate, including any endorsements, riders and the attached applications, if any, constitutes the entire Certificate.

10. Fraud and Abusive Billing.
We have processes to review claims before and after payment to detect fraud and abusive billing. Members seeking services from Non-Participating Providers could be balance billed by the Non-Participating Provider for those services that are determined to be not payable as a result of a reasonable belief of fraud or other intentional misconduct or abusive billing.

11. Furnishing Information and Audit.
The Group and all persons covered under this Certificate will promptly furnish Us with all information and records that We may require from time to time to perform Our obligations under this Certificate. You must provide Us with information over the telephone for reasons such as the following: to allow Us to determine the level of care You need; so that We may certify care authorized by Your Physician; or to make decisions regarding the Medical Necessity of Your care. The Group will, upon reasonable notice, make available to Us, and We may audit and make copies of, any and all records relating to Group enrollment at the Group's New York office.

12. Identification Cards.
Identification ("ID") cards are issued by Us for identification purposes only. Possession of any ID card confers no right to services or benefits under this Certificate. To be entitled to such services or benefits, Your Premiums must be paid in full at the time the services are sought to be received.

13. Incontestability.
No statement made by You will be the basis for avoiding or reducing coverage unless it is in writing and signed by You. All statements contained in any such written instrument shall be deemed representations and not warranties.

14. Input in Developing Our Policies.
Subscribers may participate in the development of Our policies by writing to Us at **EmblemHealth, Customer Service Department, 55 Water Street, New York, NY 10041-8190**; e-mail Us by visiting www.emblemhealth.com, or calling Us at the number on Your ID card.

15. Material Accessibility.
We will give the Group, and the Group will give You ID cards, Certificates, riders and other necessary materials.

16. More Information about Your Health Plan.
You can request additional information about Your coverage under this Certificate. Upon Your request, We will provide the following information:

- A list of the names, business addresses and official positions of Our board of directors, officers and members; and Our most recent annual certified financial statement which includes a balance sheet and a summary of the receipts and disbursements.
- The information that We provide the State regarding Our consumer complaints.
- A copy of Our procedures for maintaining confidentiality of Member information.
- A copy of Our drug Formulary. You may also inquire if a specific drug is Covered under this Certificate.
- A written description of Our quality assurance program.
- A copy of Our medical policy regarding an experimental or investigational drug, medical device or treatment in clinical trials.
- Provider affiliations with participating Hospitals.
- A copy of Our clinical review criteria (e.g., Medical Necessity criteria), and where appropriate, other clinical information We may consider regarding a specific disease, course of treatment or Utilization Review guidelines, including clinical review criteria relating to a step therapy protocol override determination.
- Written application procedures and minimum qualification requirements for Providers.
- Documents that contain the processes, strategies, evidentiary standards, and other factors used to apply a treatment limitation with respect to medical/surgical benefits and mental health or substance use disorder benefits under the Certificate.

17. Notice.
Any notice that We give You under this Certificate will be mailed to Your address as it appears in Our records or delivered electronically if You consent to electronic delivery or to the address of the Group. If notice is delivered to You electronically, You may also request a copy of the notice from Us. You agree to provide Us with notice of any change of Your address. If You have to give Us any notice, it should be sent by U.S. mail, first class, postage prepaid to: EmblemHealth, 55 Water Street, New York, NY 10041.

18. Premium Refund.
We will give any refund of Premiums, if due, to the Group.

19. Recovery of Overpayments.
On occasion, a payment will be made to You when You are not covered, for a service that is not Covered, or which is more than is proper. When this happens, We will explain the problem to You and You must return the amount of the overpayment to Us within sixty (60) days after receiving notification from Us. However, We shall not initiate overpayment recovery efforts more than twenty-four (24) months after the original payment was made unless We have a reasonable belief of fraud or other intentional misconduct.

20. Renewal Date.
The renewal date for this Certificate is the anniversary of the effective date of the Group Contract of each year. This Certificate will automatically renew each year on the renewal date, unless otherwise terminated by Us as permitted by this Certificate or by the Group upon thirty (30) days' prior written notice to Us.

21. Right to Develop Guidelines and Administrative Rules.
We may develop or adopt standards that describe in more detail when We will or will not make payments under this Certificate. Examples of the use of the standards are to determine whether: Hospital inpatient care was Medically Necessary; surgery was Medically Necessary to treat Your illness or injury; or certain services are skilled care. Those standards will not be contrary to the descriptions in this Certificate. If You have a question about the standards that apply to a particular benefit, You may contact Us and We will explain the standards or send You a copy of the standards. We may also develop administrative rules pertaining to enrollment and other administrative matters. We shall have all the powers necessary or appropriate to enable Us to carry out Our duties in connection with the administration of this Certificate.

22. Right to Offset.
If We make a claim payment to You or on Your behalf in error or You owe Us any money, You must repay the amount You owe Us. Except as otherwise required by law, if We owe You a payment for other claims received, We have the right to subtract any amount You owe Us from any payment We owe You.

23. Severability.
The unenforceability or invalidity of any provision of this Certificate shall not affect the validity and enforceability of the remainder of this Certificate.

24. Significant Change in Circumstances.
If We are unable to arrange for Covered Services as provided under this Certificate as the result of events outside of Our control, We will make a good faith effort to make alternative arrangements. These events would include a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of Participating Providers' personnel, or similar causes. We will make reasonable attempts to arrange for Covered Services. We and Our Participating Providers will not be liable for delay, or failure to provide or arrange for Covered Services if such failure or delay is caused by such an event.

25. Subrogation and Reimbursement.
These paragraphs apply when another party (including any insurer) is, or may be found to be, responsible for Your injury, illness or other condition and We have provided benefits related to that injury, illness or condition. As permitted by applicable state law, unless preempted by federal law, We may be subrogated to all rights of recovery against any such party (including Your own insurance carrier) for the benefits We have provided to You under this Certificate. Subrogation means that We have the right, independently of You, to proceed directly against the other party to recover the benefits that We have provided.

Subject to applicable state law, unless preempted by federal law, We may have a right of reimbursement if You or anyone on Your behalf receives payment from any responsible party (including Your own insurance carrier) from any settlement, verdict or insurance proceeds, in connection with an injury, illness, or condition for which We provided benefits. Under Section 5-335 of the New York General Obligations Law, Our right of recovery does not apply when a settlement is reached between a plaintiff and defendant, unless a statutory right of reimbursement exists. The law also provides that, when entering into a settlement, it is presumed that You did not take any action against Our rights or violate any contract between You and Us. The law presumes that the settlement between You and the responsible party does not include compensation for the cost of health care services for which We provided benefits.

We request that You notify Us within thirty (30) days of the date when any notice is given to any party, including an insurance company or attorney, of Your intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, illness or condition sustained by You for which We have provided benefits. You must provide all information requested by Us or Our representatives including, but not limited to, completing and submitting any applications or other forms or statements as We may reasonably request.

26. Third Party Beneficiaries.
No third party beneficiaries are intended to be created by this Certificate and nothing in this Certificate shall confer upon any person or entity other than You or Us any right, benefit, or remedy of any nature whatsoever under or by reason of this Certificate. No other party can enforce this Certificate's provisions or seek any remedy arising out of either Our or Your performance or failure to perform any portion of this Certificate, or to bring an action or pursuit for the breach of any terms of this Certificate.

27. Time to Sue.
No action at law or in equity may be maintained against Us prior to the expiration of sixty (60) days after written submission of a claim has been furnished to Us as required in this Certificate. You must start any lawsuit against Us under this Certificate within two (2) years from the date the claim was required to be filed.

28. Translation Services.
Translation services are available under this Certificate for non-English speaking Members. Please contact Us at the number on Your ID card to access these services.

29. Venue for Legal Action.
If a dispute arises under this Certificate, it must be resolved in a court located in the State of New York. You agree not to start a lawsuit against Us in a court anywhere else. You also consent to New York State courts having personal jurisdiction over You. That means that, when the proper procedures for starting a lawsuit in these courts have been followed, the courts can order You to defend any action We bring against You.

30. Waiver.
The waiver by any party of any breach of any provision of this Certificate will not be construed as a waiver of any subsequent breach of the same or any other provision. The failure to exercise any right hereunder will not operate as a waiver of such right.

31. Who May Change this Certificate.
This Certificate may not be modified, amended, or changed, except in writing and signed by Our President and Chief Executive Officer ("CEO") or a person designated by the President and CEO. No employee, agent, or other person is authorized to interpret, amend, modify, or otherwise change this Certificate in a manner that expands or limits the scope of coverage, or the conditions of eligibility, enrollment, or participation, unless in writing and signed by the President and CEO or person designated by the President and CEO.

32. Who Receives Payment under this Certificate.
Payments under this Certificate for services provided by a Participating Provider will be made directly by Us to the Provider. If You receive services from a Non-Participating Provider, We reserve the right to pay either You or the Provider. If You assign benefits for a surprise bill to a Non-Participating Provider, We will pay the Non-Participating Provider directly. See the How Your Coverage Works section of this Certificate for more information about surprise bills.

33. Workers' Compensation Not Affected.
The coverage provided under this Certificate is not in lieu of and does not affect any requirements for coverage by workers' compensation insurance or law.

34. Your Medical Records and Reports.
In order to provide Your coverage under this Certificate, it may be necessary for Us to obtain Your medical records and information from Providers who treated You. Our actions to provide that coverage include processing Your claims, reviewing Grievances, Appeals or complaints involving Your care, and quality assurance reviews of Your care, whether based on a specific complaint or a routine audit of randomly selected cases. By accepting coverage under this Certificate, except as prohibited by state or federal law, You automatically give Us or Our designee permission to obtain and use Your medical records for those purposes and You authorize each and every Provider who renders services to You to:

- Disclose all facts pertaining to Your care, treatment, and physical condition to Us or to a medical, dental, or mental health professional that We may engage to assist Us in reviewing a treatment or claim, or in connection with a complaint or quality of care review;
- Render reports pertaining to Your care, treatment, and physical condition to Us, or to a medical, dental, or mental health professional that We may engage to assist Us in reviewing a treatment or claim; and
- Permit copying of Your medical records by Us.

We agree to maintain Your medical information in accordance with state and federal confidentiality requirements. However, to the extent permitted under state or federal law, You automatically give Us permission to share Your information with the New York State Department of Health, quality oversight organizations, and third parties with which We contract to assist Us in administering this Certificate, so long as they also agree to maintain the information in accordance with state and federal confidentiality requirements.

35. Your Rights and Responsibilities.
As a Member, You have rights and responsibilities when receiving health care. As Your health care partner, We want to make sure Your rights are respected while providing Your health benefits. You have the right to obtain complete and current information concerning a diagnosis, treatment and prognosis from a Physician or other Provider in terms You can reasonably understand. When it is not

advisable to give such information to You, the information shall be made available to an appropriate person acting on Your behalf.

You have the right to receive information from Your Physician or other Provider that You need in order to give Your informed consent prior to the start of any procedure or treatment.

You have the right to refuse treatment to the extent permitted by law and to be informed of the medical consequences of that action.

You have the right to formulate advance directives regarding Your care.

You have the right to access Our Participating Providers.

As a Member, You should also take an active role in Your care. We encourage You to:

- Understand Your health problems as well as You can and work with Your Providers to make a treatment plan that You all agree on;
- Follow the treatment plan that You have agreed on with Your doctors or Providers;
- Give Us, Your doctors and other Providers the information needed to help You get the care You need and all the benefits You are eligible for under Your Certificate. This may include information about other health insurance benefits You have along with Your coverage with Us; and
- Inform Us if You have any changes to Your name, address or Dependents covered under Your Certificate.

Commercial Certificate of Coverage without Rx

Provided on the following pages is our Commercial Certificate of Coverage without prescription drug coverage. Note that we are submitting both versions since there are minor differences, such as section numbers, between both certificates beyond the prescription drug coverage section.

EmblemHealth

THIS IS YOUR

EMBLEMHEALTH HEALTH MAINTENANCE ORGANIZATION (HMO) CERTIFICATE OF COVERAGE

Issued by

HEALTH INSURANCE PLAN OF GREATER NEW YORK (hereinafter referred to as "HIP")

55 Water Street, New York, New York 10041

This Certificate of Coverage ("Certificate") explains the benefits available to You under a Group Contract between HIP (hereinafter referred to as "We", "Us" or "Our") and the Group listed in the Group Contract. This Certificate is not a contract between You and Us. Amendments, riders or endorsements may be delivered with the Certificate or added thereafter.

In-Network Benefits. This Certificate only covers in-network benefits. To receive in-network benefits You must receive care exclusively from Participating Providers in Our Prime network. Care Covered under this Certificate (including Hospitalization) must be provided, arranged or authorized in advance by Your Primary Care Physician and, when required, approved by Us. In order to receive the benefits under this Certificate, You must contact Your Primary Care Physician before You obtain the services, except for services to treat an Emergency or urgent Condition described in the Emergency Services and Urgent Care section of this Certificate. Except for care for an Emergency Condition described in the Emergency Services and Urgent Care section of this Certificate, You will be responsible for paying the cost of all care that is provided by Non-Participating Providers.

READ THIS ENTIRE CERTIFICATE CAREFULLY. IT DESCRIBES THE BENEFITS AVAILABLE UNDER THE GROUP CONTRACT. IT IS YOUR RESPONSIBILITY TO UNDERSTAND THE TERMS AND CONDITIONS IN THIS CERTIFICATE.

This Certificate is governed by the laws of New York State.

Signed for Health Insurance Plan of Greater New York

Karen Ignagni
President and CEO

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Section I

Definitions

Defined terms will appear capitalized throughout this Certificate.

Acute: The onset of disease or injury, or a change in the Member's condition that would require prompt medical attention.

Allowed Amount: The maximum amount on which Our payment is based for Covered Services. See the Cost-Sharing Expenses and Allowed Amount section of this Certificate for a description of how the Allowed Amount is calculated.

Ambulatory Surgical Center: A Facility currently licensed by the appropriate state regulatory agency for the provision of surgical and related medical services on an outpatient basis.

Appeal: A request for Us to review a Utilization Review decision or a Grievance again.

Balance Billing: When a Non-Participating Provider bills You for the difference between the Non-Participating Provider's charge and the Allowed Amount. A Participating Provider may not Balance Bill You for Covered Services.

Certificate: This Certificate issued by HIP, including the Schedule of Benefits and any attached riders.

Child, Children: The Subscriber's Children, including any natural, adopted or step-children, unmarried disabled Children, newborn Children, or any other Children as described in the Who is Covered section of this Certificate.

Coinsurance: Your share of the costs of a Covered Service, calculated as a percent of the Allowed Amount for the service that You are required to pay to a Provider. The amount can vary by the type of Covered Service.

Copayment: A fixed amount You pay directly to a Provider for a Covered Service when You receive the service. The amount can vary by the type of Covered Service.

Cost-Sharing: Amounts You must pay for Covered Services, expressed as Copayments, Deductibles and/or Coinsurance.

Cover, Covered or Covered Services: The Medically Necessary services paid for, arranged, or authorized for You by Us under the terms and conditions of this Certificate.

Deductible: The amount You owe before We begin to pay for Covered Services. The Deductible applies before any Copayments or Coinsurance are applied. The Deductible may not apply to all Covered Services. You may also have a Deductible that applies to a specific Covered Service (e.g., a Prescription Drug Deductible) that You owe before We begin to pay for a particular Covered Service.

Dependents: The Subscriber's Spouse and Children.

Durable Medical Equipment ("DME"): Equipment which is:

- Designed and intended for repeated use;
- Primarily and customarily used to serve a medical purpose;
- Generally not useful to a person in the absence of disease or injury; and
- Appropriate for use in the home.

Emergency Condition: A medical or behavioral condition that manifests itself by Acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;
- Serious impairment to such person's bodily functions;
- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of such person.

Emergency Department Care: Emergency Services You get in a Hospital emergency department.

Emergency Services: A medical screening examination which is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Condition; and within the capabilities of the staff and facilities available at the Hospital, such further medical examination and treatment as are required to stabilize the patient. "To stabilize" is to provide such medical treatment of an Emergency Condition as may be necessary to assure that, within reasonable medical probability, no material deterioration of the condition is likely to result from or occur during the transfer of the patient from a Facility, or to deliver a newborn child (including the placenta).

Exclusions: Health care services that We do not pay for or Cover.

External Appeal Agent: An entity that has been certified by the New York State Department of Financial Services to perform external appeals in accordance with New York law.

Facility: A Hospital; Ambulatory Surgical Center; birthing center; dialysis center; rehabilitation Facility; Skilled Nursing Facility; hospice; Home Health Agency or home care services agency certified or licensed under Article 36 of the New York Public Health Law; a comprehensive care center for eating disorders pursuant to Article 27-J of the New York Public Health Law; and a Facility defined in New York Mental Hygiene Law Sections 1.03(10) and (33), certified by the New York State Office of Alcoholism and Substance Abuse Services, or certified under Article 28 of the New York Public Health Law (or, in other states, a similarly licensed or certified Facility). If You receive treatment for substance use disorder outside of New York State, a Facility also includes one which is accredited by the Joint Commission to provide a substance use disorder treatment program.

Grievance: A complaint that You communicate to Us that does not involve a Utilization Review determination.

Group: The employer or party that has entered into an agreement with Us as a contractholder.

Habilitation Services: Health care services that help a person keep, learn or improve skills and functioning for daily living. Habilitative Services include the management of limitations and disabilities, including services or programs that help maintain or prevent deterioration in physical, cognitive, or behavioral function. These services consist of physical therapy, occupational therapy and speech therapy.

Health Care Professional: An appropriately licensed, registered or certified Physician; dentist; optometrist; chiropractor; psychologist; social worker; podiatrist; physical therapist; occupational therapist; midwife; speech-language pathologist; audiologist; pharmacist; behavior analyst; or any other licensed, registered or certified Health Care Professional under Title 8 of the New York Education Law (or other comparable state law, if applicable) that the New York Insurance Law requires to be recognized who charges and bills patients for Covered Services. The Health Care Professional's services must be rendered within the lawful scope of practice for that type of Provider in order to be covered under this Certificate.

Home Health Agency: An organization currently certified or licensed by the State of New York or the state in which it operates and renders home health care services.

Hospice Care: Care to provide comfort and support for persons in the last stages of a terminal illness and their families that are provided by a hospice organization certified pursuant to Article 40 of the New York Public Health Law or under a similar certification process required by the state in which the hospice organization is located.

Hospital: A short term, acute, general Hospital, which:

- Is primarily engaged in providing, by or under the continuous supervision of Physicians, to patients, diagnostic services and therapeutic services for diagnosis, treatment and care of injured or sick persons;
- Has organized departments of medicine and major surgery;
- Has a requirement that every patient must be under the care of a Physician or dentist;
- Provides 24-hour nursing service by or under the supervision of a registered professional nurse (R.N.);
- If located in New York State, has in effect a Hospitalization review plan applicable to all patients which meets at least the standards set forth in 42 U.S.C. Section 1395x(k);
- Is duly licensed by the agency responsible for licensing such Hospitals; and
- Is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial, educational, or rehabilitory care.

Hospital does not mean health resorts, spas, or infirmaries at schools or camps.

Hospitalization: Care in a Hospital that requires admission as an inpatient and usually requires an overnight stay.

Hospital Outpatient Care: Care in a Hospital that usually does not require an overnight stay.

Medically Necessary: See the How Your Coverage Works section of this Certificate for the definition.

Medicare: Title XVIII of the Social Security Act, as amended.

Member: The Subscriber or a covered Dependent for whom required Premiums have been paid. Whenever a Member is required to provide a notice pursuant to a Grievance or emergency department visit or admission, "Member" also means the Member's designee.

Non-Participating Provider: A Provider who does not have a contract with Us to provide services to You. The services of Non-Participating Providers are Covered only for Emergency Services or when authorized by Us.

Out-of-Pocket Limit: The most You pay during a Plan Year in Cost-Sharing before We begin to pay 100% of the Allowed Amount for Covered Services. This limit never includes Your Premium, Balance Billing charges or the cost of health care services We do not Cover.

Participating Provider: A Provider who has a contract with Us to provide services to You. A list of Participating Providers and their locations is available on Our website at www.emblemhealth.com or upon Your request to Us. The list will be revised from time to time by Us.

Physician or Physician Services: Health care services a licensed medical Physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan Year: The twelve (12)-month period beginning on the effective date of the Group Policy or any anniversary date thereafter, during which this Certificate is in effect.

Preauthorization: A decision by Us prior to Your receipt of a Covered Service, procedure, treatment plan, device, or Prescription Drug that the Covered Service, procedure, treatment plan, device or Prescription Drug is Medically Necessary. We indicate which Covered Services require Preauthorization in the Schedule of Benefits section of this Certificate.

Premium: The amount that must be paid for Your health insurance coverage.

Prescription Drugs: A medication, product or device that has been approved by the Food and Drug Administration ("FDA") and that can, under federal or state law, be dispensed only pursuant to a prescription order or refill and is on Our formulary. A Prescription Drug includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver.

Primary Care Physician ("PCP"): A participating nurse practitioner or Physician who typically is an internal medicine, family practice or pediatric Physician and who directly provides or coordinates a range of health care services for You.

Provider: A Physician, Health Care Professional, or Facility licensed, registered, certified or accredited as required by state law. A Provider also includes a vendor or dispenser of diabetic equipment and supplies, durable medical equipment, medical supplies, or any other equipment or supplies that are Covered under this Certificate that is licensed, registered, certified or accredited as required by state law.

Referral: An authorization given to one Participating Provider from another Participating Provider (usually from a PCP to a participating Specialist) in order to arrange for additional care for a Member. A Referral can be transmitted electronically or by Your Provider completing a paper Referral form. Except as provided in the Access to Care and Transitional Care section of this Certificate or as otherwise authorized by Us, a Referral will not be made to a Non-Participating Provider.

Rehabilitation Services: Health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services consist of physical therapy, occupational therapy, and speech therapy in an inpatient and/or outpatient setting.

Schedule of Benefits: The section of this Certificate that describes the Copayments, Deductibles, Coinsurance, Out-of-Pocket Limits, Preauthorization requirements, Referral requirements, and other limits on Covered Services.

Service Area: The geographical area, designated by Us and approved by the State of New York, in which We provide coverage. Our Service Area consists of: Bronx, Kings, Manhattan, Queens, Richmond, Rockland, Nassau, Suffolk, Westchester, Broome, Otsego, Albany, Columbia, Fulton, Greene, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, Washington, Delaware, Dutchess, Orange, Putnam, Sullivan and Ulster counties.

Skilled Nursing Facility: An institution or a distinct part of an institution that is currently licensed or approved under state or local law; primarily engaged in providing skilled nursing care and related services as a Skilled Nursing Facility, extended care Facility, or nursing care Facility approved by the Joint Commission, or the Bureau of Hospitals of the American Osteopathic Association, or as a Skilled Nursing Facility under Medicare; or as otherwise determined by Us to meet the standards of any of these authorities.

Specialist: A Physician who focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.

Spouse: The person to whom the Subscriber is legally married, including a same sex Spouse.

Subscriber: The person to whom this Certificate is issued.

UCR (Usual, Customary and Reasonable): The cost of a medical service in a geographic area based on what Providers in the area usually charge for the same or similar medical service.

Urgent Care: Medical care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require Emergency Department Care. Urgent Care may be rendered in a participating Physician's office or Urgent Care Center.

Urgent Care Center: A licensed Facility (other than a Hospital) that provides Urgent Care.

Us, We, Our: Health Insurance Plan of Greater New York ("HIP") and anyone to whom We legally delegate performance, on Our behalf, under this Certificate.

Utilization Review: The review to determine whether services are or were Medically Necessary or experimental or investigational (i.e., treatment for a rare disease or a clinical trial).

You, Your: The Member.

Section II

How Your Coverage Works

A. Your Coverage Under this Certificate.
Your employer (referred to as the "Group") has purchased a Group HMO Contract from Us. We will provide the benefits described in this Certificate to covered Members of the Group, that is, to employees of the Group and their covered Dependents. However, this Certificate is not a contract between You and Us. You should keep this Certificate with Your other important papers so that it is available for Your future reference.

B. Covered Services.
You will receive Covered Services under the terms and conditions of this Certificate only when the Covered Service is:

- Medically Necessary;
- Provided by a Participating Provider;
- Listed as a Covered Service;
- Not in excess of any benefit limitations described in the Schedule of Benefits section of this Certificate; and
- Received while Your Certificate is in force.

When You are outside Our Service Area, coverage is limited to Emergency Services, Pre-Hospital Emergency Medical Services and ambulance services to treat Your Emergency Condition.

C. Participating Providers.
To find out if a Provider is a Participating Provider, and for details about licensure and training:

- Check Our Provider directory, available at Your request;
- Call the number on Your ID card; or
- Visit Our website at www.emblemhealth.com.

D. The Role of Primary Care Physicians.
This Certificate has a gatekeeper, usually known as a Primary Care Physician ("PCP"). This Certificate requires that You select a PCP. You need a written Referral from a PCP before receiving Specialist care from a Participating Provider.

You may select any participating PCP who is available from the list of PCPs in the HIP Prime Network. Each Member may select a different PCP. Children covered under this Certificate may designate a participating PCP who specializes in pediatric care. In certain circumstances, You may designate a Specialist as Your PCP. See the Access to Care and Transitional Care section of this Certificate for more information about designating a Specialist. To select a PCP, visit Our website at www.emblemhealth.com. If You do not select a PCP, We will assign one to You.

For purposes of Cost-Sharing, if You seek services from a PCP (or a Physician covering for a PCP) who has a primary or secondary specialty other than general practice, family practice, internal medicine, pediatrics and OB/GYN, You must pay the specialty office visit Cost-Sharing in the Schedule of Benefits section of this Certificate when the services provided are related to specialty care.

E. Services Not Requiring a Referral from Your PCP.
Your PCP is responsible for determining the most appropriate treatment for Your health care needs. You do not need a Referral from Your PCP to a Participating Provider for the following services:

- Primary and preventive obstetric and gynecologic services including annual examinations, care resulting from such annual examinations, treatment of Acute gynecologic conditions, or for any care related to a pregnancy from a qualified Participating Provider of such services;
- Emergency Services;
- Pre-Hospital Emergency Medical Services and emergency ambulance transportation;
- Maternal depression screening;
- Urgent Care;
- Chiropractic services;
- Outpatient mental health care;
- Outpatient substance use services;
- Refractive eye exams from an optometrist; and
- Diabetic eye exams from an ophthalmologist.

However, the Participating Provider must discuss the services and treatment plan with Your PCP; agree to follow Our policies and procedures including any procedures regarding Referrals or Preauthorization for services other than obstetric and gynecologic services rendered by such Participating Provider; and agree to provide services pursuant to a treatment plan (if any) approved by Us. See the Schedule of Benefits section of this Certificate for the services that require a Referral.

F. Access to Providers and Changing Providers.
Sometimes Providers in Our Provider directory are not available. Prior to notifying Us of the PCP You selected, You should call the PCP to make sure he or she is a Participating Provider and is accepting new patients.

To see a Provider, call his or her office and tell the Provider that You are a HIP Member, and explain the reason for Your visit. Have Your ID card available. The Provider's office may ask You for Your Group or Member ID number. When You go to the Provider's office, bring Your ID card with You.

You may change Your PCP by accessing Our website at www.emblemhealth.com, or by calling Customer Service. This can be done at any time through website access, or through Customer Service, Monday through Friday between 8 am and 6 pm.

You may change Your Specialist by contacting Your PCP to obtain a Referral. This can be done at any time during Your PCP's office hours.

If We do not have a Participating Provider for certain provider types in the county in which You live or in a bordering county that is within approved time and distance standards, We will approve a Referral to a specific Non-Participating Provider until You no longer need the care or We have a Participating Provider in Our network that meets the time and distance standards and Your care has been transitioned to that Participating Provider. Covered Services rendered by the Non-Participating Provider will be paid as if they were provided by a Participating Provider. You will be responsible only for any applicable in-network Cost-Sharing.

G. Services Subject to Preauthorization.
Our Preauthorization is required before You receive certain Covered Services. Your PCP is responsible for requesting Preauthorization for in-network services.

H. Preauthorization / Notification Procedure.
If You seek coverage for services that require Preauthorization or notification, Your Provider must call Us or Our vendor at the number on Your ID card.

Your Provider must contact Us to request Preauthorization as follows:

- At least two (2) weeks prior to a planned admission or surgery when Your Provider recommends inpatient Hospitalization. If that is not possible, then as soon as reasonably possible during regular business hours prior to the admission.
- At least two (2) weeks prior to ambulatory surgery or any ambulatory care procedure when Your Provider recommends the surgery or procedure be performed in an ambulatory surgical unit of a Hospital or in an Ambulatory Surgical Center. If that is not possible, then as soon as reasonably possible during regular business hours prior to the surgery or procedure.
- Within the first three (3) months of a pregnancy, or as soon as reasonably possible and again within forty-eight (48) hours after the actual delivery date if Your Hospital stay is expected to extend beyond forty-eight (48) hours for a vaginal birth or ninety-six (96) hours for cesarean birth.
- Before air ambulance services are rendered for a non-Emergency Condition.

You must contact Us to provide notification as follows:

- As soon as reasonably possible when air ambulance services are rendered for an Emergency Condition.
- If You are hospitalized in cases of an Emergency Condition, You must call Us within forty-eight (48) hours after Your admission or as soon thereafter as reasonably possible.

After receiving a request for approval, We will review the reasons for Your planned treatment and determine if benefits are available. Criteria will be based on multiple sources which may include medical policy, clinical guidelines, and pharmacy and therapeutic guidelines.

I. Medical Management.
The benefits available to You under this Certificate are subject to pre-service, concurrent and retrospective reviews to determine when services should be Covered by Us. The purpose of these reviews is to promote the delivery of cost-effective medical care by reviewing the use of procedures and, where appropriate, the setting or place the services are performed. Covered Services must be Medically Necessary for benefits to be provided.

J. Medical Necessity.
We Cover benefits described in this Certificate as long as the health care service, procedure, treatment, test, device, Prescription Drug or supply (collectively, "service") is Medically Necessary. The fact that a Provider has furnished, prescribed, ordered, recommended, or approved the service does not make it Medically Necessary or mean that We have to Cover it.

We may base Our decision on a review of:

- Your medical records;
- Our medical policies and clinical guidelines;
- Medical opinions of a professional society, peer review committee or other groups of Physicians;
- Reports in peer-reviewed medical literature;
- Reports and guidelines published by nationally-recognized health care organizations that include supporting scientific data;
- Professional standards of safety and effectiveness, which are generally-recognized in the United States for diagnosis, care, or treatment;
- The opinion of Health Care Professionals in the generally-recognized health specialty involved;
- The opinion of the attending Providers, which have credence but do not overrule contrary opinions.

Services will be deemed Medically Necessary only if:

- They are clinically appropriate in terms of type, frequency, extent, site, and duration, and considered effective for Your illness, injury, or disease;
- They are required for the direct care and treatment or management of that condition;
- Your condition would be adversely affected if the services were not provided;
- They are provided in accordance with generally-accepted standards of medical practice;
- They are not primarily for the convenience of You, Your family, or Your Provider;
- They are not more costly than an alternative service or sequence of services, that is at least as likely to produce equivalent therapeutic or diagnostic results;
- When setting or place of service is part of the review, services that can be safely provided to You in a lower cost setting will not be Medically Necessary if they are performed in a higher cost setting. For example, We will not provide coverage for an inpatient admission for surgery if the surgery could have been performed on an outpatient basis or an infusion or injection of a specialty drug provided in the outpatient department of a Hospital if the drug could be provided in a Physician's office or the home setting.

See the Utilization Review and External Appeal sections of this Certificate for Your right to an internal Appeal and external appeal of Our determination that a service is not Medically Necessary.

K. Protection from Surprise Bills.

1. A surprise bill is a bill You receive for Covered Services in the following circumstances:

- For services performed by a non-participating Physician at a participating Hospital or Ambulatory Surgical Center, when:
  - A participating Physician is unavailable at the time the health care services are performed;
  - A non-participating Physician performs services without Your knowledge; or
  - Unforeseen medical issues or services arise at the time the health care services are performed.

A surprise bill does not include a bill for health care services when a participating Physician is available and You elected to receive services from a non-participating Physician.

- You were referred by a participating Physician to a Non-Participating Provider without

Your explicit written consent acknowledging that the Referral is to a Non-Participating Provider and it may result in costs not covered by Us. For a surprise bill, a Referral to a Non-Participating Provider means:

- Covered Services are performed by a Non-Participating Provider in the participating Physician's office or practice during the same visit;
- The participating Physician sends a specimen taken from You in the participating Physician's office to a non-participating laboratory or pathologist; or
- For any other Covered Services performed by a Non-Participating Provider at the participating Physician's request, when Referrals are required under Your Certificate.

You will be held harmless for any Non-Participating Provider charges for the surprise bill that exceed Your Copayment, Deductible or Coinsurance if You assign benefits to the Non-Participating Provider in writing. In such cases, the Non-Participating Provider may only bill You for Your Copayment, Deductible or Coinsurance.

The assignment of benefits form for surprise bills is available at www.dfs.ny.gov or You can visit Our website at www.emblemhealth.com for a copy of the form. You need to mail a copy of the assignment of benefits form to Us at the address on Your ID card and to Your Provider.

2. **Independent Dispute Resolution Process.** Either We or a Provider may submit a dispute involving a surprise bill to an independent dispute resolution entity ("IDRE") assigned by the state. Disputes are submitted by completing the IDRE application form, which can be found at www.dfs.ny.gov. The IDRE will determine whether Our payment or the Provider's charge is reasonable within thirty (30) days of receiving the dispute.

L. Delivery of Covered Services Using Telehealth.

If Your Participating Provider offers Covered Services using telehealth, We will not deny the Covered Services because they are delivered using telehealth. Covered Services delivered using telehealth may be subject to utilization review and quality assurance requirements and other terms and conditions of the Certificate that are at least as favorable as those requirements for the same service when not delivered using telehealth. "Telehealth" means the use of electronic information and communication technologies by a Participating Provider to deliver Covered Services to You while Your location is different than Your Provider's location.

M. Early Intervention Program Services.

We will not exclude Covered Services solely because they are Early Intervention Program services for infants and toddlers under three (3) years of age who have a confirmed disability or an established developmental delay. Additionally, if Early Intervention Program services are otherwise covered under this Certificate, coverage for Early Intervention Program services will not be applied against any maximum annual or lifetime dollar limits if applicable. Visit limits and other terms and conditions will continue to apply to coverage for Early Intervention Program services. However, any visits used for Early Intervention Program services will not reduce the number of visits otherwise available under this Certificate.

N. Case Management.

Case management helps coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions. Our programs coordinate benefits and educate Members

who agree to take part in the case management program to help meet their health-related needs.

Our case management programs are confidential and voluntary. These programs are given at no extra cost to You and do not change Covered Services. If You meet program criteria and agree to take part, We will help You meet Your identified health care needs. This is reached through contact and team work with You and/or Your authorized representative, treating Physician(s), and other Providers. In addition, We may assist in coordinating care with existing community-based programs and services to meet Your needs, which may include giving You information about external agencies and community-based programs and services.

In certain cases of severe or chronic illness or injury, We may provide benefits for alternate care through Our case management program that is not listed as a Covered Service. We may also extend Covered Services beyond the benefit maximums of this Certificate. We will make Our decision on a case-by-case basis if We determine the alternate or extended benefit is in the best interest of You and Us.

Nothing in this provision shall prevent You from appealing Our decision. A decision to provide extended benefits or approve alternate care in one case does not obligate Us to provide the same benefits again to You or to any other Member. We reserve the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, We will notify You or Your representative in writing.

O. Important Telephone Numbers and Addresses.

- CLAIMS
  Submit claim forms to this address:
  Medical Claims: P.O. Box 2845, New York, NY 10116-2845
  Hospital Claims: P.O. Box 2803, New York, NY 10116-2803

  Submit electronic claim forms to this email address:
  EmblemHealthClaimSubmission@emblemhealth.com

- COMPLAINTS, GRIEVANCES AND UTILIZATION REVIEW APPEALS
  Members may call 1-800-447-8255

  Submit written Complaints and Grievances to this address:
  EmblemHealth Grievance and Appeals Department
  JAF Station
  P.O. Box 2844
  New York, NY 10016-2844

- ASSIGNMENT OF BENEFITS FORM
  Submit assignment of benefits forms for surprise bills to the address on Your ID card.

- CUSTOMER SERVICE
  1-800-447-8255
  (Customer Services Representatives are available Monday – Friday, 8:00 a.m. – 6:00p.m.)

- PREAUTHORIZATION
  1-800-447-8255

- BEHAVIORAL HEALTH SERVICES
  Call the number on Your ID card

- OUR WEBSITE
  www.emblemhealth.com

Section III

Access to Care and Transitional Care

A. Referral to a Non-Participating Provider.
If We determine that We do not have a Participating Provider that has the appropriate training and experience to treat Your condition, We will approve a Referral to an appropriate Non-Participating Provider. Your Participating Provider must request prior approval of the Referral to a specific Non-Participating Provider. Approvals of Referrals to Non-Participating Providers will not be made for the convenience of You or another treating Provider and may not necessarily be to the specific Non-Participating Provider You requested. If We approve the Referral, all services performed by the Non-Participating Provider are subject to a treatment plan approved by Us in consultation with Your PCP, the Non-Participating Provider and You. Covered Services rendered by the Non-Participating Provider will be Covered as if they were provided by a Participating Provider. You will be responsible only for any applicable in-network Cost-Sharing. In the event a Referral is not approved, any services rendered by a Non-Participating Provider will not be Covered.

B. When a Specialist Can Be Your Primary Care Physician.
If You have a life-threatening condition or disease or a degenerative and disabling condition or disease that requires specialty care over a long period of time, You may ask that a Specialist who is a Participating Provider be Your PCP. We will consult with the Specialist and Your PCP and decide whether the Specialist should be Your PCP. Any Referral will be pursuant to a treatment plan approved by Us in consultation with Your PCP, the Specialist and You. We will not approve a non-participating Specialist unless We determine that We do not have an appropriate Provider in Our network. If We approve a non-participating Specialist, Covered Services rendered by the non-participating Specialist pursuant to the approved treatment plan will be paid as if they were provided by a Participating Provider. You will only be responsible for any applicable in-network Cost-Sharing.

C. Standing Referral to a Participating Specialist.
If You need ongoing specialty care, You may receive a standing Referral to a Specialist who is a Participating Provider. This means that You will not need a new Referral from Your PCP every time You need to see that Specialist. We will consult with the Specialist and Your PCP and decide whether You should have a standing Referral. Any Referral will be pursuant to a treatment plan approved by Us in consultation with Your PCP, the Specialist and You. The treatment plan may limit the number of visits, or the period during which the visits are authorized and may require the Specialist to provide Your PCP with regular updates on the specialty care provided as well as all necessary medical information. We will not approve a standing Referral to a non-participating Specialist unless We determine that We do not have an appropriate Provider in Our network. If We approve a standing Referral to a non-participating Specialist, Covered Services rendered by the non-participating Specialist pursuant to the approved treatment plan will be paid as if they were provided by a Participating Provider. You will be responsible only for any applicable in-network Cost-Sharing.

D. Specialty Care Center.
If You have a life-threatening condition or disease or a degenerative and disabling condition or disease that requires specialty care over a long period of time, You may request a Referral to a specialty care center with expertise in treating Your condition or disease. A specialty care center is a center that has an accreditation or designation from a state agency, the federal government or a national health organization as having special expertise to treat Your disease or condition. We will consult with Your PCP, Your Specialist, and the specialty care center to decide whether to approve such a Referral. Any Referral will be pursuant to a treatment plan developed by the specialty care center, and approved by Us in consultation with Your PCP or Specialist and You. We will not approve a Referral to a non-participating specialty care center unless We determine that We do not have an appropriate specialty care center in Our network. If We approve a Referral to a non-participating specialty care center, Covered Services rendered by the non-participating specialty care center pursuant to the approved treatment plan will be paid as if they were provided by a participating specialty care center. You will be responsible only for any applicable in-network Cost-Sharing.

E. When Your Provider Leaves the Network.
If You are in an ongoing course of treatment when Your Provider leaves Our network, then You may be able to continue to receive Covered Services for the ongoing treatment from the former Participating Provider for up to ninety (90) days from the date Your Provider's contractual obligation to provide services to You terminates. If You are pregnant and in Your second or third trimester, You may be able to continue care with a former Participating Provider through delivery and any postpartum care directly related to the delivery.

In order for You to continue to receive Covered Services for up to ninety (90) days or through a pregnancy with a former Participating Provider, the Provider must agree to accept as payment the negotiated fee that was in effect just prior to the termination of Our relationship with the Provider. The Provider must also agree to provide Us necessary medical information related to Your care and adhere to Our policies and procedures, including those for assuring quality of care, obtaining Preauthorization, Referrals, and a treatment plan approved by Us. If the Provider agrees to these conditions, You will receive the Covered Services as if they were being provided by a Participating Provider. You will be responsible only for any applicable in-network Cost-Sharing. Please note that if the Provider was terminated by Us due to fraud, imminent harm to patients or final disciplinary action by a state board or agency that impairs the Provider's ability to practice, continued treatment with that Provider is not available.

F. New Members In a Course of Treatment.
If You are in an ongoing course of treatment with a Non-Participating Provider when Your coverage under this Certificate becomes effective, You may be able to receive Covered Services for the ongoing treatment from the Non-Participating Provider for up to sixty (60) days from the effective date of Your coverage under this Certificate. This course of treatment must be for a life-threatening disease or condition or a degenerative and disabling condition or disease. You may also continue care with a Non-Participating Provider if You are in the second or third trimester of a pregnancy when Your coverage under this Certificate becomes effective. You may continue care through delivery and any post-partum services directly related to the delivery.

In order for You to continue to receive Covered Services for up to sixty (60) days or through pregnancy, the Non-Participating Provider must agree to accept as payment Our fees for such services. The

Provider must also agree to provide Us necessary medical information related to Your care and to adhere to Our policies and procedures including those for assuring quality of care, obtaining Preauthorization, Referrals, and a treatment plan approved by Us. If the Provider agrees to these conditions, You will receive the Covered Services as if they were being provided by a Participating Provider. You will be responsible only for any applicable in-network Cost-Sharing.

Section IV

Cost-Sharing Expenses and Allowed Amount

A. Deductible.
There is no Deductible for Covered Services under this Certificate during each Plan Year.

B. Copayments.
Except where stated otherwise, You must pay the Copayments, or fixed amounts, in the Schedule of Benefits section of this Certificate for Covered Services. However, when the Allowed Amount for a service is less than the Copayment, You are responsible for the lesser amount.

C. Coinsurance.
Except where stated otherwise, You must pay a percentage of the Allowed Amount for Covered Services. We will pay the remaining percentage of the Allowed Amount as Your benefit as shown in the Schedule of Benefits section of this Certificate.

D. Out-of-Pocket Limit.
When You have met Your Out-of-Pocket Limit in payment of Copayments, Deductibles and Coinsurance for a Plan Year in the Schedule of Benefits section of this Certificate, We will provide coverage for 100% of the Allowed Amount for Covered Services for the remainder of that Plan Year. If You have other than individual coverage, once a person within a family meets the individual Out-of-Pocket Limit in the Schedule of Benefits section of this Certificate, We will provide coverage for 100% of the Allowed Amount for the rest of that Plan Year for that person. If other than individual coverage applies, when persons in the same family covered under this Certificate have collectively met the family Out-of-Pocket Limit in payment of Copayments, Deductibles and Coinsurance for a Plan Year in the Schedule of Benefits section of this Certificate, We will provide coverage for 100% of the Allowed Amount for the rest of that Plan Year for the entire family.

Cost-Sharing for out-of-network services, except for Emergency Services, out-of-network services approved by Us as an in-network exception and out-of-network dialysis does not apply toward Your Out-of-Pocket Limit.

E. Allowed Amount.
"Allowed Amount" means the maximum amount We will pay for the services or supplies Covered under this Certificate, before any applicable Copayment, Deductible and Coinsurance amounts are subtracted. We determine Our Allowed Amount as follows:

The Allowed Amount for Participating Providers will be the amount We have negotiated with the Participating Provider, or the Participating Provider's charge, if less.

See the Emergency Services and Urgent Care section of this Certificate for the Allowed Amount for Emergency Services rendered by Non-Participating Providers. See the Ambulance and Pre-Hospital Emergency Medical Services section of this Certificate for the Allowed Amount for Pre-Hospital Emergency Medical Services rendered by Non-Participating Providers.

Section V

Who is Covered

A. Who is Covered Under this Certificate.
You, the Subscriber to whom this Certificate is issued, are covered under this Certificate. You must live, work, or reside in Our Service Area to be covered under this Certificate. Members of Your family may also be covered depending on the type of coverage You selected.

B. Types of Coverage.
We offer the following types of coverage:

1. **Individual.** If You selected individual coverage, then You are covered.

2. **Individual and Spouse.** If You selected individual and Spouse coverage, then You and Your Spouse are covered.

3. **Parent and Child/Children.** If You selected parent and child/children coverage, then You and Your Child or Children, as described below, are covered.

4. **Family.** If You selected family coverage, then You and Your Spouse and Your Child or Children, as described below, are covered.

C. Children Covered Under this Certificate.
If You selected parent and child/children or family coverage, Children covered under this Certificate include Your natural Children, legally adopted Children, step Children, and Children for whom You are the proposed adoptive parent without regard to financial dependence, residency with You, student status or employment. A proposed adopted Child is eligible for coverage on the same basis as a natural Child during any waiting period prior to the finalization of the Child's adoption. Coverage lasts until the end of the month in which the Child turns twenty-six (26) years of age. Coverage also includes Children for whom You are a permanent legal guardian if the Children are chiefly dependent upon You for support and You have been appointed the legal guardian by a court order. Foster Children and grandchildren are not covered.

Any unmarried dependent Child, regardless of age, who is incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation (as defined in the New York Mental Hygiene Law), or physical handicap and who became so incapable prior to attainment of the age at which the Child's coverage would otherwise terminate and who is chiefly dependent upon You for support and maintenance, will remain covered while Your insurance remains in force and Your Child remains in such condition. You have thirty-one (31) days from the date of Your Child's attainment of the termination age to submit an application to request that the Child be included in Your coverage and proof of the Child's incapacity. We have the right to check whether a Child is and continues to qualify under this section.

We have the right to request and be furnished with such proof as may be needed to determine eligibility status of a prospective or covered Subscriber and all other prospective or covered Members in relation to

eligibility for coverage under this Certificate at any time.

D. When Coverage Begins.

Coverage under this Certificate will begin as follows:

1. If You, the Subscriber, elect coverage before becoming eligible, or within thirty (30) days of becoming eligible for other than a special enrollment period, coverage begins on the date You become eligible, or on the date determined by Your Group. Groups cannot impose waiting periods that exceed ninety (90) days.
2. If You, the Subscriber, do not elect coverage upon becoming eligible or within thirty (30) days of becoming eligible for other than a special enrollment period, You must wait until the Group's next open enrollment period to enroll, except as provided below.
3. If You, the Subscriber, marry while covered, and We receive notice of such marriage and any Premium payment within thirty (30) days thereafter, coverage for Your Spouse and Child starts on the date of the marriage. If We do not receive notice within thirty (30) days of the marriage, You must wait until the Group's next open enrollment period to add Your Spouse or Child.
4. If You, the Subscriber, have a newborn or adopted newborn Child and We receive notice of such birth within thirty (30) days thereafter, coverage for Your newborn starts at the moment of birth; otherwise, coverage begins on the date on which We receive notice. Your adopted newborn Child will be covered from the moment of birth if You take physical custody of the infant as soon as the infant is released from the Hospital after birth and You file a petition pursuant to Section 115-c of the New York Domestic Relations Law within thirty (30) days of the infant's birth; and provided further that no notice of revocation to the adoption has been filed pursuant to Section 115-b of the New York Domestic Relations Law, and consent to the adoption has not been revoked. However, We will not provide Hospital benefits for the adopted newborn's initial Hospital stay if one of the infant's natural parents has coverage for the newborn's initial Hospital stay. If You have individual or individual and Spouse coverage, You must also notify Us of Your desire to switch to parent and child/children or family coverage and pay any additional Premium within thirty (30) days of the birth or adoption in order for coverage to start at the moment of birth. Otherwise, coverage begins on the date on which We receive notice, provided that You pay any additional Premium when due.

E. Special Enrollment Periods.

You, Your Spouse or Child can also enroll for coverage within thirty (30) days of the loss of coverage in another group health plan if coverage was terminated because You, Your Spouse or Child are no longer eligible for coverage under the other group health plan due to:

1. Termination of employment;
2. Termination of the other group health plan;
3. Death of the Spouse;
4. Legal separation, divorce or annulment;
5. Reduction of hours of employment;
6. Employer contributions toward the group health plan were terminated for You or Your Dependents' coverage; or
7. A Child no longer qualifies for coverage as a Child under the other group health plan.

You, Your Spouse or Child can also enroll thirty (30) days from exhaustion of Your COBRA or continuation coverage or if You gain a Dependent or become a Dependent through marriage, birth, adoption, or placement for adoption.

We must receive notice and Premium payment within thirty (30) days of one (1) of these events. Your coverage will begin on the first day of the following month after We receive Your application. If You gain a Dependent or become a Dependent due to a birth, adoption, or placement for adoption, Your coverage will begin on the date of the birth, adoption or placement for adoption.

In addition, You, Your Spouse or Child, can also enroll for coverage within sixty (60) days of the occurrence of one of the following events:

1. You or Your Spouse or Child loses eligibility for Medicaid or Child Health Plus; or
2. You or Your Spouse or Child becomes eligible for Medicaid or Child Health Plus.

We must receive notice and Premium payment within sixty (60) days of one of these events. Your coverage will begin on the first day of the following month after We receive Your application.

Section VI

Preventive Care

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

Preventive Care.
We Cover the following services for the purpose of promoting good health and early detection of disease. Preventive services are not subject to Cost-Sharing (Copayments, Deductibles or Coinsurance) when performed by a Participating Provider and provided in accordance with the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA"), or if the items or services have an "A" or "B" rating from the United States Preventive Services Task Force ("USPSTF"), or if the immunizations are recommended by the Advisory Committee on Immunization Practices ("ACIP"). However, Cost-Sharing may apply to services provided during the same visit as the preventive services. Also, if a preventive service is provided during an office visit wherein the preventive service is not the primary purpose of the visit, the Cost-Sharing amount that would otherwise apply to the office visit will still apply. You may contact Us at 1-800-447-8255 or visit Our website at www.emblemhealth.com for a copy of the comprehensive guidelines supported by HRSA, items or services with an "A" or "B" rating from USPSTF, and immunizations recommended by ACIP.

A. Well-Baby and Well-Child Care. We Cover well-baby and well-child care which consists of routine physical examinations including vision screenings and hearing screenings, developmental assessment, anticipatory guidance, and laboratory tests ordered at the time of the visit as recommended by the American Academy of Pediatrics. We also Cover preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF. If the schedule of well-child visits referenced above permits one (1) well-child visit per Plan Year, We will not deny a well-child visit if three hundred sixty-five (365) days have not passed since the previous well-child visit. Immunizations and boosters as recommended by ACIP are also Covered. This benefit is provided to Members from birth through attainment of age nineteen (19) and is not subject to Copayments, Deductibles or Coinsurance when provided by a Participating Provider.

B. Adult Annual Physical Examinations. We Cover adult annual physical examinations and preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF.

Examples of items or services with an "A" or "B" rating from USPSTF include, but are not limited to, blood pressure screening for adults, lung cancer screening, colorectal cancer screening, alcohol misuse screening, depression screening, and diabetes screening. A complete list of the Covered preventive Services is available on Our website at www.emblemhealth.com, or will be mailed to You upon request.

You are eligible for a physical examination once every Plan Year, regardless of whether or not three hundred sixty-five (365) days have passed since the previous physical examination visit. Vision screenings do not include refractions.

This benefit is not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF and when provided by a Participating Provider.

C. Adult Immunizations. We Cover adult immunizations as recommended by ACIP. This benefit is not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the recommendations of ACIP and when provided by a Participating Provider.

D. Well-Woman Examinations. We Cover well-woman examinations which consist of a routine gynecological examination, breast examination and annual screening for cervical cancer, including laboratory and diagnostic services in connection with evaluating cervical cancer screening tests. We also Cover preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF. A complete list of the Covered preventive Services is available on Our website at www.emblemhealth.com, or will be mailed to You upon request. This benefit is not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF, which may be less frequent than described above, and when provided by a Participating Provider.

E. Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer. We Cover mammograms, which may be provided by breast tomosynthesis (i.e., 3D mammograms), for the screening of breast cancer as follows:

- One (1) baseline screening mammogram for Members age thirty-five (35) through thirty-nine (39);
- Upon the recommendation of the Member's Provider, an annual screening mammogram for Members age thirty-five (35) through thirty-nine (39) if Medically Necessary; and
- One (1) screening mammogram annually for Members age forty (40) and over.

If a Member of any age has a history of breast cancer or a first degree relative has a history of breast cancer, We Cover mammograms as recommended by the Member's Provider. However, in no event will more than one (1) preventive screening per Plan Year be Covered.

Mammograms for the screening of breast cancer are not subject to Copayments, Deductibles or Coinsurance when provided by a Participating Provider.

We also Cover additional screening and diagnostic imaging for the detection of breast cancer, including diagnostic mammograms, breast ultrasounds and MRIs. Screening and diagnostic imaging for the detection of breast cancer, including diagnostic mammograms, breast ultrasounds and MRIs are not subject to Copayments, Deductibles or Coinsurance when provided by a Participating Provider.

F. Family Planning and Reproductive Health Services. We Cover family planning services which consist of: FDA-approved contraceptive methods prescribed by a Provider not otherwise Covered under the Prescription Drug Coverage section of this Certificate; patient education and counseling on use of contraceptives and related topics; follow-up services related to contraceptive methods, including management of side effects, counseling for continued

adherence, and device insertion and removal; and sterilization procedures for women. Such services are not subject to Copayments, Deductibles or Coinsurance when provided by a Participating Provider.

We also Cover vasectomies subject to Copayments, Deductibles or Coinsurance.

We do not Cover services related to the reversal of elective sterilizations.

G. Bone Mineral Density Measurements or Testing. We Cover bone mineral density measurements or tests, and Prescription Drugs and devices approved by the FDA or generic equivalents as approved substitutes. Coverage of Prescription Drugs is subject to the Prescription Drug Coverage section of this Certificate. Bone mineral density measurements or tests, drugs or devices shall include those covered for individuals meeting the criteria under the federal Medicare program and those in accordance with the criteria of the National Institutes of Health. You will also qualify for coverage of bone mineral density measurements and testing if You meet any of the following:

- Previously diagnosed as having osteoporosis or having a family history of osteoporosis;
- With symptoms or conditions indicative of the presence or significant risk of osteoporosis;
- On a prescribed drug regimen posing a significant risk of osteoporosis;
- With lifestyle factors to a degree as posing a significant risk of osteoporosis; or
- With such age, gender, and/or other physiological characteristics which pose a significant risk for osteoporosis.

We also Cover bone mineral density measurements or tests, and Prescription Drugs and devices as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF.

This benefit is not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF, which may not include all of the above services such as drugs and devices and when provided by a Participating Provider.

H. Screening for Prostate Cancer. We Cover an annual standard diagnostic examination including, but not limited to, a digital rectal examination and a prostate specific antigen test for men age fifty (50) and over who are asymptomatic and for men age forty (40) and over with a family history of prostate cancer or other prostate cancer risk factors. We also Cover standard diagnostic testing including, but not limited to, a digital rectal examination and a prostate-specific antigen test, at any age for men having a prior history of prostate cancer.

This benefit is not subject to Copayments, Deductibles or Coinsurance when provided by a Participating Provider.

Section VII

Ambulance and Pre-Hospital Emergency Medical Services

Please refer to the Schedule of Benefits section of this Certificate for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits. Pre-Hospital Emergency Medical Services and ambulance services for the treatment of an Emergency Condition do not require Preauthorization.

A. Emergency Ambulance Transportation.

1. Pre-Hospital Emergency Medical Services. We Cover Pre-Hospital Emergency Medical Services worldwide for the treatment of an Emergency Condition when such services are provided by an ambulance service.

"Pre-Hospital Emergency Medical Services" means the prompt evaluation and treatment of an Emergency Condition and/or non-airborne transportation to a Hospital. The services must be provided by an ambulance service issued a certificate under the New York Public Health Law. We will, however, only Cover transportation to a Hospital provided by such an ambulance service when a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in:

- Placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;
- Serious impairment to such person's bodily functions;
- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of such person.

An ambulance service must hold You harmless and may not charge or seek reimbursement from You for Pre-Hospital Emergency Medical Services except for the collection of any applicable Copayment, Deductible or Coinsurance.

In the absence of negotiated rates, We will pay a Non-Participating Provider the usual and customary charge for Pre-Hospital Emergency Medical Services, which shall not be excessive or unreasonable. The usual and customary charge for Pre-Hospital Emergency Medical Services is the FAIR Health rate at the 80th percentile.

2. Emergency Ambulance Transportation. In addition to Pre-Hospital Emergency Medical Services, We also Cover emergency ambulance transportation worldwide by a licensed ambulance service (either ground, water or air ambulance) to the nearest Hospital where Emergency Services can be performed. This coverage includes emergency ambulance transportation to a Hospital when the originating Facility does not have the ability to treat Your Emergency Condition.

B. Non-Emergency Ambulance Transportation.

We Cover non-emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as appropriate) between Facilities when the transport is any of the following:

- From a non-participating Hospital to a participating Hospital;

- To a Hospital that provides a higher level of care that was not available at the original Hospital;
- To a more cost-effective Acute care Facility; or
- From an Acute care Facility to a sub-Acute setting.

C. Limitations/Terms of Coverage.

- We do not Cover travel or transportation expenses, unless connected to an Emergency Condition or due to a Facility transfer approved by Us, even though prescribed by a Physician.
- We do not Cover non-ambulance transportation such as ambulette, van or taxi cab.
- Coverage for air ambulance related to an Emergency Condition or air ambulance related to non-emergency transportation is provided when Your medical condition is such that transportation by land ambulance is not appropriate; and Your medical condition requires immediate and rapid ambulance transportation that cannot be provided by land ambulance; and one (1) of the following is met:
    - The point of pick-up is inaccessible by land vehicle; or
    - Great distances or other obstacles (e.g., heavy traffic) prevent Your timely transfer to the nearest Hospital with appropriate facilities.

Section VIII

Emergency Services and Urgent Care

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

A. Emergency Services.
We Cover Emergency Services for the treatment of an Emergency Condition in a Hospital.

We define an **"Emergency Condition"** to mean: A medical or behavioral condition that manifests itself by Acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;
- Serious impairment to such person's bodily functions;
- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of such person.

For example, an Emergency Condition may include, but is not limited to, the following conditions:

- Severe chest pain
- Severe or multiple injuries
- Severe shortness of breath
- Sudden change in mental status (e.g., disorientation)
- Severe bleeding
- Acute pain or conditions requiring immediate attention such as suspected heart attack or appendicitis
- Poisonings
- Convulsions

Coverage of Emergency Services for treatment of Your Emergency Condition will be provided regardless of whether the Provider is a Participating Provider. We will also Cover Emergency Services to treat Your Emergency Condition worldwide. However, We will Cover only those Emergency Services and supplies that are Medically Necessary and are performed to treat or stabilize Your Emergency Condition in a Hospital.

Please follow the instructions listed below regardless of whether or not You are in Our Service Area at the time Your Emergency Condition occurs:

1. **Hospital Emergency Department Visits.** In the event that You require treatment for an Emergency Condition, seek immediate care at the nearest Hospital emergency department or call 911. Emergency Department Care does not require Preauthorization. **However, only Emergency Services for the treatment of an Emergency Condition are Covered in an emergency department**.

We do not Cover follow-up care or routine care provided in a Hospital emergency department. You should contact Us to make sure You receive the appropriate follow-up care.

2. **Emergency Hospital Admissions.** In the event that You are **admitted** to the Hospital, You or someone on Your behalf must notify Us at the number listed in this Certificate and on Your ID card within forty-eight (48) hours of Your admission, or as soon as is reasonably possible.

   We Cover inpatient Hospital services at a non-participating Hospital at the in-network Cost-Sharing for as long as Your medical condition prevents Your transfer to a participating Hospital, unless We authorize continued treatment at the non-participating Hospital. If Your medical condition permits Your transfer to a participating Hospital, We will notify You and arrange the transfer. Any inpatient Hospital services received from a non-participating Hospital after We have notified You and arranged for a transfer to a participating Hospital will not be Covered.

3. **Payments Relating to Emergency Services Rendered.** The amount We pay a Non-Participating Provider for Emergency Services will be the greater of: 1) the amount We have negotiated with Participating Providers for the Emergency Service (and if more than one amount is negotiated, the median of the amounts); 2) 100% of the Allowed Amount for services provided by a Non-Participating Provider (i.e., the amount We would pay in the absence of any Cost-Sharing that would otherwise apply for services of Non-Participating Providers); or 3) the amount that would be paid under Medicare. The amounts described above exclude any Copayment or Coinsurance that applies to Emergency Services provided by a Participating Provider.

   If a dispute involving a payment for physician or Hospital services is submitted to an independent dispute resolution entity ("IDRE"), We will pay the amount, if any, determined by the IDRE for physician or Hospital services.

   You are responsible for any Copayment, Deductible or Coinsurance. You will be held harmless for any Non-Participating Provider charges that exceed Your Copayment, Deductible or Coinsurance.

B. Urgent Care.

Urgent Care is medical care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require Emergency Department Care. **Urgent Care is Covered in Our Service Area**.

1. **In-Network.** We Cover Urgent Care from a participating Physician or a participating Urgent Care Center. You do not need to contact Us prior to or after Your visit.

2. **Out-of-Network.** We do not Cover Urgent Care from non-participating Urgent Care Centers or Physicians in Our Service Area.

If Urgent Care results in an emergency admission, please follow the instructions for emergency Hospital admissions described above.

Section IX

Outpatient and Professional Services

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

A. Advanced Imaging Services.
We Cover PET scans, MRI, nuclear medicine, and CAT scans.

B. Allergy Testing and Treatment.
We Cover testing and evaluations including injections, and scratch and prick tests to determine the existence of an allergy. We also Cover allergy treatment, including desensitization treatments, routine allergy injections and serums.

C. Ambulatory Surgical Center Services.
We Cover surgical procedures performed at Ambulatory Surgical Centers including services and supplies provided by the center the day the surgery is performed.

D. Chemotherapy.
We Cover chemotherapy in an outpatient Facility or in a Health Care Professional's office. Chemotherapy may be administered by injection or infusion.

E. Chiropractic Services.
We Cover chiropractic care when performed by a Doctor of Chiropractic ("chiropractor") in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for the purpose of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of the vertebral column. This includes assessment, manipulation and any modalities. Any laboratory tests will be Covered in accordance with the terms and conditions of this Certificate.

F. Clinical Trials.
We Cover the routine patient costs for Your participation in an approved clinical trial and such coverage shall not be subject to Utilization Review if You are:

- Eligible to participate in an approved clinical trial to treat either cancer or other life-threatening disease or condition; and
- Referred by a Participating Provider who has concluded that Your participation in the approved clinical trial would be appropriate.

All other clinical trials, including when You do not have cancer or other life-threatening disease or condition, may be subject to the Utilization Review and External Appeal sections of this Certificate.

We do not Cover: the costs of the investigational drugs or devices; the costs of non-health services required for You to receive the treatment; the costs of managing the research; or costs that would not be covered under this Certificate for non-investigational treatments provided in the clinical trial.

An “approved clinical trial” means a phase I, II, III, or IV clinical trial that is:

- A federally funded or approved trial;
- Conducted under an investigational drug application reviewed by the federal Food and Drug Administration; or
- A drug trial that is exempt from having to make an investigational new drug application.

G. Dialysis.

We Cover dialysis treatments of an Acute or chronic kidney ailment.

We also Cover dialysis treatments provided by a Non-Participating Provider subject to all the following conditions:

- The Non-Participating Provider is duly licensed to practice and authorized to provide such treatment.
- The Non-Participating Provider is located outside Our Service Area.
- The Participating Provider who is treating You has issued a written order indicating that dialysis treatment by the Non-Participating Provider is necessary.
- You notify Us in writing at least thirty (30) days in advance of the proposed treatment date(s) and include the written order referred to above. The thirty (30)-day advance notice period may be shortened when You need to travel on sudden notice due to a family or other emergency, provided that We have a reasonable opportunity to review Your travel and treatment plans.
- We have the right to Preauthorize the dialysis treatment and schedule.
- We will provide benefits for no more than ten (10) dialysis treatments by a Non-Participating Provider per Member per calendar year.
- Benefits for services of a Non-Participating Provider are Covered when all the above conditions are met and are subject to any applicable Cost-Sharing that applies to dialysis treatments by a Participating Provider. However, You are also responsible for paying any difference between the amount We would have paid had the service been provided by a Participating Provider and the Non-Participating Provider’s charge.

H. Habilitation Services.

We Cover Habilitation Services consisting of physical therapy, speech therapy and occupational therapy in the outpatient department of a Facility or in a Health Care Professional’s office for up to ninety (90) visits per Plan Year. The visit limit applies to all therapies combined.

I. Home Health Care.

We Cover care provided in Your home by a Home Health Agency certified or licensed by the appropriate state agency. The care must be provided pursuant to Your Physician’s written treatment plan and must be in lieu of Hospitalization or confinement in a Skilled Nursing Facility. Home care includes:

- Part-time or intermittent nursing care by or under the supervision of a registered professional nurse;
- Part-time or intermittent services of a home health aide;
- Physical, occupational or speech therapy provided by the Home Health Agency; and
- Medical supplies, Prescription Drugs and medications prescribed by a Physician, and laboratory services by or on behalf of the Home Health Agency to the extent such items would have been Covered during a Hospitalization or confinement in a Skilled Nursing Facility.

Home Health Care is limited to two hundred (200) visits per Plan Year. Each visit by a member of the Home Health Agency is considered one (1) visit. Each visit of up to four (4) hours by a home health aide is considered one (1) visit. Any Rehabilitation or Habilitation Services received under this benefit will not reduce the amount of services available under the Rehabilitation or Habilitation Services benefits.

J. Infertility Treatment.

We Cover services for the diagnosis and treatment (surgical and medical) of infertility. "Infertility" is a disease or condition characterized by the incapacity to impregnate another person or to conceive, defined by the failure to establish a clinical pregnancy after twelve (12) months of regular, unprotected sexual intercourse or therapeutic donor insemination, or after six (6) months of regular, unprotected sexual intercourse or therapeutic donor insemination for a female thirty-five (35) years of age or older. Earlier evaluation and treatment may be warranted based on a Member's medical history or physical findings.

Such coverage is available as follows:

1. **Basic Infertility Services.** Basic infertility services will be provided to a Member who is an appropriate candidate for infertility treatment. In order to determine eligibility, We will use guidelines established by the American College of Obstetricians and Gynecologists, the American Society for Reproductive Medicine, and the State of New York.

   Basic infertility services include:
   - Initial evaluation;
   - Semen analysis;
   - Laboratory evaluation;
   - Evaluation of ovulatory function;
   - Postcoital test;
   - Endometrial biopsy;
   - Pelvic ultra sound;
   - Hysterosalpingogram;
   - Sono-hystogram;
   - Testis biopsy;
   - Blood tests; and
   - Medically appropriate treatment of ovulatory dysfunction.

   Additional tests may be Covered if the tests are determined to be Medically Necessary.

2. **Comprehensive Infertility Services.** If the basic infertility services do not result in increased fertility, We Cover comprehensive infertility services.

   Comprehensive infertility services include:
   - Ovulation induction and monitoring;
   - Pelvic ultra sound;
   - Artificial insemination;
   - Hysteroscopy;

- Laparoscopy; and
- Laparotomy.

3. **Advanced Infertility Services.** We Cover the following advanced infertility services:
   - Three (3) cycles per lifetime of in vitro fertilization;
   - Sperm storage costs in connection with in vitro fertilization; and
   - Cryopreservation and storage of embryos in connection with in vitro fertilization.

   A "cycle" is all treatment that starts when: preparatory medications are administered for ovarian stimulation for oocyte retrieval with the intent of undergoing in vitro fertilization using a fresh embryo transfer, or medications are administered for endometrial preparation with the intent of undergoing in vitro fertilization using a frozen embryo transfer.

4. **Fertility Preservation Services.** We Cover standard fertility preservation services when a medical treatment will directly or indirectly lead to iatrogenic infertility. Standard fertility preservation services include the collecting, preserving, and storing of ova and sperm. "Iatrogenic infertility" means an impairment of Your fertility by surgery, radiation, chemotherapy or other medical treatment affecting reproductive organs or processes.

5. **Exclusions and Limitations.** We do not Cover:
   - Gamete intrafallopian tube transfers or zygote intrafallopian tube transfers;
   - Costs for an ovum donor or donor sperm;
   - Ovulation predictor kits;
   - Reversal of tubal ligations;
   - Reversal of vasectomies;
   - Costs for and relating to surrogate motherhood (maternity services are Covered for Members acting as surrogate mothers);
   - Cloning; or
   - Medical and surgical procedures that are experimental or investigational, unless Our denial is overturned by an External Appeal Agent.

   All services must be provided by Providers who are qualified to provide such services in accordance with the guidelines established and adopted by the American Society for Reproductive Medicine. We will not discriminate based on Your expected length of life, present or predicted disability, degree of medical dependency, perceived quality of life, other health conditions, or based on personal characteristics including age, sex, sexual orientation, marital status or gender identity, when determining coverage under this benefit.

K. Infusion Therapy.

We Cover infusion therapy which is the administration of drugs using specialized delivery systems. Drugs or nutrients administered directly into the veins are considered infusion therapy. Drugs taken by mouth or self-injected are not considered infusion therapy. The services must be ordered by a Physician or other authorized Health Care Professional and provided in an office or by an agency licensed or certified to provide infusion therapy.

L. Interruption of Pregnancy.

We Cover medically necessary abortions including abortions in cases of rape, incest or fetal malformation. We Cover elective abortions for one (1) procedure per Member, per Plan Year.

M. Laboratory Procedures, Diagnostic Testing and Radiology Services.
We Cover x-ray, laboratory procedures and diagnostic testing, services and materials, including diagnostic x-rays, x-ray therapy, fluoroscopy, electrocardiograms, electroencephalograms, laboratory tests, and therapeutic radiology services.

N. Maternity and Newborn Care.
We Cover services for maternity care provided by a Physician or midwife, nurse practitioner, Hospital or birthing center. We Cover prenatal care (including one (1) visit for genetic testing), postnatal care, delivery, and complications of pregnancy. In order for services of a midwife to be Covered, the midwife must be licensed pursuant to Article 140 of the New York Education Law, practicing consistent with Section 6951 of the New York Education Law and affiliated or practicing in conjunction with a Facility licensed pursuant to Article 28 of the New York Public Health Law. We will not pay for duplicative routine services provided by both a midwife and a Physician. See the Inpatient Services section of this Certificate for coverage of inpatient maternity care.

We Cover breastfeeding support, counseling and supplies, including the cost of renting one (1) breast pump per pregnancy for the duration of breast feeding from a Participating Provider or designated vendor.

O. Office Visits.
We Cover office visits for the diagnosis and treatment of injury, disease and medical conditions. Office visits may include house calls.

P. Outpatient Hospital Services.
We Cover Hospital services and supplies as described in the Inpatient Services section of this Certificate that can be provided to You while being treated in an outpatient Facility. For example, Covered Services include but are not limited to inhalation therapy, pulmonary rehabilitation, infusion therapy and cardiac rehabilitation. Unless You are receiving preadmission testing, Hospitals are not Participating Providers for outpatient laboratory procedures and tests.

Q. Preadmission Testing.
We Cover preadmission testing ordered by Your Physician and performed in Hospital outpatient Facilities prior to a scheduled surgery in the same Hospital provided that:

- The tests are necessary for and consistent with the diagnosis and treatment of the condition for which the surgery is to be performed;
- Reservations for a Hospital bed and operating room were made prior to the performance of the tests;
- Surgery takes place within seven (7) days of the tests; and
- The patient is physically present at the Hospital for the tests.

R. Prescription Drugs for Use in the Office.
We Cover Prescription Drugs (excluding self-injectable drugs) used by Your Provider in the Provider's office for preventive and therapeutic purposes. This benefit applies when Your Provider orders the

Prescription Drug and administers it to You.

S. Rehabilitation Services.

We Cover Rehabilitation Services consisting of physical therapy, speech therapy, occupational therapy and pulmonary rehabilitation in the outpatient department of a Facility or in a Health Care Professional's office for up to ninety (90) visits per Plan Year. The visit limit applies to all therapies combined.

We Cover speech and physical therapy only when:

- Such therapy is related to the treatment or diagnosis of Your illness or injury (in the case of a covered Child, this includes a medically diagnosed congenital defect); and
- The therapy is ordered by a Physician.

Covered Rehabilitation Services must begin within six (6) months of the later to occur:

- The date of the injury or illness that caused the need for the therapy;
- The date You are discharged from a Hospital where surgical treatment was rendered; or
- The date outpatient surgical care is rendered.

In no event will the therapy continue beyond three hundred sixty-five (365) days after such event.

We also Cover Cardiac Rehabilitation for thirty-two (32) visits when performed in a Specialist Office or Outpatient Hospital Services.

T. Second Opinions.

1. **Second Cancer Opinion.** We Cover a second medical opinion by an appropriate Specialist, including but not limited to a Specialist affiliated with a specialty care center, in the event of a positive or negative diagnosis of cancer or a recurrence of cancer or a recommendation of a course of treatment for cancer. You may obtain a second opinion from a Non-Participating Provider on an in-network basis when Your attending Physician provides a written Referral to a non-participating Specialist.

2. **Second Surgical Opinion.** We Cover a second surgical opinion by a qualified Physician on the need for surgery.

3. **Required Second Surgical Opinion.** We may require a second opinion before We preauthorize a surgical procedure. There is no cost to You when We request a second opinion.
    - The second opinion must be given by a board-certified Specialist who personally examines You.
    - If the first and second opinions do not agree, You may obtain a third opinion.
    - The second and third surgical opinion consultants may not perform the surgery on You.

4. **Second Opinions in Other Cases.** There may be other instances when You will disagree with a Provider's recommended course of treatment. In such cases, You may request that We designate another Provider to render a second opinion. If the first and second opinions do not agree, We will designate another Provider to render a third opinion. After completion of the second opinion process, We will preauthorize Covered Services supported by a majority of the Providers reviewing Your case.

U. Surgical Services.
We Cover Physicians' services for surgical procedures, including operating and cutting procedures for the treatment of a sickness or injury, and closed reduction of fractures and dislocations of bones, endoscopies, incisions, or punctures of the skin on an inpatient and outpatient basis, including the services of the surgeon or Specialist, assistant (including a Physician's assistant or a nurse practitioner), and anesthetist or anesthesiologist, together with preoperative and post-operative care. Benefits are not available for anesthesia services provided as part of a surgical procedure when rendered by the surgeon or the surgeon's assistant.

If Covered multiple surgical procedures are performed during the same operative session through the same or different incisions, We will pay:

- For the procedure with the highest Allowed Amount; and
- 50% of the amount We would otherwise pay for the other procedures.

V. Oral Surgery.
We Cover the following limited dental and oral surgical procedures:

- Oral surgical procedures for jaw bones or surrounding tissue and dental services for the repair or replacement of sound natural teeth that are required due to accidental injury. Replacement is Covered only when repair is not possible. Dental services must be obtained within twelve (12) months of the injury.
- Oral surgical procedures for jaw bones or surrounding tissue and dental services necessary due to congenital disease or anomaly.
- Oral surgical procedures required for the correction of a non-dental physiological condition which has resulted in a severe functional impairment.
- Removal of tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth. Cysts related to teeth are not Covered.
- Surgical/nonsurgical medical procedures for temporomandibular joint disorders and orthognathic surgery.

W. Reconstructive Breast Surgery.
We Cover breast reconstruction surgery after a mastectomy or partial mastectomy. Coverage includes: all stages of reconstruction of the breast on which the mastectomy or partial mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and physical complications of the mastectomy or partial mastectomy, including lymphedemas, in a manner determined by You and Your attending Physician to be appropriate. We also Cover implanted breast prostheses following a mastectomy or partial mastectomy.

X. Other Reconstructive and Corrective Surgery.
We Cover reconstructive and corrective surgery other than reconstructive breast surgery only when it is:

- Performed to correct a congenital birth defect of a covered Child which has resulted in a functional defect;
- Incidental to surgery or follows surgery that was necessitated by trauma, infection or disease of the involved part; or
- Otherwise Medically Necessary.

Y. Transplants.
We Cover only those transplants determined to be non-experimental and non-investigational. Covered transplants include but are not limited to: kidney, corneal, liver, heart, and heart/lung transplants; and bone marrow transplants for aplastic anemia, leukemia, severe combined immunodeficiency disease and Wiskott-Aldrich Syndrome.

All transplants must be prescribed by Your Specialist(s). Additionally, all transplants must be performed at Hospitals that We have specifically approved and designated to perform these procedures.

We Cover the Hospital and medical expenses, including donor search fees, of the Member-recipient. We Cover transplant services required by You when You serve as an organ donor only if the recipient is a Member. We do not Cover the medical expenses of a non-Member acting as a donor for You if the non-Member's expenses will be Covered under another health plan or program.

Section X

Additional Benefits, Equipment and Devices

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

A. Autism Spectrum Disorder.
We Cover the following services when such services are prescribed or ordered by a licensed Physician or a licensed psychologist and are determined by Us to be Medically Necessary for the screening, diagnosis, and treatment of autism spectrum disorder. For purposes of this benefit, "autism spectrum disorder" means any pervasive developmental disorder defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders at the time services are rendered.

1. **Screening and Diagnosis.** We Cover assessments, evaluations, and tests to determine whether someone has autism spectrum disorder.

2. **Assistive Communication Devices.** We Cover a formal evaluation by a speech-language pathologist to determine the need for an assistive communication device. Based on the formal evaluation, We Cover the rental or purchase of assistive communication devices when ordered or prescribed by a licensed Physician or a licensed psychologist if You are unable to communicate through normal means (i.e., speech or writing) when the evaluation indicates that an assistive communication device is likely to provide You with improved communication. Examples of assistive communication devices include communication boards and speech-generating devices. Coverage is limited to dedicated devices. We will only Cover devices that generally are not useful to a person in the absence of a communication impairment. We do not Cover items, such as, but not limited to, laptop, desktop or tablet computers. We Cover software and/or applications that enable a laptop, desktop or tablet computer to function as a speech-generating device. Installation of the program and/or technical support is not separately reimbursable. We will determine whether the device should be purchased or rented.

   We Cover repair, replacement fitting and adjustments of such devices when made necessary by normal wear and tear or significant change in Your physical condition. We do not Cover the cost of repair or replacement made necessary because of loss or damage caused by misuse, mistreatment, or theft; however, We Cover one (1) repair or replacement per device type that is necessary due to behavioral issues. Coverage will be provided for the device most appropriate to Your current functional level. We do not Cover delivery or service charges or routine maintenance.

3. **Behavioral Health Treatment.** We Cover counseling and treatment programs that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual. We will provide such coverage when provided by a licensed Provider. We Cover applied behavior analysis when provided by a licensed or certified applied behavior analysis Health Care Professional. "Applied behavior analysis" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct

observation, measurement, and functional analysis of the relationship between environment and behavior. The treatment program must describe measurable goals that address the condition and functional impairments for which the intervention is to be applied and include goals from an initial assessment and subsequent interim assessments over the duration of the intervention in objective and measurable terms.

4. **Psychiatric and Psychological Care.** We Cover direct or consultative services provided by a psychiatrist, psychologist or a licensed clinical social worker with the experience required by the New York Insurance Law, licensed in the state in which they are practicing.

5. **Therapeutic Care.** We Cover therapeutic services necessary to develop, maintain, or restore, to the greatest extent practicable, functioning of the individual when such services are provided by licensed or certified speech therapists, occupational therapists, physical therapists and social workers to treat autism spectrum disorder and when the services provided by such Providers are otherwise Covered under this Certificate. Except as otherwise prohibited by law, services provided under this paragraph shall be included in any visit maximums applicable to services of such therapists or social workers under this Certificate.

6. **Pharmacy Care.** We Cover Prescription Drugs to treat autism spectrum disorder that are prescribed by a Provider legally authorized to prescribe under Title 8 of the New York Education Law. Coverage of such Prescription Drugs is subject to all the terms, provisions, and limitations that apply to Prescription Drug benefits under this Certificate.

7. **Limitations.** We do not Cover any services or treatment set forth above when such services or treatment are provided pursuant to an individualized education plan under the New York Education Law. The provision of services pursuant to an individualized family service plan under Section 2545 of the New York Public Health Law, an individualized education plan under Article 89 of the New York Education Law, or an individualized service plan pursuant to regulations of the New York State Office for People With Developmental Disabilities shall not affect coverage under this Certificate for services provided on a supplemental basis outside of an educational setting if such services are prescribed by a licensed Physician or licensed psychologist.

   You are responsible for any applicable Copayment, Deductible or Coinsurance provisions under this Certificate for similar services. For example, any Copayment, Deductible or Coinsurance that applies to physical therapy visits will generally also apply to physical therapy services Covered under this benefit; and any Copayment, Deductible or Coinsurance for Prescription Drugs will generally also apply to Prescription Drugs Covered under this benefit. See the Schedule of Benefits section of this Certificate for the Cost-Sharing requirements that apply to applied behavior analysis services and assistive communication devices.

   Nothing in this Certificate shall be construed to affect any obligation to provide coverage for otherwise Covered Services solely on the basis that the services constitute early intervention program services pursuant to Section 3235-a of the New York Insurance Law or an individualized service plan pursuant to regulations of the New York State Office for People With Developmental Disabilities.

B. Diabetic Equipment, Supplies and Self-Management Education.
We Cover diabetic equipment, supplies, and self-management education if recommended or prescribed by a Physician or other licensed Health Care Professional legally authorized to prescribe under Title 8 of the New York Education Law as described below:

1. **Equipment and Supplies.**
   We Cover the following equipment and related supplies for the treatment of diabetes when prescribed by Your Physician or other Provider legally authorized to prescribe:
   - Acetone reagent strips
   - Acetone reagent tablets
   - Alcohol or peroxide by the pint
   - Alcohol wipes
   - All insulin preparations
   - Automatic blood lance kit
   - Blood glucose kit
   - Blood glucose strips (test or reagent)
   - Blood glucose monitor with or without special features for visually impaired, control solutions, and strips for home blood glucose monitor
   - Cartridges for the visually impaired
   - Diabetes data management systems
   - Disposable insulin and pen cartridges
   - Drawing-up devices for the visually impaired
   - Equipment for use of the pump
   - Glucagon for injection to increase blood glucose concentration
   - Glucose acetone reagent strips
   - Glucose reagent strips
   - Glucose reagent tape
   - Injection aides
   - Injector (Busher) Automatic
   - Insulin
   - Insulin cartridge delivery
   - Insulin infusion devices
   - Insulin pump
   - Lancets
   - Oral agents such as glucose tablets and gels
   - Oral anti-diabetic agents used to reduce blood sugar levels
   - Syringe with needle; sterile 1 cc box
   - Urine testing products for glucose and ketones
   - Additional supplies, as the New York State Commissioner of Health shall designate by regulation as appropriate for the treatment of diabetes.

   Diabetic equipment and supplies are Covered only when obtained from a designated diabetic equipment or supply manufacturer which has an agreement with Us to provide all diabetic equipment or supplies required by law for Members through participating pharmacies. If You require a certain item not available from Our designated diabetic equipment or supply manufacturer, You or Your Provider must submit a request for a medical exception by calling the number on Your ID card. Our medical director will make all medical exception determinations.

Diabetic equipment and supplies are limited to a thirty (30)-day supply up to a maximum of a ninety (90)-day supply when purchased at a pharmacy.

2. Self-Management Education.
Diabetes self-management education is designed to educate persons with diabetes as to the proper self-management and treatment of their diabetic condition, including information on proper diets. We Cover education on self-management and nutrition when: diabetes is initially diagnosed; a Physician diagnoses a significant change in Your symptoms or condition which necessitates a change in Your self-management education; or when a refresher course is necessary. It must be provided in accordance with the following:

- By a Physician, other health care Provider authorized to prescribe under Title 8 of the New York Education Law, or their staff during an office visit;
- Upon the Referral of Your Physician or other health care Provider authorized to prescribe under Title 8 of the New York Education Law to the following non-Physician, medical educators: certified diabetes nurse educators; certified nutritionists; certified dietitians; and registered dietitians in a group setting when practicable; and
- Education will also be provided in Your home when Medically Necessary.

3. Limitations.
The items will only be provided in amounts that are in accordance with the treatment plan developed by the Physician for You. We Cover only basic models of blood glucose monitors unless You have special needs relating to poor vision or blindness or as otherwise Medically Necessary.

Step Therapy for Diabetes Equipment and Supplies. Step therapy is a program that requires You to try one (1) type of diabetic Prescription Drug, supply or equipment unless another Prescription Drug, supply or equipment is Medically Necessary. The diabetic Prescription Drugs, supplies and equipment that are subject to step therapy include:

- Diabetic glucose meters and test strips;
- Diabetic supplies (including but not limited to syringes, lancets, needles, pens);
- Insulin;
- Injectable anti-diabetic agents; and
- Oral anti-diabetic agents.

These items also require Preauthorization and will be reviewed for Medical Necessity. For diabetic Prescription Drugs, refer to the step therapy provisions in the Prescription Drug section and the Step Therapy Protocol Override Determination provisions in the Utilization Review section of this Certificate.

C. Durable Medical Equipment and Braces.
We Cover the rental or purchase of durable medical equipment and braces.

1. Durable Medical Equipment.
Durable Medical Equipment is equipment which is:

- Designed and intended for repeated use;
- Primarily and customarily used to serve a medical purpose;

- Generally not useful to a person in the absence of disease or injury; and
- Appropriate for use in the home.

Coverage is for standard equipment only. We Cover the cost of repair or replacement when made necessary by normal wear and tear. We do not Cover the cost of repair or replacement that is the result of misuse or abuse by You. We will determine whether to rent or purchase such equipment. We do not Cover over-the-counter durable medical equipment.

We do not Cover equipment designed for Your comfort or convenience (e.g., pools, hot tubs, air conditioners, saunas, humidifiers, dehumidifiers, exercise equipment), as it does not meet the definition of durable medical equipment.

2. Braces.
We Cover braces, including orthotic braces, that are worn externally and that temporarily or permanently assist all or part of an external body part function that has been lost or damaged because of an injury, disease or defect. Coverage is for standard equipment only. We Cover replacements when growth or a change in Your medical condition make replacement necessary. We do not Cover the cost of repair or replacement that is the result of misuse or abuse by You.

D. Hearing Aids.
Cochlear Implants.
We Cover bone anchored hearing aids (i.e., cochlear implants) when they are Medically Necessary to correct a hearing impairment. Examples of when bone anchored hearing aids are Medically Necessary include the following:

- Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or
- Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

Coverage is provided for one (1) hearing aid per ear during the entire period of time that You are enrolled under this Certificate. We Cover repair and/or replacement of a bone anchored hearing aid only for malfunctions.

E. Hospice.
Hospice Care is available if Your primary attending Physician has certified that You have six (6) months or less to live. We Cover inpatient Hospice Care in a Hospital or hospice and home care and outpatient services provided by the hospice, including drugs and medical supplies. Coverage is provided for two hundred ten (210) days of Hospice Care. We also Cover five (5) visits for supportive care and guidance for the purpose of helping You and Your immediate family cope with the emotional and social issues related to Your death, either before or after Your death.

We Cover Hospice Care only when provided as part of a Hospice Care program certified pursuant to Article 40 of the New York Public Health Law. If care is provided outside New York State, the hospice must be certified under a similar certification process required by the state in which the hospice is located. We do not Cover: funeral arrangements; pastoral, financial, or legal counseling; or homemaker, caretaker, or respite care.

F. Medical Supplies.

We Cover medical supplies that are required for the treatment of a disease or injury which is Covered under this Certificate. We also Cover maintenance supplies (e.g., ostomy supplies) for conditions Covered under this Certificate. All such supplies must be in the appropriate amount for the treatment or maintenance program in progress. We do not Cover over-the-counter medical supplies. See the Diabetic Equipment, Supplies, and Self-Management Education section above for a description of diabetic supply coverage.

G. Prosthetics.

1. External Prosthetic Devices.

We Cover prosthetic devices (including wigs) that are worn externally and that temporarily or permanently replace all or part of an external body part that has been lost or damaged because of an injury or disease. We Cover wigs only when You have severe hair loss due to injury or disease or as a side effect of the treatment of a disease (e.g., chemotherapy). We do not Cover wigs made from human hair unless You are allergic to all synthetic wig materials.

We do not Cover dentures or other devices used in connection with the teeth unless required due to an accidental injury to sound natural teeth or necessary due to congenital disease or anomaly.

Eyeglasses and contact lenses are not Covered under this section of the Certificate and are only Covered under the Vision Care section of this Certificate.

We Cover external breast prostheses following a mastectomy, which are not subject to any lifetime limit.

Coverage is for standard equipment only.

We Cover the cost of one (1) prosthetic device, per limb, per lifetime. We also Cover the cost of repair and replacement of the prosthetic device and its parts. We do not Cover the cost of repair or replacement covered under warranty or if the repair or replacement is the result of misuse or abuse by You.

2. Internal Prosthetic Devices.

We Cover surgically implanted prosthetic devices and special appliances if they improve or restore the function of an internal body part which has been removed or damaged due to disease or injury. This includes implanted breast prostheses following a mastectomy or partial mastectomy in a manner determined by You and Your attending Physician to be appropriate.

Coverage also includes repair and replacement due to normal growth or normal wear and tear.

Coverage is for standard equipment only.

H. Shoe Inserts.

We Cover shoe inserts that are necessary to: support, restore or protect body function; redirect, eliminate or restrict motion of an impaired body part; or relieve or correct a condition caused by an injury or illness. We Cover replacements: due to a change in Your condition; when required repairs would

exceed the cost of a replacement device or parts that need to be replaced; or when there has been an irreparable change in the condition of the device due to normal wear and tear. We do not Cover the cost of repair or replacement that is the result of misuse or abuse by You.

Section XI

Inpatient Services

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

A. Hospital Services.
We Cover inpatient Hospital services for Acute care or treatment given or ordered by a Health Care Professional for an illness, injury or disease of a severity that must be treated on an inpatient basis, including:

- Semiprivate room and board;
- General, special and critical nursing care;
- Meals and special diets;
- The use of operating, recovery and cystoscopic rooms and equipment;
- The use of intensive care, special care or cardiac care units and equipment;
- Diagnostic and therapeutic items, such as drugs and medications, sera, biologicals and vaccines, intravenous preparations and visualizing dyes and administration, but not including those which are not commercially available for purchase and readily obtainable by the Hospital;
- Dressings and casts;
- Supplies and the use of equipment in connection with oxygen, anesthesia, physiotherapy, chemotherapy, electrocardiographs, electroencephalographs, x-ray examinations and radiation therapy, laboratory and pathological examinations;
- Blood and blood products except when participation in a volunteer blood replacement program is available to You;
- Radiation therapy, inhalation therapy, chemotherapy, pulmonary rehabilitation, infusion therapy and cardiac rehabilitation;
- Short-term physical, speech and occupational therapy; and
- Any additional medical services and supplies which are provided while You are a registered bed patient and which are billed by the Hospital.

The Cost-Sharing requirements in the Schedule of Benefits section of this Certificate apply to a continuous Hospital confinement, which is consecutive days of in-Hospital service received as an inpatient or successive confinements when discharge from and readmission to the Hospital occur within a period of not more than ninety (90) days for the same or related causes.

B. Observation Services.
We Cover observation services in a Hospital. Observation services are Hospital outpatient services provided to help a Physician decide whether to admit or discharge You. These services include use of a bed and periodic monitoring by nursing or other licensed staff.

C. Inpatient Medical Services.
We Cover medical visits by a Health Care Professional on any day of inpatient care Covered under this Certificate.

D. Inpatient Stay for Maternity Care.
We Cover inpatient maternity care in a Hospital for the mother, and inpatient newborn care in a Hospital for the infant, for at least forty-eight (48) hours following a normal delivery and at least ninety-six (96) hours following a caesarean section delivery, regardless of whether such care is Medically Necessary. The care provided shall include parent education, assistance, and training in breast or bottle-feeding, and the performance of any necessary maternal and newborn clinical assessments. We will also Cover any additional days of such care that We determine are Medically Necessary. In the event the mother elects to leave the Hospital and requests a home care visit before the end of the forty-eight (48)-hour or ninety-six (96)-hour minimum coverage period, We will Cover a home care visit. The home care visit will be provided within twenty-four (24) hours after the mother's discharge, or at the time of the mother's request, whichever is later. Our coverage of this home care visit shall be in addition to home health care visits under this Certificate and shall not be subject to any Cost-Sharing amounts in the Schedule of Benefits section of this Certificate that apply to home care benefits.

We also Cover the inpatient use of pasteurized donor human milk, which may include fortifiers as Medically Necessary, for which a Health Care Professional has issued an order for an infant who is medically or physically unable to receive maternal breast milk, participate in breast feeding, or whose mother is medically or physically unable to produce maternal breast milk at all or in sufficient quantities or participate in breast feeding despite optimal lactation support. Such infant must have a documented birth weight of less than one thousand five hundred (1,500) grams, or a congenital or acquired condition that places the infant at a high risk for development of necrotizing enterocolitis.

E. Inpatient Stay for Mastectomy Care.
We Cover inpatient services for Members undergoing a lymph node dissection, lumpectomy, mastectomy or partial mastectomy for the treatment of breast cancer and any physical complications arising from the mastectomy, including lymphedema, for a period of time determined to be medically appropriate by You and Your attending Physician.

F. Autologous Blood Banking Services.
We Cover autologous blood banking services only when they are being provided in connection with a scheduled, Covered inpatient procedure for the treatment of a disease or injury. In such instances, We Cover storage fees for a reasonable storage period that is appropriate for having the blood available when it is needed.

G. Habilitation Services.
We Cover inpatient Habilitation Services consisting of physical therapy, speech therapy and occupational therapy for thirty (30) days per Plan Year. The visit limit applies to all therapies combined.

H. Rehabilitation Services.
We Cover inpatient Rehabilitation Services consisting of physical therapy, speech therapy and occupational therapy for thirty (30) days per Plan Year. The visit limit applies to all therapies combined.

We Cover speech and physical therapy only when:
1. Such therapy is related to the treatment or diagnosis of Your illness or injury (in the case of a covered Child, this includes a medically diagnosed congenital defect); and

2. The therapy is ordered by a Physician.

Covered Rehabilitation Services must begin within six (6) months of the later to occur:
1. The date of the injury or illness that caused the need for the therapy;
2. The date You are discharged from a Hospital where surgical treatment was rendered; or
3. The date outpatient surgical care is rendered.

I. Skilled Nursing Facility.
We Cover services provided in a Skilled Nursing Facility, including care and treatment in a semi-private room, as described in "Hospital Services" above. Custodial, convalescent or domiciliary care is not Covered (see the Exclusions and Limitations section of this Certificate). An admission to a Skilled Nursing Facility must be supported by a treatment plan prepared by Your Provider and approved by Us. We Cover up to unlimited days per Plan Year for non-custodial care.

J. End of Life Care.
If You are diagnosed with advanced cancer and You have fewer than sixty (60) days to live, We will Cover Acute care provided in a licensed Article 28 Facility or Acute care Facility that specializes in the care of terminally ill patients. Your attending Physician and the Facility's medical director must agree that Your care will be appropriately provided at the Facility. If We disagree with Your admission to the Facility, We have the right to initiate an expedited external appeal to an External Appeal Agent. We will Cover and reimburse the Facility for Your care, subject to any applicable limitations in this Certificate until the External Appeal Agent renders a decision in Our favor.

We will reimburse Non-Participating Providers for this end of life care as follows:
1. We will reimburse a rate that has been negotiated between Us and the Provider.
2. If there is no negotiated rate, We will reimburse Acute care at the Facility's current Medicare Acute care rate.
3. If it is an alternate level of care, We will reimburse at 75% of the appropriate Medicare Acute care rate.

K. Centers of Excellence.
Centers of Excellence are Hospitals that We have approved and designated for certain services. We Cover a range of services when performed at Centers of Excellence.

Our network of facilities includes designated Centers of Excellence. We closely monitor the quality of Our provider network, assuring a high level of board certification. In addition, EmblemHealth looks to contract with providers who have achieved National Committee for Quality Assurance ("NCQA") medical home designation, offer electronic medical records, and facilities that have been designated as a Center of Excellence by the Centers for Medicare and Medicaid Services ("CMS").

We provide case management for Members undergoing transplants and for those awaiting organ transplant, Members are listed in a minimum of two regions. Through Our vendor relationships for in-network access to designated transplant centers, We provide Members access to a nationally recognized network of transplant providers for the following services:

- Bone marrow transplant
- Heart transplant

- Liver transplant
- Lung transplant
- Pancreas transplant
- Kidney transplant
- Bone marrow/stem cell transplant

We also provide Members a link to the CMS designated Centers of Excellence for Obesity on Our website and encourage Members to access services through these centers for gastric bypass surgery and pre- and post-surgery support.

L. Limitations/Terms of Coverage.

1. When You are receiving inpatient care in a Facility, We will not Cover additional charges for special duty nurses, charges for private rooms (unless a private room is Medically Necessary), or medications and supplies You take home from the Facility. If You occupy a private room, and the private room is not Medically Necessary, Our coverage will be based on the Facility's maximum semi-private room charge. You will have to pay the difference between that charge and the private room charge.
2. We do not Cover radio, telephone or television expenses, or beauty or barber services.
3. We do not Cover any charges incurred after the day We advise You it is no longer Medically Necessary for You to receive inpatient care, unless Our denial is overturned by an External Appeal Agent.

Section XII

Mental Health Care and Substance Use Services

Please refer to the Schedule of Benefits section of this Certificate for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits which are no more restrictive than those that apply to medical and surgical benefits in accordance with the federal Mental Health Parity and Addiction Equity Act of 2008.

A. Mental Health Care Services. We Cover the following mental health care services to treat a mental health condition. For purposes of this benefit, "mental health condition" means any mental health disorder as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.

1. **Inpatient Services.** We Cover inpatient mental health care services relating to the diagnosis and treatment of mental health conditions comparable to other similar Hospital, medical and surgical coverage provided under this Certificate. Coverage for inpatient services for mental health care is limited to Facilities defined in New York Mental Hygiene Law Section 1.03(10), such as:
    - A psychiatric center or inpatient Facility under the jurisdiction of the New York State Office of Mental Health;
    - A state or local government run psychiatric inpatient Facility;
    - A part of a Hospital providing inpatient mental health care services under an operating certificate issued by the New York State Commissioner of Mental Health;
    - A comprehensive psychiatric emergency program or other Facility providing inpatient mental health care that has been issued an operating certificate by the New York State Commissioner of Mental Health;

    and, in other states, to similarly licensed or certified Facilities. In the absence of a similarly licensed or certified Facility, the Facility must be accredited by the Joint Commission on Accreditation of Health Care Organizations or a national accreditation organization recognized by Us.

    We also Cover inpatient mental health care services relating to the diagnosis and treatment of mental health conditions received at Facilities that provide residential treatment, including room and board charges. Coverage for residential treatment services is limited to Facilities defined in New York Mental Hygiene Law Section 1.03(33) and to residential treatment facilities that are part of a comprehensive care center for eating disorders identified pursuant to Article 27-J of the New York Public Health Law; and, in other states, to Facilities that are licensed or certified to provide the same level of treatment. In the absence of a licensed or certified Facility that provides the same level of treatment, the Facility must be accredited by the Joint Commission on Accreditation of Health Care Organizations or a national accreditation organization recognized by Us.

2. **Outpatient Services.** We Cover outpatient mental health care services, including but not limited to partial hospitalization program services and intensive outpatient program services, relating to the diagnosis and treatment of mental health conditions. Coverage for outpatient services for

mental health care includes Facilities that have been issued an operating certificate pursuant to Article 31 of the New York Mental Hygiene Law or are operated by the New York State Office of Mental Health and, in other states, to similarly licensed or certified Facilities; and services provided by a licensed psychiatrist or psychologist; a licensed clinical social worker; a nurse practitioner; a licensed mental health counselor; a licensed marriage and family therapist; a licensed psychoanalyst; or a professional corporation or a university faculty practice corporation thereof. In the absence of a similarly licensed or certified Facility, the Facility must be accredited by the Joint Commission on Accreditation of Health Care Organizations or a national accreditation organization recognized by Us.

B. Substance Use Services. We Cover the following substance use services to treat a substance use disorder. For purposes of this benefit, "substance use disorder" means any substance use disorder as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.

1. **Inpatient Services.** We Cover inpatient substance use services relating to the diagnosis and treatment of substance use disorders. This includes coverage for detoxification and rehabilitation services for substance use disorders. Inpatient substance use services are limited to Facilities in New York State which are licensed, certified or otherwise authorized by the Office of Alcoholism and Substance Abuse Services ("OASAS"); and, in other states, to those Facilities that are licensed, certified or otherwise authorized by a similar state agency and accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs.

   We also Cover inpatient substance use services relating to the diagnosis and treatment of substance use disorders received at Facilities that provide residential treatment, including room and board charges. Coverage for residential treatment services is limited to Facilities that are licensed, certified or otherwise authorized by OASAS; and, in other states, to those Facilities that are licensed, certified or otherwise authorized by a similar state agency and accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs to provide the same level of treatment.

2. **Outpatient Services.** We Cover outpatient substance use services relating to the diagnosis and treatment of substance use disorders, including but not limited to partial hospitalization program services, intensive outpatient program services, counseling, and medication-assisted treatment. Such coverage is limited to Facilities in New York State that are licensed, certified or otherwise authorized by OASAS to provide outpatient substance use disorder services and, in other states, to those that are licensed, certified or otherwise authorized by a similar state agency and accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs. Coverage in an OASAS-certified Facility includes services relating to the diagnosis and treatment of a substance use disorder provided by an OASAS credentialed Provider. Coverage is also available in a professional office setting for outpatient substance use disorder services relating to the diagnosis and treatment of alcoholism, substance use and dependency or by Physicians who have been granted a waiver pursuant to the federal Drug Addiction Treatment Act of 2000 to prescribe Schedule III, IV and V narcotic medications for the treatment of opioid addiction during the Acute detoxification stage of treatment or during stages of rehabilitation.

Additional Family Counseling. We also Cover outpatient visits per Plan Year for family counseling. A family member will be deemed to be covered, for the purposes of this provision, so long as that family member: 1) identifies himself or herself as a family member of a person suffering from a substance use disorder; and 2) is covered under the same family Certificate that covers the person receiving, or in need of, treatment for a substance use disorder. Our payment for a family member therapy session will be the same amount, regardless of the number of family members who attend the family therapy session.

Section XIII

Wellness Benefits

A. The ExerciseRewards™ Program.
The ExerciseRewards Program will reward the Subscriber and each covered Dependent for meeting the activity requirements at qualified fitness centers which maintain equipment and programs that promote cardiovascular wellness.

Activity in tennis clubs, country clubs, weight loss clinics, spas or any other similar facilities will not be eligible for rewards. Reward activity is limited to actual workout visits. We will not provide reimbursement for equipment, clothing, vitamins or other services that may be offered by the fitness center (e.g., massages, etc.).

In order to be eligible for Your reward, You must:

- Be an active member of the fitness center, and
- Work out at least fifty (50) times each six (6) month calendar year period.

You can track Your exercise in the following four (4) ways:

- The ExerciseRewards CheckIn!® app – an app to check in and out at thousands of fitness centers nationwide.
- The Active&Fit Direct™ Program – an optional program that provides discounts at thousands of participating fitness centers to eligible Members and will submit visits on Your behalf.
- Auto-Reporting – work out at participating fitness center that submit Your visits on Your behalf.
- Paper Log – track Your fitness center visits manually to earn rewards.

Subscribers are eligible to receive a $200 reward and covered Dependents are eligible to receive $100 each six (6) month calendar year period. Once ExerciseRewards receives confirmation of activity that meets the requirement of fifty (50) visits, You will receive an email to redeem Your reward. Rewards will be issued fourteen (14) days after You have redeemed Your reward on the ExerciseRewards website or forty-five (45) days from the end of Your reward period if You do not redeem Your reward. We encourage You to use the reward for a product or service that promotes good health, such as healthy cookbooks, over-the-counter vitamins or exercise equipment.

The ExerciseRewards and Active&Fit Direct programs are provided by American Specialty Health Fitness, Inc., a subsidiary of American Specialty Health Incorporated (ASH). ExerciseRewards, ExerciseRewards CheckIn! and Active&Fit Direct are trademarks of ASH and used with permission herein.

B. Wellness Program.

1. Purpose.
The purpose of this wellness program is to encourage You to take a more active role in managing Your health and well-being.

2. Description.
We provide benefits in connection with the use of or participation in any of the following wellness and health promotion actions and activities:

DISCOUNT PROGRAMS
The Healthy Discount programs are available to all EmblemHealth Members but are not a covered benefit under Your plan. The offerings include:

- **Acupuncture, Massage Therapy and Nutrition Counseling** — Members can save up to 25 percent on acupuncture, therapeutic massage and nutrition counseling. Call **1-877-327-2746** to get more information.
- **Jenny Craig** — Join Jenny Craig and receive a free three (3)-month program (food not included) with up to $120 in food savings (purchase required) or save 50% off our premium programs (food not included). Visit www.jennycraig.com/emblem for details. You can register at www.jennycraig.com/emblem to receive Your discount. Print Your personalized registration coupon. Call **1-877-JENNY70 (1-877-536-6970)** to speak to Your closest Jenny Craig Center or Jenny Craig anywhere. Please be sure to take Your registration coupon to Your free consultation and be sure to mention that You are an EmblemHealth member when getting started.
- **NutriSystem** — Members receive $30 off all Select, Basic, Silver, Diabetic and Vegetarian program orders, plus all the benefits found at www.nutrisystem.com. Members can sign up online at www.nutrisystem.com/emblem or call **1-877-690-6534** to enroll.
- **Vision Discount Program** — You are eligible to access vision care, including examinations, eyewear, contact lenses and laser vision correction, at discounted rates through a network of vision providers. To locate discount program participating vision providers, go online at www.eyemed.com or call **1-844-790-3878**. To access the discount vision program services, contact a participating vision provider to schedule an appointment, identify yourself as Our Member and present Your ID card at the appointment. You must pay the full, discounted cost of the services that You receive under this program directly to the participating provider. Services may vary by provider.

If Your Certificate includes coverage for certain vision care services or if such services are covered under an insurance plan that You have with another insurer, You should generally use Your insured vision benefit to access Covered Services, and only use this discount program to access non-covered services.

- **Hearing Care Discount Programs** — You are eligible to access discounts from the following selected vendors:

  HearUSA/Hearx — Offers discounts of up to 20% on hearing aid purchases and up to 10% on listening products and hearing aid accessories. To identify participating locations where discounts apply, go online at www.hearusa.com/centers/search_criteria.asp?m=1&type=corporate&switch=no, or call **1-800-442-8231**. TTD users can call **1-888-300-3277**. To access the discounts for listening products and hearing aid accessories go to www.hearingshop.com. To receive the discount, view Your shopping cart and enter coupon code Emblem.

  Amplifon — Take control of Your hearing and improve Your quality of life with a low-price

guarantee on hearing aids, free batteries, follow-up care and screenings. Amplifon offers a 60-day trial period with a 100% money-back guarantee. Call **1-888-534-4427** or visit www.amplifonusa.com/emblem to schedule Your evaluation today.

If Your Certificate includes coverage for hearing aids and/or listening products and hearing aid accessories or if these items are covered under another insurance plan if You are covered under more than one health plan, You should generally use Your insured hearing aid benefit, and only use this discount program to access non-covered hearing aid purchases.

- **Medical Equipment and Services Discount Program** — You may save up to 50% on comprehensive health care services and products – including prescription medications, dental care, medical supplies, home nursing care and more. Register online at www.careexpresshealth.com/Emblem, or call **1-866-635-9532**. (Membership fee is required to access discounts.)

If Your Certificate includes coverage for prescription drugs, dental care, medical supplies, home nursing care, and other discount services available under this program, or if these services are covered under an insurance plan that You have with another insurer if You are covered under more than one health plan, You should use Your insured benefits to access covered services, and only use this discount program to access non-covered services.

To read more about these and other discount programs, visit www.emblemhealth.com/goodhealth.

CARE MANAGEMENT PROGRAMS

We offer programs designed to help Members with chronic conditions improve their health and well-being. To accomplish this goal, You can receive support and education from a specially trained nurse or other health care professional.

Care Management programs includes:

1. **Emergency Department (ED) Utilization** – A program designed to increase alignment of the care delivery system for Our high-need Members who have preventable ED visits. The goal of the program is to provide clinical oversight to reduce avoidable ED visits, engage Members in their primary care system, provide education to disease process and management and assist in care coordination to improve health outcomes. To find out more or to enroll, call 800-447-0768, Monday to Friday, 9 a.m. to 5 p.m.

2. **Transitions of Care** – A program designed to prevent hospital readmissions through a comprehensive clinical program that provides Member education, ensuring post-discharge doctors' appointments, obtaining needed medications and understanding their usage, times of administration and signs and symptoms of concern to report, navigation for appropriate resources and assist in care coordination to meet health care needs. To find out more or to enroll, call 800-447-0768, Monday to Friday, 9 a.m. to 5 p.m.

3. **Complex Case Management** – A clinical oversight program designed to support Members with complex comorbid chronic medical conditions. This program provides high-level of outreach

with one-on-one intervention, advocacy for their health care, coordinates healthcare services and communications between the health care providers, Member and their families at a time when help is most needed. To find out more or to enroll, call 800-447-0768, Monday to Friday, 9 a.m. to 5 p.m.

4. **Transplant Program** – A program designed for Members who are in the process of receiving or being evaluated for transplant services. This includes collaboration with facilities and providers to ensure that Members obtain the best care while navigating through the transplant medical process. To find out more or to enroll, call 800-447-0768, Monday to Friday, 9 a.m. to 5 p.m.

5. **HIV Program** – A program designed to provide support to Members with home life, medical care, and psychological issues. The program aids with finding community resources and supports the Member in navigating the medical system. To find out more or to enroll, call 800-447-0768, Monday to Friday, 9 a.m. to 5 p.m.

6. **Neonatal Intensive Care Unit (NICU) Program** – A program designed to address the needs of compromised newborns through one (1) year of age with collaboration with the facility NICU nurses and social workers to assess neonates at the time of discharge for continuing care needs. To find out more or to enroll, call 800-447-0768, Monday to Friday, 9 a.m. to 5 p.m.

7. **Disease Management** – A program designed for Members with Chronic Kidney Disease ("CKD") and End Stage Renal Disease ("ESRD"). The CKD portion of this program is designed to delay progression to dialysis and avoid co-morbidities. If dialysis is unavoidable, Members are assisted selecting the type of dialysis and provider that best meets their individual needs. To find out more or to enroll, call 866-561-7518, Monday to Friday, 9 a.m. to 5 p.m.

WELLNESS PROGRAMS

1. **Diabetes Prevention Program** – A program designed to teach Members at risk for diabetes the habits and techniques necessary to avoid or delay the onset of diabetes and lead healthier lives. To find out more or to enroll, call 866-447-8080, Monday to Friday, 9 a.m. to 5 p.m.

2. **Tobacco Free Quit-Smoking Program** – A program designed to offer a telephonic-based behavior modification to Members that are eighteen (18) years old and older who want to stop smoking. The program consists of a comprehensive educational kit and support calls from a smoking cessation specialist. New York residents call **866-NY-QUITS** (866-697-8487), non-New York residents, call 877-500-2393 Monday to Friday, 8 a.m. to 9 p.m., Saturday, 9 a.m. to 7 p.m. and Sunday, 9 a.m. to 5 p.m. (**TTY: 711**).

3. **24-Hour Nurse Health Information Line** – A program designed to provide a 24-hour toll-free health information line that is staffed by highly-trained registered nurses and is available 7 days a week. Nurses trained in telephone triaging gives eligible Members access to immediate clinical support for everyday health issues and guide callers in making informed decisions about a multitude of health conditions and how best to handle a medical concern. To find out more, call 877-444-7988.

4. **Healthy Beginnings Pregnancy Program** – A prenatal program designed to provide expectant

mothers with important information about having a healthy pregnancy. The program conducts Obstetrical Risk Assessments. Members identified as high risk are referred to a complex care manager for further evaluation and intervention. To find out more, call 888-447-0337, Monday to Friday, 9 a.m. to 5 p.m.

We also provide the following preventive health screening reminders and health management tools for Your convenience:

- **Preventive Health Screening Reminders** — You may receive mail, email and/or telephone reminders from Us to schedule important health screenings for breast, cervical and colorectal cancer, as well as other preventive health care messages.
- **Health Management Tools** — Interactive online tools are available to You to help manage Your health and wellness at www.emblemhealth.com/en/Health-and-Wellness/Stay-Healthy/Health-Manager-Tools.aspx.
    - **A health risk assessment tool; Health Assessment (HA):** The Health Assessment includes approximately 40 questions, based on individual risks and status, and takes Members approximately 10 to 15 minutes to complete. The assessment establishes a baseline of consumer risks and provides a Health Score for the Member by collecting only essential data. The questions included in the HA have been validated through rigorous third-party research, evaluates Members' physical health as well as their social health, mental health and work-life balance – the key components in maintaining optimal wellness. Immediately following completion of the assessment, Members are provided a summary report of their health status, including a personalized Health Score indicating their potential for improvement and related health improvement opportunities. After completing the HA, each Member receives a recommended digital coaching program to improve unhealthy behavior, impacting their quality of life and health status.

      Personal Health Record (PHR) — Your health records are among Your most important documents. When you visit Our website at www.emblemhealth.com and sign in as a Member, You will be connected to myEmblemHealth, which provides resources to help You manage Your membership and Your health, including accessing Your health records and keeping them well organized and at Your fingertips. You can also retain a concise record of Your medications, medical history, tests, health care contacts and more in Your personal health record, as well as elect to have Your prescription records automatically added to Your PHR. You can even print out copies of Your PHR to share with Your doctor(s).

3. Eligibility.
You, the Subscriber, and each covered Dependent can participate in the wellness program.

4. Participation.
The preferred method for accessing the wellness program is through Our website at http://www.emblemhealth.com/en/Health-and-Wellness.aspx. You need to have access to a computer

with internet access in order to participate in the website program. However, if You do not have access to a computer, please call Us at the number on Your ID card and We will provide You with information regarding how to participate without internet access.

5. Rewards.

If You have one (1) or more chronic conditions or suspected chronic conditions, You may be eligible to earn a $50 reward card for participating in a free, convenient in-home or mobile clinic preventive health visit with a nurse practitioner. We will determine Your eligibility for this opportunity based on Your claims data. You may be eligible if You have or may be at risk for certain chronic conditions, such as diabetes, certain cancers, certain metabolic or endocrine disorders, certain mental health and substance use disorders, immune system disorders, congenital anomalies, liver diseases and/or certain other types of conditions. If We determine that You are eligible, You will receive a letter from Our vendor inviting You to schedule the free preventive care visit. The visit will take about an hour. After Your visit, You will receive a Personal Health Summary in the mail detailing Your health information. We will also share the information We learn from Your visit with Your doctor. You will receive the reward card by mail within two to three weeks after You complete the visit. We suggest that You use the reward card for products or services that promote Your good health, such as healthy cook books, over-the-counter vitamins or exercise equipment.

The in-home or mobile clinic visit is not intended to replace regular visits with Your doctor. The in-home or mobile preventive examination visit is free. Additional services may be subject to Cost-Sharing as set forth in this Certificate.

Section XIV

Vision Care

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

A. Vision Care.

We Cover emergency, preventive and routine vision care.

B. Vision Examinations.

We Cover vision examinations for the purpose of determining the need for corrective lenses, and if needed, to provide a prescription for corrective lenses. We Cover a vision examination one (1) time in any twelve (12)-month period, unless more frequent examinations are Medically Necessary as evidenced by appropriate documentation. The vision examination may include, but is not limited to:

- Case history;
- External examination of the eye or internal examination of the eye;
- Ophthalmoscopic exam;
- Determination of refractive status;
- Binocular distance;
- Tonometry tests for glaucoma;
- Gross visual fields and color vision testing; and
- Summary findings and recommendation for corrective lenses.

C. Prescribed Lenses and Frames.

We Cover standard prescription lenses and will pay the dollar allowance shown in the Schedule of Benefits section of this Certificate one (1) time in any twenty-four (24)-month period, unless it is Medically Necessary for You to have new lenses more frequently, as evidenced by appropriate documentation. Prescription lenses may be constructed of either glass or plastic. We also Cover standard frames adequate to hold lenses one (1) time in any twenty-four (24)-month period, unless it is Medically Necessary for You to have new frames more frequently, as evidenced by appropriate documentation. You must choose the frames and lenses from a Participating Provider.

Section XV

Exclusions and Limitations

No coverage is available under this Certificate for the following:

A. Aviation.
We do not Cover services arising out of aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline.

B. Convalescent and Custodial Care.
We do not Cover services related to rest cures, custodial care or transportation. "Custodial care" means help in transferring, eating, dressing, bathing, toileting and other such related activities. Custodial care does not include Covered Services determined to be Medically Necessary.

C. Conversion Therapy.
We do not Cover conversion therapy. Conversion therapy is any practice by a mental health professional that seeks to change the sexual orientation or gender identity of a Member under eighteen (18) years of age, including efforts to change behaviors, gender expressions, or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same sex. Conversion therapy does not include counseling or therapy for an individual who is seeking to undergo a gender transition or who is in the process of undergoing a gender transition, that provides acceptance, support, and understanding of an individual or the facilitation of an individual's coping, social support, and identity exploration and development, including sexual orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices, provided that the counseling or therapy does not seek to change sexual orientation or gender identity.

D. Cosmetic Services.
We do not Cover cosmetic services, Prescription Drugs, or surgery, unless otherwise specified, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered Child which has resulted in a functional defect. We also Cover services in connection with reconstructive surgery following a mastectomy, as provided elsewhere in this Certificate. Cosmetic surgery does not include surgery determined to be Medically Necessary. If a claim for a procedure listed in 11 NYCRR 56 (e.g., certain plastic surgery and dermatology procedures) is submitted retrospectively and without medical information, any denial will not be subject to the Utilization Review process in the Utilization Review and External Appeal sections of this Certificate unless medical information is submitted.

E. Coverage Outside of the United States, Canada or Mexico.
We do not Cover care or treatment provided outside of the United States, its possessions, Canada or Mexico except for Emergency Services, Pre-Hospital Emergency Medical Services and ambulance services to treat Your Emergency Condition.

F. Dental Services.
We do not Cover dental services except for: care or treatment due to accidental injury to sound natural

teeth within twelve (12) months of the accident; dental care or treatment necessary due to congenital disease or anomaly; or dental care or treatment specifically stated in the Outpatient and Professional Services section of this Certificate.

G. Experimental or Investigational Treatment.
We do not Cover any health care service, procedure, treatment, device or Prescription Drug that is experimental or investigational. However, We will Cover experimental or investigational treatments, including treatment for Your rare disease or patient costs for Your participation in a clinical trial as described in the Outpatient and Professional Services section of this Certificate, when Our denial of services is overturned by an External Appeal Agent certified by the State. However, for clinical trials, We will not Cover the costs of any investigational drugs or devices, non-health services required for You to receive the treatment, the costs of managing the research, or costs that would not be Covered under this Certificate for non-investigational treatments. See the Utilization Review and External Appeal sections of this Certificate for a further explanation of Your Appeal rights.

H. Felony Participation.
We do not Cover any illness, treatment or medical condition due to Your participation in a felony, riot or insurrection. This exclusion does not apply to coverage for services involving injuries suffered by a victim of an act of domestic violence or for services as a result of Your medical condition (including both physical and mental health conditions).

I. Foot Care.
We do not Cover routine foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet. However, We will Cover foot care when You have a specific medical condition or disease resulting in circulatory deficits or areas of decreased sensation in Your legs or feet.

J. Government Facility.
We do not Cover care or treatment provided in a Hospital that is owned or operated by any federal, state or other governmental entity, except as otherwise required by law unless You are taken to the Hospital because it is close to the place where You were injured or became ill and Emergency Services are provided to treat Your Emergency Condition.

K. Medically Necessary.
In general, We will not Cover any health care service, procedure, treatment, test, device or Prescription Drug that We determine is not Medically Necessary. If an External Appeal Agent certified by the State overturns Our denial, however, We will Cover the service, procedure, treatment, test, device or Prescription Drug for which coverage has been denied, to the extent that such service, procedure, treatment, test, device or Prescription Drug is otherwise Covered under the terms of this Certificate.

L. Medicare or Other Governmental Program.
We do not Cover services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid).

M. Military Service.
We do not Cover an illness, treatment or medical condition due to service in the Armed Forces or

auxiliary units.

N. No-Fault Automobile Insurance.
We do not Cover any benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable. This exclusion applies even if You do not make a proper or timely claim for the benefits available to You under a mandatory no-fault policy.

O. Services Not Listed.
We do not Cover services that are not listed in this Certificate as being Covered.

P. Services Provided by a Family Member.
We do not Cover services performed by a member of the covered person's immediate family. "Immediate family" shall mean a child, spouse, mother, father, sister or brother of You or Your Spouse.

Q. Services Separately Billed by Hospital Employees.
We do not Cover services rendered and separately billed by employees of Hospitals, laboratories or other institutions.

R. Services with No Charge.
We do not Cover services for which no charge is normally made.

S. Vision Services.
We do not Cover the examination or fitting of eyeglasses or contact lenses, except as specifically stated in the Vision Care section of this Certificate.

T. War.
We do not Cover an illness, treatment or medical condition due to war, declared or undeclared.

U. Workers' Compensation.
We do not Cover services if benefits for such services are provided under any state or federal Workers' Compensation, employers' liability or occupational disease law.

Section XVI

Claim Determinations

A. Claims.
A claim is a request that benefits or services be provided or paid according to the terms of this Certificate. When You receive services from a Participating Provider, You will not need to submit a claim form. However, if You receive services from a Non-Participating Provider either You or the Provider must file a claim form with Us. If the Non-Participating Provider is not willing to file the claim form, You will need to file it with Us. See the Coordination of Benefits section of this Certificate for information on how We coordinate benefit payments when You also have group health coverage with another plan.

B. Notice of Claim.
Claims for services must include all information designated by Us as necessary to process the claim, including, but not limited to: Member identification number; name; date of birth; date of service; type of service; the charge for each service; procedure code for the service as applicable; diagnosis code; name and address of the Provider making the charge; and supporting medical records, when necessary. A claim that fails to contain all necessary information will not be accepted and must be resubmitted with all necessary information. Claim forms are available from Us by calling the number on Your ID card or visiting Our website at www.emblemhealth.com. Completed claim forms should be sent to the address in the How Your Coverage Works section of this Certificate. You may also submit a claim to Us electronically by sending it to the e-mail address in the How Your Coverage Works section of this Certificate.

C. Timeframe for Filing Claims.
Claims for services must be submitted to Us for payment within one hundred eighty (180) days after You receive the services for which payment is being requested. If it is not reasonably possible to submit a claim within the one hundred eighty (180) day period, You must submit it as soon as reasonably possible.

D. Claims for Prohibited Referrals.
We are not required to pay any claim, bill or other demand or request by a Provider for clinical laboratory services, pharmacy services, radiation therapy services, physical therapy services or x-ray or imaging services furnished pursuant to a referral prohibited by Section 238-a(1) of the New York Public Health Law.

E. Claim Determinations.
Our claim determination procedure applies to all claims that do not relate to a medical necessity or experimental or investigational determination. For example, Our claim determination procedure applies to contractual benefit denials and Referrals. If You disagree with Our claim determination, You may submit a Grievance pursuant to the Grievance Procedures section of this Certificate.

For a description of the Utilization Review procedures and Appeal process for medical necessity or experimental or investigational determinations, see the Utilization Review and External Appeal sections of this Certificate.

F. Pre-Service Claim Determinations.

1. A pre-service claim is a request that a service or treatment be approved before it has been received. If We have all the information necessary to make a determination regarding a pre-service claim (e.g., a covered benefit determination or Referral), We will make a determination and provide notice to You (or Your designee) within fifteen (15) days from receipt of the claim.

   If We need additional information, We will request it within fifteen (15) days from receipt of the claim. You will have forty-five (45) calendar days to submit the information. If We receive the information within forty-five (45) days, We will make a determination and provide notice to You (or Your designee) in writing, within fifteen (15) days of Our receipt of the information. If all necessary information is not received within forty-five (45) days, We will make a determination within fifteen (15) calendar days of the end of the forty-five (45)-day period.

2. **Urgent Pre-Service Reviews.** With respect to urgent pre-service requests, if We have all information necessary to make a determination, We will make a determination and provide notice to You (or Your designee) by telephone, within seventy-two (72) hours of receipt of the request. Written notice will follow within three (3) calendar days of the decision. If We need additional information, We will request it within twenty-four (24) hours. You will then have forty-eight (48) hours to submit the information. We will make a determination and provide notice to You (or Your designee) by telephone within forty-eight (48) hours of the earlier of Our receipt of the information or the end of the forty-eight (48)-hour period. Written notice will follow within three (3) calendar days of the decision.

G. Post-Service Claim Determinations.

A post-service claim is a request for a service or treatment that You have already received. If We have all information necessary to make a determination regarding a post-service claim, We will make a determination and notify You (or Your designee) within thirty (30) calendar days of the receipt of the claim if We deny the claim in whole or in part. If We need additional information, We will request it within thirty (30) calendar days. You will then have forty-five (45) calendar days to provide the information. We will make a determination and provide notice to You (or Your designee) in writing within fifteen (15) calendar days of the earlier of Our receipt of the information or the end of the forty-five (45)-day period if We deny the claim in whole or in part.

H. Payment of Claims.

Where Our obligation to pay a claim is reasonably clear, We will pay the claim within thirty (30) days of receipt of the claim (when submitted through the internet or e-mail) and forty-five (45) days of receipt of the claim (when submitted through other means, including paper or fax). If We request additional information, We will pay the claim within thirty (30) days (for claims submitted through the internet or e-mail) or forty-five (45) days (for claims submitted through other means, including paper or fax) of receipt of the information.

Section XVII

Grievance Procedures

A. Grievances.
Our Grievance procedure applies to any issue not relating to a Medical Necessity or experimental or investigational determination by Us. For example, it applies to contractual benefit denials or issues or concerns You have regarding Our administrative policies or access to Providers.

B. Filing a Grievance.
You can contact Us by phone at 1-800-447-8255, in person, or in writing to file a Grievance. You may submit an oral Grievance in connection with a denial of a Referral or a covered benefit determination. We may require that You sign a written acknowledgement of Your oral Grievance, prepared by Us. You or Your designee has up to one hundred eighty (180) calendar days from when You received the decision You are asking Us to review to file the Grievance.

When We receive Your Grievance, We will mail an acknowledgment letter within fifteen (15) business days. The acknowledgment letter will include the name, address, and telephone number of the person handling Your Grievance, and indicate what additional information, if any, must be provided.

We keep all requests and discussions confidential and We will take no discriminatory action because of Your issue. We have a process for both standard and expedited Grievances, depending on the nature of Your inquiry.

C. Grievance Determination.
Qualified personnel will review Your Grievance, or if it is a clinical matter, a licensed, certified or registered Health Care Professional will look into it. We will decide the Grievance and notify You within the following timeframes:

Expedited/Urgent Grievances:	By phone, within the earlier of forty-eight (48) hours of receipt of all necessary information or seventy-two (72) hours of receipt of Your Grievance. Written notice will be provided within seventy-two (72) hours of receipt of Your Grievance.
Pre-Service Grievances: (A request for a service or treatment that has not yet been provided.)	In writing, within fifteen (15) calendar days of receipt of Your Grievance.
Post-Service Grievances: (A claim for a service or treatment that has already been provided.)	In writing, within thirty (30) calendar days of receipt of Your Grievance.

All Other Grievances: (That are not in relation to a claim or request for a service or treatment.)	In writing, within forty-five (45) calendar days of receipt of all necessary information.

D. Grievance Appeals.
If You are not satisfied with the resolution of Your Grievance, You or Your designee may file an Appeal by phone at 1-800-447-8255, in person, or in writing. However, Urgent Appeals may be filed by phone. You have up to sixty (60) business days from receipt of the Grievance determination to file an Appeal.

When We receive Your Appeal, We will mail an acknowledgment letter within fifteen (15) business days. The acknowledgement letter will include the name, address, and telephone number of the person handling Your Appeal and indicate what additional information, if any, must be provided.

One or more qualified personnel at a higher level than the personnel that rendered the Grievance determination will review it, or if it is a clinical matter, a clinical peer reviewer will look into it. We will decide the Appeal and notify You in writing within the following timeframes:

Expedited/Urgent Grievances:	The earlier of two (2) business days of receipt of all necessary information or seventy-two (72) hours of receipt of Your Appeal.
Pre-Service Grievances: (A request for a service or treatment that has not yet been provided.)	Fifteen (15) calendar days of receipt of Your Appeal.
Post-Service Grievances: (A claim for a service or treatment that has already been provided.)	Thirty (30) calendar days of receipt of Your Appeal.
All Other Grievances: (That are not in relation to a claim or request for a service or treatment.)	Thirty (30) business days of receipt of all necessary information to make a determination.

E. Assistance.
If You remain dissatisfied with Our Appeal determination, or at any other time You are dissatisfied, You may:

Call the New York State Department of Health at 1-800-206-8125 or write them at:
New York State Department of Health
Office of Health Insurance Programs
Bureau of Consumer Services – Complaint Unit
Corning Tower – OCP Room 1609
Albany, NY 12237
Email: managedcarecomplaint@health.ny.gov
Website: www.health.ny.gov

If You need assistance filing a Grievance or Appeal, You may also contact the state independent Consumer Assistance Program at:
Community Health Advocates
633 Third Avenue, 10th Floor
New York, NY 10017
Or call toll free: 1-888-614-5400, or e-mail cha@cssny.org
Website: www.communityhealthadvocates.org

Section XVIII

Utilization Review

A. Utilization Review.

We review health services to determine whether the services are or were Medically Necessary or experimental or investigational ("Medically Necessary"). This process is called Utilization Review. Utilization Review includes all review activities, whether they take place prior to the service being performed (Preauthorization); when the service is being performed (concurrent); or after the service is performed (retrospective). If You have any questions about the Utilization Review process, please call the number on Your ID card; or, for mental health and substance use disorder services, also call the number on Your ID card. The toll-free telephone number is available at least forty (40) hours a week with an after-hours answering machine.

All determinations that services are not Medically Necessary will be made by: 1) licensed Physicians; or 2) licensed, certified, registered or credentialed Health Care Professionals who are in the same profession and same or similar specialty as the Provider who typically manages Your medical condition or disease or provides the health care service under review; or 3) with respect to mental health or substance use disorder treatment, licensed Physicians or licensed, certified, registered or credentialed Health Care Professionals who specialize in behavioral health and have experience in the delivery of mental health or substance use disorder courses of treatment. We do not compensate or provide financial incentives to Our employees or reviewers for determining that services are not Medically Necessary.

We have developed guidelines and protocols to assist Us in this process. For substance use disorder treatment, We will use evidence-based and peer reviewed clinical review tools designated by OASAS that are appropriate to the age of the patient. Specific guidelines and protocols are available for Your review upon request. For more information, call the number on Your ID card or visit Our website at www.emblemhealth.com.

B. Preauthorization Reviews.

1. **Non-Urgent Preauthorization Reviews.** If We have all the information necessary to make a determination regarding a Preauthorization review, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within three (3) business days of receipt of the request.

   If We need additional information, We will request it within three (3) business days. You or Your Provider will then have forty-five (45) calendar days to submit the information. If We receive the requested information within forty-five (45) days, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within three (3) business days of Our receipt of the information. If all necessary information is not received within forty-five (45) days, We will make a determination within fifteen (15) calendar days of the earlier of the receipt of part of the requested information or the end of the forty-five (45)-day period.

2. **Urgent Preauthorization Reviews.** With respect to urgent Preauthorization requests, if We have all information necessary to make a determination, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone, within seventy-two (72) hours of receipt of the request. Written notice will be provided within three (3) business days of receipt of the request. If We need additional information, We will request it within twenty-four (24) hours. You or Your Provider will then have forty-eight (48) hours to submit the information. We will make a determination and provide notice to You (or Your designee) and Your Provider by telephone within forty-eight (48) hours of the earlier of Our receipt of the information or the end of the forty-eight (48)-hour period. Written notification will be provided within the earlier of three (3) business days of Our receipt of the information or three (3) calendar days after the verbal notification.

3. **Court Ordered Treatment.** With respect to requests for mental health and/or substance use disorder services that have not yet been provided, if You (or Your designee) certify, in a format prescribed by the Superintendent of Financial Services, that You will be appearing, or have appeared, before a court of competent jurisdiction and may be subject to a court order requiring such services, We will make a determination and provide notice to You (or Your designee) and Your Provider by telephone within seventy-two (72) hours of receipt of the request. Written notification will be provided within three (3) business days of Our receipt of the request. Where feasible, the telephonic and written notification will also be provided to the court.

C. Concurrent Reviews.

1. **Non-Urgent Concurrent Reviews.** Utilization Review decisions for services during the course of care (concurrent reviews) will be made, and notice provided to You (or Your designee) and Your Provider, by telephone and in writing, within one (1) business day of receipt of all necessary information. If We need additional information, We will request it within one (1) business day. You or Your Provider will then have forty-five (45) calendar days to submit the information. We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within one (1) business day of Our receipt of the information or, if We do not receive the information, within the earlier of fifteen (15) calendar days of the receipt of part of the requested information or fifteen (15) calendar days of the end of the forty-five (45)-day period.

2. **Urgent Concurrent Reviews.** For concurrent reviews that involve an extension of urgent care, if the request for coverage is made at least twenty-four (24) hours prior to the expiration of a previously approved treatment, We will make a determination and provide notice to You (or Your designee) and Your Provider by telephone within twenty-four (24) hours of receipt of the request. Written notice will be provided within one (1) business day of receipt of the request.

   If the request for coverage is not made at least twenty-four (24) hours prior to the expiration of a previously approved treatment and We have all the information necessary to make a determination, We will make a determination and provide written notice to You (or Your designee) and Your Provider within the earlier of seventy-two (72) hours or one (1) business day of receipt of the request. If We need additional information, We will request it within twenty-four (24) hours. You or Your Provider will then have forty-eight (48) hours to submit the information. We will make a determination and provide written notice to You (or Your designee) and Your Provider within the earlier of one (1) business day or forty-eight (48) hours

of Our receipt of the information or, if We do not receive the information, within forty-eight (48) hours of the end of the forty-eight (48)-hour period.

3. **Home Health Care Reviews.** After receiving a request for coverage of home care services following an inpatient Hospital admission, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within one (1) business day of receipt of the necessary information. If the day following the request falls on a weekend or holiday, We will make a determination and provide notice to You (or Your designee) and Your Provider within seventy-two (72) hours of receipt of the necessary information. When We receive a request for home care services and all necessary information prior to Your discharge from an inpatient hospital admission, We will not deny coverage for home care services while Our decision on the request is pending.

4. **Inpatient Substance Use Disorder Treatment Reviews.** If a request for inpatient substance use disorder treatment is submitted to Us at least twenty-four (24) hours prior to discharge from an inpatient substance use disorder treatment admission, We will make a determination within twenty-four (24) hours of receipt of the request and We will provide coverage for the inpatient substance use disorder treatment while Our determination is pending.

5. **Inpatient Mental Health Treatment for Members under eighteen (18) at Participating Hospitals Licensed by the Office of Mental Health (OMH).** Coverage for inpatient mental health treatment at a participating OMH-licensed Hospital is not subject to Preauthorization. Coverage will not be subject to concurrent review for the first fourteen (14) days of the inpatient admission if the OMH-licensed Hospital notifies Us of both the admission and the initial treatment plan within two (2) business days of the admission. After the first fourteen (14) days of the inpatient admission, We may review the entire stay to determine whether it is Medically Necessary, and We will use clinical review tools approved by OMH. If any portion of the stay is denied as not Medically Necessary, You are only responsible for the in-network Cost-Sharing that would otherwise apply to Your inpatient admission.

6. **Inpatient Substance Use Disorder Treatment at Participating OASAS-Certified Facilities.** Coverage for inpatient substance use disorder treatment at a participating OASAS-certified Facility is not subject to Preauthorization. Coverage will not be subject to concurrent review for the first twenty-eight (28) days of the inpatient admission if the OASAS-certified Facility notifies Us of both the admission and the initial treatment plan within two (2) business days of the admission. After the first twenty-eight (28) days of the inpatient admission, We may review the entire stay to determine whether it is Medically Necessary and We will use clinical review tools designated by OASAS. If any portion of the stay is denied as not Medically Necessary, You are only responsible for the in-network Cost-Sharing that would otherwise apply to Your inpatient admission.

7. **Outpatient Substance Use Disorder Treatment at Participating OASAS-Certified Facilities.** Coverage for outpatient, intensive outpatient, outpatient rehabilitation and opioid treatment at a participating OASAS-certified Facility is not subject to Preauthorization. Coverage will not be subject to concurrent review for the first four (4) weeks of continuous treatment, not to exceed twenty-eight (28) visits, if the OASAS-certified Facility notifies Us of both the start of treatment and the initial treatment plan within two (2) business days. After the first four (4) weeks of

continuous treatment, not to exceed twenty-eight (28) visits, We may review the entire outpatient treatment to determine whether it is Medically Necessary and We will use clinical review tools designated by OASAS. If any portion of the outpatient treatment is denied as not Medically Necessary, You are only responsible for the in-network Cost-Sharing that would otherwise apply to Your outpatient treatment.

D. Retrospective Reviews.

If We have all information necessary to make a determination regarding a retrospective claim, We will make a determination and notify You and Your Provider within thirty (30) calendar days of the receipt of the request. If We need additional information, We will request it within thirty (30) calendar days. You or Your Provider will then have forty-five (45) calendar days to provide the information. We will make a determination and provide notice to You and Your Provider in writing within fifteen (15) calendar days of the earlier of Our receipt of all or part of the requested information or the end of the forty-five (45)-day period.

Once We have all the information to make a decision, Our failure to make a Utilization Review determination within the applicable time frames set forth above will be deemed an adverse determination subject to an internal Appeal.

E. Retrospective Review of Preauthorized Services.

We may only reverse a preauthorized treatment, service or procedure on retrospective review when:

- The relevant medical information presented to Us upon retrospective review is materially different from the information presented during the Preauthorization review;
- The relevant medical information presented to Us upon retrospective review existed at the time of the Preauthorization but was withheld or not made available to Us;
- We were not aware of the existence of such information at the time of the Preauthorization review; and
- Had We been aware of such information, the treatment, service or procedure being requested would not have been authorized. The determination is made using the same specific standards, criteria or procedures as used during the Preauthorization review.

F. Step Therapy Override Determinations.

You, Your designee, or Your Health Care Professional may request a step therapy protocol override determination for coverage of a Prescription Drug selected by Your Health Care Professional. When conducting Utilization Review for a step therapy protocol override determination, We will use recognized evidence-based and peer reviewed clinical review criteria that is appropriate for You and Your medical condition.

1. **Supporting Rationale and Documentation.** A step therapy protocol override determination request must include supporting rationale and documentation from a Health Care Professional, demonstrating that:
   - The required Prescription Drug(s) is contraindicated or will likely cause an adverse reaction or physical or mental harm to You;
   - The required Prescription Drug(s) is expected to be ineffective based on Your known clinical history, condition, and Prescription Drug regimen;

- You have tried the required Prescription Drug(s) while covered by Us or under Your previous health insurance coverage, or another Prescription Drug in the same pharmacologic class or with the same mechanism of action, and that Prescription Drug(s) was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event;
- You are stable on a Prescription Drug(s) selected by Your Health Care Professional for Your medical condition, provided this does not prevent Us from requiring You to try an AB-rated generic equivalent; or
- The required Prescription Drug(s) is not in Your best interest because it will likely cause a significant barrier to Your adherence to or compliance with Your plan of care, will likely worsen a comorbid condition, or will likely decrease Your ability to achieve or maintain reasonable functional ability in performing daily activities.

2. **Standard Review.** We will make a step therapy protocol override determination and provide notification to You (or Your designee) and where appropriate, Your Health Care Professional, within seventy-two (72) hours of receipt of the supporting rationale and documentation.

3. **Expedited Review.** If You have a medical condition that places Your health in serious jeopardy without the Prescription Drug prescribed by Your Health Care Professional, We will make a step therapy protocol override determination and provide notification to You (or Your designee) and Your Health Care Professional within twenty-four (24) hours of receipt of the supporting rationale and documentation.

If the required supporting rationale and documentation are not submitted with a step therapy protocol override determination request, We will request the information within seventy-two (72) hours for Preauthorization and retrospective reviews, the lesser of seventy-two (72) hours or one (1) business day for concurrent reviews, and twenty-four (24) hours for expedited reviews. You or Your Health Care Professional will have forty-five (45) calendar days to submit the information for Preauthorization, concurrent and retrospective reviews, and forty-eight (48) hours for expedited reviews. For Preauthorization reviews, We will make a determination and provide notification to You (or Your designee) and Your Health Care Professional within the earlier of seventy-two (72) hours of Our receipt of the information or fifteen (15) calendar days of the end of the forty-five (45)-day period if the information is not received. For concurrent reviews, We will make a determination and provide notification to You (or Your designee) and Your Health Care Professional within the earlier of seventy-two (72) hours or one (1) business day of Our receipt of the information or fifteen (15) calendar days of the end of the forty-five (45)-day period if the information is not received. For retrospective reviews, We will make a determination and provide notification to You (or Your designee) and Your Health Care Professional within the earlier of seventy-two (72) hours of Our receipt of the information or fifteen (15) calendar days of the end of the forty-five (45)-day period if the information is not received. For expedited reviews, We will make a determination and provide notification to You (or Your designee) and Your Health Care Professional within the earlier of twenty-four (24) hours of Our receipt of the information or forty-eight (48) hours of the end of the forty-eight (48)-hour period if the information is not received.

If We do not make a determination within seventy-two (72) hours (or twenty-four (24) hours for expedited reviews) of receipt of the supporting rationale and documentation, the step therapy protocol override request will be approved.

If We determine that the step therapy protocol should be overridden, We will authorize immediate coverage for the Prescription Drug prescribed by Your treating Health Care Professional. An adverse step therapy override determination is eligible for an Appeal.

G. Reconsideration.
If We did not attempt to consult with Your Provider who recommended the Covered Service before making an adverse determination, the Provider may request reconsideration by the same clinical peer reviewer who made the adverse determination or a designated clinical peer reviewer if the original clinical peer reviewer is unavailable. For Preauthorization and concurrent reviews, the reconsideration will take place within one (1) business day of the request for reconsideration. If the adverse determination is upheld, a notice of adverse determination will be given to You and Your Provider, by telephone and in writing.

H. Utilization Review Internal Appeals.
You, Your designee, and, in retrospective review cases, Your Provider, may request an internal Appeal of an adverse determination, either by phone, in person, or in writing.

You have up to one hundred eighty (180) calendar days after You receive notice of the adverse determination to file an Appeal. We will acknowledge Your request for an internal Appeal within fifteen (15) calendar days of receipt. This acknowledgment will include the name, address, and phone number of the person handling Your Appeal and, if necessary, inform You of any additional information needed before a decision can be made. The Appeal will be decided by a clinical peer reviewer who is not subordinate to the clinical peer reviewer who made the initial adverse determination and who is 1) a Physician or 2) a Health Care Professional in the same or similar specialty as the Provider who typically manages the disease or condition at issue.

1. **Out-of-Network Service Denial.** You also have the right to Appeal the denial of a Preauthorization request for an out-of-network health service when We determine that the out-of-network health service is not materially different from an available in-network health service. A denial of an out-of-network health service is a service provided by a Non-Participating Provider, but only when the service is not available from a Participating Provider. For a Utilization Review Appeal of denial of an out-of-network health service, You or Your designee must submit:
   - A written statement from Your attending Physician, who must be a licensed, board-certified or board-eligible Physician qualified to practice in the specialty area of practice appropriate to treat Your condition, that the requested out-of-network health service is materially different from the alternate health service available from a Participating Provider that We approved to treat Your condition; and
   - Two (2) documents from the available medical and scientific evidence that the out-of-network service: 1) is likely to be more clinically beneficial to You than the alternate in-network service; and 2) that the adverse risk of the out-of-network service would likely not be substantially increased over the in-network health service.

2. **Out-of-Network Referral Denial.** You also have the right to Appeal the denial of a request for a Referral to a Non-Participating Provider when We determine that We have a Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service. For a Utilization Review Appeal of an

out-of-network Referral denial, You or Your designee must submit a written statement from Your attending Physician, who must be a licensed, board-certified or board-eligible Physician qualified to practice in the specialty area of practice appropriate to treat Your condition:

- That the Participating Provider recommended by Us does not have the appropriate training and experience to meet Your particular health care needs for the health care service; and
- Recommending a Non-Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service.

I. Standard Appeal.

1. **Preauthorization Appeal.** If Your Appeal relates to a Preauthorization request, We will decide the Appeal within thirty (30) calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee), and where appropriate, Your Provider, within two (2) business days after the determination is made, but no later than thirty (30) calendar days after receipt of the Appeal request.

2. **Retrospective Appeal.** If Your Appeal relates to a retrospective claim, We will decide the Appeal within sixty (60) calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee), and where appropriate, Your Provider, within two (2) business days after the determination is made, but no later than sixty (60) calendar days after receipt of the Appeal request.

3. **Expedited Appeal.** An Appeal of a review of continued or extended health care services, additional services rendered in the course of continued treatment, home health care services following discharge from an inpatient Hospital admission, services in which a Provider requests an immediate review, mental health and/or substance use disorder services that may be subject to a court order, or any other urgent matter will be handled on an expedited basis. An expedited Appeal is not available for retrospective reviews. For an expedited Appeal, Your Provider will have reasonable access to the clinical peer reviewer assigned to the Appeal within one (1) business day of receipt of the request for an Appeal. Your Provider and a clinical peer reviewer may exchange information by telephone or fax. An expedited Appeal will be determined within the earlier of seventy-two (72) hours of receipt of the Appeal or two (2) business days of receipt of the information necessary to conduct the Appeal. Written notice of the determination will be provided to You (or Your designee) within twenty-four (24) hours after the determination is made, but no later than seventy-two (72) hours after receipt of the Appeal request.

   If You are not satisfied with the resolution of Your expedited Appeal, You may file a standard internal Appeal or an external appeal.

   Our failure to render a determination of Your Appeal within sixty (60) calendar days of receipt of the necessary information for a standard Appeal or within two (2) business days of receipt of the necessary information for an expedited Appeal will be deemed a reversal of the initial adverse determination.

4. **Substance Use Appeal.** If We deny a request for inpatient substance use disorder treatment that was submitted at least twenty-four (24) hours prior to discharge from an inpatient admission, and You or Your Provider file an expedited internal Appeal of Our adverse determination, We will

decide the Appeal within twenty-four (24) hours of receipt of the Appeal request. If You or Your Provider file the expedited internal Appeal and an expedited external appeal within twenty-four (24) hours of receipt of Our adverse determination, We will also provide coverage for the inpatient substance use disorder treatment while a determination on the internal Appeal and external appeal is pending.

J. Full and Fair Review of an Appeal.

We will provide You, free of charge, with any new or additional evidence considered, relied upon, or generated by Us or any new or additional rationale in connection with Your Appeal. The evidence or rationale will be provided as soon as possible and sufficiently in advance of the date on which the notice of final adverse determination is required to be provided to give You a reasonable opportunity to respond prior to that date.

K. Appeal Assistance.

If You need assistance filing an Appeal, You may contact the state independent Consumer Assistance Program at:
Community Health Advocates
633 Third Avenue, 10th Floor
New York, NY 10017
Or call toll free: 1-888-614-5400, or e-mail cha@cssny.org
Website: www.communityhealthadvocates.org

Section XIX

External Appeal

A. Your Right to an External Appeal.
In some cases, You have a right to an external appeal of a denial of coverage. If We have denied coverage on the basis that a service is not Medically Necessary (including appropriateness, health care setting, level of care or effectiveness of a Covered benefit); or is an experimental or investigational treatment (including clinical trials and treatments for rare diseases); or is an out-of-network treatment, You or Your representative may appeal that decision to an External Appeal Agent, an independent third party certified by the State to conduct these appeals.

In order for You to be eligible for an external appeal You must meet the following two (2) requirements:

- The service, procedure, or treatment must otherwise be a Covered Service under this Certificate; and
- In general, You must have received a final adverse determination through Our internal Appeal process. But, You can file an external appeal even though You have not received a final adverse determination through Our internal Appeal process if:
    - We agree in writing to waive the internal Appeal. We are not required to agree to Your request to waive the internal Appeal; or
    - You file an external appeal at the same time as You apply for an expedited internal Appeal; or
    - We fail to adhere to Utilization Review claim processing requirements (other than a minor violation that is not likely to cause prejudice or harm to You, and We demonstrate that the violation was for good cause or due to matters beyond Our control and the violation occurred during an ongoing, good faith exchange of information between You and Us).

B. Your Right to Appeal a Determination that a Service is Not Medically Necessary.
If We have denied coverage on the basis that the service is not Medically Necessary, You may appeal to an External Appeal Agent if You meet the requirements for an external appeal in paragraph "A" above.

C. Your Right to Appeal a Determination that a Service is Experimental or Investigational.
If We have denied coverage on the basis that the service is an experimental or investigational treatment (including clinical trials and treatments for rare diseases), You must satisfy the two (2) requirements for an external appeal in paragraph "A" above and Your attending Physician must certify that Your condition or disease is one for which:

1. Standard health services are ineffective or medically inappropriate; or
2. There does not exist a more beneficial standard service or procedure Covered by Us; or
3. There exists a clinical trial or rare disease treatment (as defined by law).

In addition, Your attending Physician must have recommended one (1) of the following:

1. A service, procedure or treatment that two (2) documents from available medical and scientific evidence indicate is likely to be more beneficial to You than any standard Covered Service (only certain documents will be considered in support of this recommendation – Your attending

Physician should contact the State for current information as to what documents will be considered or acceptable); or

2. A clinical trial for which You are eligible (only certain clinical trials can be considered); or
3. A rare disease treatment for which Your attending Physician certifies that there is no standard treatment that is likely to be more clinically beneficial to You than the requested service, the requested service is likely to benefit You in the treatment of Your rare disease, and such benefit outweighs the risk of the service. In addition, Your attending Physician must certify that Your condition is a rare disease that is currently or was previously subject to a research study by the National Institutes of Health Rare Disease Clinical Research Network or that it affects fewer than 200,000 U.S. residents per year.

For purposes of this section, Your attending Physician must be a licensed, board-certified or board eligible Physician qualified to practice in the area appropriate to treat Your condition or disease. In addition, for a rare disease treatment, the attending Physician may not be Your treating Physician.

D. Your Right to Appeal a Determination that a Service is Out-of-Network.
If We have denied coverage of an out-of-network treatment because it is not materially different than the health service available in-network, You may appeal to an External Appeal Agent if You meet the two (2) requirements for an external appeal in paragraph "A" above, and You have requested Preauthorization for the out-of-network treatment.

In addition, Your attending Physician must certify that the out-of-network service is materially different from the alternate recommended in-network health service, and based on two (2) documents from available medical and scientific evidence, is likely to be more clinically beneficial than the alternate in-network treatment and that the adverse risk of the requested health service would likely not be substantially increased over the alternate in-network health service.

For purposes of this section, Your attending Physician must be a licensed, board-certified or board-eligible Physician qualified to practice in the specialty area appropriate to treat You for the health service.

E. Your Right to Appeal an Out-of-Network Referral Denial to a Non-Participating Provider.
If We have denied coverage of a request for a Referral to a Non-Participating Provider because We determine We have a Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service, You may appeal to an External Appeal Agent if You meet the two (2) requirements for an external appeal in paragraph "A" above.

In addition, Your attending Physician must: 1) certify that the Participating Provider recommended by Us does not have the appropriate training and experience to meet Your particular health care needs; and 2) recommend a Non-Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service.

For purposes of this section, Your attending Physician must be a licensed, board-certified or board-eligible Physician qualified to practice in the specialty area appropriate to treat You for the health service.

F. Your Right to Appeal a Formulary Exception Denial.
If We have denied Your request for coverage of a non-formulary Prescription Drug through Our formulary exception process, You, Your designee or the prescribing Health Care Professional may appeal the formulary exception denial to an External Appeal Agent. See the Prescription Drug Coverage section of this Certificate for more information on the formulary exception process.

G. The External Appeal Process.
You have four (4) months from receipt of a final adverse determination or from receipt of a waiver of the internal Appeal process to file a written request for an external appeal. If You are filing an external appeal based on Our failure to adhere to claim processing requirements, You have four (4) months from such failure to file a written request for an external appeal.

We will provide an external appeal application with the final adverse determination issued through the first level of Our internal Appeal process or Our written waiver of an internal Appeal. You may also request an external appeal application from the New York State Department of Financial Services at 1-800-400-8882. Submit the completed application to the Department of Financial Services at the address indicated on the application. If You meet the criteria for an external appeal, the State will forward the request to a certified External Appeal Agent.

You can submit additional documentation with Your external appeal request. If the External Appeal Agent determines that the information You submit represents a material change from the information on which We based Our denial, the External Appeal Agent will share this information with Us in order for Us to exercise Our right to reconsider Our decision. If We choose to exercise this right, We will have three (3) business days to amend or confirm Our decision. Please note that in the case of an expedited external appeal (described below), We do not have a right to reconsider Our decision.

In general, the External Appeal Agent must make a decision within thirty (30) days of receipt of Your completed application. The External Appeal Agent may request additional information from You, Your Physician, or Us. If the External Appeal Agent requests additional information, it will have five (5) additional business days to make its decision. The External Appeal Agent must notify You in writing of its decision within two (2) business days.

If Your attending Physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to Your health; or if Your attending Physician certifies that the standard external appeal time frame would seriously jeopardize Your life, health or ability to regain maximum function; or if You received Emergency Services and have not been discharged from a Facility and the denial concerns an admission, availability of care or continued stay, You may request an expedited external appeal. In that case, the External Appeal Agent must make a decision within seventy-two (72) hours of receipt of Your completed application. Immediately after reaching a decision, the External Appeal Agent must notify You and Us by telephone or facsimile of that decision. The External Appeal Agent must also notify You in writing of its decision.

If Your internal Formulary exception request received a standard review through Our Formulary exception process, the External Appeal Agent must make a decision on Your external appeal and notify You or Your designee and the prescribing Health Care Professional by telephone within seventy-two (72) hours of receipt of Your completed application. The External Appeal Agent will notify You or Your designee and the prescribing Health Care Professional in writing within two (2) business days of

making a determination. If the External Appeal Agent overturns Our denial, We will Cover the Prescription Drug while You are taking the Prescription Drug, including any refills.

If Your internal Formulary exception request received an expedited review through Our Formulary exception process, the External Appeal Agent must make a decision on Your external appeal and notify You or Your designee and the prescribing Health Care Professional by telephone within twenty-four (24) hours of receipt of Your completed application. The External Appeal Agent will notify You or Your designee and the prescribing Health Care Professional in writing within seventy-two (72) hours of receipt of Your completed application. If the External Appeal Agent overturns Our denial, We will Cover the Prescription Drug while You suffer from the health condition that may seriously jeopardize Your health, life or ability to regain maximum function or for the duration of Your current course of treatment using the non-Formulary Prescription Drug.

If the External Appeal Agent overturns Our decision that a service is not Medically Necessary or approves coverage of an experimental or investigational treatment or an out-of-network treatment, We will provide coverage subject to the other terms and conditions of this Certificate. Please note that if the External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, We will only Cover the cost of services required to provide treatment to You according to the design of the trial. We will not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing the research, or costs that would not be Covered under this Certificate for non-investigational treatments provided in the clinical trial.

The External Appeal Agent's decision is binding on both You and Us. The External Appeal Agent's decision is admissible in any court proceeding.

We will charge You a fee of twenty-five dollars ($25) for each external appeal, not to exceed seventy-five dollars ($75) in a single Plan Year. The external appeal application will explain how to submit the fee. We will waive the fee if We determine that paying the fee would be a hardship to You. If the External Appeal Agent overturns the denial of coverage, the fee will be refunded to You.

H. Your Responsibilities.

It is Your responsibility to start the external appeal process. You may start the external appeal process by filing a completed application with the New York State Department of Financial Services. You may appoint a representative to assist You with Your application; however, the Department of Financial Services may contact You and request that You confirm in writing that You have appointed the representative.

Under New York State law, Your completed request for external appeal must be filed within four (4) months of either the date upon which You receive a final adverse determination, or the date upon which You receive a written waiver of any internal Appeal, or Our failure to adhere to claim processing requirements. We have no authority to extend this deadline.

Section XX

Coordination of Benefits

This section applies when You also have group health coverage with another plan. When You receive a Covered Service, We will coordinate benefit payments with any payment made by another plan. The primary plan will pay its full benefits and the other plan may pay secondary benefits, if necessary, to cover some or all of the remaining expenses. This coordination prevents duplicate payments and overpayments.

A. Definitions.

1. **"Allowable expense"** is the necessary, reasonable, and customary item of expense for health care, when the item is covered at least in part under any of the plans involved, except where a statute requires a different definition. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered as both an allowable expense and a benefit paid.

2. **"Plan"** is other group health coverage with which We will coordinate benefits. The term "plan" includes:
   - Group health benefits and group blanket or group remittance health benefits coverage, whether insured, self-insured, or self-funded. This includes group HMO and other prepaid group coverage, but does not include blanket school accident coverage or coverages issued to a substantially similar group (e.g., Girl Scouts, Boy Scouts) where the school or organization pays the premiums.
   - Medical benefits coverage, in group and individual automobile "no-fault" and traditional liability "fault" type contracts.
   - Hospital, medical, and surgical benefits coverage of Medicare or a governmental plan offered, required, or provided by law, except Medicaid or any other plan whose benefits are by law excess to any private insurance coverage.

3. **"Primary plan"** is one whose benefits must be determined without taking the existence of any other plan into consideration. A plan is primary if either: 1) the plan has no order of benefits rules or its rules differ from those required by regulation; or 2) all plans which cover the person use the order of benefits rules required by regulation and under those rules the plan determines its benefits first. More than one plan may be a primary plan (for example, two plans which have no order of benefit determination rules).

4. **"Secondary plan"** is one which is not a primary plan. If a person is covered by more than one secondary plan, the order of benefit determination rules decide the order in which their benefits are determined in relation to each other.

B. Rules to Determine Order of Payment.

The first of the rules listed below in paragraphs 1-6 that applies will determine which plan will be primary:

1. If the other plan does not have a provision similar to this one, then the other plan will be primary.

2. If the person receiving benefits is the Subscriber and is only covered as a Dependent under the other plan, this Certificate will be primary.

3. If a child is covered under the plans of both parents and the parents are not separated or divorced, the plan of the parent whose birthday falls earlier in the year will be primary. If both parents have the same birthday, the plan which covered the parent longer will be primary. To determine whose birthday falls earlier in the year, only the month and day are considered. However, if the other plan does not have this birthday rule, but instead has a rule based on the sex of the parent and as a result the plans do not agree on which is primary, then the rule in the other plan will determine which plan is primary.

4. If a child is covered by both parents' plans, the parents are separated or divorced, and there is no court decree between the parents that establishes financial responsibility for the child's health care expenses:
    - The plan of the parent who has custody will be primary;
    - If the parent with custody has remarried, and the child is also covered as a child under the step-parent's plan, the plan of the parent with custody will pay first, the step-parent's plan will pay second, and the plan of the parent without custody will pay third; and
    - If a court decree between the parents says which parent is responsible for the child's health care expenses, then that parent's plan will be primary if that plan has actual knowledge of the decree.

5. If the person receiving services is covered under one plan as an active employee or member (i.e., not laid-off or retired), or as the spouse or child of such an active employee, and is also covered under another plan as a laid-off or retired employee or as the spouse or child of such a laid-off or retired employee, the plan that covers such person as an active employee or spouse or child of an active employee will be primary. If the other plan does not have this rule, and as a result the plans do not agree on which will be primary, this rule will be ignored.

6. If none of the above rules determine which plan is primary, the plan that covered the person receiving services longer will be primary.

C. Effects of Coordination.
When this plan is secondary, its benefits will be reduced so that the total benefits paid by the primary plan and this plan during a claim determination period will not exceed Our maximum available benefit for each Covered Service. Also, the amount We pay will not be more than the amount We would pay if We were primary. As each claim is submitted, We will determine Our obligation to pay for allowable expenses based upon all claims that have been submitted up to that point in time during the claim determination period.

D. Right to Receive and Release Necessary Information.
We may release or receive information that We need to coordinate benefits. We do not need to tell anyone or receive consent to do this. We are not responsible to anyone for releasing or obtaining this information. You must give Us any needed information for coordination purposes, in the time frame requested.

E. Our Right to Recover Overpayment.
If We made a payment as a primary plan, You agree to pay Us any amount by which We should have reduced Our payment. Also, We may recover any overpayment from the primary plan or the Provider receiving payment and You agree to sign all documents necessary to help Us recover any overpayment.

F. Coordination with "Always Excess," "Always Secondary," or "Non-Complying" Plans.
Except as described below, We will coordinate benefits with plans, whether insured or self-insured, that provide benefits that are stated to be always excess or always secondary or use order of benefit determination rules that are inconsistent with the rules described above in the following manner:

1. If this Certificate is primary, as defined in this section, We will pay benefits first.

2. If this Certificate is secondary, as defined in this section, We will pay only the amount We would pay as the secondary insurer.

3. If We request information from a non-complying plan and do not receive it within thirty (30) days, We will calculate the amount We should pay on the assumption that the non-complying plan and this Certificate provide identical benefits. When the information is received, We will make any necessary adjustments.

If a blanket accident insurance policy issued in accordance with Section 1015.11 of the General Business Law contains a provision that its benefits are excess or always secondary, then this Certificate is primary.

Section XXI

Termination of Coverage

Coverage under this Certificate will automatically be terminated on the first of the following to apply:

1. The Group and/or Subscriber has failed to pay Premiums within thirty (30) days of when Premiums are due. Coverage will terminate as of the last day for which Premiums were paid.

2. The end of the month in which the Subscriber ceases to meet the eligibility requirements as defined by the Group.

3. Upon the Subscriber's death, coverage will terminate unless the Subscriber has coverage for Dependents. If the Subscriber has coverage for Dependents, then coverage will terminate as of the last day of the month for which the Premium had been paid.

4. For Spouses in cases of divorce, the date of the divorce.

5. For Children, until the end of the month in which the Child turns twenty-six (26) years of age.

6. For all other Dependents, the end of the month in which the Dependent ceases to be eligible.

7. The end of the month during which the Group or Subscriber provides written notice to Us requesting termination of coverage, or on such later date requested for such termination by the notice.

8. If the Subscriber or the Subscriber's Dependent has performed an act that constitutes fraud or the Subscriber has made an intentional misrepresentation of material fact in writing on his or her enrollment application, or in order to obtain coverage for a service, coverage will terminate immediately upon written notice of termination delivered by Us to the Subscriber and/or the Subscriber's Dependent, as applicable. However, if the Subscriber makes an intentional misrepresentation of material fact in writing on his or her enrollment application, We will rescind coverage if the facts misrepresented would have led Us to refuse to issue the coverage. Rescission means that the termination of Your coverage will have a retroactive effect of up to Your enrollment under the Certificate. If termination is a result of the Subscriber's action, coverage will terminate for the Subscriber and any Dependents. If termination is a result of the Dependent's action, coverage will terminate for the Dependent.

9. The date that the Group Contract is terminated. If We decide to stop offering a particular class of group contracts, without regard to claims experience or health related status, to which this Certificate belongs, We will provide the Group and Subscribers at least ninety (90) days' prior written notice.

10. If We decide to stop offering all hospital, surgical and medical expense coverage in the large group market in this state, We will provide written notice to the Group and Subscriber at least one hundred eighty (180) days prior to when the coverage will cease.

11. The Group has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.

12. The Group ceases to meet the statutory requirements to be defined as a group for the purposes of obtaining coverage. We will provide written notice to the Group and Subscriber at least thirty (30) days prior to when the coverage will cease.

13. The date there is no longer any Subscriber who lives, resides, or works in Our Service Area.

No termination shall prejudice the right to a claim for benefits which arose prior to such termination.

See the Continuation of Coverage section of this Certificate for Your right to continuation of this coverage. See the Conversion Right to a New Contract after Termination section of this Certificate for Your right to conversion to an individual Contract.

Section XXII

Extension of Benefits

When Your coverage under this Certificate ends, benefits stop. But, if You are totally disabled on the date the Group Contract terminates, or on the date Your coverage under this Certificate terminates, continued benefits may be available for the treatment of the injury or sickness that is the cause of the total disability.

For purposes of this section, "total disability" means You are prevented because of injury or disease from engaging in any work or other gainful activity. Total disability for a minor means that the minor is prevented because of injury or disease from engaging in substantially all of the normal activities of a person of like age and sex who is in good health.

A. When You May Continue Benefits.
When Your coverage under this Certificate ends, We will provide benefits during a period of total disability for a Hospital stay commencing, or surgery performed, within thirty-one (31) days from the date Your coverage ends. The Hospital stay or surgery must be for the treatment of the injury, sickness, or pregnancy causing the total disability.

If Your coverage ends because You are no longer employed, We will provide benefits during a period of total disability for up to twelve (12) months from the date Your coverage ends for Covered Services to treat the injury, sickness, or pregnancy that caused the total disability, unless these services are covered under another group health plan.

B. Termination of Extension of Benefits.
Extended benefits will end on the earliest of the following:

- The date You are no longer totally disabled;
- The date the contractual benefit has been exhausted;
- Twelve (12) months from the date extended benefits began (if Your benefits are extended based on termination of employment); or
- With respect to the twelve (12) month extension of coverage, the date You become eligible for benefits under any group policy providing medical benefits.

C. Limits on Extended Benefits.
We will not pay extended benefits:

- For any Member who is not totally disabled on the date coverage under this Certificate ends; or
- Beyond the extent to which We would have paid benefits under this Certificate if coverage had not ended.

Section XXIII

Continuation of Coverage

Under the continuation of coverage provisions of the federal Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), most employer-sponsored group health plans must offer employees and their families the opportunity for a temporary continuation of health insurance coverage when their coverage would otherwise end. If You are not entitled to temporary continuation of coverage under COBRA, You may be entitled to temporary continuation coverage under the New York Insurance Law as described below. Call or write Your employer to find out if You are entitled to temporary continuation of coverage under COBRA or under the New York Insurance Law. Any period of continuation of coverage will terminate automatically at the end of the period of continuation provided under COBRA or the New York Insurance Law.

A. Qualifying Events.
Pursuant to federal COBRA and state continuation coverage laws, You, the Subscriber, Your Spouse and Your Children may be able to temporarily continue coverage under this Certificate in certain situations when You would otherwise lose coverage, known as qualifying events.

1. If Your coverage ends due to voluntary or involuntary termination of employment or a change in Your employee class (e.g., a reduction in the number of hours of employment), You may continue coverage. Coverage may be continued for You, Your Spouse and any of Your covered Children.

2. If You are a covered Spouse, You may continue coverage if Your coverage ends due to:
    - Voluntary or involuntary termination of the Subscriber's employment;
    - Reduction in the hours worked by the Subscriber or other change in the Subscriber's class;
    - Divorce or legal separation from the Subscriber; or
    - Death of the Subscriber.

3. If You are a covered Child, You may continue coverage if Your coverage ends due to:
    - Voluntary or involuntary termination of the Subscriber's employment;
    - Reduction in the hours worked by the Subscriber or other change in the Subscriber's class;
    - Loss of covered Child status under the plan rules; or
    - Death of the Subscriber.

If You want to continue coverage, You must request continuation from the Group in writing and make the first Premium payment within the sixty (60)-day period following the later of:
1. The date coverage would otherwise terminate; or
2. The date You are sent notice by first class mail of the right of continuation by the Group.

The Group may charge up to 102% of the Group Premium for continued coverage.

Continued coverage under this section will terminate at the earliest of the following:

1. The date thirty-six (36) months after the Subscriber's coverage would have terminated because of termination of employment;
2. If You are a covered Spouse or Child, the date thirty-six (36) months after coverage would have terminated due to the death of the Subscriber, divorce or legal separation, the Subscriber's eligibility for Medicare, or the failure to qualify under the definition of "Children";
3. The date You become covered by an insured or uninsured arrangement that provides group hospital, surgical or medical coverage;
4. The date You become entitled to Medicare;
5. The date to which Premiums are paid if You fail to make a timely payment; or
6. The date the Group Contract terminates. However, if the Group Contract is replaced with similar coverage, You have the right to become covered under the new Group Contract for the balance of the period remaining for Your continued coverage.

When Your continuation of coverage ends, You may have a right to conversion. See the Conversion Right to a New Contract after Termination section of this Certificate.

B. Supplementary Continuation, Conversion, and Temporary Suspension Rights During Active Duty.

If You, the Subscriber are a member of a reserve component of the armed forces of the United States, including the National Guard, You have the right to continuation, conversion, or a temporary suspension of coverage during active duty and reinstatement of coverage at the end of active duty if Your Group does not voluntarily maintain Your coverage and if:

1. Your active duty is extended during a period when the president is authorized to order units of the reserve to active duty, provided that such additional active duty is at the request and for the convenience of the federal government; and
2. You serve no more than four (4) years of active duty.

When Your Group does not voluntarily maintain Your coverage during active duty, coverage under this Certificate will be suspended unless You elect to continue coverage in writing within sixty (60) days of being ordered to active duty and You pay the Group the required Premium payment but not more frequently than on a monthly basis in advance. This right of continuation extends to You and Your eligible Dependents. Continuation of coverage is not available for any person who is eligible to be covered under Medicare; or any person who is covered as an employee, member or dependent under any other insured or uninsured arrangement which provides group hospital, surgical or medical coverage, except for coverage available to active duty members of the uniformed services and their family members.

Upon completion of active duty:

1. Your coverage under this Certificate may be resumed as long as You are reemployed or restored to participation in the Group upon return to civilian status. The right of resumption extends to coverage for Your covered Dependents. For coverage that was suspended while on active duty, coverage under the Group plan will be retroactive to the date on which active duty terminated.
2. If You are not reemployed or restored to participation in Your Group upon return to civilian status, You will be eligible for continuation and conversion as long as You apply to Us for coverage within thirty-one (31) days of the termination of active duty or discharge from a Hospitalization resulting from active duty as long as the Hospitalization was not in excess of one (1) year.

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

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

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

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

The Subscriber's Child may elect this coverage:

1. Within sixty (60) days of the date that his or her coverage would otherwise end due to reaching the maximum age for Dependent coverage, in which case coverage will be retroactive to the date that coverage would otherwise have terminated;
2. Within sixty (60) days of newly meeting the eligibility requirements, in which case coverage will be prospective and start within thirty (30) days of when the Group or the Group's designee receives notice and We receive Premium payment; or
3. During an annual thirty (30)-day open enrollment period, in which case coverage will be prospective and will start within thirty (30) days of when the Group or the Group's designee receives notice of election and We receive Premium payment.

The Subscriber or Subscriber's Child must pay the Premium rate that applies to individual coverage. Coverage will be the same as the coverage provided under this Certificate. The Child's children are not eligible for coverage under this option.

Section XXIV

Conversion Right to a New Contract after Termination

A. Circumstances Giving Rise to Right to Conversion.
You have the right to convert to a new Contract if coverage under this Certificate terminates under the circumstances described below.

1. **Termination of the Group Contract.** If the Group Contract between Us and the Group is terminated as set forth in the Termination of Coverage section of this Certificate, and the Group has not replaced the coverage with similar and continuous health care coverage, whether insured or self-insured, You are entitled to purchase a new Contract as a direct payment member.

2. **If You Are No Longer Covered in a Group.** If Your coverage terminates under the Termination of Coverage section of this Certificate because You are no longer a member of a Group, You are entitled to purchase a new Contract as a direct payment member.

3. **On the Death of the Subscriber.** If coverage terminates under the Termination of Coverage section of this Certificate because of the death of the Subscriber, the Subscriber's Dependents are entitled to purchase a new Contract as direct payment members.

4. **Termination of Your Marriage.** If a Spouse's coverage terminates under the Termination of Coverage section of this Certificate because the Spouse becomes divorced from the Subscriber or the marriage is annulled, that former Spouse is entitled to purchase a new Contract as a direct payment member.

5. **Termination of Coverage of a Child.** If a Child's coverage terminates under the Termination of Coverage section of this Certificate because the Child no longer qualifies as a Child, the Child is entitled to purchase a new Contract as a direct payment member.

6. **Termination of Your Temporary Continuation of Coverage.** If coverage terminates under the Termination of Coverage section of this Certificate because You are no longer eligible for continuation of coverage, You are entitled to purchase a new Contract as a direct payment member.

7. **Termination of Your Young Adult Coverage.** If a Child's young adult coverage terminates under the Termination of Coverage section of this Certificate, the Child is entitled to purchase a new Contract as a direct payment member.

B. When to Apply for the New Contract.
If You are entitled to purchase a new Contract as described above, You must apply to Us for the new Contract within sixty (60) days after termination of coverage under this Certificate. You must also pay the first Premium of the new Contract at the time You apply for coverage.

C. The New Contract.
We will offer You an individual direct payment Contract at each level of coverage (i.e., bronze, silver, gold or platinum) that Covers all benefits required by state and federal law. You may choose among any of the four (4) Contracts offered by Us. The coverage may not be the same as Your current coverage.

Section XXV

General Provisions

1. Agreements Between Us and Participating Providers.
Any agreement between Us and Participating Providers may only be terminated by Us or the Providers. This Certificate does not require any Provider to accept a Member as a patient. We do not guarantee a Member's admission to any Participating Provider or any health benefits program.

2. Assignment.
You cannot assign any benefits under this Certificate or legal claims based on a denial of benefits or request for plan documents to any person, corporation or other organization. You cannot assign any monies due under this Certificate to any person, corporation or other organization unless it is an assignment to Your Provider for a surprise bill or to a Hospital for Emergency Services, including inpatient services following Emergency Department Care. See the How Your Coverage Works section of this Certificate for more information about surprise bills. Any assignment of benefits or legal claims based on a denial of benefits or request for plan documents by You other than for monies due for a surprise bill or an assignment of monies due to a Hospital for Emergency Services, including inpatient services following Emergency Department Care, will be void and unenforceable. Assignment means the transfer to another person, corporation or other organization of Your right to the services provided under this Certificate or Your right to collect money from Us for those services or Your right to sue based on a denial of benefits or request for plan documents. Nothing in this paragraph shall affect Your right to appoint a designee or representative as otherwise permitted by applicable law.

3. Changes in this Certificate.
We may unilaterally change this Certificate upon renewal, if We give the Group thirty (30) days' prior written notice.

4. Choice of Law.
This Certificate shall be governed by the laws of the State of New York.

5. Clerical Error.
Clerical error, whether by the Group or Us, with respect to this Certificate, or any other documentation issued by Us in connection with this Certificate, or in keeping any record pertaining to the coverage hereunder, will not modify or invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated.

6. Conformity with Law.
Any term of this Certificate which is in conflict with New York State law or with any applicable federal law that imposes additional requirements from what is required under New York State law will be amended to conform with the minimum requirements of such law.

7. Continuation of Benefit Limitations.
Some of the benefits in this Certificate may be limited to a specific number of visits, and/or subject to a Deductible. You will not be entitled to any additional benefits if Your coverage status should change during the year. For example, if Your coverage status changes from covered family member to

Subscriber, all benefits previously utilized when You were a covered family member will be applied toward Your new status as a Subscriber.

8. Enrollment ERISA.
The Group will develop and maintain complete and accurate payroll records, as well as any other records of the names, addresses, ages, and social security numbers of all Group Members covered under this Certificate, and any other information required to confirm their eligibility for coverage.

The Group will provide Us with this information upon request. The Group may also have additional responsibilities as the "plan administrator" as defined by the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended. The "plan administrator" is the Group, or a third party appointed by the Group. We are not the ERISA plan administrator.

9. Entire Agreement.
This Certificate, including any endorsements, riders and the attached applications, if any, constitutes the entire Certificate.

10. Fraud and Abusive Billing.
We have processes to review claims before and after payment to detect fraud and abusive billing. Members seeking services from Non-Participating Providers could be balance billed by the Non-Participating Provider for those services that are determined to be not payable as a result of a reasonable belief of fraud or other intentional misconduct or abusive billing.

11. Furnishing Information and Audit.
The Group and all persons covered under this Certificate will promptly furnish Us with all information and records that We may require from time to time to perform Our obligations under this Certificate. You must provide Us with information over the telephone for reasons such as the following: to allow Us to determine the level of care You need; so that We may certify care authorized by Your Physician; or to make decisions regarding the Medical Necessity of Your care. The Group will, upon reasonable notice, make available to Us, and We may audit and make copies of, any and all records relating to Group enrollment at the Group's New York office.

12. Identification Cards.
Identification ("ID") cards are issued by Us for identification purposes only. Possession of any ID card confers no right to services or benefits under this Certificate. To be entitled to such services or benefits, Your Premiums must be paid in full at the time the services are sought to be received.

13. Incontestability.
No statement made by You will be the basis for avoiding or reducing coverage unless it is in writing and signed by You. All statements contained in any such written instrument shall be deemed representations and not warranties.

14. Input in Developing Our Policies.
Subscribers may participate in the development of Our policies by writing to Us at **EmblemHealth, Customer Service Department, 55 Water Street, New York, NY 10041-8190**; e-mail Us by visiting www.emblemhealth.com, or calling Us at the number on Your ID card.

15. Material Accessibility.
We will give the Group, and the Group will give You ID cards, Certificates, riders and other necessary materials.

16. More Information about Your Health Plan.
You can request additional information about Your coverage under this Certificate. Upon Your request, We will provide the following information:

- A list of the names, business addresses and official positions of Our board of directors, officers and members; and Our most recent annual certified financial statement which includes a balance sheet and a summary of the receipts and disbursements.
- The information that We provide the State regarding Our consumer complaints.
- A copy of Our procedures for maintaining confidentiality of Member information.
- A copy of Our drug Formulary. You may also inquire if a specific drug is Covered under this Certificate.
- A written description of Our quality assurance program.
- A copy of Our medical policy regarding an experimental or investigational drug, medical device or treatment in clinical trials.
- Provider affiliations with participating Hospitals.
- A copy of Our clinical review criteria (e.g., Medical Necessity criteria), and where appropriate, other clinical information We may consider regarding a specific disease, course of treatment or Utilization Review guidelines, including clinical review criteria relating to a step therapy protocol override determination.
- Written application procedures and minimum qualification requirements for Providers.
- Documents that contain the processes, strategies, evidentiary standards, and other factors used to apply a treatment limitation with respect to medical/surgical benefits and mental health or substance use disorder benefits under the Certificate.

17. Notice.
Any notice that We give You under this Certificate will be mailed to Your address as it appears in Our records or delivered electronically if You consent to electronic delivery or to the address of the Group. If notice is delivered to You electronically, You may also request a copy of the notice from Us. You agree to provide Us with notice of any change of Your address. If You have to give Us any notice, it should be sent by U.S. mail, first class, postage prepaid to: EmblemHealth, 55 Water Street, New York, NY 10041.

18. Premium Refund.
We will give any refund of Premiums, if due, to the Group.

19. Recovery of Overpayments.
On occasion, a payment will be made to You when You are not covered, for a service that is not Covered, or which is more than is proper. When this happens, We will explain the problem to You and You must return the amount of the overpayment to Us within sixty (60) days after receiving notification from Us. However, We shall not initiate overpayment recovery efforts more than twenty-four (24) months after the original payment was made unless We have a reasonable belief of fraud or other intentional misconduct.

20. Renewal Date.
The renewal date for this Certificate is the anniversary of the effective date of the Group Contract of each year. This Certificate will automatically renew each year on the renewal date, unless otherwise terminated by Us as permitted by this Certificate or by the Group upon thirty (30) days' prior written notice to Us.

21. Right to Develop Guidelines and Administrative Rules.
We may develop or adopt standards that describe in more detail when We will or will not make payments under this Certificate. Examples of the use of the standards are to determine whether: Hospital inpatient care was Medically Necessary; surgery was Medically Necessary to treat Your illness or injury; or certain services are skilled care. Those standards will not be contrary to the descriptions in this Certificate. If You have a question about the standards that apply to a particular benefit, You may contact Us and We will explain the standards or send You a copy of the standards. We may also develop administrative rules pertaining to enrollment and other administrative matters. We shall have all the powers necessary or appropriate to enable Us to carry out Our duties in connection with the administration of this Certificate.

22. Right to Offset.
If We make a claim payment to You or on Your behalf in error or You owe Us any money, You must repay the amount You owe Us. Except as otherwise required by law, if We owe You a payment for other claims received, We have the right to subtract any amount You owe Us from any payment We owe You.

23. Severability.
The unenforceability or invalidity of any provision of this Certificate shall not affect the validity and enforceability of the remainder of this Certificate.

24. Significant Change in Circumstances.
If We are unable to arrange for Covered Services as provided under this Certificate as the result of events outside of Our control, We will make a good faith effort to make alternative arrangements. These events would include a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of Participating Providers' personnel, or similar causes. We will make reasonable attempts to arrange for Covered Services. We and Our Participating Providers will not be liable for delay, or failure to provide or arrange for Covered Services if such failure or delay is caused by such an event.

25. Subrogation and Reimbursement.
These paragraphs apply when another party (including any insurer) is, or may be found to be, responsible for Your injury, illness or other condition and We have provided benefits related to that injury, illness or condition. As permitted by applicable state law, unless preempted by federal law, We may be subrogated to all rights of recovery against any such party (including Your own insurance carrier) for the benefits We have provided to You under this Certificate. Subrogation means that We have the right, independently of You, to proceed directly against the other party to recover the benefits that We have provided.

Subject to applicable state law, unless preempted by federal law, We may have a right of reimbursement if You or anyone on Your behalf receives payment from any responsible party (including Your own insurance carrier) from any settlement, verdict or insurance proceeds, in connection with an injury, illness, or condition for which We provided benefits. Under Section 5-335 of the New York General Obligations Law, Our right of recovery does not apply when a settlement is reached between a plaintiff and defendant, unless a statutory right of reimbursement exists. The law also provides that, when entering into a settlement, it is presumed that You did not take any action against Our rights or violate any contract between You and Us. The law presumes that the settlement between You and the responsible party does not include compensation for the cost of health care services for which We provided benefits.

We request that You notify Us within thirty (30) days of the date when any notice is given to any party, including an insurance company or attorney, of Your intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, illness or condition sustained by You for which We have provided benefits. You must provide all information requested by Us or Our representatives including, but not limited to, completing and submitting any applications or other forms or statements as We may reasonably request.

26. Third Party Beneficiaries.
No third party beneficiaries are intended to be created by this Certificate and nothing in this Certificate shall confer upon any person or entity other than You or Us any right, benefit, or remedy of any nature whatsoever under or by reason of this Certificate. No other party can enforce this Certificate's provisions or seek any remedy arising out of either Our or Your performance or failure to perform any portion of this Certificate, or to bring an action or pursuit for the breach of any terms of this Certificate.

27. Time to Sue.
No action at law or in equity may be maintained against Us prior to the expiration of sixty (60) days after written submission of a claim has been furnished to Us as required in this Certificate. You must start any lawsuit against Us under this Certificate within two (2) years from the date the claim was required to be filed.

28. Translation Services.
Translation services are available under this Certificate for non-English speaking Members. Please contact Us at the number on Your ID card to access these services.

29. Venue for Legal Action.
If a dispute arises under this Certificate, it must be resolved in a court located in the State of New York. You agree not to start a lawsuit against Us in a court anywhere else. You also consent to New York State courts having personal jurisdiction over You. That means that, when the proper procedures for starting a lawsuit in these courts have been followed, the courts can order You to defend any action We bring against You.

30. Waiver.
The waiver by any party of any breach of any provision of this Certificate will not be construed as a waiver of any subsequent breach of the same or any other provision. The failure to exercise any right hereunder will not operate as a waiver of such right.

31. Who May Change this Certificate.
This Certificate may not be modified, amended, or changed, except in writing and signed by Our President and Chief Executive Officer ("CEO") or a person designated by the President and CEO. No employee, agent, or other person is authorized to interpret, amend, modify, or otherwise change this Certificate in a manner that expands or limits the scope of coverage, or the conditions of eligibility, enrollment, or participation, unless in writing and signed by the President and CEO or person designated by the President and CEO.

32. Who Receives Payment under this Certificate.
Payments under this Certificate for services provided by a Participating Provider will be made directly by Us to the Provider. If You receive services from a Non-Participating Provider, We reserve the right to pay either You or the Provider. If You assign benefits for a surprise bill to a Non-Participating Provider, We will pay the Non-Participating Provider directly. See the How Your Coverage Works section of this Certificate for more information about surprise bills.

33. Workers' Compensation Not Affected.
The coverage provided under this Certificate is not in lieu of and does not affect any requirements for coverage by workers' compensation insurance or law.

34. Your Medical Records and Reports.
In order to provide Your coverage under this Certificate, it may be necessary for Us to obtain Your medical records and information from Providers who treated You. Our actions to provide that coverage include processing Your claims, reviewing Grievances, Appeals or complaints involving Your care, and quality assurance reviews of Your care, whether based on a specific complaint or a routine audit of randomly selected cases. By accepting coverage under this Certificate, except as prohibited by state or federal law, You automatically give Us or Our designee permission to obtain and use Your medical records for those purposes and You authorize each and every Provider who renders services to You to:

- Disclose all facts pertaining to Your care, treatment, and physical condition to Us or to a medical, dental, or mental health professional that We may engage to assist Us in reviewing a treatment or claim, or in connection with a complaint or quality of care review;
- Render reports pertaining to Your care, treatment, and physical condition to Us, or to a medical, dental, or mental health professional that We may engage to assist Us in reviewing a treatment or claim; and
- Permit copying of Your medical records by Us.

We agree to maintain Your medical information in accordance with state and federal confidentiality requirements. However, to the extent permitted under state or federal law, You automatically give Us permission to share Your information with the New York State Department of Health, quality oversight organizations, and third parties with which We contract to assist Us in administering this Certificate, so long as they also agree to maintain the information in accordance with state and federal confidentiality requirements.

35. Your Rights and Responsibilities.
As a Member, You have rights and responsibilities when receiving health care. As Your health care partner, We want to make sure Your rights are respected while providing Your health benefits. You have the right to obtain complete and current information concerning a diagnosis, treatment and prognosis from a Physician or other Provider in terms You can reasonably understand. When it is not

advisable to give such information to You, the information shall be made available to an appropriate person acting on Your behalf.

You have the right to receive information from Your Physician or other Provider that You need in order to give Your informed consent prior to the start of any procedure or treatment.

You have the right to refuse treatment to the extent permitted by law and to be informed of the medical consequences of that action.

You have the right to formulate advance directives regarding Your care.

You have the right to access Our Participating Providers.

As a Member, You should also take an active role in Your care. We encourage You to:

- Understand Your health problems as well as You can and work with Your Providers to make a treatment plan that You all agree on;
- Follow the treatment plan that You have agreed on with Your doctors or Providers;
- Give Us, Your doctors and other Providers the information needed to help You get the care You need and all the benefits You are eligible for under Your Certificate. This may include information about other health insurance benefits You have along with Your coverage with Us; and
- Inform Us if You have any changes to Your name, address or Dependents covered under Your Certificate.

Commercial Schedule of Benefits with Rx - DFS Approved Form

Provided on the following pages is our Commercial Schedule of Benefits with prescription drug coverage included.

Section XXVII

EmblemHealth HMO Prime Schedule of Benefits

COST-SHARING	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	
Equipment and Devices • Deductible	$0	Non-Participating Provider services are not Covered except as required for emergency care.	
Plan Year Out-of-Pocket Limit • Individual • Family	$6,850 $13,700		
Deductibles, Coinsurance and Copayments that make up Your Out-of-Pocket Limit accumulate on a calendar year ending on December 31 of each year.			
OFFICE VISITS	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Primary Care Office Visits (or Home Visits)	$5 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Specialist Office Visits (or Home Visits) **Referral required**	$10 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description

PREVENTIVE CARE	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
• Well Child Visits and Immunizations*	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
• Adult Annual Physical Examinations*	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	
• Adult Immunizations*	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	
• Routine Gynecological Services/Well Woman Exams*	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	
• Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	
• Sterilization Procedures for Women*	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	
• Vasectomy	$10 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Bone Density Testing*	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	
• Screening for Prostate Cancer	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	

PREVENTIVE CARE – Continued	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
• All other preventive services required by USPSTF and HRSA	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	
• *When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	Non-Participating Provider services are not Covered and You pay the full cost	
EMERGENCY CARE	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Pre-Hospital Emergency Medical Services (Ambulance Services)	$0 Copayment	$0 Copayment	See benefit for description
Non-Emergency Ambulance Services **Preauthorization required**	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Emergency Department Copayment waived if admitted to Hospital	$75 Copayment Health care forensic examinations performed under Public Health Law § 2805-i are not subject to Cost-Sharing	$75 Copayment	See benefit for description
Urgent Care Center	$5 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description

PROFESSIONAL SERVICES and OUTPATIENT CARE	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Advanced Imaging Services • Performed in a Specialist Office • Performed in a Freestanding Radiology Facility • Performed as Outpatient Hospital Services **Preauthorization required**	 $10 Copayment $0 Copayment $0 Copayment	 Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Allergy Testing and Treatment • Performed in a PCP Office • Performed in a Specialist Office **Referral required**	 $5 Copayment $10 Copayment	 Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Ambulatory Surgical Center Facility Fee **Preauthorization required**	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Anesthesia Services (all settings)	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Autologous Blood Banking	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description

PROFESSIONAL SERVICES and OUTPATIENT CARE – Continued	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Cardiac Rehabilitation • Performed in a Specialist Office • Performed as Outpatient Hospital Services • Performed as Inpatient Hospital Services **Preauthorization required**	 $10 Copayment $0 Copayment Included as part of inpatient Hospital service Cost-Sharing	 Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost	Thirty-two (32) visits when performed in a Specialist Office or Outpatient Hospital Services
Chemotherapy • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services **Preauthorization required**	 $5 Copayment $10 Copayment $0 Copayment	 Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Chiropractic Services	$10 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Clinical Trials **Preauthorization required**	Use Cost-Sharing for appropriate service	Use Cost-Sharing for appropriate service	See benefit for description

PROFESSIONAL SERVICES and OUTPATIENT CARE – Continued	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Diagnostic Testing			See benefit for description
• Performed in a PCP Office	$5 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed in a Specialist Office **Referral required**	$10 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed as Outpatient Hospital Services **Preauthorization required**	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
Dialysis			See benefit for description Dialysis performed by Non-Participating Providers is limited to ten (10) visits per calendar year **Preauthorization required**
• Performed in a PCP Office	$5 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed in a Specialist Office **Referral required**	$10 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed in a Freestanding Center **Referral required**	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed as Outpatient Hospital Services **Referral required**	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	

PROFESSIONAL SERVICES and OUTPATIENT CARE – Continued	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) • Performed in a PCP Office • Performed in a Specialist Office • Performed in an Outpatient Facility **Preauthorization required**	 $5 Copayment $10 Copayment $0 Copayment	 Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost	Ninety (90) visits per Plan Year combined therapies
Home Health Care **Preauthorization required**	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	Two hundred (200) visits per Plan Year
Infertility Services **Preauthorization required**	Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory and Diagnostic Procedures)	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description

PROFESSIONAL SERVICES and OUTPATIENT CARE – Continued	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Infusion Therapy			See benefit for description
• Performed in a PCP Office	$5 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed in a Specialist Office **Referral required**	$10 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed as Outpatient Hospital Services **Preauthorization required**	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Home Infusion Therapy **Preauthorization required**	$10 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
Inpatient Medical Visits	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Interruption of Pregnancy • Medically Necessary Abortions	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	Unlimited
• Elective Abortions **Preauthorization required**	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	One (1) procedure per Plan Year

PROFESSIONAL SERVICES and OUTPATIENT CARE – Continued	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Laboratory Procedures			See benefit for description
• Performed in a PCP Office	$5 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed in a Specialist Office	$10 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed in a Freestanding Laboratory Facility	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed as Outpatient Hospital Services **Preauthorization required**	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	

PROFESSIONAL SERVICES and OUTPATIENT CARE – Continued	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Maternity and Newborn Care • Prenatal Care			See benefit for description
• Prenatal Care provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	
• Prenatal Care that is not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	Non-Participating Provider services are not Covered and You pay the full cost	
• Inpatient Hospital Services and Birthing Center	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	One (1) home care visit is Covered at no Cost-Sharing if mother is discharged from Hospital early
• Physician and Midwife Services for Delivery	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	
• Breastfeeding Support, Counseling and Supplies, including Breast Pumps	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	Covered for duration of breast feeding
• Postnatal Care **Preauthorization required for inpatient services**	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	
Outpatient Hospital Surgery Facility Charge **Preauthorization required**	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description

PROFESSIONAL SERVICES and OUTPATIENT CARE – Continued	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Preadmission Testing **Preauthorization required**	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Prescription Drugs Administered in Office			See benefit for description
• Performed in a PCP Office	Included as part of the PCP office visit Cost-Sharing	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed in a Specialist Office	Included as part of the Specialist office visit Cost-Sharing	Non-Participating Provider services are not Covered and You pay the full cost	
Diagnostic Radiology Services			See benefit for description
• Performed in a PCP Office	$5 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed in a Specialist Office **Preauthorization required**	$10 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed in a Freestanding Radiology Facility **Preauthorization required**	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed as Outpatient Hospital Services **Preauthorization required**	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	

PROFESSIONAL SERVICES and OUTPATIENT CARE – Continued	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Therapeutic Radiology Services			See benefit for description
• Performed in a Specialist Office	$10 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed in a Freestanding Radiology Facility	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed as Outpatient Hospital Services **Preauthorization required**	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)			Ninety (90) visits per Plan Year combined therapies
• Performed in a PCP Office	$5 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed in a Specialist Office	$10 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed in an Outpatient Facility **Preauthorization required**	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	

PROFESSIONAL SERVICES and OUTPATIENT CARE – Continued	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Second Opinions on the Diagnosis of Cancer, Surgery and Other **Referral required**	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost Second opinions on diagnosis of cancer are Covered at participating Cost-Sharing for non-participating Specialist when a Referral is obtained.	See benefit for description
Surgical Services (including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; and Transplants)			See benefit for description
• Inpatient Hospital Surgery	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	**All transplants must be performed at designated Facilities**
• Outpatient Hospital Surgery	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Surgery Performed at an Ambulatory Surgical Center	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Office Surgery • Performed in a PCP Office	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed in a Specialist Office **Preauthorization required**	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	

ADDITIONAL SERVICES, EQUIPMENT and DEVICES	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
ABA Treatment for Autism Spectrum Disorder **Preauthorization required**	$5 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Assistive Communication Devices for Autism Spectrum Disorder **Preauthorization required**	$10 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Diabetic Equipment, Supplies and Self-Management Education • Diabetic Equipment, Supplies and Insulin (Up to a 90-day supply) • Diabetic Education **Preauthorization required**	 $5 Copayment $5 Copayment	 Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Durable Medical Equipment and Braces **Preauthorization required**	$0 Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
Cochlear Implants **Preauthorization required**	$0 Deductible	Non-Participating Provider services are not Covered and You pay the full cost	One (1) per ear per time Covered
Hospice Care • Inpatient • Outpatient **Preauthorization required**	 $0 Copayment $0 Copayment	 Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost	 Two hundred ten (210) days per Plan Year Five (5) visits for family bereavement counseling

ADDITIONAL SERVICES, EQUIPMENT and DEVICES – Continued	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Medical Supplies **Preauthorization required**	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Prosthetic Devices • External	$0 Deductible	Non-Participating Provider services are not Covered and You pay the full cost	One (1) prosthetic device, per limb, per lifetime with coverage for repairs and replacements. Unlimited; See benefit for description
• Internal **Preauthorization required**	Included as part of inpatient Hospital Cost-Sharing	Non-Participating Provider services are not Covered and You pay the full cost	
Shoe Inserts **Preauthorization required**	$0 Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description

INPATIENT SERVICES and FACILITIES	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care) **Preauthorization required. However, Preauthorization is not required for emergency admissions or services provided in a neonatal intensive care unit of a Hospital certified pursuant to Article 28 of the Public Health Law.**	$0 Copayment per admission	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Observation Stay	$75 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation) **Preauthorization required**	$0 Copayment per admission	Non-Participating Provider services are not Covered and You pay the full cost	Unlimited days per Plan Year
Inpatient Habilitation Services (Physical, Speech and Occupational Therapy) **Preauthorization required**	$0 Copayment per admission	Non-Participating Provider services are not Covered and You pay the full cost	Thirty (30) days per Plan Year combined therapies
Inpatient Rehabilitation Services (Physical, Speech and Occupational Therapy) **Preauthorization required**	$0 Copayment per admission	Non-Participating Provider services are not Covered and You pay the full cost	Thirty (30) days per Plan Year combined therapies

MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Inpatient Mental Health Care for a continuous confinement when in a Hospital (including Residential Treatment) **Preauthorization required. However, Preauthorization is not required for emergency admissions or for admissions at Participating OHM-licensed Facilities for Members under eighteen (18).**	$0 Copayment per admission	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services) • Office Visits • All Other Outpatient Services	$0 Copayment $0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Inpatient Substance Use Services for a continuous confinement when in a Hospital (including Residential Treatment) **Preauthorization required. However, Preauthorization is not required for emergency admissions or for Participating OASAS-certified Facilities.**	$0 Copayment per admission	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description

MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES – Continued	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Outpatient Substance Use Services (including Partial Hospitalization, Intensive Outpatient Program Services, and Medication Assisted Treatment) • Office Visits • All Other Outpatient Services	$5 Copayment $5 Copayment	Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost	Unlimited
PRESCRIPTION DRUGS *Certain Prescription Drugs are not subject to Cost-Sharing when provided in accordance with the comprehensive guidelines supported by HRSA or if the item or service has an "A" or "B" rating from the USPSTF and obtained at a participating pharmacy.	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**

PRESCRIPTION DRUGS – Continued	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Retail Pharmacy			
30-day supply Tier 1 Tier 2 Preauthorization is not required for a Covered Prescription Drug used to treat a substance use disorder, including a Prescription Drug to manage opioid withdrawal and/or stabilization and for opioid overdose reversal.	 $5 Copayment $20 Copayment	Non-Participating Provider services are not Covered and You pay the full cost The Deductible, if applicable, does not apply to preventive Prescription Drugs used to manage asthma, diabetes, high blood pressure, high cholesterol, osteoporosis and stroke. Visit Our website at www.emblemhealth.com or call 1-855-283-2150 to find out if a particular Prescription Drug is on the preventive drug list.	See benefit for description
Mail Order Pharmacy			
Up to a 90-day supply Tier 1 Tier 2	 $7.50 Copayment $30 Copayment	Non-Participating Provider services are not Covered and You pay the full cost The Deductible, if applicable, does not apply to preventive Prescription Drugs used to manage asthma, diabetes, high blood pressure, high cholesterol, osteoporosis and stroke. Visit Our website at www.emblemhealth.com or call 1-855-283-2150 to find out if a particular Prescription Drug is on the preventive drug list.	See benefit for description
Enteral Formulas Tier 1 Tier 2	 $0 Copayment $0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description

WELLNESS BENEFITS	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Gym Reimbursement	$200 per six (6) month calendar year period; an additional $100 per six (6) month calendar year period for covered Dependents	$200 per six (6) month calendar year period; an additional $100 per six (6) month calendar year period for covered Dependents	$200 per six (6) month calendar year period; an additional $100 per six (6) month calendar year period for covered Dependents
VISION CARE	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Vision Care • Refractive Eye Exam with dilation as necessary • Frames • Standard Plastic Lenses o Single vision o Bifocal o Trifocal • Standard Progressive Lenses • Premium Progressive Lenses	$0 Copayment $0 Copayment for $80 allowance, 20% discount on balance over $80 allowance $35 Copayment $35 Copayment $35 Copayment $100 Copayment $100 Copayment, 20% discount on balance over $120 allowance	Non-Participating Provider services are not Covered and You pay the full cost	Once per Calendar Year One (1) prescribed lenses and frames per twenty-four (24) month period

All in-network Preauthorization requests are the responsibility of Your Participating Provider. You will not be penalized for a Participating Provider's failure to obtain a required Preauthorization. However, if services are not Covered under the Certificate, You will be responsible for the full cost of the services.

Commercial Schedule of Benefits without Rx - DFS Approved Form

Provided on the following pages is our Commercial Schedule of Benefits without prescription drug coverage.

Section XXVI

EmblemHealth HMO Prime Schedule of Benefits

COST-SHARING	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	
Equipment and Devices • Deductible	$0	Non-Participating Provider services are not Covered except as required for emergency care.	
Plan Year Out-of-Pocket Limit • Individual • Family	$6,850 $13,700		
Deductibles, Coinsurance and Copayments that make up Your Out-of-Pocket Limit accumulate on a calendar year ending on December 31 of each year.			
OFFICE VISITS	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Primary Care Office Visits (or Home Visits)	$5 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Specialist Office Visits (or Home Visits) **Referral required**	$10 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description

PREVENTIVE CARE	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
• Well Child Visits and Immunizations*	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
• Adult Annual Physical Examinations*	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	
• Adult Immunizations*	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	
• Routine Gynecological Services/Well Woman Exams*	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	
• Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	
• Sterilization Procedures for Women*	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	
• Vasectomy	$10 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Bone Density Testing*	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	
• Screening for Prostate Cancer	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	

PREVENTIVE CARE – Continued	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
• All other preventive services required by USPSTF and HRSA	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	
• *When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	Non-Participating Provider services are not Covered and You pay the full cost	
EMERGENCY CARE	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Pre-Hospital Emergency Medical Services (Ambulance Services)	$0 Copayment	$0 Copayment	See benefit for description
Non-Emergency Ambulance Services **Preauthorization required**	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Emergency Department Copayment waived if admitted to Hospital	$75 Copayment Health care forensic examinations performed under Public Health Law § 2805-i are not subject to Cost-Sharing	$75 Copayment	See benefit for description
Urgent Care Center	$5 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description

PROFESSIONAL SERVICES and OUTPATIENT CARE	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Advanced Imaging Services • Performed in a Specialist Office • Performed in a Freestanding Radiology Facility • Performed as Outpatient Hospital Services **Preauthorization required**	 $10 Copayment $0 Copayment $0 Copayment	 Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Allergy Testing and Treatment • Performed in a PCP Office • Performed in a Specialist Office **Referral required**	 $5 Copayment $10 Copayment	 Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Ambulatory Surgical Center Facility Fee **Preauthorization required**	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Anesthesia Services (all settings)	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Autologous Blood Banking	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description

PROFESSIONAL SERVICES and OUTPATIENT CARE – Continued	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Cardiac Rehabilitation • Performed in a Specialist Office • Performed as Outpatient Hospital Services • Performed as Inpatient Hospital Services **Preauthorization required**	 $10 Copayment $0 Copayment Included as part of inpatient Hospital service Cost-Sharing	 Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost	Thirty-two (32) visits when performed in a Specialist Office or Outpatient Hospital Services
Chemotherapy • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services **Preauthorization required**	 $5 Copayment $10 Copayment $0 Copayment	 Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Chiropractic Services	$10 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Clinical Trials **Preauthorization required**	Use Cost-Sharing for appropriate service	Use Cost-Sharing for appropriate service	See benefit for description

PROFESSIONAL SERVICES and OUTPATIENT CARE – Continued	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Diagnostic Testing			See benefit for description
• Performed in a PCP Office	$5 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed in a Specialist Office **Referral required**	$10 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed as Outpatient Hospital Services **Preauthorization required**	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
Dialysis			See benefit for description Dialysis performed by Non-Participating Providers is limited to ten (10) visits per calendar year **Preauthorization required**
• Performed in a PCP Office	$5 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed in a Specialist Office **Referral required**	$10 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed in a Freestanding Center **Referral required**	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed as Outpatient Hospital Services **Referral required**	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	

PROFESSIONAL SERVICES and OUTPATIENT CARE – Continued	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) • Performed in a PCP Office • Performed in a Specialist Office • Performed in an Outpatient Facility **Preauthorization required**	 $5 Copayment $10 Copayment $0 Copayment	 Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost	Ninety (90) visits per Plan Year combined therapies
Home Health Care **Preauthorization required**	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	Two hundred (200) visits per Plan Year
Infertility Services **Preauthorization required**	Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory and Diagnostic Procedures)	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description

PROFESSIONAL SERVICES and OUTPATIENT CARE – Continued	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Infusion Therapy			See benefit for description
• Performed in a PCP Office	$5 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed in a Specialist Office **Referral required**	$10 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed as Outpatient Hospital Services **Preauthorization required**	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Home Infusion Therapy **Preauthorization required**	$10 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
Inpatient Medical Visits	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Interruption of Pregnancy • Medically Necessary Abortions	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	Unlimited
• Elective Abortions **Preauthorization required**	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	One (1) procedure per Plan Year

PROFESSIONAL SERVICES and OUTPATIENT CARE – Continued	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Laboratory Procedures			See benefit for description
• Performed in a PCP Office	$5 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed in a Specialist Office	$10 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed in a Freestanding Laboratory Facility	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed as Outpatient Hospital Services **Preauthorization required**	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	

PROFESSIONAL SERVICES and OUTPATIENT CARE – Continued	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Maternity and Newborn Care • Prenatal Care			See benefit for description
• Prenatal Care provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	
• Prenatal Care that is not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	Non-Participating Provider services are not Covered and You pay the full cost	
• Inpatient Hospital Services and Birthing Center	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	One (1) home care visit is Covered at no Cost-Sharing if mother is discharged from Hospital early
• Physician and Midwife Services for Delivery	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	
• Breastfeeding Support, Counseling and Supplies, including Breast Pumps	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	Covered for duration of breast feeding
• Postnatal Care **Preauthorization required for inpatient services**	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	
Outpatient Hospital Surgery Facility Charge **Preauthorization required**	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description

PROFESSIONAL SERVICES and OUTPATIENT CARE – Continued	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Preadmission Testing **Preauthorization required**	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Prescription Drugs Administered in Office			See benefit for description
• Performed in a PCP Office	Included as part of the PCP office visit Cost-Sharing	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed in a Specialist Office	Included as part of the Specialist office visit Cost-Sharing	Non-Participating Provider services are not Covered and You pay the full cost	
Diagnostic Radiology Services			See benefit for description
• Performed in a PCP Office	$5 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed in a Specialist Office **Preauthorization required**	$10 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed in a Freestanding Radiology Facility **Preauthorization required**	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed as Outpatient Hospital Services **Preauthorization required**	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	

PROFESSIONAL SERVICES and OUTPATIENT CARE – Continued	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Therapeutic Radiology Services			See benefit for description
• Performed in a Specialist Office	$10 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed in a Freestanding Radiology Facility	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed as Outpatient Hospital Services **Preauthorization required**	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)			Ninety (90) visits per Plan Year combined therapies
• Performed in a PCP Office	$5 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed in a Specialist Office	$10 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed in an Outpatient Facility **Preauthorization required**	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	

PROFESSIONAL SERVICES and OUTPATIENT CARE – Continued	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Second Opinions on the Diagnosis of Cancer, Surgery and Other **Referral required**	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost Second opinions on diagnosis of cancer are Covered at participating Cost-Sharing for non-participating Specialist when a Referral is obtained.	See benefit for description
Surgical Services (including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; and Transplants)			See benefit for description
• Inpatient Hospital Surgery	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	**All transplants must be performed at designated Facilities**
• Outpatient Hospital Surgery	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Surgery Performed at an Ambulatory Surgical Center	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Office Surgery • Performed in a PCP Office	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed in a Specialist Office **Preauthorization required**	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	

ADDITIONAL SERVICES, EQUIPMENT and DEVICES	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
ABA Treatment for Autism Spectrum Disorder **Preauthorization required**	$5 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Assistive Communication Devices for Autism Spectrum Disorder **Preauthorization required**	$10 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Diabetic Equipment, Supplies and Self-Management Education • Diabetic Equipment, Supplies and Insulin (Up to a 90-day supply) • Diabetic Education **Preauthorization required**	 $5 Copayment $5 Copayment	 Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Durable Medical Equipment and Braces **Preauthorization required**	$0 Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
Cochlear Implants **Preauthorization required**	$0 Deductible	Non-Participating Provider services are not Covered and You pay the full cost	One (1) per ear per time Covered
Hospice Care • Inpatient • Outpatient **Preauthorization required**	 $0 Copayment $0 Copayment	 Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost	 Two hundred ten (210) days per Plan Year Five (5) visits for family bereavement counseling

ADDITIONAL SERVICES, EQUIPMENT and DEVICES – Continued	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Medical Supplies **Preauthorization required**	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Prosthetic Devices • External	$0 Deductible	Non-Participating Provider services are not Covered and You pay the full cost	One (1) prosthetic device, per limb, per lifetime with coverage for repairs and replacements. Unlimited; See benefit for description
• Internal **Preauthorization required**	Included as part of inpatient Hospital Cost-Sharing	Non-Participating Provider services are not Covered and You pay the full cost	
Shoe Inserts **Preauthorization required**	$0 Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description

INPATIENT SERVICES and FACILITIES	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care) **Preauthorization required. However, Preauthorization is not required for emergency admissions or services provided in a neonatal intensive care unit of a Hospital certified pursuant to Article 28 of the Public Health Law.**	$0 Copayment per admission	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Observation Stay	$75 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation) **Preauthorization required**	$0 Copayment per admission	Non-Participating Provider services are not Covered and You pay the full cost	Unlimited days per Plan Year
Inpatient Habilitation Services (Physical, Speech and Occupational Therapy) **Preauthorization required**	$0 Copayment per admission	Non-Participating Provider services are not Covered and You pay the full cost	Thirty (30) days per Plan Year combined therapies
Inpatient Rehabilitation Services (Physical, Speech and Occupational Therapy) **Preauthorization required**	$0 Copayment per admission	Non-Participating Provider services are not Covered and You pay the full cost	Thirty (30) days per Plan Year combined therapies

MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Inpatient Mental Health Care for a continuous confinement when in a Hospital (including Residential Treatment) **Preauthorization required. However, Preauthorization is not required for emergency admissions or for admissions at Participating OHM-licensed Facilities for Members under eighteen (18).**	$0 Copayment per admission	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services) • Office Visits • All Other Outpatient Services	$0 Copayment $0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Inpatient Substance Use Services for a continuous confinement when in a Hospital (including Residential Treatment) **Preauthorization required. However, Preauthorization is not required for emergency admissions or for Participating OASAS-certified Facilities.**	$0 Copayment per admission	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description

MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES – Continued	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Outpatient Substance Use Services (including Partial Hospitalization, Intensive Outpatient Program Services, and Medication Assisted Treatment) • Office Visits • All Other Outpatient Services	$5 Copayment $5 Copayment	Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost	Unlimited
WELLNESS BENEFITS	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Gym Reimbursement	$200 per six (6) month calendar year period; an additional $100 per six (6) month calendar year period for covered Dependents	$200 per six (6) month calendar year period; an additional $100 per six (6) month calendar year period for covered Dependents	$200 per six (6) month calendar year period; an additional $100 per six (6) month calendar year period for covered Dependents

VISION CARE	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Vision Care • Refractive Eye Exam with dilation as necessary • Frames • Standard Plastic Lenses o Single vision o Bifocal o Trifocal • Standard Progressive Lenses • Premium Progressive Lenses	 $0 Copayment $0 Copayment for $80 allowance, 20% discount on balance over $80 allowance $35 Copayment $35 Copayment $35 Copayment $100 Copayment $100 Copayment, 20% discount on balance over $120 allowance	Non-Participating Provider services are not Covered and You pay the full cost	 Once per Calendar Year One (1) prescribed lenses and frames per twenty-four (24) month period

All in-network Preauthorization requests are the responsibility of Your Participating Provider. You will not be penalized for a Participating Provider's failure to obtain a required Preauthorization. However, if services are not Covered under the Certificate, You will be responsible for the full cost of the services.

Commercial Contract

Provided on the following pages is our Commercial HMO Group Contract.

This is Your

HEALTH MAINTENANCE ORGANIZATION GROUP CONTRACT

Issued by

HEALTH INSURANCE PLAN OF GREATER NEW YORK (hereinafter referred to as "HIP")
55 Water Street, New York, New York 10041

To Group Contractholder:
Group Contract Number:
Group Address:
Effective Date: , 12:00 a.m. Eastern Standard Time (the "Effective Date")
Contract Renewal Date:

HIP is a health maintenance organization (HMO) organized under the laws of the State of New York. HIP agrees with the above named party to arrange for and provide Covered Services and other benefits described in this Group Contract and the attached Schedule of Benefits to enrolled Subscribers and eligible Dependents during the term of this Group Contract, in consideration of the Premium payments to be remitted by the above named party, subject to the following conditions:

Entire Contract:
This Group Contract, together with the attached Certificate, Schedule of Benefits, applications, and any amendment or rider amending the terms of this agreement, constitute the entire agreement between HIP and the above named party.

THIS GROUP CONTRACT DOES NOT PROVIDE COVERAGE FOR BENEFITS FROM NON-PARTICIPATING PROVIDERS EXCEPT IN THE CASE OF AN EMERGENCY CONDITION.

READ THIS ENTIRE CONTRACT CAREFULLY. IT IS YOUR RESPONSIBILITY TO UNDERSTAND THE TERMS AND CONDITIONS IN THIS CONTRACT.

IN WITNESS WHEREOF, HIP has caused this Group Contract to be duly executed as of the effective date indicated above.

This Contract is governed by the laws of New York State.

HEALTH INSURANCE PLAN OF GREATER NEW YORK

Karen Ignagni
President and CEO

TABLE OF CONTENTS

Section I

Introduction

HIP hereby agrees with the Group to provide the Covered Services set forth herein to Members, subject to the exclusions, limitations, conditions and other terms of this Group Contract and the Schedule of Benefits.

The Group Contract is given in return for the Group's application and payment of the required Premium on behalf of the Group's employees/Members and their eligible Dependents covered by this Group Contract.

The Group Contract shall take effect as specified on the cover page. It will be continued in force by the timely payments of the required Premium charges when due, subject to termination of the Group Contract as set forth herein.

All coverage under the Group Contract shall begin and end at 12:01 a.m., Eastern Standard Time.

The Group Contract may not be modified, amended, or changed, except in writing and signed by Our President and Chief Executive Officer ("CEO") or a person designated by the President and CEO. No employee, agent, or other person is authorized to interpret, amend, modify, or otherwise change the Group Contract in a manner that expands or limits the scope of coverage, or the conditions of eligibility, enrollment, or participation, unless in writing and signed by the President and CEO, or person designated by the President and CEO.

HIP reserves the right to develop administrative policies as may be necessary to carry out the intent of the Group Contract. The right of HIP to develop administrative policies shall extend to the development of reasonable interpretation of Group Contract language in compliance with New York Insurance Law and Regulation. All administrative policies so developed by HIP shall be fully enforceable under this Group Contract insofar as they represent reasonable interpretation or application of the terms and provisions stated in the Group Contract.

This Group Contract provides Covered Services through an HMO agreement. In an HMO, care must be Medically Necessary and must be referred by the Primary Care Physician ("PCP") and/or approved in advance by the HIP care management program, or its designee. Also, coverage will only be provided for care that is rendered by Participating Providers, except in the case of an Emergency Condition or when the care required is not available from a Participating Provider.

Section II

Definitions

Definitions. As used in this Group Contract, the following words and phrases shall apply:

Cover, Covered or Covered Services: The Medically Necessary services paid for, arranged, or authorized for Members by Us under the terms and conditions of this Group Contract.

Dependents: The Subscriber's Spouse and Children.

Emergency Condition: A medical or behavioral condition that manifests itself by Acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;
- Serious impairment to such person's bodily functions;
- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of such person.

Emergency Services: A medical screening examination which is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Condition; and within the capabilities of the staff and facilities available at the Hospital, such further medical examination and treatment as are required to stabilize the patient. "To stabilize" is to provide such medical treatment of an Emergency Condition as may be necessary to assure that, within reasonable medical probability, no material deterioration of the condition is likely to result from or occur during the transfer of the patient from a Facility, or to deliver a newborn child (including the placenta).

Group: The employer or party that has entered into an agreement with Us as a contractholder.

Group Contract: A contract of insurance made with and issued to an employer, association, corporation, labor union, Taft-Hartley trust fund or other group contracting that covers a group of people who purchase this contract.

HIP: The Health Insurance Plan of Greater New York (HIP) and anyone to whom We legally delegate performance, on Our behalf, under this Contract.

Medically Necessary: Covered Services that are:

- clinically appropriate in terms of type, frequency, extent, site, and duration, and considered effective for the Member's illness, injury, or disease;
- required for the direct care and treatment or management of that condition;
- needed because the Member's condition would be adversely affected if the services were not provided;
- provided in accordance with generally-accepted standards of medical practice;
- not primarily for the convenience of the Member, the Member's family, or the Member's Provider;
- not more costly than an alternative service or sequence of services, that is they are at least as likely to produce equivalent therapeutic or diagnostic results.

When setting or place of service is part of the review, services that can be safely provided to the Member in a lower cost setting will not be Medically Necessary if they are performed in a higher cost setting. For example, We will not provide coverage for an inpatient admission for surgery if the surgery could have been performed on an outpatient basis or an infusion or injection of a specialty drug provided in the outpatient department of a Hospital if the drug could be provided in a Physician's office or the home setting.

Member: The Subscriber or a covered Dependent for whom required Premiums have been paid. Whenever a Member is required to provide a notice pursuant to a Grievance or emergency department visit or admission, "Member" also means the Member's designee.

Non-Participating Provider: A Provider who does not have a contract with Us to provide services to Members. The services of Non-Participating Providers are Covered only for Emergency Services or when authorized by Us.

Participating Provider: A Provider who has a contract with Us to provide Covered Services to Members. A list of Participating Providers and their locations is available on Our website at www.emblemhealth.com or upon Your request to Us. The list will be revised from time to time by Us.

Plan Year: The twelve (12)-month period beginning on the effective date of the Contract or any anniversary date thereafter, during which the Contract is in effect.

Premium: The amount that must be paid for a Member's health insurance coverage.

Primary Care Physician ("PCP"): A participating Physician who typically is an internal medicine, family practice or pediatric Physician and who directly provides or coordinates a range of health care services for Members.

Schedule of Benefits: The form attached to this Group Contract that describes the Copayments, Deductibles, Coinsurance, Out-of-Pocket Limits, Preauthorization requirements, Referral requirements, and other limits on Covered Services.

Service Area: The geographical area, designated by Us and approved by the State of New York, in which We provide coverage. Our Service Area consists of: Bronx, Kings, Manhattan, Queens, Richmond, Rockland, Nassau, Suffolk, Westchester, Broome, Otsego, Albany, Columbia, Fulton, Greene, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, Washington, Delaware, Dutchess, Orange, Putnam, Sullivan and Ulster counties.

Subscriber: The person to whom the Certificate under this Group Contract is issued.

Us, We, Our: Health Insurance Plan of Greater New York ("HIP") and anyone to whom We legally delegate performance, on Our behalf, under this Group Contract.

You, Your: The Group contractholder.

Section III

General Group Provisions

All Premiums are payable monthly in advance by the Group to HIP at its office. The Group will arrange to collect any necessary Subscriber Premium contributions and pay the total monthly Premium due to HIP on or before the first day of any month during which coverage is to be provided to Members. The first Premiums are due and payable on the first day of each month during the term of the Group Contract as set forth on the face page herein. The Group agrees that it shall act as the agent for the Subscriber and not, under any circumstances, as an agent, employee or representative of HIP in collecting any amounts from such Subscriber and paying it to HIP. The initial Premium for coverage is set forth on the application. HIP will provide the Group with at least thirty (30) days notice of an increase or decrease in Premium.

It is understood that the same rate will be charged for the entire Contract Year. However, if during any Contract Year there shall have been an increase or decrease in the Premium charge, HIP will adjust the Premium for the ensuing Contract Year to reflect any increase or decrease to the Premium. Settlement of any increases or decreases to the Premium will occur no later than twelve (12) months after the end of the prior contract year or upon termination of this Group Contract, if earlier.

HIP shall calculate the Premium based upon its records of the number and coverage of Subscribers as of the fifteenth day of the month proceeding the date that the next month's Premium is due and payable. HIP shall provide the Group with written notice of the Premium payable to HIP at least one (1) week prior to the date the Premium is payable to HIP. The Group agrees to promptly notify HIP of the termination or addition of any Members covered or to be covered by HIP. HIP and the Group shall cooperate to complete any retroactive adjustments to the Premium necessary as a result of the addition or termination of Members under this Group Contract. In adjusting for additions of covered Members, HIP will charge Premium for additions if the effective date of coverage is between the 1st and the 15th day of the month. HIP will not charge Premium if the effective date of coverage is between the 16th and the end of the month. In adjusting for terminations of covered Members, HIP will not charge Premium if the effective date of termination is between the 1st and 15th day of the month. HIP will charge Premium if the termination is effective between the 16th day and the end of the month. HIP does not allow additions, terminations or changes to members type that is more than thirty (30) days late, or in the case of loss of Medicaid or a state child health plan, no later than sixty (60) days. Applications or modifications must be received by HIP within thirty (30) days of the effective date of change, or sixty (60) days, in the case of changes due to loss of Medicaid or a state child health plan.

Acceptance by the Group. Payment by the Group of the first Premium billed by HIP shall be deemed to be unconditional acceptance by the Group of all Premium due under this agreement. Such payment by the Group shall also be deemed to be unconditional acceptance by the Group of all terms and conditions of this agreement.

Agreements Between Us and Participating Providers. Any agreement between Us and Participating Providers may only be terminated by Us or the Providers. This Contract does not require any Provider to accept a Member as a patient. We do not guarantee a Member's admission to any Participating Provider or any health benefits program.

Amendments. Any amendments to this agreement shall be in writing and must be approved by authorized representatives of both the Group and HIP. No other individual has the authority to modify this agreement, waive any of its provisions or restrictions, extend the time for making payment, or bind HIP by making any other commitment or representation.

Formal acceptance of an amendment to this agreement by the Group shall not be required: if the change has been negotiated by means of a request by the Group and agreed to in writing by HIP; if the change is required to bring the agreement into conformance with any applicable law, regulation or ruling of the jurisdiction in which the agreement is delivered or of federal government; or if the Group makes payment of any applicable Premium on and after the effective date of such amendment.

Assignment. This agreement may not be assigned by the Group without the prior written consent of HIP. This agreement may not be assigned by HIP without the consent of the Group provided that HIP may assign this agreement to any parent, affiliate or subsidiary and to any entity that controls, is controlled by, or that is under common control with it now or in the future, or which succeeds to its business through a sale, merger or other corporate transaction.

Changes in this Contract. We may unilaterally change this Contract upon renewal, if We give the Group thirty (30) days' prior written notice.

Choice of Law. This Contract shall be governed by the laws of the State of New York.

Clerical Error. Clerical error, whether by the Group or Us, with respect to this Group Contract, or any other documentation issued by Us in connection with this Group Contract or in keeping any record pertaining to the coverage hereunder, will not modify or invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated.

Enrollment ERISA. The Group will develop and maintain complete and accurate payroll records, as well as any other records of the names, addresses, ages, and social security numbers of all Group Members covered under this Group Contract, and any other information required to confirm their eligibility for coverage.

The Group will provide Us with this information upon request. The Group may also have additional responsibilities as the "plan administrator" as defined by the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended. The "plan administrator" is the Group, or a third party appointed by the Group. We are not the ERISA plan administrator.

Furnishing Information and Audit. The Group will promptly furnish Us with all information and records that We may require from time to time to perform Our obligations under this Group Contract. The Group will, upon reasonable notice, make available to Us, and We may audit and make copies of, any and all records relating to Group enrollment at the Group's New York office.

Governing Law. The construction, interpretation and performance of this agreement and all transactions under this agreement shall be governed by the laws of the State of New York, except as such laws are preempted by any provision of ERISA.

Grace Period. A grace period of thirty (30) days will be granted for the payment of any Premium. If the Premium is not paid within the grace period, the coverage of all Members covered by this Group Contract will be deemed to have terminated automatically without notice from HIP to the Group or the Members as of the last date for which payment has been made. HIP shall be entitled but not required to notify Members of the non-payment of Premium to enable them to make necessary arrangements to pay for the health services upon the termination of this Group Contract. HIP shall not be responsible for payment for services rendered during the grace period.

Guaranteed Renewability of Coverage. This Group Contract may be non-renewed or discontinued only for one (1) or more of the following reasons:

- Failure of the Group or a participating entity to pay any Premiums or contributions in accordance with the terms herein.
- The Group ceases to meet the requirements for a group under applicable laws or an employer, labor union, association or other entity ceases Members in the Group to which this Group Contract is issued.
- There is no longer any Member of the Group who lives, resides or works within HIP's Service Area.
- HIP ceases offering this Group Contract form to all Groups, as discussed below.
- The Group or a participating entity has failed to comply with a material provision of this Group Contract relating to Group participation rules.
- The Group has performed an act or practice that constitutes fraud or made an intentional misrepresentation of fact under the terms of this Group Contract.
- Any other reason as may be acceptable to the State of New York Department of Financial Services.

HIPAA – Privacy Requirements. The parties acknowledge that the Health Insurance Portability and Accountability Act of 1996, Public Law No. 104-191, and the regulations promulgated thereunder, as amended from time to time ("HIPAA") required HIP to protect and safeguard and restrict the use and disclosure of "protected health information" of a Member. HIP shall not use or further disclose protected health information of a Member other than as permitted by law. The Group recognizes and agrees that HIP may not disclose health information beyond "summary/aggregated health information" to the Group except when the Group satisfies all the requirements of HIPAA, in particular Section 164.50, and otherwise

provides HIP with appropriate assurance as to the Group's compliance with the relevant HIPAA Privacy requirements as may be appropriate in the opinion of legal counsel to HIP.

Independent Contractors. Participating Providers are independent contractors. They are not Our agents or employees. We and Our employees are not the agent or employee of any Participating Provider. We are not liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries alleged to be suffered by Members while receiving care from any Participating Provider or in any Participating Provider's facility.

Notice. Any notice that We give You under this Group Contract will be mailed to the Group contractholder at the address as it appears in Our records or delivered electronically if You consent to electronic delivery. If notice is delivered to You electronically, You may also request a copy of the notice from Us. The Group contractholder agrees to provide Us with notice of any change of address. If the Group contractholder has to give Us any notice, it should be sent by U.S. Mail, first class, postage prepaid to: EmblemHealth, 55 Water Street, New York, NY 10041.

Premium Refund. We will give any refund of Premiums, if due, to the Group.

Renewal Date. The renewal date for this Group Contract is the anniversary of the effective date of the Group Contract of each year. This Group Contract will automatically renew each year on the renewal date, unless otherwise terminated by Us as permitted by this Group Contract or by the Group upon thirty (30) days' prior written notice to Us.

Severability. The unenforceability or invalidity of any provision of this Group Contract shall not affect the validity and enforceability of the remainder of this Group Contract.

Significant Change in Circumstances. If We are unable to arrange for Covered Services as provided under this Group Contract as the result of events outside of Our control, We will make a good faith effort to make alternative arrangements. These events would include a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of Participating Providers' personnel, or similar causes. We will make reasonable attempts to arrange for Covered Services. We and Our Participating Providers will not be liable for delay, or failure to provide or arrange for Covered Services if such failure or delay is caused by such an event.

Venue for Legal Action. Any action or proceeding arising out of or relating to this agreement shall be brought and tried in a court of competent jurisdiction in any New York State Court and any Federal Court situated in the State of New York.

Waiver. The waiver by any party of any breach of any provision of this Group Contract will not be construed as a waiver of any subsequent breach of the same or any other provision. The failure to exercise any right hereunder will not operate as a waiver of such right.

Section IV

Termination of Coverage

Described below are the reasons why coverage under the Group Contract or Certificate of Coverage may terminate. Unless otherwise set forth below, HIP will provide at least thirty (30) days prior notice of termination of coverage under this Group Contract. All terminations are effective on the date specified in the notice.

Termination by Its Terms – The Group terminates the Group Contract pursuant to its terms.

By Failure of the Group to Pay Premium – HIP does not receive Premium payment from the Group as of the date the Premium was due. Coverage for each Member will terminate on the date to which the Premium has been paid.

For Fraud or Intentional Misrepresentation – The Group has committed fraud or made an intentional misrepresentation of material fact under the terms of the Group Contract. In this case, coverage for each Member will terminate thirty (30) days from the date the Subscribers receive notice.

Group No Longer Operating in Service Area – There is no longer any Subscriber living, residing or working in HIP's Service Area.

Discontinuance of this Group Contract. We may discontinue offering a class of group contracts if:

- HIP provides at least ninety (90) days notice to the Group and to each Member covered under this Group Contract prior to discontinuance.
- HIP offers the Group the option to purchase any other coverage currently being offered by HIP.
- HIP acts without regard to claims experience of the Group or any health status factors.

Discontinuance of All Coverage in the Group Market. HIP may discontinue offering all coverage in New York if:

- HIP provides notice to the State of New York Department of Financial Services one hundred eighty (180) days prior to discontinuation;
- All health insurance delivered for issuance in New York is discontinued and such coverage is not renewed.
- HIP provides to the State of New York Department of Financial Services with a written plan to minimize potential disruption in the marketplace occasioned by its withdrawal from the market.

If HIP elects to cease offering all coverage, HIP may not provide any health coverage in the group market for a period of five (5) years beginning on the date of discontinuance of the last health plan not renewed.

Upon termination of this Group Contract, the Group shall pay to HIP any and all Premiums that are due but unpaid at the time of termination.

Commercial Transplants Expenses Rider

Provided on the following pages is our Commercial *Transportation, Lodging and Meal Expenses for Transplants Rider*.

Section XXVIII

Transportation, Lodging and Meal Expenses for Transplants Rider

A. General.
This rider amends the benefits of Your Certificate and provides coverage for Transportation, Lodging and Meal Expenses for Transplants as described herein.

B. Definitions.
Terms used in this section are defined as follows. (Other defined terms can be found in the Definitions section of this Certificate).

1. **Benefit Period:** With respect to any Covered Transplant Procedure, the 366-day period beginning one (1) day immediately prior to the date on which the Covered transplant procedure occurs. In the case of a covered bone marrow transplant procedure, the transplant procedure will be deemed to have occurred on the day of re-infusion for the first transplant procedure, regardless of whether such transplant may be the first of a series of such transplants that comprise a single, discrete treatment plan.

C. Terms and Conditions of Coverage.
Coverage for transportation, lodging and meals shall be limited to reasonable, out-of-pocket expenses which are actually incurred. The maximum overall coverage shall be ten thousand dollars ($10,000) per Covered transplant procedure. The maximum daily coverage for lodging and meals shall be two hundred dollars ($200) per day.

Expenses for transportation, lodging and meals are covered for the transplant recipient and his or her companion (two (2), if the candidate is a minor) when traveling outside of a fifty (50) mile radius from the recipient's home. Coverage is also offered for transportation, lodging and meals for the transplant donor and one (1) companion (two (2), if the donor is a minor) when traveling outside of a fifty (50) mile radius from the donor's home.

Transportation, lodging and meals expenses will be reimbursed at transplant evaluation.

Transportation, lodging and meal receipts are required for reimbursement (unless travel is by personal automobile in which case mileage is reimbursed at the applicable IRS rate).

D. Benefit Limitations.
There is no coverage for the following expenses:

- Any expenses for anyone other than the transplant recipient and designated traveling companion (two (2), if the candidate is a minor).
- Any transportation, lodging and meals expenses incurred when receiving care from an out-of-network provider.
- Any expenses other than the transportation, lodging and meals described in this provision.
- Expenses over the total per day limits for lodging and meals or the overall ten thousand dollar ($10,000) limit.

E. Controlling Certificate.
All of the terms, conditions, limitations, and exclusions of Your Certificate to which this rider is attached shall also apply to this rider except where specifically changed by this rider.

HEALTH INSURANCE PLAN OF GREATER NEW YORK

Karen Ignagni
President and CEO

Commercial Rx Rider for Certain Drugs

Provided on the following pages is our *Prescription Drug Rider for Certain Drugs*.

Section XXVII

Prescription Drug Rider for Certain Drugs

This rider amends Your Certificate to provide benefits for the Covered Services described below.

A. Covered Prescription Drugs.
We Cover Medically Necessary Prescription Drugs listed below that, except as specifically provided otherwise, can be dispensed only pursuant to a prescription and are:

- Required by law to bear the legend "Caution – Federal Law prohibits dispensing without a prescription";
- FDA-approved;
- Ordered by a Provider authorized to prescribe and within the Provider's scope of practice;
- Prescribed within the approved FDA administration and dosing guidelines;
- On Our Formulary; and
- Dispensed by a licensed pharmacy.

We Cover the following Prescription Drugs:

1. Medication for the detoxification or maintenance treatment of substance use disorder ("SUD Medications") that are FDA-approved for the treatment of substance use disorder.
2. Prescription Drugs prescribed in conjunction with Covered in-vitro fertilization services or fertility preservation services.
3. Contraceptive drugs, devices and other products, including over-the-counter contraceptive drugs, devices and other products, approved by the FDA and as prescribed or otherwise authorized under State or Federal law.
    a. "Over-the-counter contraceptive products" means those products provided for in comprehensive guidelines supported by HRSA.
    b. Coverage also includes emergency contraception when provided pursuant to a prescription or order or when lawfully provided over-the-counter. You may request coverage for an alternative version of a contraceptive drug, device and other product if the Covered contraceptive drug, device and other product is not available or is deemed medically inadvisable, as determined by Your attending Health Care Provider.

You may request a copy of Our Formulary. Our Formulary is also available on Our website at www.emblemhealth.com. You may inquire if a specific drug is Covered under this rider by contacting Us at 1-855-283-2150.

B. Refills.
We Cover Refills of Prescription Drugs only when dispensed at a retail pharmacy. Benefits for Refills will not be provided beyond one (1) year from the original prescription date.

C. Benefit and Payment Information.

1. **Cost-Sharing Expenses.** Your Cost-Sharing for Prescription Drugs is as follows:

SUD MEDICATIONS AND PRESCRIPTION DRUGS FOR IN VITRO FERTILIZATION AND FERTILITY PRESERVATION	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**
Retail Pharmacy		
30-day supply Tier 1 Tier 2 Tier 3	 $30 Copayment $30 Copayment $30 Copayment	Non-Participating Provider services are not Covered and You pay the full cost
CONTRACEPTIVE DRUGS, DEVICES AND OTHER PRODUCTS	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**
Retail Pharmacy		
Up to a twelve (12)-month supply Tier 1 Tier 2 Tier 3	 Covered in full Covered in full Covered in full	Non-Participating Provider services are not Covered and You pay the full cost

You have a three (3) tier plan design, which means that Your out-of-pocket expenses will generally be lowest for Prescription Drugs on tier 1 and highest for Prescription Drugs on tier 3. Your out-of-pocket expense for Prescription Drugs on tier 2 will generally be more than for tier 1 but less than tier 3.

You are responsible for paying the full cost (the amount the pharmacy charges You) for any non-Covered Prescription Drugs, and Our contracted rates (Our Medication Cost) will not be available to You.

2. **Participating Pharmacies.** For Prescription Drugs purchased at a Participating Pharmacy, You are responsible for paying the lower of:
   - The applicable Cost-Sharing; or
   - The Medication Cost for that Prescription Drug.

   (Your Cost-Sharing will never exceed the Usual and Customary Charge of the Prescription Drug.)

   In the event that Our Participating Pharmacies are unable to provide the Covered Prescription Drug and cannot order the Prescription Drug within a reasonable time, You may, with Our prior written approval, go to a Non-Participating Pharmacy that is able to provide the Prescription Drug. We will pay You the Prescription Drug Cost for such approved Prescription Drug less Your required in-network Cost-Sharing upon receipt of a

complete claim form. Contact Us at 1-855-283-2150 or visit Our website at www.emblemhealth.com to request approval.

3. **Non-Participating Pharmacies.** We will not pay for any Prescription Drugs that You purchase at a Non-Participating Pharmacy other than as described above.

4. **Designated Pharmacies.** We may direct You to a Designated Pharmacy with whom We have an arrangement to provide those Prescription Drugs for certain Prescription Drugs Covered by this Rider, including specialty Prescription Drugs.

   Generally, specialty Prescription Drugs are Prescription Drugs that are approved to treat limited patient populations or conditions; are normally injected, infused or require close monitoring by a Provider; or have limited availability, special dispensing and delivery requirements and/or require additional patient supports.

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

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

5. **Tier Status.** The tier status of a Prescription Drug may change periodically. Changes will generally be quarterly, but no more than four (4) times per calendar year, based on Our periodic tiering decisions. These changes may occur without prior notice to You. However, if You have a prescription for a drug that is being moved to a higher tier or is being removed from Our Formulary, We will notify You at least thirty (30) days before the change is effective. When such changes occur, Your Cost-Sharing may change. You may access the most up to date tier status on Our website at www.emblemhealth.com or by calling 1-855-283-2150.

6. **When a Brand-Name Drug Becomes Available as a Generic Drug.** When a Brand-Name Drug becomes available as a Generic Drug, the tier placement of the Brand-Name prescription Drug may change. If this happens, You will pay the Cost-Sharing applicable to the tier to which the Prescription Drug is assigned. Please note, if You are taking a Brand-Name Drug that is being placed on a higher tier due to a Generic Drug becoming available, You will receive thirty (30) days' advance written notice of the change before it is effective. You may request a Formulary exception for a Prescription Drug that is no longer on the Formulary as outlined below and in the External Appeal section of the Certificate.

7. **Formulary Exception Process.** If a Prescription Drug in a category that is Covered under this Rider is not on Our Formulary, You, Your designee or Your prescribing Health Care Professional may request a Formulary exception for a clinically-appropriate Prescription Drug in writing, electronically or telephonically. The request should include

a statement from Your prescribing Health Care Professional that all Formulary drugs will be or have been ineffective, would not be as effective as the non-Formulary drug, or would have adverse effects. If coverage is denied under Our standard or expedited Formulary exception process, You are entitled to an external appeal as outlined in the External Appeal section of the Certificate. Visit Our website at www.emblemhealth.com or call 1-855-283-2150 to find out more about this process.

Standard Review of a Formulary Exception. We will make a decision and notify You or Your designee and the prescribing Health Care Professional by telephone no later than seventy-two (72) hours after Our receipt of Your request. We will notify You in writing within three (3) business days of receipt of Your request. If We approve the request, We will Cover the Prescription Drug while You are taking the Prescription Drug, including any refills.

Expedited Review of a Formulary Exception. If You are suffering from a health condition that may seriously jeopardize Your health, life or ability to regain maximum function or if You are undergoing a current course of treatment using a non-Formulary Prescription Drug, You may request an expedited review of a Formulary exception. The request should include a statement from Your prescribing Health Care Professional that harm could reasonably come to You if the requested drug is not provided within the timeframes for Our standard Formulary exception process. We will make a decision and notify You or Your designee and the prescribing Health Care Professional by telephone no later than twenty-four (24) hours after Our receipt of Your request. We will notify You in writing within three (3) business days of receipt of Your request. If We approve the request, We will Cover the Prescription Drug while You suffer from the health condition that may seriously jeopardize Your health, life or ability to regain maximum function or for the duration of Your current course of treatment using the non-Formulary Prescription Drug.

8. **Supply Limits.** Except for contraceptive drugs, devices or products, We will pay for no more than a ninety (90)-day supply of a Prescription Drug purchased at a retail pharmacy. You are responsible for one (1) Cost-Sharing amount for up to a thirty (30)-day supply. However, for Maintenance Drugs We will pay for up to a ninety (90)-day supply of a drug purchased at a retail pharmacy. You are responsible for up to three (3) Cost-Sharing amounts for a ninety (90)-day supply at a retail pharmacy.

   You may have the entire supply (of up to twelve (12) months) of the contraceptive drug, device, or product dispensed at the same time. Contraceptive drugs, devices, or products are not subject to Cost-Sharing when provided by a Participating Pharmacy.

   Some Prescription Drugs may be subject to quantity limits based on criteria that We have developed, subject to Our periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply. You can determine whether a Prescription Drug has been assigned a maximum quantity level for dispensing by accessing Our website at www.emblemhealth.com or by calling 1-855-283-2150. If We deny a request to Cover

an amount that exceeds Our quantity level, You are entitled to an Appeal pursuant to the Utilization Review and External Appeal sections of the Certificate.

D. Medical Management. This Rider includes certain features to determine when Prescription Drugs should be Covered, which are described below. As part of these features, Your prescribing Provider may be asked to give more details before We can decide if the Prescription Drug is Medically Necessary.

1. **Preauthorization.** Preauthorization may be needed for certain Prescription Drugs to make sure proper use and guidelines for Prescription Drug coverage are followed. When appropriate, Your Provider will be responsible for obtaining Preauthorization for the Prescription Drug. Preauthorization is not required for Covered medications to treat substance use disorder, including opioid overdose reversal medications prescribed or dispensed to You.

   For a list of Prescription Drugs that need Preauthorization, please visit Our website at www.emblemhealth.com or call 1-855-283-2150. The list will be reviewed and updated from time to time. We also reserve the right to require Preauthorization for any new Prescription Drug on the market or for any currently available Prescription Drug which undergoes a change in prescribing protocols and/or indications regardless of the therapeutic classification, including if a Prescription Drug or related item on the list is not Covered under Your Rider. Your Provider may check with Us to find out which Prescription Drugs are Covered.

2. **Step Therapy.** Step therapy is a process in which You may need to use one (1) or more types of Prescription Drugs before We will Cover another as Medically Necessary. A "step therapy protocol" means Our policy, protocol or program that establishes the sequence in which We approve Prescription Drugs for Your medical condition. When establishing a step therapy protocol, We will use recognized evidence-based and peer reviewed clinical review criteria that also takes into account the needs of atypical patient populations and diagnoses. We check certain Prescription Drugs to make sure that proper prescribing guidelines are followed. These guidelines help You get high quality and cost-effective Prescription Drugs. The Prescription Drugs that require Preauthorization under the step therapy program are also included on the Preauthorization drug list. If a step therapy protocol is applicable to Your request for coverage of a Prescription Drug, You, Your designee, or Your Health Care Professional can request a step therapy override determination as outlined in the Utilization Review section of the Certificate.

E. Limitations/Terms of Coverage.

1. We reserve the right to limit quantities, day supply, early Refill access and/or duration of therapy for certain medications based on Medical Necessity including acceptable medical standards and/or FDA recommended guidelines.

2. If We determine that You may be using a Prescription Drug in a harmful or abusive manner, or with harmful frequency, Your selection of Participating Pharmacies may be limited. If this happens, We may require You to select a single Participating Pharmacy

that will provide and coordinate all future pharmacy services. Benefits will be paid only if You use the selected single Participating Pharmacy. If You do not make a selection within thirty-one (31) days of the date We notify You, We will select a single Participating Pharmacy for You.

3. Various specific and/or generalized "use management" protocols will be used from time to time in order to ensure appropriate utilization of medications. Such protocols will be consistent with standard medical/drug treatment guidelines. The primary goal of the protocols is to provide Our Members with a quality-focused Prescription Drug benefit. In the event a use management protocol is implemented, and You are taking the drug(s) affected by the protocol, You will be notified in advance.

4. Injectable drugs (other than self-administered injectable drugs) and diabetic insulin, oral hypoglycemics, and diabetic supplies and equipment are not Covered under this section but are Covered under other sections of the Certificate.

5. We do not Cover charges for the administration or injection of any Prescription Drug. Prescription Drugs given or administered in a Physician's office are Covered under other sections of the Certificate.

6. We do not Cover drugs that do not by law require a prescription, except for smoking cessation drugs, over-the-counter preventive drugs or devices provided in accordance with the comprehensive guidelines supported by HRSA or with an "A" or "B" rating from USPSTF, or as otherwise provided in this Rider.

7. We do not Cover Prescription Drugs to replace those that may have been lost or stolen.

8. We do not Cover Prescription Drugs dispensed to You while in a Hospital, nursing home, other institution, Facility, or if You are a home care patient, except in those cases where the basis of payment by or on behalf of You to the Hospital, nursing home, Home Health Agency or home care services agency, or other institution, does not include services for drugs.

9. We reserve the right to deny benefits as not Medically Necessary or experimental or investigational for any drug prescribed or dispensed in a manner contrary to standard medical practice. If coverage is denied, You are entitled to an Appeal as described in the Utilization Review and External Appeal sections of the Certificate.

10. A pharmacy need not dispense a Prescription Order that, in the pharmacist's professional judgment, should not be filled.

F. General Conditions.

1. You must show Your ID card to a retail pharmacy at the time You obtain Your Prescription Drug or You must provide the pharmacy with identifying information that can be verified by Us during regular business hours.

2. **Drug Utilization, Cost Management and Rebates.** We conduct various utilization management activities designed to ensure appropriate Prescription Drug usage, to avoid inappropriate usage, and to encourage the use of cost-effective drugs. Through these efforts, You benefit by obtaining appropriate Prescription Drugs in a cost-effective manner. The cost savings resulting from these activities are reflected in the Premiums for Your coverage.

   We may also, from time to time, enter into agreements that result in Us receiving rebates or other funds ("rebates") directly or indirectly from Prescription Drug manufacturers, Prescription Drug distributors or others. Any rebates are based upon utilization of Prescription Drugs across all of Our business and not solely on any one Member's utilization of Prescription Drugs. Any rebates received by Us may or may not be applied, in whole or part, to reduce premiums either through an adjustment to claims costs or as an adjustment to the administrative expenses component of Our Prescription Drug premiums. Any such rebates may be retained by Us, in whole or part, in order to fund such activities as new utilization management activities, community benefit activities and increasing reserves for the protection of Members. Rebates will not change or reduce the amount of any Copayment or Coinsurance applicable under Our Prescription Drug coverage.

G. Definitions.

Terms used in this Rider are defined as follows. (Other defined terms can be found in the Definitions section of the Certificate).

1. **Brand-Name Drug:** A Prescription Drug that: 1) is manufactured and marketed under a trademark or name by a specific drug manufacturer; or 2) We identify as a Brand-Name Prescription Drug, based on available data resources. All Prescription Drugs identified as "brand name" by the manufacturer, pharmacy, or Your Physician may not be classified as a Brand-Name Drug by Us.

2. **Designated Pharmacy:** A pharmacy that has entered into an agreement with Us or with an organization contracting on Our behalf, to provide specific Prescription Drugs, including but not limited to, specialty Prescription Drugs. The fact that a pharmacy is a Participating Pharmacy does not mean that it is a Designated Pharmacy.

3. **Formulary:** The list that identifies those Prescription Drugs for which coverage may be available under this Rider. This list is subject to Our periodic review and modification (no more than four (4) times per calendar year or when a Brand-Name Drug becomes available as a Generic Drug). To determine which tier a particular Prescription Drug has been assigned, visit Our website at www.emblemhealth.com or call 1-855-283-2150.

4. **Generic Drug:** A Prescription Drug that: 1) is chemically equivalent to a Brand-Name Drug; or 2) We identify as a Generic Prescription Drug based on available data resources. All Prescription Drugs identified as "generic" by the manufacturer, pharmacy or Your Physician may not be classified as a Generic Drug by Us.

5. **Non-Participating Pharmacy:** A pharmacy that has not entered into an agreement with Us to provide prescription drugs to Members. We will not make any payment for prescriptions or Refills filled at a Non-Participating Pharmacy other than as described above.

6. **Participating Pharmacy:** A pharmacy that has:
   - Entered into an agreement with Us or Our designee to provide Prescription Drugs to Members;
   - Agreed to accept specified reimbursement rates for dispensing Prescription Drugs; and
   - Been designated by Us as a Participating Pharmacy.

7. **Prescription Drug:** A medication, product or device that has been approved by the FDA and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill and is on Our Formulary. A Prescription Drug includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver.

8. **Prescription Drug Cost:** The amount, including a dispensing fee and any sales tax, We have agreed to pay Our Participating Pharmacies for a Covered Prescription Drug dispensed at a Participating Pharmacy. If Your Rider includes coverage at Non-Participating Pharmacies, the Prescription Drug Cost for a Prescription Drug dispensed at a Non-Participating Pharmacy is calculated using the Prescription Drug Cost that applies for that particular Prescription Drug at most Participating Pharmacies.

9. **Prescription Order or Refill:** The directive to dispense a prescription drug issued by a duly licensed Health Care Professional who is acting within the scope of his or her practice.

10. **Usual and Customary Charge:** The usual fee that a pharmacy charges individuals for a Prescription Drug without reference to reimbursement to the pharmacy by third parties as required by New York Education Law Section 6826-a.

H. Controlling Certificate.

All of the terms, conditions, limitations, and exclusions of Your Certificate to which this Rider is attached shall also apply to this rider except where specifically changed by this Rider.

HEALTH INSURANCE PLAN OF GREATER NEW YORK

Karen Ignagni
President and CEO

Medicare Evidence of Coverage – Filed Information

27. *Evidence of Coverage (for Medicare Advantage Plans) and coverage riders, if offering a Medicare Advantage Plan. The proposed Medicare standard contract and riders should be available with prescription drug coverage and without prescription drug coverage. If the Evidence of Coverage is the same but for the prescription drug coverage, please submit only one copy of the Evidence of Coverage and separate out the prescription drug coverage provisions.*

As required, please see our Evidence of Coverage both with and without prescription drug coverage for our Medicare Advantage HMO Plan as provided on the following pages as part of our hardcopy response submission. Although these files are essentially the same except for prescription drug coverage information, we have included both versions since there are minor differences, such as chapter numbers, that do change between versions. Overall, our attachments included in the following pages (in order) and on our USBs submitted are:

- *Attachment 17. Medicare Evidence of Coverage with Rx*
- *Attachment 18. Medicare Evidence of Coverage without Rx*

Medicare Evidence of Coverage with Rx

Provided on the following pages is our Medicare Evidence of Coverage with prescription drug coverage included.

January 1 – December 31, 2021

Evidence of Coverage:

Your Medicare Health Benefits and Services and Prescription Drug Coverage as a Member of EmblemHealth VIP Premier (HMO) - Group

This booklet gives you the details about your Medicare health care and prescription drug coverage from January 1 – December 31, 2021. It explains how to get coverage for the health care services and prescription drugs you need. **This is an important legal document. Please keep it in a safe place.**

This plan, EmblemHealth VIP Premier (HMO) Group, is offered by HIP Health Plan of New York (HIP)/EmblemHealth. When this *Evidence of Coverage* says "we," "us," or "our," it means HIP/EmblemHealth. When it says "plan" or "our plan," it means EmblemHealth VIP Premier (HMO) Group

HIP Health Plan of New York (HIP) is a HMO plan with a Medicare contract. Enrollment in HIP depends on contract renewal. HIP is an EmblemHealth company.

This document is available for free in Spanish.

Please contact our Customer Service number at 877-344-7364 for additional information. (TTY users should call 711.) Hours are 7 days a week, 8:00 am to 8:00 pm.

This information is also available in alternate formats such as large print and braille. Please call Customer Service at the above numbers for more information.

ATTENTION: If you speak other languages, language assistance services, free of charge, are available to you. Call 877-344-7364 (TTY 711).

ATENCIÓN: Si usted habla español, tiene a su disposición, gratis, servicios de ayuda para idiomas. Llame al 877-344-7364 (TTY 711).

Benefits, premium, deductible, and/or copayments/coinsurance may change on January 1, 2022.

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

H3330_201473_C Group

OMB Approval 0938-1051 (Expires: December 31, 2021)

2021 Evidence of Coverage

Table of Contents

This list of chapters and page numbers is your starting point. For more help in finding information you need, go to the first page of a chapter. **You will find a detailed list of topics at the beginning of each chapter.**

CHAPTER 1

Getting started as a member

Chapter 1. Getting started as a member

SECTION 1 Introduction

Section 1.1 You are enrolled in EmblemHealth VIP Premier (HMO) Group, which is a Medicare HMO

You are covered by Medicare, and you have chosen to get your Medicare health care and your prescription drug coverage through our plan, EmblemHealth VIP Premier (HMO) Group.

There are different types of Medicare health plans. EmblemHealth VIP Premier (HMO) Group is a Medicare Advantage HMO Plan (HMO stands for Health Maintenance Organization) approved by Medicare and run by a private company.

Coverage under this Plan qualifies as Qualifying Health Coverage (QHC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at: www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

Section 1.2 What is the *Evidence of Coverage* booklet about?

This *Evidence of Coverage* booklet tells you how to get your Medicare medical care and prescription drugs covered through our plan. This booklet explains your rights and responsibilities, what is covered, and what you pay as a member of the plan.

The word "coverage" and "covered services" refers to the medical care and services and the prescription drugs available to you as a member of EmblemHealth VIP Premier (HMO) Group.

It's important for you to learn what the plan's rules are and what services are available to you. We encourage you to set aside some time to look through this *Evidence of Coverage* booklet.

If you are confused or concerned or just have a question, please contact our plan's Customer Service (phone numbers are printed on the back cover of this booklet).

Section 1.3 Legal information about the *Evidence of Coverage*

It's part of our contract with you

This *Evidence of Coverage* is part of our contract with you about how *our* plan covers your care. Other parts of this contract include your enrollment form, the *List of Covered Drugs (Formulary)*, and any notices you receive from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called "riders" or "amendments."

The contract is in effect for months in which you are enrolled in *our* plan between January 1, 2021 and December 31, 2021.

Each calendar year, Medicare allows us to make changes to the plans that we offer. This means we can change the costs and benefits of *our* plan after December 31, 2021. We can also choose to stop offering the plan, or to offer it in a different service area, after December 31, 2021.

Medicare must approve our plan each year

Medicare (the Centers for Medicare & Medicaid Services) must approve our plan each year. You can continue to get Medicare coverage as a member of our plan as long as we choose to continue to offer the plan and Medicare renews its approval of the plan.

SECTION 2 What makes you eligible to be a plan member?

Section 2.1 Your eligibility requirements

You are eligible for membership in our plan as long as:

- You have both Medicare Part A and Medicare Part B (Section 2.2 tells you about Medicare Part A and Medicare Part B)
- -- *and* -- you live in our geographic service area (Section 2.3 below describes our service area).
- -- *and* -- you are a United States citizen or are lawfully present in the United States
- -- *and* -- you do not have End-Stage Renal Disease (ESRD), with limited exceptions, such as if you develop ESRD when you are already a member of a plan that we offer, or you were a member of a different plan that was terminated.

Section 2.2 What are Medicare Part A and Medicare Part B?

When you first signed up for Medicare, you received information about what services are covered under Medicare Part A and Medicare Part B. Remember:

- Medicare Part A generally helps cover services provided by hospitals (for inpatient services, skilled nursing facilities, or home health agencies).
- Medicare Part B is for most other medical services (such as physician's services and other outpatient services) and certain items (such as durable medical equipment (DME) and supplies).

Section 2.3 Here is the plan service area for our plan

Although Medicare is a Federal program, *our* plan is available only to individuals who live in our plan service area. To remain a member of our plan, you must continue to reside in the plan service area. The service area is described below.

Our service area includes these counties in New York State:

New York, Bronx, Queens, Kings, Richmond, Nassau, Suffolk and Westchester.

If you plan to move out of the service area, please contact Customer Service (phone numbers are printed on the back cover of this booklet). When you move, you will have a Special Enrollment Period that will allow you to switch to Original Medicare or enroll in a Medicare health or drug plan that is available in your new location.

It is also important that you call Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

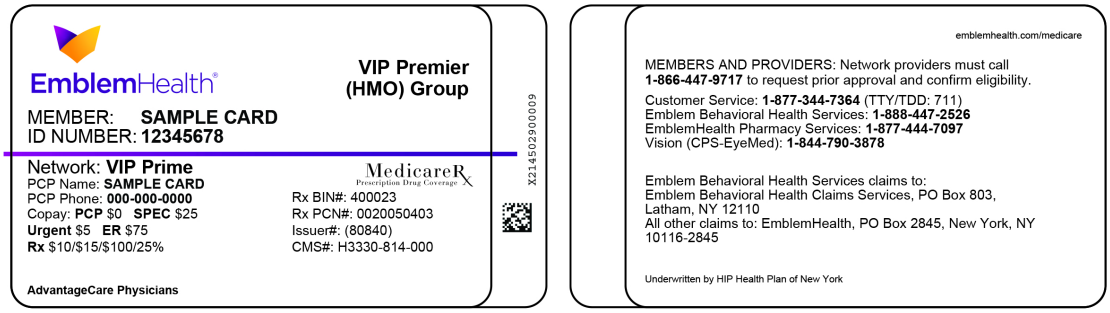
Section 2.4 U.S. Citizen or Lawful Presence

A member of a Medicare health plan must be a U.S. citizen or lawfully present in the United States. Medicare (the Centers for Medicare & Medicaid Services) will notify our plan if you are not eligible to remain a member on this basis. We must disenroll you if you do not meet this requirement.

SECTION 3 What other materials will you get from us?

Section 3.1 Your plan membership card – Use it to get all covered care and prescription drugs

While you are a member of our plan, you must use your membership card for our plan whenever you get any services covered by this plan and for prescription drugs you get at network pharmacies. You should also show the provider your Medicaid card, if applicable. Here's a sample membership card to show you what yours will look like:



As long as you are a member of our plan, in most cases, DO NOT use your new red, white, and blue Medicare card for covered medical services while you are a member of this plan. If you use your Medicare card instead of your EmblemHealth VIP Premier (HMO) –Group membership card, you may have to pay the full cost of medical services yourself. Keep your Medicare card in a safe place. You may be asked to show it if you need hospital services, hospice services, or participate in routine research studies.

Here's why this is so important: If you get covered services using your new red, white, and blue Medicare card instead of using your EmblemHealth VIP Premier (HMO) –Group membership card while you are a plan member, you may have to pay the full cost yourself.

If your plan membership card is damaged, lost, or stolen, call Customer Service right away and we will send you a new card. (Phone numbers for Customer Service are printed on the back cover of this booklet.)

Section 3.2 The *Provider Directory*: Your guide to all providers in the plan's network

The *Provider Directory* lists our network providers and durable medical equipment suppliers.

What are "network providers"?

Network providers are the doctors and other health care professionals, medical groups, durable medical equipment suppliers, hospitals, and other health care facilities that have an agreement with us to accept our payment and any plan cost-sharing as payment in full. We have arranged for these providers to deliver covered services to members in our plan. The most recent list of providers and suppliers are available on our website at www.emblemhealth.com/medicare .

Why do you need to know which providers are part of our network?

It is important to know which providers are part of our network because, with limited exceptions, while you are a member of our plan you must use network providers to get your medical care and services. The only exceptions are emergencies, urgently needed services when the network is not

available (generally, when you are out of the area), out-of-area dialysis services, and cases in which *our* plan authorizes use of out-of-network providers. See Chapter 3 (*Using the plan's coverage for your medical services*) for more specific information about emergency, out-of-network, and out-of-area coverage.

If you don't have your copy of the *Provider Directory*, you can request a copy from Customer Service (phone numbers are printed on the back cover of this booklet). You may ask Customer Service for more information about our network providers, including their qualifications). You may ask Customer Service for more information about our network providers, including their qualifications. You can also see the Provider Directory at www.emblemhealth.com/medicare, or download it from this website. Both Customer Service and the website can give you the most up-to-date information about changes in our network providers.

Section 3.3 The *Pharmacy Directory*: Your guide to pharmacies in our network

What are "network pharmacies"?

Network pharmacies are all of the pharmacies that have agreed to fill covered prescriptions for our plan members.

Why do you need to know about network pharmacies?

You can use the *Pharmacy Directory* to find the network pharmacy you want to use. There are changes to our network of pharmacies for next year. An updated Pharmacy Directory is located on our website at www.emblemhealth.com/medicare. You may call Customer Service for updated provider information or to ask us to mail you a Pharmacy Directory. **Please review the 2021 Pharmacy Directory to see which pharmacies are in our network**.

The Pharmacy Directory will also tell you which of the pharmacies in our network have preferred cost-sharing, which may be lower than the standard cost-sharing offered by other network pharmacies for some drugs.

If you don't have the *Pharmacy Directory*, you can get a copy from Customer Service (phone numbers are printed on the back cover of this booklet). At any time, you can call Customer Service to get up-to-date information about changes in the pharmacy network. You can also find this information on our website at www.emblemhealth.com/medicare.

Section 3.4 The plan's List of Covered Drugs *(Formulary)*

The plan has a *List of Covered Drugs (Formulary)*. We call it the "Drug List" for short. It tells which Part D prescription drugs are covered under the Part D benefit included in our plan. The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved the plan's Drug List.

The Drug List also tells you if there are any rules that restrict coverage for your drugs.

We will provide you a copy of the Drug List. To get the most complete and current information about which drugs are covered, you can visit the plan's website (www.emblemhealth.com/medicare or call Customer Service (phone numbers are printed on the back cover of this booklet).

Section 3.5 The *Part D Explanation of Benefits* (the "Part D EOB"): Reports with a summary of payments made for your Part D prescription drugs

When you use your Part D prescription drug benefits, we will send you a summary report to help you understand and keep track of payments for your Part D prescription drugs. This summary report is called the *Part D Explanation of Benefits* (or the "Part D EOB").

The *Part D Explanation of Benefits* tells you the total amount you, or others on your behalf, have spent on your Part D prescription drugs and the total amount we have paid for each of your Part D prescription drugs during the month. The Part D EOB provides more information about the drugs you take, such as increases in price and other drugs with lower cost sharing that may be available. You should consult with your prescriber about these lower cost options. Chapter 6 (*What you pay for your Part D prescription drugs*) gives more information about the *Part D Explanation of Benefits* and how it can help you keep track of your drug coverage.

A *Part D Explanation of Benefits* summary is also available upon request. To get a copy, please contact Customer Service (phone numbers are printed on the back cover of this booklet).

SECTION 4 Your monthly premium for our plan

Section 4.1 How much is your plan premium?

Your coverage is provided through contract with your current employer or former employer or union. Please contact the employer's or union's benefits administrator or see your Cost Sharing Guide for information about your plan premium.

In some situations, your plan premium could be less

There are programs to help people with limited resources pay for their drugs. These include "Extra Help" and State Pharmaceutical Assistance Programs. Chapter 2, Section 7 tells more about these programs. If you qualify, enrolling in the program might lower your monthly plan premium.

If you are *already enrolled* and getting help from one of these programs, **the information about premiums in this *Evidence of Coverage* may not apply to you**. We sent you a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription

Drugs" (also known as the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug coverage. If you don't have this insert, please call Customer Service and ask for the "LIS Rider." (Phone numbers for Customer Service are printed on the back cover of this booklet.)

In some situations, your plan premium could be more

In some situations, your plan premium could be more than the amount listed above in Section 4.1. These situations are described below.

- Some members are required to pay a Part D **late enrollment penalty** because they did not join a Medicare drug plan when they first became eligible or because they had a continuous period of 63 days or more when they didn't have "creditable" prescription drug coverage. ("Creditable" means the drug coverage is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) For these members, the Part D late enrollment penalty is added to the plan's monthly premium. Their premium amount will be the monthly plan premium plus the amount of their Part D late enrollment penalty.
    - If you are required to pay the Part D late enrollment penalty, the cost of the late enrollment penalty depends on how long you went without Part D or creditable prescription drug coverage. Chapter 1, Section 5 explains the Part D late enrollment penalty.
    - If you have a Part D late enrollment penalty and do not pay it, you could be disenrolled from the plan.
- Some members may be required to pay an extra charge, known as the Part D Income Related Monthly Adjustment Amount, also known as IRMAA, because, 2 years ago, they had a modified adjusted gross income, above a certain amount, on their IRS tax return. Members subject to an IRMAA will have to pay the standard premium amount and this extra charge, which will be added to their premium. Chapter 1, Section 6 explains the IRMAA in further detail.

SECTION 5 Do you have to pay the Part D "late enrollment penalty"?

Section 5.1 What is the Part D "late enrollment penalty"?

Note: If you receive "Extra Help" from Medicare to pay for your prescription drugs, you will not pay a late enrollment penalty.

The late enrollment penalty is an amount that is added to you Part D premium. You may owe a Part D late enrollment penalty if at any time after your initial enrollment period is over, there is a period of 63 days or more in a row when you did not have Part D or other creditable prescription drug coverage. "Creditable prescription drug coverage" is coverage that meets Medicare's

minimum standards since it is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. The cost of the late enrollment penalty depends on how long you went without Part D or other creditable prescription drug coverage. You will have to pay this penalty for as long as you have Part D coverage.

The Part D late enrollment penalty is added to your monthly premium. (Members who choose to pay their premium every three months will have the penalty added to their three-month premium.) When you first enroll in EmblemHealth VIP Premier (HMO) Group, we let you know the amount of the penalty.

Your Part D late enrollment penalty is considered part of your plan premium. If you do not pay your Part D late enrollment penalty, you could lose your prescription drug benefits for failure to pay your plan premium.

Section 5.2 How much is the Part D late enrollment penalty?

Medicare determines the amount of the penalty. Here is how it works:

- First count the number of full months that you delayed enrolling in a Medicare drug plan, after you were eligible to enroll. Or count the number of full months in which you did not have creditable prescription drug coverage, if the break in coverage was 63 days or more. The penalty is 1% for every month that you didn't have creditable coverage. For example, if you go 14 months without coverage, the penalty will be 14%.
- Then Medicare determines the amount of the average monthly premium for Medicare drug plans in the nation from the previous year. For 2020, this average premium amount is $32.74. This amount may change for 2021.
- To calculate your monthly penalty, you multiply the penalty percentage and the average monthly premium and then round it to the nearest 10 cents. In the example here, it would be 14% times $35.02, which equals $4.90. This rounds to $ 5.00. This amount would be added **to the monthly premium for someone with a Part D late enrollment penalty**.

There are three important things to note about this monthly Part D late enrollment penalty:

- First, **the penalty may change each year**, because the average monthly premium can change each year. If the national average premium (as determined by Medicare) increases, your penalty will increase.
- Second, **you will continue to pay a penalty** every month for as long as you are enrolled in a plan that has Medicare Part D drug benefits, even if you change plans.
- Third, if you are under 65 and currently receiving Medicare benefits, the Part D late enrollment penalty will reset when you turn 65. After age 65, your Part D late enrollment penalty will be based only on the months that you don't have coverage after your initial enrollment period for aging into Medicare.

Section 5.3 In some situations, you can enroll late and not have to pay the penalty

Even if you have delayed enrolling in a plan offering Medicare Part D coverage when you were first eligible, sometimes you do not have to pay the Part D late enrollment penalty.

You will not have to pay a penalty for late enrollment if you are in any of these situations:

- If you already have prescription drug coverage that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. Medicare calls this "**creditable drug coverage**." Please note:
  - Creditable coverage could include drug coverage from a former employer or union, TRICARE, or the Department of Veterans Affairs. Your insurer or your human resources department will tell you each year if your drug coverage is creditable coverage. This information may be sent to you in a letter or included in a newsletter from the plan. Keep this information, because you may need it if you join a Medicare drug plan later.
    - Please note: If you receive a "certificate of creditable coverage" when your health coverage ends, it may not mean your prescription drug coverage was creditable. The notice must state that you had "creditable" prescription drug coverage that expected to pay as much as Medicare's standard prescription drug plan pays.
  - The following are *not* creditable prescription drug coverage: prescription drug discount cards, free clinics, and drug discount websites.
  - For additional information about creditable coverage, please look in your *Medicare & You 2021* Handbook or call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.
- If you were without creditable coverage, but you were without it for less than 63 days in a row.
- If you are receiving "Extra Help" from Medicare.

Section 5.4 What can you do if you disagree about your Part D late enrollment penalty?

If you disagree about your Part D late enrollment penalty, you or your representative can ask for a review of the decision about your late enrollment penalty. Generally, you must request this review **within 60 days** from the date on the first letter you receive stating you have to pay a late enrollment penalty. If you were paying a penalty before joining our plan, you may not have another chance to request a review of that late enrollment penalty. Call Customer Service to find out more about how to do this (phone numbers are printed on the back cover of this booklet).

Important: Do not stop paying your Part D late enrollment penalty while you're waiting for a review of the decision about your late enrollment penalty. If you do, you could be disenrolled for failure to pay your plan premiums.

SECTION 6 Do you have to pay an extra Part D amount because of your income?

Section 6.1 Who pays an extra Part D amount because of income?

If your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain amount, you'll pay the standard premium amount and an Income Related Monthly Adjustment Amount, also known as IRMAA. IRMAA is an extra charge added to your premium.

If you have to pay an extra amount, Social Security, not your Medicare plan, will send you a letter telling you what that extra amount will be and how to pay it. The extra amount will be withheld from your Social Security, Railroad Retirement Board, or Office of Personnel Management benefit check, no matter how you usually pay your plan premium, unless your monthly benefit isn't enough to cover the extra amount owed. If your benefit check isn't enough to cover the extra amount, you will get a bill from Medicare. **You must pay the extra amount to the government. It cannot be paid with your monthly plan premium.**

Section 6.2 How much is the extra Part D amount?

If your modified adjusted gross income (MAGI) as reported on your IRS tax return is above a certain amount, you will pay an extra amount in addition to your monthly plan premium. For more information on the extra amount you may have to pay based on your income, visit www.medicare.gov/part-d/costs/premiums/drug-plan-premiums.html.

Section 6.3 What can you do if you disagree about paying an extra Part D amount?

If you disagree about paying an extra amount because of your income, you can ask Social Security to review the decision. To find out more about how to do this, contact Social Security at 1-800-772-1213 (TTY 1-800-325-0778).

Section 6.4 What happens if you do not pay the extra Part D amount?

The extra amount is paid directly to the government (not your Medicare plan) for your Medicare Part D coverage. If you are required by law to pay the extra amount and you do not pay it, you will be disenrolled from the plan and lose prescription drug coverage.

SECTION 7 More information about your monthly premium

Many members are required to pay other Medicare premiums

In addition to paying the monthly plan premium, many members are required to pay other Medicare premiums. As explained in Section 2 above, in order to be eligible for our plan, you must have both Medicare Part A and Medicare Part B. Some plan members (those who aren't eligible for premium-free Part A) pay a premium for Medicare Part A. Most plan members pay a premium for Medicare Part B. **You must continue paying your Medicare premiums to remain a member of the plan.**

If your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain amount, you'll pay the standard premium amount and an Income Related Monthly Adjustment Amount, also known as IRMAA. IRMAA is an extra charge added to your premium.

- **If you are required to pay the extra amount and you do not pay it, you will be disenrolled from the plan and lose prescription drug coverage.**
- If you have to pay an extra amount, Social Security, **not your Medicare plan,** will send you a letter telling you what that extra amount will be.
- For more information about Part D premiums based on income, go to Chapter 1, Section 6 of this booklet. You can also visit www.medicare.gov on the Web or call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Or you may call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

Your copy of *Medicare & You 2021* gives information about the Medicare premiums in the section called "2021 Medicare Costs." This explains how the Medicare Part B and Part D premiums differ for people with different incomes. Everyone with Medicare receives a copy of *Medicare & You* each year in the fall. Those new to Medicare receive it within a month after first signing up. You can also download a copy of *Medicare & You 2021* from the Medicare website (www.medicare.gov). Or, you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, and 7 days a week. TTY users call 1-877-486-2048.

Section 7.1 There are several ways you can pay your plan premium

There are four ways you can pay your plan premium. They are listed below. Please contact Customer Service at the number listed in this booklet to tell us what option you choose. You can change your premium payment option at any time by calling our Customer Service. It may take us a few weeks to process your request. If you do not make a selection, you will be sent a monthly premium invoice.

If you decide to change the way you pay your premium, it can take up to three months for your new payment method to take effect. While we are processing your request for a new payment method, you are responsible for making sure that your plan premium is paid on time.

Option 1: You can pay by check

You will receive a monthly bill from us approximately two weeks before the month the premium is due. Your premium payment by check is due the first day of each month. For example, you will receive a monthly bill in February. We must receive your check by March 1. Checks should be made payable to EmblemHealth, not CMS. You can arrange to be billed monthly, quarterly or annually.

You can mail your premium to:
EmblemHealth-HIP
Box 9221, G.P.O.
New York, NY 10087

Or you can drop off your premium payment at:
EmblemHealth
55 Water Street
New York, NY 10041-8190

Hours are Monday to Friday, 8:30 am to 5:00 pm

Option 2: Web Pay

You can pay your premium on the Web using EmblemHealth's secure online payment system. To do so, sign into your EmblemHealth website account and select "Pay My Bill." You will be transferred to our banking partner payment system, where you can make one-time or recurring payments utilizing options for e-check, Visa, MasterCard or debit card at your convenience. Online access is available 24 hours a day, 7 days a week. Please note that our plan is prohibited from furnishing discounts for enrollees who use the Web to pay their plan premiums.

Option 3: EmblemHealth's secure automated phone system

You can pay your premium over the phone using EmblemHealth's secure automated phone system, or EmblemHealth Interactive Voice Response (EIVR). Contact Customer Service and you will hear a prompt to check your account balance and make a payment. You will be transferred to our secure banking partner payment system and may use your checking or savings account, VISA or MasterCard to make a payment. There is no fee for these transactions. The EIVR payment option is available 24 hours a day, 7 days a week. (Phone numbers for Customer Service are printed on the back cover of this booklet.)

Option 4: You can have the plan premium taken out of your monthly Social Security check

You can have the plan premium taken out of your monthly Social Security check. Contact Customer Service for more information on how to pay your plan premium this way. We will be

happy to help you set this up. (Phone numbers for Customer Service are printed on the back cover of this booklet.)

What to do if you are having trouble paying your plan premium

Your plan premium is due in our office by the first day of each month. If you are required to pay a Part D late enrollment penalty, you must pay the penalty to keep your prescription drug coverage.

If you are having trouble paying your premium on time, please contact Customer Service to see if we can direct you to programs that will help with your premium. (Phone numbers for Customer Service are printed on the back cover of this booklet.)

If we end your membership because you did not pay your premium, you will have health coverage under Original Medicare.

If we end your membership with the plan because you did not pay your plan premium, then you may not be able to receive Part D coverage until the following year if you enroll in a new plan during the annual enrollment period. During the annual Medicare open enrollment period, you may either join a stand-alone prescription drug plan or a health plan that also provides drug coverage. (If you go without "creditable" drug coverage for more than 63 days, you may have to pay a Part D late enrollment penalty for as long as you have Part D coverage.)

At the time we end your membership, you may still owe us for premiums you have not paid. We have the right to pursue collection of the premiums you owe. In the future, if you want to enroll again in our plan (or another plan that we offer), you will need to pay the amount you owe before you can enroll. If you think we have wrongfully ended your membership, you have a right to ask us to reconsider this decision by making a complaint. Chapter 9, Section 10 of this booklet tells how to make a complaint. If you had an emergency circumstance that was out of your control and it caused you to not be able to pay your premiums within our grace period, you can ask us to reconsider this decision by calling 1-877-344-7364 between 7 days a week, 8:00 am to 8:00 pm. TTY users should call 711. You must make your request no later than 60 days after the date your membership ends.

Section 7.2 Can we change your monthly plan premium during the year?

No. We are not allowed to change the amount we charge for the plan's monthly plan premium during the year. If the monthly plan premium changes for next year we will tell you in September and the change will take effect on January 1.

However, in some cases the part of the premium that you have to pay can change during the year. This happens if you become eligible for the "Extra Help" program or if you lose your eligibility for the "Extra Help" program during the year. If a member qualifies for "Extra Help" with their prescription drug costs, the "Extra Help" program will pay part of the member's monthly plan premium. A member who loses their eligibility during the year will need to start paying their full

monthly premium. You can find out more about the "Extra Help" program in Chapter 2, Section 7.

SECTION 8 Please keep your plan membership record up to date

Section 8.1 How to help make sure that we have accurate information about you

Your membership record has information from your enrollment form, including your address and telephone number. It shows your specific plan coverage including your Primary Care Provider.

The doctors, hospitals, pharmacists, and other providers in the plan's network need to have correct information about you. **These network providers use your membership record to know what services and drugs are covered and the cost-sharing amounts for you**. Because of this, it is very important that you help us keep your information up to date.

Let us know about these changes:

- Changes to your name, your address, or your phone number
- Changes in any other health insurance coverage you have (such as from your employer, your spouse's employer, workers' compensation, or Medicaid)
- If you have any liability claims, such as claims from an automobile accident
- If you have been admitted to a nursing home
- If you receive care in an out-of-area or out-of-network hospital or emergency room
- If your designated responsible party (such as a caregiver) changes
- If you are participating in a clinical research study

If any of this information changes, please let us know by calling Customer Service (phone numbers are printed on the back cover of this booklet).

It is also important to contact Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

Read over the information we send you about any other insurance coverage you have

Medicare requires that we collect information from you about any other medical or drug insurance coverage that you have. That's because we must coordinate any other coverage you have with your benefits under our plan. (For more information about how our coverage works when you have other insurance, see Section 10 in this chapter.)

Once each year, we will send you a letter that lists any other medical or drug insurance coverage that we know about. Please read over this information carefully. If it is correct, you don't need to do anything. If the information is incorrect, or if you have other coverage that is not listed, please call Customer Service (phone numbers are printed on the back cover of this booklet).

SECTION 9 We protect the privacy of your personal health information

Section 9.1 We make sure that your health information is protected

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

For more information about how we protect your personal health information, please go to Chapter 8, Section 1.3 of this booklet.

SECTION 10 How other insurance works with our plan

Section 10.1 Which plan pays first when you have other insurance?

When you have other insurance (like employer group health coverage), there are rules set by Medicare that decide whether our plan or your other insurance pays first. The insurance that pays first is called the "primary payer" and pays up to the limits of its coverage. The one that pays second, called the "secondary payer," only pays if there are costs left uncovered by the primary coverage. The secondary payer may not pay all of the uncovered costs.

These rules apply for employer or union group health plan coverage:

- If you have retiree coverage, Medicare pays first.
- If your group health plan coverage is based on your or a family member's current employment, who pays first depends on your age, the number of people employed by your employer, and whether you have Medicare based on age, disability, or End-Stage Renal Disease (ESRD):
    - If you're under 65 and disabled and you or your family member is still working, your group health plan pays first if the employer has 100 or more employees or at least one employer in a multiple employer plan that has more than 100 employees.
    - If you're over 65 and you or your spouse is still working, your group health plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan that has more than 20 employees.
- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

These types of coverage usually pay first for services related to each type:

- No-fault insurance (including automobile insurance)
- Liability (including automobile insurance)
- Black lung benefits
- Workers' compensation

Medicaid and TRICARE never pay first for Medicare-covered services. They only pay after Medicare, employer group health plans, and/or Medigap have paid.

If you have other insurance, tell your doctor, hospital, and pharmacy. If you have questions about who pays first, or you need to update your other insurance information, call Customer Service (phone numbers are printed on the back cover of this booklet). You may need to give your plan member ID number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.

CHAPTER 2

Important phone numbers and resources

Chapter 2. Important phone numbers and resources

SECTION 1 Our plan contacts (how to contact us, including how to reach Customer Service at the plan)

How to contact our plan's Customer Service

For assistance with claims, billing, or member card questions, please call or write to EmblemHealth VIP Premier (HMO) – Group Customer Service. We will be happy to help you.

Method	Customer Service – Contact Information
CALL	1-877-344-7364 Calls to this number are free. 7 days a week, 8:00 am to 8:00 pm. Customer Service also has free language interpreter services available for non-English speakers.
TTY	711 (New York State Relay Service) Calls to this number are free. 7 days a week, 8:00 am to 8:00 pm.
FAX	1-212-510-5373
WRITE	EmblemHealth Medicare HMO ATTN: Customer Service 55 Water Street New York, NY 10041-8190
WEBSITE	www.emblemhealth.com/medicare

How to contact us when you are asking for a coverage decision about your medical care

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services. For more information on asking for coverage decisions about your medical care, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints*).

You may call us if you have questions about our coverage decision process.

Method	Coverage Decisions For Medical Care – Contact Information
CALL	1-877-344-7364 Calls to this number are free. 7 days a week, 8:00 am to 8:00 pm.
TTY	711 (New York State Relay Service) Calls to this number are free 7 days a week, 8:00 am to 8:00 pm.
FAX	1-866-215-2928
WRITE	EmblemHealth Medicare HMO ATTN: Utilization Management 55 Water Street New York, NY 10041
WEBSITE	www.emblemhealth.com/medicare

How to contact us when you are making an appeal about your medical care

An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on making an appeal about your medical care, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints*).

Method	Appeals For Medical Care – Contact Information
CALL	1-877-344-7364 Calls to this number are free. 7 days a week, 8:00 am to 8:00 pm For expedited appeals: 1-888-447-6855
TTY	711 (New York State Relay Service) Calls to this number are free. 7 days a week, 8:00 am to 8:00 pm For expedited appeals: 711
FAX	1-212-510-5320 For expedited appeals: 1-866-350-2168
WRITE	EmblemHealth Grievance and Appeal Department P.O. Box 2807 New York, NY 10116-2807
WEBSITE	www.emblemhealth.com/medicare

How to contact us when you are making a complaint about your medical care

You can make a complaint about us or one of our network providers, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. (If your problem is about the plan's coverage or payment, you should look at the section above about making an appeal.) For more information on making a complaint about your medical care, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints*).

Method	Complaints About Medical Care – Contact Information
CALL	1-877-344-7364 Calls to this number are free. 7 days a week, 8:00 am to 8:00 pm
TTY	711 (New York State Relay Service) Calls to this number are free. 7 days a week, 8:00 am to 8:00 pm
FAX	1-212-510-5320 For expedited appeals: 1-866-350-2168
WRITE	EmblemHealth Grievance and Appeal Department P.O. Box 2807 New York, NY 10116-2807
MEDICARE WEBSITE	You can submit a complaint about our plan directly to Medicare. To submit an online complaint to Medicare go to www.medicare.gov/MedicareComplaintForm/home.aspx.

How to contact us when you are asking for a coverage decision about your Part D prescription drugs

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your prescription drugs covered under the Part D benefit included in your plan. For more information on asking for coverage decisions about your Part D prescription drugs, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints*).

Method	Coverage Decisions for Part D Prescription Drugs – Contact Information
CALL	1-877-344-7364 Calls to this number are free. 7 days a week, 8:00 am to 8:00 pm
TTY	711 (New York State Relay Service) Calls to this number are free. 7 days a week, 8:00 am to 8:00 pm
FAX	1-877-300-9695
WRITE	EmblemHealth Medicare HMO Pharmacy Services 55 Water Street New York, NY 10041
WEBSITE	www.emblemhealth.com/medicare

How to contact us when you are making an appeal about your Part D prescription drugs

An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on making an appeal about your Part D prescription drugs, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints*)).

Method	Appeals for Part D Prescription Drugs – Contact Information
CALL	1-877-344-7364 Calls to this number are free. 7 days a week, 8:00 am to 8:00 pm For expedited appeals: 1-888-447-6855
TTY	711 (New York State Relay Service) Calls to this number are free. 7 days a week, 8:00 am to 8:00 pm
FAX	1-212-510-5320 For expedited appeals: 1-866-350-2168
WRITE	EmblemHealth Grievance and Appeal Department P.O. Box 2807 New York, NY 10116-2807
WEBSITE	www.emblemhealth.com/medicare

How to contact us when you are making a complaint about your Part D prescription drugs

You can make a complaint about us or one of our network pharmacies, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. (If your problem is about the plan's coverage or payment, you should look at the section above about making an appeal.) For more information on making a complaint about your Part D prescription drugs, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints*).

Method	Complaints about Part D prescription drugs – Contact Information
CALL	1-877-344-7364 Calls to this number are free. 7 days a week, 8:00 am to 8:00 pm
TTY	711 (New York State Relay Service) Calls to this number are free. 7 days a week, 8:00 am to 8:00 pm
FAX	1-877-300-9695
WRITE	EmblemHealth Grievance and Appeal Department P.O. Box 2807 New York, NY 10116-2807
MEDICARE WEBSITE	You can submit a complaint about our plan directly to Medicare. To submit an online complaint to Medicare go to www.medicare.gov/MedicareComplaintForm/home.aspx.

Where to send a request asking us to pay for our share of the cost for medical care or a drug you have received

For more information on situations in which you may need to ask us for reimbursement or to pay a bill you have received from a provider, see Chapter 7 (*Asking us to pay our share of a bill you have received for covered medical services or drugs*).

Please note: If you send us a payment request and we deny any part of your request, you can appeal our decision. See Chapter 9 *(What to do if you have a problem or complaint (coverage decisions, appeals, complaints))* for more information.

Method	Medicare Payment Request – Contact Information
WRITE	EmblemHealth Claims P.O. Box 2845 New York, NY 10116-2845
WEBSITE	**www.emblemhealth.com/medicare**

Method	Part D Payment Requests – Contact Information
CALL	1-877-344-7364 Calls to this number are free. 7 days a week, 8:00 am to 8:00
TTY	711 (New York State Relay Service) Calls to this number are free. 7 days a week, 8:00 am to 8:00 pm
WRITE	EmblemHealth Medicare HMO PO Box 1520 JAF Station New York, NY 10116-1520
WEBSITE	www.emblemhealth.com/medicare

SECTION 2 Medicare
(how to get help and information directly from the Federal Medicare program)

Medicare is the Federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

The Federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (sometimes called "CMS"). This agency contracts with Medicare Advantage organizations including us.

Method	Medicare – Contact Information
CALL	1-800-MEDICARE, or 1-800-633-4227 Calls to this number are free. 24 hours a day, 7 days a week.

Method	Medicare – Contact Information
TTY	1-877-486-2048 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
WEBSITE	www.medicare.gov This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes booklets you can print directly from your computer. You can also find Medicare contacts in your state. The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools: • **Medicare Eligibility Tool:** Provides Medicare eligibility status information. • **Medicare Plan Finder:** Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an *estimate* of what your out-of-pocket costs might be in different Medicare plans. You can also use the website to tell Medicare about any complaints you have about EmblemHealth VIP Premier (HMO) Group: • **Tell Medicare about your complaint:** You can submit a complaint about *our plan)* directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program. If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare and tell them what information you are looking for. They will find the information on the website, print it out, and send it to you. (You can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)

SECTION 3 State Health Insurance Assistance Program (free help, information, and answers to your questions about Medicare)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In New York State, the SHIP is called the Health Insurance Information Counseling and Assistance Program (HIICAP).

HIICAP is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

HIICAP counselors can help you with your Medicare questions or problems. They can help you understand your Medicare rights, help you make complaints about your medical care or treatment, and help you straighten out problems with your Medicare bills. HIICAP counselors can also help you understand your Medicare plan choices and answer questions about switching plans.

Method	Health Insurance Information Counseling and Assistance Program (HIICAP) (New York's SHIP)
CALL	1-800-701-0501
TTY	711 (New York State Relay Service)
WRITE	New York State Office for the Aging 2 Empire State Plaza Albany, New York 12223-1251
WEBSITE	www.aging.ny.gov/

SECTION 4 Quality Improvement Organization (paid by Medicare to check on the quality of care for people with Medicare)

There is a designated Quality Improvement Organization for serving Medicare beneficiaries in each state. For New York State, the Quality Improvement Organization is called Livanta.

Livanta has a group of doctors and other health care professionals who are paid by the Federal government. This organization is paid by Medicare to check on and help improve the quality of care for people with Medicare. Livanta is an independent organization. It is not connected with our plan.

You should contact Livanta in any of these situations:

- You have a complaint about the quality of care you have received.
- You think coverage for your hospital stay is ending too soon.
- You think coverage for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon.

Method	LIVANTA (New York State's Quality Improvement Organization)
CALL	1-866-815-5440
TTY	1-866-868-2289
FAX	1-855-236-2423 (for appeals) 1-844-420-6671 (for all other reviews)
WRITE	Livanta BFCC-QIO Program 10820 Guilford Road, Suite 202 Annapolis Junction, MD 20701
WEBSITE	www.Livanta.com

SECTION 5 Social Security

Social Security is responsible for determining eligibility and handling enrollment for Medicare. U.S. citizens and lawful permanent residents who are 65 or older, or who have a disability or End-Stage Renal Disease and meet certain conditions, are eligible for Medicare. If you are already getting Social Security checks, enrollment into Medicare is automatic. If you are not getting Social Security checks, you have to enroll in Medicare. Social Security handles the enrollment process for Medicare. To apply for Medicare, you can call Social Security or visit your local Social Security office.

Social Security is also responsible for determining who has to pay an extra amount for their Part D drug coverage because they have a higher income. If you got a letter from Social Security telling you that you have to pay the extra amount and have questions about the amount or if your income went down because of a life-changing event, you can call Social Security to ask for reconsideration.

If you move or change your mailing address, it is important that you contact Social Security to let them know.

Method	Social Security– Contact Information
CALL	1-800-772-1213 Calls to this number are free. Available 7:00 am to 7:00 pm, Monday through Friday. You can use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	1-800-325-0778 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 7:00 am to 7:00 pm, Monday through Friday.
WEBSITE	www.ssa.gov

SECTION 6 Medicaid
(a joint Federal and state program that helps with medical costs for some people with limited income and resources)

Medicaid is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid.

In addition, there are programs offered through Medicaid that help people with Medicare pay their Medicare costs, such as their Medicare premiums. These "Medicare Savings Programs" help people with limited income and resources save money each year:

- **Qualified Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums, and other cost-sharing (like deductibles, coinsurance, and copayments). (Some people with QMB are also eligible for full Medicaid benefits (QMB+).)
- **Specified Low-Income Medicare Beneficiary (SLMB):** Helps pay Part B premiums. (Some people with SLMB are also eligible for full Medicaid benefits (SLMB+).)
- **Qualified Individual (QI):** Helps pay Part B premiums.
- Qualified Disabled & Working Individuals (QDWI): Helps pay Part A premiums.

To find out more about Medicaid and its programs, contact the New York State Department of Health.

Method	New York State Department of Health (New York's Medicaid program – Contact Information
CALL	1-800-541-2831
TTY	711 (New York State Relay Service)
WRITE	New York State Department of Health Corning Tower Empire State Plaza, Albany, NY 12237
WEBSITE	www.health.ny.gov/health_care/medicaid

SECTION 7 Information about programs to help people pay for their prescription drugs

Medicare's "Extra Help" Program

Medicare provides "Extra Help" to pay prescription drug costs for people who have limited income and resources. Resources include your savings and stocks, but not your home or car. If you qualify, you get help paying for any Medicare drug plan's monthly premium, yearly deductible, and prescription copayments. This "Extra Help" also counts toward your out-of-pocket costs.

People with limited income and resources may qualify for "Extra Help." Some people automatically qualify for "Extra Help" and don't need to apply. Medicare mails a letter to people who automatically qualify for "Extra Help."

You may be able to get "Extra Help" to pay for your prescription drug premiums and costs. To see if you qualify for getting "Extra Help," call:

- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
- The Social Security Office at 1-800-772-1213, between 7 am to 7 pm, Monday through Friday. TTY users should call 1-800-325-0778 (applications); or
- Your State Medicaid Office (applications) (See Section 6 of this chapter for contact information).

If you believe you have qualified for "Extra Help" and you believe that you are paying an incorrect cost-sharing amount when you get your prescription at a pharmacy, our plan has established a process that allows you to either request assistance in obtaining evidence of your proper copayment level, or, if you already have the evidence, to provide this evidence to us. Call our plan's Customer Service at the number listed on the back cover of this booklet and let us

know you have the evidence available. You can also mail the evidence to us at the address below:

EmblemHealth
Attention: Medicare Enrollment
P.O. Box 2859
New York, NY 10117-7894

You can send one of the following as a prof that you are eligible for extra help:

- Your Medicaid Number. We will check Medicaid system to confirm you are eligible.
- A letter from New York State telling you that you qualify for Medicaid.
- A Social Security Administration award letter.
- When we receive the evidence showing your copayment level, we will update our system so that you can pay the correct copayment when you get your next prescription at the pharmacy. If you overpay your copayment, we will reimburse you. Either we will forward a check to you in the amount of your overpayment or we will offset future copayments. If the pharmacy hasn't collected a copayment from you and is carrying your copayment as a debt owed by you, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Please contact Customer Service if you have questions (phone numbers are printed on the back cover of this booklet).

Medicare Coverage Gap Discount Program

The Medicare Coverage Gap Discount Program provides manufacturer discounts on brand name drugs to Part D members who have reached the coverage gap and are not receiving "Extra Help." For brand name drugs, the 70% discount provided by manufacturers excludes any dispensing fee for costs in the gap. Members pay 25% of the negotiated price and a portion of the dispensing fee for brand name drugs.

If you reach the coverage gap, we will automatically apply the discount when your pharmacy bills you for your prescription and your Part D Explanation of Benefits (Part D EOB) will show any discount provided. Both the amount you pay and the amount discounted by the manufacturer count toward your out-of-pocket costs as if you had paid them and move you through the coverage gap. The amount paid by the plan (5%) does not count toward your out-of-pocket costs.

You also receive some coverage for generic drugs. If you reach the coverage gap, the plan pays 63% of the price for generic drugs and you pay the remaining 37% of the price. For generic drugs, the amount paid by the plan (63%) does not count toward your out-of-pocket costs. Only the amount you pay counts and moves you through the coverage gap. Also, the dispensing fee is included as part of the cost of the drug.

If you have any questions about the availability of discounts for the drugs you are taking or about the Medicare Coverage Gap Discount Program in general, please contact Customer Service (phone numbers are printed on the back cover of this booklet).

What if you have coverage from a State Pharmaceutical Assistance Program (SPAP)?

If you are enrolled in a State Pharmaceutical Assistance Program (SPAP), or any other program that provides coverage for Part D drugs (other than "Extra Help"), you still get the 70% discount on covered brand name drugs. Also, the plan pays 5% of the costs of brand drugs in the coverage gap. The 70% discount and the 5% paid by the plan are both applied to the price of the drug before any SPAP or other coverage.

What if you have coverage from an AIDS Drug Assistance Program (ADAP)?
What is the AIDS Drug Assistance Program (ADAP)?

The AIDS Drug Assistance Program (ADAP) helps ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance from the New York State HIV Uninsured Care Program. Note: To be eligible for the ADAP operating in your State, individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status.

If you are currently enrolled in an ADAP, it can continue to provide you with Medicare Part D prescription cost-sharing assistance for drugs on the ADAP formulary. In order to be sure you continue receiving this assistance, please notify your local ADAP enrollment worker of any changes in your Medicare Part D plan name or policy number.

Method	New York State HIV Uninsured Care Program – Contact Information
CALL	1-800-542-2437 (for New York State residents) 1-518-459-1641 (for non-New York State residents)
TTY	1-518-459-0121 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	New York State HIV Uninsured Care Program Empire Station P.O. Box 2052 Albany, NY 12220-0052
WEBSITE	www.health.ny.gov/diseases/aids/general/resources/adap

For information on eligibility criteria, covered drugs, or how to enroll in the program, please call the New York State HIV Uninsured Care Program at 1-800-542-2437 (for New York State residents) and -518-459-1641 (for non-New York State residents). TTY caller please call 1-518-459-0121.

What if you get "Extra Help" from Medicare to help pay your prescription drug costs? Can you get the discounts?

No. If you get "Extra Help," you already get coverage for your prescription drug costs during the coverage gap.

What if you don't get a discount, and you think you should have?

If you think that you have reached the coverage gap and did not get a discount when you paid for your brand name drug, you should review your next *Part D Explanation of Benefits* (Part D EOB) notice. If the discount doesn't appear on your *Part D Explanation of Benefits*, you should contact us to make sure that your prescription records are correct and up-to-date. If we don't agree that you are owed a discount, you can appeal. You can get help filing an appeal from your State Health Insurance Assistance Program (SHIP) (telephone numbers are in Section 3 of this Chapter) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

State Pharmaceutical Assistance Programs

Many states have State Pharmaceutical Assistance Programs that help some people pay for prescription drugs based on financial need, age, medical condition, or disabilities. Each state has different rules to provide drug coverage to its members.

In New York State, the State Pharmaceutical Assistance Program is the Elderly Pharmaceutical Insurance Coverage (EPIC) Program.

Method	Elderly Pharmaceutical Insurance Coverage (EPIC) Program (New York's State Pharmaceutical Assistance Program) – Contact Information
CALL	1-800-332-3742
TTY	1-800-290-9138 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	EPIC P.O. Box 15018 Albany, NY 12212-5018
WEBSITE	www.health.ny.gov/health_care/epic/

SECTION 8 How to contact the Railroad Retirement Board

The Railroad Retirement Board is an independent Federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you have questions regarding your benefits from the Railroad Retirement Board, contact the agency.

If you receive your Medicare through the Railroad Retirement Board, it is important that you let them know if you move or change your mailing address.

Method	Railroad Retirement Board – Contact Information
CALL	1-877-772-5772 Calls to this number are free. Available 9:00 am to 3:30 pm, Monday through Friday. If you have a touch-tone telephone, recorded information and automated services are available 24 hours a day, including weekends and holidays.
TTY	1-312-751-4701 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are *not* free.
WEBSITE	rrb.gov

SECTION 9 Do you have "group insurance" or other health insurance from an employer?

If you (or your spouse) get benefits from your (or your spouse's) employer or retiree group as part of this plan, you may call the employer/union benefits administrator or Customer Service if you have any questions. You can ask about your (or your spouse's) employer or retiree health benefits, premiums, or the enrollment period. (Phone numbers for Customer Service are printed on the back cover of this booklet.) You may also call 1-800-MEDICARE (1-800-633-4227; TTY: 1-877-486-2048) with questions related to your Medicare coverage under this plan.

If you have other prescription drug coverage through your (or your spouse's) employer or retiree group, please contact **that group's benefits administrator.** The benefits administrator can help you determine how your current prescription drug coverage will work with our plan.

CHAPTER 3

Using the plan's coverage for your medical services

Chapter 3. Using the plan's coverage for your medical services

SECTION 1 Things to know about getting your medical care covered as a member of our plan

This chapter explains what you need to know about using the plan to get your medical care covered. It gives definitions of terms and explains the rules you will need to follow to get the medical treatments, services, and other medical care that are covered by the plan.

Section 1.1 What are "network providers" and "covered services"?

Here are some definitions that can help you understand how you get the care and services that are covered for you as a member of our plan:

- **"Providers"** are doctors and other health care professionals licensed by the state to provide medical services and care. The term "providers" also includes hospitals and other health care facilities.
- **"Network providers"** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and your cost-sharing amount as payment in full. We have arranged for these providers to deliver covered services to members in our plan. The providers in our network bill us directly for care they give you. When you see a network provider, you pay only your share of the cost for their services.
- **"Covered services"** include all the medical care, health care services, supplies, and equipment that are covered by our plan. Your covered services for medical care are listed in the benefits chart in Chapter 4.

Section 1.2 Basic rules for getting your medical care covered by the plan

As a Medicare health plan, our plan must cover all services covered by Original Medicare and must follow Original Medicare's coverage rules.

Our plan will generally cover your medical care as long as:

- **The care you receive is included in the plan's Medical Benefits Chart** (this chart is in Chapter 4 of this booklet).
- **The care you receive is considered medically necessary**. "Medically necessary" 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.
- **You have a network primary care provider (a PCP) who is providing and overseeing your care.** As a member of our plan, you must choose a network PCP (for more information about this, see Section 2.1 in this chapter).
    - In most situations, your network PCP must give you approval in advance before you can use other providers in the plan's network, such as specialists, hospitals,

skilled nursing facilities, or home health care agencies. This is called giving you a "referral." For more information about this, see Section 2.3 of this chapter.

- Referrals from your PCP are not required for emergency care or urgently needed services. There are also some other kinds of care you can get without having approval in advance from your PCP (for more information about this, see Section 2.2 of this chapter).

- **You must receive your care from a network provider** (for more information about this, see Section 2 in this chapter). In most cases, care you receive from an out-of-network provider (a provider who is not part of our plan's network) will not be covered. *Here are three exceptions:*
  - The plan covers emergency care or urgently needed services that you get from an out-of-network provider. For more information about this, and to see what emergency or urgently needed services means, see Section 3 in this chapter.
  - If you need medical care that Medicare requires our plan to cover and the providers in our network cannot provide this care, you can get this care from an out-of-network provider. Authorization should be obtained from the plan prior to seeking care. In this situation, you will pay the same as you would pay if you got the care from a network provider. For information about getting approval to see an out-of-network doctor, see Section 2.4 in this chapter.
  - The plan covers kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area.

SECTION 2 Use providers in the plan's network to get your medical care

Section 2.1 You must choose a Primary Care Provider (PCP) to provide and oversee your medical care

What is a "PCP" and what does the PCP do for you?

When you become a member of our plan, you must choose a network provider to be your Primary Care Provider, or PCP. The name and office telephone number of your PCP is printed on your Member ID card. Your PCP can be a family practice or internal medicine physician, nurse practitioner, geriatrician or other health care professional who meets state requirements and is trained to give you basic medical care. Usually, you will get most of your routine or basic care from your PCP. Your PCP will coordinate the rest of the covered services you get as a plan member and will give you the referrals to see other providers, like specialists. The services your PCP will coordinate for you include, but are not limited to:

- X-rays and laboratory tests
- Therapies and specialist visits.

In some cases, your PCP will need to get prior authorization (prior approval) from the plan for other services. Chapter 4 has more information on which services require prior authorization.

Call your PCP to make an appointment. When you change your PCP, ask your doctors to send your medical record to your new PCP. It will help your PCP understand your medical history and coordinate your care better

How do you choose your PCP?

You may choose your PCP by using our Provider Directory or getting help from Customer Service. You can also get most up-to-date list by going to our website at www.emblemhealth.com/medicare.

Changing your PCP

You may change your PCP for any reason, at any time. Also, it's possible that your PCP might leave our plan's network of providers and you would have to find a new PCP. Your new PCP will be effective on the day that you make the change.

You may change your PCP online at www.emblemhealth.com/medicare or call Customer Service. Be sure to tell Customer Service if you are seeing specialists that need your PCP's approval. They will help make sure you can continue with the specialty care and other services you have been getting when you change your PCP.

Section 2.2 What kinds of medical care can you get without getting approval in advance from your PCP?

You can get the services listed below without getting approval in advance from your PCP.

- Routine women's health care, which includes breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams*:* as long as you get them from a network provider.
- Flu shots Hepatitis B vaccinations, and pneumonia vaccinations as long as you get them from a network provider.
- Emergency services from network providers or from out-of-network providers.
- Urgently needed services from network providers or from out-of-network providers when network providers are temporarily unavailable or inaccessible (e.g., when you are temporarily outside of the plan's service area).
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area. (If possible, please call Customer Service before you leave the service area so we can help arrange for you to have maintenance dialysis while you are away. Phone numbers for Customer Service are printed on the back cover of this booklet.)
- All preventive services like annual wellness visit, breast cancer screening, colorectal cancer screening and many others. You will see this apple next to the preventive

services listed in Medical benefits chart in Chapter 4 of this booklet. These services do not require a referral or prior authorization.

Section 2.3 How to get care from specialists and other network providers

A specialist is a doctor who provides health care services for a specific disease or part of the body. There are many kinds of specialists. Here are a few examples:

- Oncologists care for patients with cancer.
- Cardiologists care for patients with heart conditions.
- Orthopedists care for patients with certain bone, joint, or muscle conditions.

Your PCP will give you a referral to see specialists and other providers. Where your provider gets a referral or prior authorization depends on the type of service. Please see medical benefits chart in Chapter 4, Section 2.1 for more information. The services listed in the benefits chart indicate if prior approval is required and who can provide it. Your provider may contact our plan to obtain authorization. If you are a member of a medical group, they will generally give you a referral to a specialist who also belongs to that medical group, but you are not limited to that specialist.

What if a specialist or another network provider leaves our plan?

We may make changes to the hospitals, doctors, and specialists (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan, but if your doctor or specialist does leave your plan you have certain rights and protections that are summarized below:

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider to manage your care.

If you need assistance or have questions about seeing a specialist, please contact our Customer Service (phone numbers are on the back cover of this booklet).

Section 2.4 How to get care from out-of-network providers

Generally, you must get all of your covered services from in-network providers. In some cases you can get services from out-of-network providers without prior approval from the plan. For example, you can get emergency and urgent care, and out-of-area dialysis from out-of-network providers. If you get routine care from out-of-network providers without prior approval, you will be responsible for the costs. Call Customer Service at the number listed on your booklet to find a provider near you. If you need specialized care and we do not have a network provider available, let us know and request an authorization by calling 1-877-344-7364 (TTY 711), 7 days a week 8 am to 8 pm. See the Medical Benefits Chart in Chapter 4, Section 2.1 for more information about what services require authorization.

SECTION 3 How to get covered services when you have an emergency or urgent need for care or during a disaster

Section 3.1 Getting care if you have a medical emergency

What is a "medical emergency" and what should you do if you have one?

A **"medical emergency"** is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You do *not* need to get approval or a referral first from your PCP.
- **As soon as possible, make sure that our plan has been told about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. Call Customer Service at 1-877-344-7364, 7 days a week from 8:00 am to 8:00 pm, or 711 for TTY.

What is covered if you have a medical emergency?

You may get covered emergency medical care whenever you need it, anywhere in the United States or its territories. Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. For more information, see the Medical Benefits Chart in Chapter 4 of this booklet.

Our plan covers emergency medical care anywhere in the world. For more information, see the Medical Benefits Chart in Chapter 4 of this booklet.

If you have an emergency, we will talk with the doctors who are giving you emergency care to help manage and follow up on your care. The doctors who are giving you emergency care will decide when your condition is stable and the medical emergency is over.

After the emergency is over you are entitled to follow-up care to be sure your condition continues to be stable. Your follow-up care will be covered by our plan. If your emergency care is provided by out-of-network providers, we will try to arrange for network providers to take over your care as soon as your medical condition and the circumstances allow.

What if it wasn't a medical emergency?

Sometimes it can be hard to know if you have a medical emergency. For example, you might go in for emergency care – thinking that your health is in serious danger – and the doctor may say that it wasn't a medical emergency after all. If it turns out that it was not an emergency, as long as you reasonably thought your health was in serious danger, we will cover your care.

However, after the doctor has said that it was *not* an emergency, we will cover additional care *only* if you get the additional care in one of these two ways:

- You go to a network provider to get the additional care.
- – *or* – The additional care you get is considered "urgently needed services" and you follow the rules for getting this urgently needed services (for more information about this, see Section 3.2 below).

Section 3.2 Getting care when you have an urgent need for services

What are "urgently needed services"?

"Urgently needed services" are non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible. The unforeseen condition could, for example, be an unforeseen flare-up of a known condition that you have.

What if you are in the plan's service area when you have an urgent need for care?

You should always try to obtain urgently needed services from network providers. However, if providers are temporarily unavailable or inaccessible and it is not reasonable to wait to obtain care from your network provider when the network becomes available, we will cover urgently needed services that you get from an out-of-network provider.

You may have an injury or an illness that is not an emergency but still needs prompt care. To locate a network urgent care center near you, visit our website at www.emblemhealth.com. On holidays, urgent care center hours of operation are subject to change. Please call the urgent care center nearest you to confirm its hours. You can also contact Customer Service for assistance (phone numbers are printed on the back cover of this booklet).

What if you are outside the plan's service area when you have an urgent need for care?

When you are outside the service area and cannot get care from a network provider, our plan will cover urgently needed services that you get from any provider.

Our plan covers urgently needed care anywhere in the world.

Section 3.3 Getting care during a disaster

If the Governor of your state, the U.S. Secretary of Health and Human Services, or the President of the United States declares a state of disaster or emergency in your geographic area, you are still entitled to care from your plan.

Please visit the following website: www.emblemhealth.com/Our-Plans/Medicare/Contact-us for information on how to obtain needed care during a disaster.

Generally, if you cannot use a network provider during a disaster, your plan will allow you to obtain care from out-of-network providers at in-network cost-sharing. If you cannot use a network pharmacy during a disaster, you may be able to fill your prescription drugs at an out-of-network pharmacy. Please see Chapter 5, Section 2.5 for more information.

SECTION 4 What if you are billed directly for the full cost of your covered services?

Section 4.1 You can ask us to pay our share of the cost of covered services

If you have paid more than your share for covered services, or if you have received a bill for the full cost of covered medical services, go to Chapter 7 (Asking us to pay our share of a bill you have received for covered medical services or drugs) for information about what to do.

Section 4.2 If services are not covered by our plan, you must pay the full cost

Our Plan covers all medical services that are medically necessary, these services are listed in the plan's Medical Benefits Chart (this chart is in Chapter 4 of this booklet), and are obtained

consistent with plan rules. You are responsible for paying the full cost of services that aren't covered by our plan, either because they are not plan covered services, or they were obtained out-of-network and were not authorized.

If you have any questions about whether we will pay for any medical service or care that you are considering, you have the right to ask us whether we will cover it before you get it. You also have the right to ask for this in writing. If we say we will not cover your services, you have the right to appeal our decision not to cover your care.

Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) has more information about what to do if you want a coverage decision from us or want to appeal a decision we have already made. You may also call Customer Service to get more information (phone numbers are printed on the back cover of this booklet).

For covered services that have a benefit limitation, you pay the full cost of any services you get after you have used up your benefit for that type of covered service. The amount you pay for services after you have used up your benefit for that type of covered service will not count toward an out of pocket maximum. You can call Customer Service when you want to know how much of your benefit limit you have already used.

SECTION 5 How are your medical services covered when you are in a "clinical research study"?

Section 5.1 What is a "clinical research study"?

A clinical research study (also called a "clinical trial") is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. They test new medical care procedures or drugs by asking for volunteers to help with the study. This kind of study is one of the final stages of a research process that helps doctors and scientists see if a new approach works and if it is safe.

Not all clinical research studies are open to members of our plan. Medicare first needs to approve the research study. If you participate in a study that Medicare has *not* approved, *you will be responsible for paying all costs for your participation in the study*.

Once Medicare approves the study, someone who works on the study will contact you to explain more about the study and see if you meet the requirements set by the scientists who are running the study. You can participate in the study as long as you meet the requirements for the study *and* you have a full understanding and acceptance of what is involved if you participate in the study.

If you participate in a Medicare-approved study, Original Medicare pays most of the costs for the covered services you receive as part of the study. When you are in a clinical research study, you

may stay enrolled in our plan and continue to get the rest of your care (the care that is not related to the study) through our plan.

If you want to participate in a Medicare-approved clinical research study, you do *not* need to get approval from us or your PCP. The providers that deliver your care as part of the clinical research study do *not* need to be part of our plan's network of providers.

Although you do not need to get our plan's permission to be in a clinical research study, **you do need to tell us before you start participating in a clinical research study.**

If you plan on participating in a clinical research study, contact Customer Service (phone numbers are printed on the back cover of this booklet) to let them know that you will be participating in a clinical trial and to find out more specific details about what your plan will pay.

Section 5.2 When you participate in a clinical research study, who pays for what?

Once you join a Medicare-approved clinical research study, you are covered for routine items and services you receive as part of the study, including:

- Room and board for a hospital stay that Medicare would pay for even if you weren't in a study.
- An operation or other medical procedure if it is part of the research study.
- Treatment of side effects and complications of the new care.

Original Medicare pays most of the cost of the covered services you receive as part of the study. After Medicare has paid its share of the cost for these services, our plan will also pay for part of the costs. We will pay the difference between the cost-sharing in Original Medicare and your cost-sharing as a member of our plan. This means you will pay the same amount for the services you receive as part of the study as you would if you received these services from our plan.

> *Here's an example of how the cost-sharing works:* Let's say that you have a lab test that costs $100 as part of the research study. Let's also say that your share of the costs for this test is $20 under Original Medicare, but the test would be $10 under our plan's benefits. In this case, Original Medicare would pay $80 for the test and we would pay another $10. This means that you would pay $10, which is the same amount you would pay under our plan's benefits.

In order for us to pay for our share of the costs, you will need to submit a request for payment. With your request, you will need to send us a copy of your Medicare Summary Notices or other documentation that shows what services you received as part of the study and how much you owe. Please see Chapter 7 for more information about submitting requests for payment.

When you are part of a clinical research study, **neither Medicare nor our plan will pay for any of the following:**

- Generally, Medicare will *not* pay for the new item or service that the study is testing unless Medicare would cover the item or service even if you were *not* in a study.
- Items and services the study gives you or any participant for free.
- Items or services provided only to collect data, and not used in your direct health care. For example, Medicare would not pay for monthly CT scans done as part of the study if your medical condition would normally require only one CT scan.

Do you want to know more?

You can get more information about joining a clinical research study by reading the publication "Medicare and Clinical Research Studies" on the Medicare website (www.medicare.gov).

You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

SECTION 6 Rules for getting care covered in a "religious non-medical health care institution"

Section 6.1 What is a religious non-medical health care institution?

A religious non-medical health care institution is a facility that provides care for a condition that would ordinarily be treated in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against a member's religious beliefs, we will instead provide coverage for care in a religious non-medical health care institution. You may choose to pursue medical care at any time for any reason. This benefit is provided only for Part A inpatient services (non-medical health care services). Medicare will only pay for non-medical health care services provided by religious non-medical health care institutions.

Section 6.2 Receiving Care from a Religious Non-Medical Health Care Institution

To get care from a religious non-medical health care institution, you must sign a legal document that says you are conscientiously opposed to getting medical treatment that is "non-excepted."

- "Non-excepted" medical care or treatment is any medical care or treatment that is *voluntary* and *not required* by any federal, state, or local law.
- "Excepted" medical treatment is medical care or treatment that you get that is *not* voluntary or *is required* under federal, state, or local law.

To be covered by our plan, the care you get from a religious non-medical health care institution must meet the following conditions:

- The facility providing the care must be certified by Medicare.
- Our plan's coverage of services you receive is limited to *non-religious* aspects of care.
- If you get services from this institution that are provided to you in a facility, the following conditions apply:
    - You must have a medical condition that would allow you to receive covered services for inpatient hospital care or skilled nursing facility care.
    - – *and* – you must get approval in advance from our plan before you are admitted to the facility or your stay will not be covered.

Please see the description of your inpatient hospital benefit in the Benefits Chart located in Chapter 4 of this booklet.

There is no limit to the number of days covered by the plan for each benefit period.

SECTION 7 Rules for ownership of durable medical equipment

Section 7.1 Will you own the durable medical equipment after making a certain number of payments under our plan?

Durable medical equipment (DME) includes items such as oxygen equipment and supplies, wheelchairs, walkers, powered mattress systems, crutches, diabetic supplies, speech generating devices, IV infusion pumps, nebulizers, and hospital beds ordered by a provider for use in the home. The member always owns certain items, such as prosthetics. In this section, we discuss other types of DME that you must rent.

In Original Medicare, people who rent certain types of DME own the equipment after paying copayments for the item for 13 months. As a member of our plan, however, you usually will not acquire ownership of rented DME items no matter how many copayments you make for the item while a member of our plan. Under certain limited circumstances we will transfer ownership of the durable medical equipment item. Call Customer Service (phone numbers are printed on the back cover of this booklet) to find out about the requirements you must meet and the documentation you need to provide.

What happens to payments you made for durable medical equipment if you switch to Original Medicare?

If you did not acquire ownership of the DME item while in our plan, you will have to make 13 new consecutive payments after you switch to Original Medicare in order to own the item. Payments you made while in our plan do not count toward these 13 consecutive payments.

If you made fewer than 13 payments for the DME item under Original Medicare before you joined our plan, your previous payments also do not count toward the 13 consecutive payments. You will have to make 13 new consecutive payments after you return to Original Medicare in order to own the item. There are no exceptions to this case when you return to Original Medicare.

SECTION 8 Rules for oxygen equipment, supplies and maintenance

Section 8.1 What oxygen benefits are you entitled to?

If you qualify for Medicare oxygen equipment coverage, then for as long as you are enrolled, EmblemHealth VIP Premier (HMO) – Group will cover:

- Rental of oxygen equipment
- Delivery of oxygen and oxygen contents
- Tubing and related oxygen accessories for the delivery of oxygen and oxygen contents
- Maintenance and repairs of oxygen equipment

If you leave EmblemHealth VIP Premier (HMO) – Group or no longer medically require oxygen equipment, then the oxygen equipment must be returned to the owner.

Section 8.2 What is your cost sharing? Will it change after 36 months?

For your cost sharing for Medicare oxygen equipment coverage per month please contact your benefits administrator or see your Cost Sharing Guide. Your cost sharing will not change after being enrolled for 36 months in EmblemHealth VIP Premier (HMO) – Group.

If prior to enrolling in EmblemHealth VIP Premier (HMO) – Group you had made 36 months of rental payment for oxygen equipment coverage, please contact your benefits administrator or see your Cost Sharing Guide for your cost share in EmblemHealth VIP Premier (HMO) – Group

Section 8.3 What happens if you leave your plan and return to Original Medicare?

If you return to Original Medicare, then you start a new 36-month cycle which renews every five years. For example, if you had paid rentals for oxygen equipment for 36 months prior to joining EmblemHealth VIP Premier (HMO) – Group, join EmblemHealth VIP Premier (HMO) – Group for 12 months, and then return to Original Medicare, you will pay full cost sharing for oxygen equipment coverage.

Similarly, if you made payments for 36 months while enrolled in EmblemHealth VIP Premier (HMO) – Group and then return to Original Medicare, you will pay full cost sharing for oxygen equipment coverage.

CHAPTER 4

Medical Benefits Chart (what is covered and what you pay)

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

SECTION 1 Understanding your out-of-pocket costs for covered services

This chapter focuses on your covered services and what you pay for your medical benefits. It includes a Medical Benefits Chart that lists your covered services and shows how much you will pay for each covered service as a member of our plan. Later in this chapter, you can find information about medical services that are not covered. It also explains limits on certain services.

Section 1.1 Types of out-of-pocket costs you may pay for your covered services

To understand the payment information we give you in this chapter, you need to know about the types of out-of-pocket costs you may pay for your covered services.

- The **"deductible"** is the amount you must pay for medical services before our plan begins to pay its share.
- A **"copayment"** is the fixed amount you pay each time you receive certain medical services. You pay a copayment at the time you get the medical service. (The Medical Benefits Chart in Section 2 tells you more about your copayments.)
- **"Coinsurance"** is the percentage you pay of the total cost of certain medical services. You pay a coinsurance at the time you get the medical service. (The Medical Benefits Chart in Section 2 tells you more about your coinsurance.)

Most people who qualify for Medicaid or for the Qualified Medicare Beneficiary (QMB) program should never pay deductibles, copayments or coinsurance. Be sure to show your proof of Medicaid or QMB eligibility to your provider, if applicable. If you think that you are being asked to pay improperly, contact Customer Service.

Section 1.2 What is the most you will pay for Medicare Part A and Part B covered medical services?

Because you are enrolled in a Medicare Advantage Plan, there is a limit to how much you have to pay out-of-pocket each year for in-network medical services that are covered under Medicare Part A and Part B (see the Medical Benefits Chart in Section 2, below). This limit is called the maximum out-of-pocket amount for medical services.

As a member of *our plan,* the most you will have to pay out-of-pocket for in-network covered Part A and Part B services in 2021. The amounts you pay for copayments, and coinsurance for in-network covered services count toward this maximum out-of-pocket amount. (The amounts you pay for your plan premiums and for your Part D prescription drugs do not count toward your maximum out-of-pocket amount. In addition, amounts you pay for some services do not count

toward your maximum out-of-pocket amount. These services are marked with an asterisk in the Medical Benefits Chart. If you reach the maximum out-of-pocket amount, you will not have to pay any out-of-pocket costs for the rest of the year for in-network covered Part A and Part B services. However, you must continue to pay your plan premium and the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party). We will send you a Cost Sharing Guide under separate cover that tells you what your maximum out-of-pocket amount will be for 2021. Or, you can call your benefits administrator for this information.

Section 1.3 Our plan does not allow providers to "balance bill" you

As a member of our plan, an important protection for you is that you only have to pay your cost-sharing amount when you get services covered by our plan. We do not allow providers to add additional separate charges, called "balance billing." This protection (that you never pay more than your cost-sharing amount) applies even if we pay the provider less than the provider charges for a service and even if there is a dispute and we don't pay certain provider charges.

Here is how this protection works.

- If your cost-sharing is a copayment (a set amount of dollars, for example, $15.00), then you pay only that amount for any covered services from a network provider.
- If your cost-sharing is a coinsurance (a percentage of the total charges), then you never pay more than that percentage. However, your cost depends on which type of provider you see:
    - If you receive the covered services from a network provider, you pay the coinsurance percentage multiplied by the plan's reimbursement rate (as determined in the contract between the provider and the plan).
    - If you receive the covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers. (Remember, the plan covers services from out-of-network providers only in certain situations, such as when you get a referral.)
    - If you receive the covered services from an out-of-network provider who does not participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers. (Remember, the plan covers services from out-of-network providers only in certain situations, such as when you get a referral.)
- If you believe a provider has "balance billed" you, call Customer Service (phone numbers are printed on the back cover of this booklet).

SECTION 2 Use the *Medical Benefits Chart* to find out what is covered for you and how much you will pay

Section 2.1 Your medical benefits and costs as a member of the plan

The Medical Benefits Chart on the following pages lists the services our plan covers and what you pay out-of-pocket for each service. Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts. The services listed in the Medical Benefits Chart are covered only when the following coverage requirements are met:

- Your Medicare covered services must be provided according to the coverage guidelines established by Medicare.
- Your services (including medical care, services, supplies, and equipment) *must* be medically necessary. "Medically necessary" 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.
- You receive your care from a network provider. In most cases, care you receive from an out-of-network provider will not be covered. Chapter 3 provides more information about requirements for using network providers and the situations when we will cover services from an out-of-network provider.
- You have a primary care provider (a PCP) who is providing and overseeing your care. In most situations, your PCP must give you approval in advance before you can see other providers in the plan's network. This is called giving you a "referral." Chapter 3 provides more information about getting a referral and the situations when you do not need a referral.
- Some of the services listed in the Medical Benefits Chart are covered only if your doctor or other network provider gets approval in advance (sometimes called "prior authorization") from us. Covered services that need approval in advance are marked in the Medical Benefits Chart by an asterisk.

Other important things to know about our coverage:

- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay *more* in our plan than you would in Original Medicare. For others, you pay *less.* (If you want to know more about the coverage and costs of Original Medicare, look in your *Medicare & You 2021* Handbook. View it online at www.medicare.gov or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)
- For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you also are treated or monitored for an

existing medical condition during the visit when you receive the preventive service, a copayment will apply for the care received for the existing medical condition.

- Sometimes, Medicare adds coverage under Original Medicare for new services during the year. If Medicare adds coverage for any services during 2021, either Medicare or our plan will cover those services.

You will see this apple next to the preventive services in the benefits chart.

Medical Benefits Chart

Services that are covered for you	**What you must pay** when you get these services
Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.
Acupuncture 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: • Lasting 12 weeks or longer; • nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious, etc. disease); • not associated with surgery; and • 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. Treatment must be discontinued if the patient is not improving or is regressing. **PRIOR AUTHORIZATION IS REQURED FOR SOME SERVICES**	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts

Services that are covered for you	**What you must pay** when you get these services
Ambulance services • Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care if they 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. Non-emergency 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. **PRIOR AUTHORIZATION REQUIRED FOR NON-EMERGENT AMBULANCE SERVICES**	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.
Annual wellness visit If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months. **Note**: Your first annual wellness visit can't take place within 12 months of your "Welcome to Medicare" preventive visit. However, you don't need to have had a "Welcome to Medicare" visit to be covered for annual wellness visits after you've had Part B for 12 months.	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.
Bone mass measurement For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.

Services that are covered for you	**What you must pay** when you get these services
Breast cancer screening (mammograms) Covered services include: • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for women age 40 and older • Clinical breast exams once every 24 months	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.
Cardiac rehabilitation services Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs. **PRIOR AUTHORIZATION REQUIRED.**	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.
Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.

Services that are covered for you	**What you must pay** when you get these services
Cervical and vaginal cancer screening Covered services include: • For all women: Pap tests and pelvic exams are covered once every 24 months • If you are at high risk of cervical or vaginal cancer or you are of childbearing age and have had an abnormal Pap test within the past 3 years: one Pap test every 12 months	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.
Chiropractic services Covered services include: • We cover only Manual manipulation of the spine to correct subluxation **PRIOR AUTHORIZATION REQUIRED FROM PALLADIAN (1-877-774-7693)**	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.
Colorectal cancer screening For people 50 and older, the following are covered: • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months One of the following every 12 months: • Guaiac-based fecal occult blood test (gFOBT) • Fecal immunochemical test (FIT) DNA based colorectal screening every 3 years For people at high risk of colorectal cancer, we cover: • Screening colonoscopy (or screening barium enema as an alternative) every 24 months For people not at high risk of colorectal cancer, we cover: • Screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.

Services that are covered for you	**What you must pay** when you get these services
Dental services In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare.	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.
Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.
Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.

Services that are covered for you	**What you must pay** when you get these services
Diabetes self-management training, diabetic services and supplies For all people who have diabetes (insulin and non-insulin users). Covered services include: • Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors • For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting. • Diabetes self-management training is covered under certain conditions	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.
Durable medical equipment (DME) and related supplies (For a definition of "durable medical equipment," see Chapter 12 of this booklet.) Covered items include, but are not limited to: wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers. We cover all medically necessary DME covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you. The most recent list of suppliers is available on our website at www.emblemhealth.com/medicare . **PRIOR AUTHORIZATION REQUIRED.**	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.

Services that are covered for you	**What you must pay** when you get these services
Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse. Cost sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network. * Emergency care is covered worldwide as described above and includes emergency transportation. * Worldwide Emergency/Urgent coverage includes emergency ground transportation to the nearest hospital when outside the United States and with the purpose of stabilizing an emergency medical condition.	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts. If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must have your inpatient care at the out-of-network hospital authorized by the plan and your cost is the cost-sharing you would pay at a network hospital.

Services that are covered for you	**What you must pay** when you get these services
Health and wellness education programs • **Health Education** - Provides education to improve outcomes for members with Diabetes, Congestive Heart Failure (CHF), Coronary Artery Disease (CAD), Asthma or Chronic Obstructive Pulmonary Disease (COPD) as well as Depression and Hypertension as co-morbid conditions. Offered to targeted groups of enrollees based on specific disease conditions. Includes interaction with a certified health educator or other qualified health professional. One-on-one instruction and or telephone-based coaching provided.	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.
• **Nursing Hotline** - 24 Hour, 7 day a week service. Members can speak confidentially, one-on-one with a registered nurse at any time. Nurses are trained in telephone triage and will provide clinical support for everyday health issues and questions. The number is 1-877-444-7988.	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.
• **Enhanced Disease Management** - Provides education, health support and disease management services to improve outcomes for members in poorest health with Diabetes, Congestive Heart Failure (CHF), Coronary Artery Disease (CAD) or Chronic Obstructive Pulmonary Disease (COPD) as well as Depression and Hypertension as co-morbid conditions. Enrollees in the target group are assigned to qualified case managers with specialized knowledge about the disease(s) who contact the enrollee to provide additional case management and monitoring services. Educational activities are provided by certified or licensed professionals that are focused on the specific disease/condition. Routine monitoring is conducted of measures, signs and symptoms, applicable to the specific disease(s)/condition(s) of the enrollee.	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.

Services that are covered for you	**What you must pay** when you get these services
Hearing services Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider. Covered supplemental services include: One routine hearing exam per year One evaluation and fitting of hearing aids per year Hearing Aids	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.
HIV screening For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover: • One screening exam every 12 months For women who are pregnant, we cover: • Up to three screening exams during a pregnancy	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.

Services that are covered for you	**What you must pay** when you get these services
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 health care 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 therapy • Medical and social services • Medical equipment and supplies **PRIOR AUTHORIZATION REQUIRED**	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.
Hospice care You may receive care from any Medicare-certified hospice program. You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: • Drugs for symptom control and pain relief • Short-term respite care • Home care	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not our plan. Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.

Services that are covered for you	**What you must pay** when you get these services
Hospice care (continued) For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis: Original Medicare (rather than our plan) will pay for your hospice services and any Part A and Part B services related to your terminal prognosis. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for. For services that are covered by Medicare Part A or B and are not related to your terminal prognosis: If you need non-emergency, non-urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network: • If you obtain the covered services from a network provider, you only pay the plan cost-sharing amount for in-network services • If you obtain the covered services from an out-of-network provider, you pay the cost-sharing under Fee-for-Service Medicare (Original Medicare) For services that are covered by our plan but are not covered by Medicare Part A or B: our plan will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal prognosis. You pay your plan cost-sharing amount for these services. For drugs that may be covered by the plan's Part D benefit: Drugs are never covered by both hospice and our plan at the same time. For more information, please see Chapter 5, Section 9.4 *(What if you're in Medicare-certified hospice*). **Note:** If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services. Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.

Services that are covered for you	**What you must pay** when you get these services
Immunizations Covered Medicare Part B services include: • Pneumonia vaccine • Flu shots, 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 • Other vaccines if you are at risk and they meet Medicare Part B coverage rules We also cover some vaccines under our Part D prescription drug benefit.	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.

Services that are covered for you	**What you must pay** when you get these services
Inpatient hospital care Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day. * Prior authorization required for non-emergent in-network hospital care. Except in an emergency, your doctor must tell the plan that you are going to the hospital to be admitted to the hospital. There is no limit to the number of days covered by the plan. Covered services include but are not limited to: • Semi-private room (or a private room if medically necessary) • Meals including special diets • Regular nursing services • Costs of special care units (such as intensive care or coronary care units) • Drugs and medications • Lab tests • X-rays and other radiology services • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical, occupational, and speech language therapy • Inpatient substance abuse services	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts. A benefit period begins when you are admitted to the hospital and ends when you are discharged. There's no limit to the number of benefit periods.

Services that are covered for you	**What you must pay** when you get these services
Inpatient hospital care (continued) • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If our plan provides transplant services at a location outside the pattern of care for transplants in your community and you chose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. • Blood - Including storage and administration. Coverage of whole blood and packed red cells begins with the first pint used. • Physician services **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at www.medicare.gov/Pubs/pdf/11435.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	If you get*:* authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at a network hospital.

Services that are covered for you	**What you must pay** when you get these services
Inpatient mental health care * Prior authorization required through Emblem Behavioral Health Services (1-888-447-2526). Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. Covered services include mental health care services that require a hospital stay. Covered services include mental health care services that require a hospital stay. There is a 190-day lifetime limit for inpatient services in a psychiatric hospital. The 190-day limit does not apply to Mental Health services provided in a psychiatric unit of a general hospital.	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts. A benefit period begins when you are admitted to the hospital and ends when you are discharged
Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay If you have exhausted your inpatient benefits or if the inpatient stay is not reasonable and necessary, we will not cover your inpatient stay. However, in some cases, we will cover certain services you receive while you are in the hospital or the skilled nursing facility (SNF). Covered services include, but are not limited to: • Physician services • Diagnostic tests (like lab tests) • X-ray, radium, and isotope therapy including technician materials and services • Surgical dressings • Splints, casts and other devices used to reduce fractures and dislocations • Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices • Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition • Physical therapy, speech therapy, and occupational therapy	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.

Services that are covered for you	**What you must pay** when you get these services
Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor. We cover 3 hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician's order. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year.	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.
Medicare Diabetes Prevention Program (MDPP) MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans. MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.

Services that are covered for you	**What you must pay** when you get these services
Medicare Part B prescription drugs **Part B to B step therapy applies.** These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include: • Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services • Drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan • Clotting factors you give yourself by injection if you have hemophilia • Immunosuppressive Drugs, if you were enrolled in Medicare Part A at the time of the organ transplant • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug • Antigens • Certain oral anti-cancer drugs and anti-nausea drugs • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases **Chapter 5 explains the Part D prescription drug benefit, including rules you must follow to have prescriptions covered. What you pay for your Part D prescription drugs through our plan is explained in Chapter 6.** **PRIOR AUTHORIZATION REQUIRED**	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.

Services that are covered for you	**What you must pay** when you get these services
Obesity screening and therapy to promote sustained weight loss If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.
Opioid treatment program services Opioid use disorder treatment services are covered under Part B of Original Medicare. Members of our plan receive coverage for these services through our plan. Covered services include: • FDA-approved opioid agonist and antagonist treatment medications and the dispensing and administration of such medications, if applicable • Substance use counseling • Individual and group therapy • Toxicology testing **PRIOR AUTHORIZATION IS REQUIRED**	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts

Services that are covered for you	**What you must pay** when you get these services
Outpatient diagnostic tests and therapeutic services and supplies * Prior authorization required for all services Covered services include, but are not limited to: • X-rays • Radiation (radium and isotope) therapy including technician materials and supplies • Surgical supplies, such as dressings • Splints, casts and other devices used to reduce fractures and dislocations • Laboratory tests • Blood - Including storage and administration. Coverage of whole blood and packed red cells begins with the first pint used. • Other outpatient diagnostic tests (including but not limited to EKG, PET, MRI, MRA, CT scan, nuclear medicine imaging, molecular diagnostics and genetic testing).	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.

Services that are covered for you	**What you must pay** when you get these services
Outpatient hospital observation Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must meet the Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at www.medicare.gov/sites/default/files/2018-09/11435-Are-You-an-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week. **PRIOR AUTHORIZATION IS REQURED FOR SOME SERVICES**	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.

Services that are covered for you	**What you must pay** when you get these services
Outpatient hospital services * Prior authorization required for some services We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include, but are not limited to: • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery • Laboratory and diagnostic tests billed by the hospital • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it • X-rays and other radiology services billed by the hospital • Medical supplies such as splints and casts • Certain drugs and biologicals that you can't give yourself **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at www.medicare.gov/Pubs/pdf/11435.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.

Services that are covered for you	**What you must pay** when you get these services
Outpatient mental health care * Prior authorization through Emblem Behavioral Health Services (1-888-447-2526) Covered services include: 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 health care professional as allowed under applicable state laws.	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.
Outpatient rehabilitation services * Prior authorization required through Palladian (1-877-774-7693) for physical therapy and occupational therapy only. Covered services include: physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.
Outpatient substance abuse services * Prior authorization through Emblem Behavioral Health Services (1-888-447-2526) Outpatient mental health care for the diagnosis of, treatment for, and counseling for substance abuse.	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.

Services that are covered for you	**What you must pay** when you get these services
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers * Prior authorization required For surgical procedures, your provider is allowed to bill you a separate copayment for professional services. **Note:** If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an "outpatient."	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.
Partial hospitalization services *Prior authorization through Emblem Behavioral Health Services (1-888-447-2526) "Partial hospitalization" is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center, that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.

Services that are covered for you	**What you must pay** when you get these services
Physician/Practitioner services, including doctor's office visits Covered services include: • Medically-necessary medical care or surgery services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location • Consultation, diagnosis, and treatment by a specialist • Basic hearing and balance exams performed by your specialist, if your doctor orders it to see if you need medical treatment • Certain additional telehealth services including consultation, diagnosis, and treatment by a physician or practitioner for patients in certain rural areas or other locations approved by Medicare • Certain additional telehealth services, including those for: Primary Care Physician visits, Specialist visits, Individual Mental Health visits, individual Psychiatric visits, or individual Substance Abuse visits. o You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth. • Brief virtual check-ins • Remote evaluation of pre-recorded video and/or images sent to your doctor • Consultation your doctor has with other doctors by phone, internet, or electronic health record assessment—<u>if</u> you're not a new patient • Second opinion by another network provider prior to surgery • Non-routine 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) **REFERRAL REQUIRED FOR SPECIALISTS**	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.

Services that are covered for you	**What you must pay** when you get these services
Podiatry services Covered services include: • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs) • Routine foot care for members with certain medical conditions affecting the lower limbs Covered supplemental services include: • Routine podiatry benefit includes removal of calluses, corns and trimming of nails. Limited to four visits per year. **REFERRAL REQUIRED**	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.
Prostate cancer screening exams For men age 50 and older, covered services include the following - once every 12 months: • Digital rectal exam • Prostate Specific Antigen (PSA) test	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.
Prosthetic devices and related supplies Devices (other than dental) that replace all or part of a body part or function. These include, but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see "Vision Care" later in this section for more detail. **PRIOR AUTHORIZATION IS REQUIRED FOR SOME SUPPLIES/DEVICES**	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.

Services that are covered for you	**What you must pay** when you get these services
Pulmonary rehabilitation services Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease. **PRIOR AUTHORIZATION IS REQUIRED**	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.
Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.

Services that are covered for you	**What you must pay** when you get these services
Screening for lung cancer with low dose computed tomography (LDCT) For qualified individuals, a LDCT is covered every 12 months. **Eligible members are**: people aged 55 – 77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 30 pack-years and who currently smoke or have quit smoking within the last 15 years, who receive a written order for LDCT during a lung cancer screening counseling and shared decision making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner. For LDCT lung cancer screenings after the initial LDCT screening*:* the members must receive a written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision-making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy. We also cover up to 2 individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.
Services to treat kidney disease Covered services include:	

Services that are covered for you	**What you must pay** when you get these services
• Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3) • Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and supplies • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B Drugs, please go to the section, "Medicare Part B prescription drugs."	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts. Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.
Skilled nursing facility (SNF) care (For a definition of "skilled nursing facility care," see Chapter 12 of this booklet. Skilled nursing facilities are sometimes called "SNFs.") Coverage is limited to the first 100 days of a stay in a skilled nursing facility per Medicare defined benefit period. Covered services include but are not limited to: • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services • Physical therapy, occupational therapy, and speech 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. Coverage of whole blood and packed red cells begins with the first pint of blood used. • Medical and surgical supplies ordinarily provided by SNFs	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts. A benefit period begins the day you are admitted as an inpatient in a skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care or skilled care in a SNF for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a

Services that are covered for you	**What you must pay** when you get these services
• Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/Practitioner services Generally, you will get your SNF care from network facilities. However, under certain conditions listed below, you may be able to pay in-network cost-sharing for a facility that isn't a network provider, if the facility accepts our plan's amounts for payment. • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care) • A SNF where your spouse is living at the time you leave the hospital **PRIOR AUTHORIZATION IS REQUIRED FOR ELECTIVE ADMISSIONS**	new benefit period begins. There is no limit to the number of benefit periods.
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) If you use tobacco, but do not have signs or symptoms of tobacco-related disease: We cover two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits. If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: We cover cessation counseling services. We cover two counseling quit attempts within a 12-month period, however, you will pay the applicable cost-sharing. Each counseling attempt includes up to four face-to-face visits.	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.

Services that are covered for you	**What you must pay** when you get these services
Supervised Exercise Therapy (SET) ***** Prior authorization required. SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment. Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must: • Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication • Be conducted in a hospital outpatient setting or a physician's office • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD • Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider.	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.
Urgently needed services Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible. Cost sharing for necessary urgently needed services furnished out-of-network is the same as for such services furnished in-network. **Covered supplemental services include:** ***** World Wide Coverage	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.

Services that are covered for you	**What you must pay** when you get these services
Vision care Covered services include: • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts • For people who are at high risk of glaucoma, we will cover one glaucoma screening each year. People at high risk of glaucoma include: people with a family history of glaucoma, people with diabetes, African-Americans who are age 50 and older and Hispanic Americans who are 65 or older • For people with diabetes, screening for diabetic retinopathy is covered once per year • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.) Covered supplemental services include: • One routine eye exam per year • One pair of eyeglasses or contact lenses per year. For a complete listing of eyewear providers that participate with your plan, please see your EmblemHealth Medicare HMO Provider Directory. If you do not have a directory, you can contact Customer Service at 1-877-344-7364; TTY call 711 during the hours of 8:00 am to 8:00 pm, 7 days a week, or visit the plan website at www.emblemhealth.com/medicare.	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.

Services that are covered for you	**What you must pay** when you get these services
"Welcome to Medicare" preventive visit The plan covers the one-time "Welcome to Medicare" preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed. **Important:** We cover the "Welcome to Medicare" preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you would like to schedule your "Welcome to Medicare" preventive visit.	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.

SECTION 3 What services are not covered by the plan?

Section 3.1 Services we do *not* cover (exclusions)

This section tells you what services are "excluded" from Medicare coverage and therefore, are not covered by this plan. If a service is "excluded," it means that this plan doesn't cover the service.

The chart below lists services and items that either are not covered under any condition or are covered only under specific conditions.

If you get services that are excluded (not covered), you must pay for them yourself. We won't pay for the excluded medical services listed in the chart below except under the specific conditions listed. The only exception: we will pay if a service in the chart below is found upon appeal to be a medical service that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a medical service, go to Chapter 9, Section 5.3 in this booklet.)

All exclusions or limitations on services are described in the Benefits Chart or in the chart below.

Even if you receive the excluded services at an emergency facility, the excluded services are still not covered and our plan will not pay for them.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Services considered not reasonable and necessary, according to the standards of Original Medicare	✓	
Experimental medical and surgical procedures, equipment and medications. Experimental procedures and items are those items and procedures determined by our plan and Original Medicare to not be generally accepted by the medical community.		✓ May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan. (See Chapter 3, Section 5 for more information on clinical research studies.)
Private room in a hospital.		✓ Covered only when medically necessary.
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television.	✓	
Full-time nursing care in your home.	✓	
*Custodial care is care provided in a nursing home, hospice, or other facility setting when you do not require skilled medical care or skilled nursing care.	✓	
Homemaker services include basic household assistance, including light housekeeping or light meal preparation.	✓	
Fees charged for care by your immediate relatives or members of your household.	✓	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Cosmetic surgery or procedures		✓ • Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member. • Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
Routine dental care, such as cleanings, fillings or dentures.	✓	
Non-routine dental care		✓ Dental care required to treat illness or injury may be covered as inpatient or outpatient care.
Routine chiropractic care		✓ Manual manipulation of the spine to correct a subluxation is covered.
Routine foot care		✓ Some limited coverage provided according to Medicare guidelines (e.g., if you have diabetes). You are covered 4 routine footcare visits per year. Routine footcare includes removal of calluses, corns and trimming of nails.
Home-delivered meals	✓	
Orthopedic shoes		✓ If shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease.
Supportive devices for the feet		✓ Orthopedic or therapeutic shoes for people with diabetic foot disease.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Routine hearing exams, hearing aids, or exams to fit hearing aids.		✓
Routine eye examinations, eyeglasses, radial keratotomy, LASIK surgery and other low vision aids.		✓ Eye exam and one pair of eyeglasses (or contact lenses) are covered for people after cataract surgery. You have supplemental vision care benefit. Please see Medical Benefits Chart for more information.
Reversal of sterilization procedures and or non-prescription contraceptive supplies.	✓	
Naturopath services (uses natural or alternative treatments).	✓	
Acupuncture		✓
Services provided to veterans in Veterans Affairs (VA) facilities		✓ When emergency services are received at VA hospital and the VA cost-sharing is more than the cost-sharing under our plan, we will reimburse veterans for the difference. Members are still responsible for our cost-sharing amounts.

*Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing.

CHAPTER 5

Using the plan's coverage for your Part D prescription drugs

Chapter 5. Using the plan's coverage for your Part D prescription drugs

Did you know there are programs to help people pay for their drugs?

There are programs to help people with limited resources pay for their drugs. These include "Extra Help" and State Pharmaceutical Assistance Programs. For more information, see Chapter 2, Section 7.

Are you currently getting help to pay for your drugs?

If you are in a program that helps pay for your drugs, **some information in this *Evidence of Coverage* about the costs for Part D prescription drugs may not apply to you.** We sent you a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also known as the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug coverage. If you don't have this insert, please call Customer Service and ask for the "LIS Rider." (Phone numbers for Customer Service are printed on the back cover of this booklet.)

SECTION 1 Introduction

Section 1.1 This chapter describes your coverage for Part D drugs

This chapter **explains rules for using your coverage for Part D drugs**. The next chapter tells what you pay for Part D drugs (Chapter *6,What you pay for your Part D prescription drugs*).

In addition to your coverage for Part D drugs, EmblemHealth VIP Premier (HMO) – Group also covers some drugs under the plan's medical benefits. Through its coverage of Medicare Part A benefits, our plan generally covers drugs you are given during covered stays in the hospital or in a skilled nursing facility. Through its coverage of Medicare Part B benefits, our plan covers drugs including certain chemotherapy drugs, certain drug injections you are given during an office visit, and drugs you are given at a dialysis facility. Chapter 4 (*Medical Benefits Chart, what is covered and what you pay*) tells about the benefits and costs for drugs during a covered hospital or skilled nursing facility stay, as well as your benefits and costs for Part B drugs.

Your drugs may be covered by Original Medicare if you are in Medicare hospice. Our plan only covers Medicare Parts A, B, and D services and drugs that are unrelated to your terminal prognosis and related conditions and therefore not covered under the Medicare hospice benefit. For more information, please see Section 9.4 *(What if you're in Medicare-certified hospice).* For information on hospice coverage, see the hospice section of Chapter 4 (*Medical Benefits Chart, what is covered and what you pay*).

The following sections discuss coverage of your drugs under the plan's Part D benefit rules. Section 9, *Part D drug coverage in special situations* includes more information on your Part D coverage and Original Medicare.

Section 1.2 Basic rules for the plan's Part D drug coverage

The plan will generally cover your drugs as long as you follow these basic rules:

- You must have a provider (a doctor, dentist or other prescriber) write your prescription.
- Your prescriber must either accept Medicare or file documentation with CMS showing that he or she is qualified to write prescriptions, or your Part D claim will be denied. You should ask your prescribers the next time you call or visit if they meet this condition. If not, please be aware it takes time for your prescriber to submit the necessary paperwork to be processed.
- You generally must use a network pharmacy to fill your prescription. (*See Section 2, Fill your prescriptions at a network pharmacy or through the plan's mail-order service.*)
- Your drug must be on the plan's *List of Covered Drugs (Formulary)* (we call it the "Drug List" for short). (See Section 3,*Your drugs need to be on the plan's "Drug List*.")

- Your drug must be used for a medically accepted indication. A "medically accepted indication" is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. (See Section 3 for more information about a medically accepted indication.)

SECTION 2 Fill your prescription at a network pharmacy or through the plan's mail-order service

Section 2.1 To have your prescription covered, use a network pharmacy

In most cases, your prescriptions are covered *only* if they are filled at the plan's network pharmacies. (See Section 2.5 for information about when we would cover prescriptions filled at out-of-network pharmacies.)

A network pharmacy is a pharmacy that has a contract with the plan to provide your covered prescription drugs. The term "covered drugs" means all of the Part D prescription drugs that are covered on the plan's Drug List.

Our network includes pharmacies that offer standard cost-sharing.

Section 2.2 Finding network pharmacies

How do you find a network pharmacy in your area?

To find a network pharmacy, you can look in your *Pharmacy Directory*, visit our website www.emblemhealth.com/medicare), or call Customer Service (phone numbers are printed on the back cover of this booklet).

The *Pharmacy Directory* will tell you which of the network pharmacies offer standard cost-sharing. You can find out more about how your out-of-pocket costs could be different for different drugs by contacting us. If you switch from one network pharmacy to another, and you need a refill of a drug you have been taking, you can ask either to have a new prescription written by a provider or to have your prescription transferred to your new network pharmacy.

What if the pharmacy you have been using leaves the network?

If the pharmacy you have been using leaves the plan's network, you will have to find a new pharmacy that is in the network. To find another network pharmacy in your area, you can get help from Customer Service (phone numbers are printed on the back cover of this booklet) or use the *Pharmacy Directory*. You can also find information on our website at www.emblemhealth.com/medicare.

What if you need a specialized pharmacy?

Sometimes prescriptions must be filled at a specialized pharmacy. Specialized pharmacies include:

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care (LTC) facility. Usually, a LTC facility (such as a nursing home) has its own pharmacy. If you are in an LTC facility, we must ensure that you are able to routinely receive your Part D benefits through our network of LTC pharmacies, which is typically the pharmacy that the LTC facility uses. If you have any difficulty accessing your Part D benefits in an LTC facility, please contact Customer Service.
- Pharmacies that serve the Indian Health Service / Tribal / Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network.
- Pharmacies that dispense drugs that are restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. (Note: This scenario should happen rarely.)

To locate a specialized pharmacy, look in your *Pharmacy Directory* or call Customer Service (phone numbers are printed on the back cover of this booklet).

Section 2.3 Using the plan's mail-order services

For certain kinds of drugs, you can use the plan's network mail-order services. Generally, the drugs provided through mail order are drugs that you take on a regular basis, for a chronic or long-term medical condition. The drugs available through our plan's mail-order service are marked as "**mail-order" drugs** in our Drug List.

Our plan's mail-order service*:* allows you to order ***at least* a 30-day supply of the drug and *no more than* a 90-day supply**.

To get order forms and information about filling your prescriptions by mail*:* Contact Customer Service (phone numbers are printed on the back cover of this booklet).

Usually a mail-order pharmacy order will get to you in no more than 14days. To ensure that you always have a supply of medications, you can ask your doctor to write a one-month prescription which can be filled at a retail pharmacy right away and a second prescription for up to 90 days that you can send with your mail order form.

New prescriptions the pharmacy receives directly from your doctor's office.
The pharmacy will automatically fill and deliver new prescriptions it receives from health care providers, without checking with you first, if either:

- You used mail order services with this plan in the past, or
- You sign up for automatic delivery of all new prescriptions received directly from health care providers. You may request automatic delivery of all new prescriptions now or at any time by calling Express Scripts Customer Service at 1-877-866-5828.

If you receive a prescription automatically by mail that you do not want, and you were not contacted to see if you wanted it before it shipped, you may be eligible for a refund.

If you used mail order in the past and do not want the pharmacy to automatically fill and ship each new prescription, please contact us by calling Express Scripts Customer Service at 1-877-866-5828.

If you have never used our mail order delivery and/or decide to stop automatic fills of new prescriptions, the pharmacy will contact you each time it gets a new prescription from a health care provider to see if you want the medication filled and shipped immediately. This will give you an opportunity to make sure that the pharmacy is delivering the correct drug (including strength, amount, and form) and, if necessary, allow you to cancel or delay the order before you are billed and it is shipped. It is important that you respond each time you are contacted by the pharmacy, to let them know what to do with the new prescription and to prevent any delays in shipping.

To opt out of automatic deliveries of new prescriptions received directly from your health care provider's office, please contact us by calling Express Scripts Customer Service at 1-877-866-5828.

Refills on mail order prescriptions. For refills, please contact your pharmacy 30 days before you think the drugs you have on hand will run out to make sure your next order is shipped to you in time.

So the pharmacy can reach you to confirm your order before shipping, please make sure to let the pharmacy know the best ways to contact you by calling Express Scripts Customer Service at **1**-800-743-2472.

Section 2.4 How can you get a long-term supply of drugs*?*

The plan offers two ways to get a long-term supply (also called an "extended supply") of "maintenance" drugs on our plan's Drug List. (Maintenance drugs are drugs that you take on a regular basis, for a chronic or long-term medical condition.) You may order this supply through mail order (see Section 2.3) or you may go to a retail pharmacy

1. **Some retail pharmacies** in our network allow you to get a long-term supply of maintenance drugs. Some of these retail pharmacies agree to accept a lower cost-sharing amount for a long-term supply of maintenance drugs. Other retail pharmacies may not

agree to accept the lower cost-sharing amounts for a long-term supply of maintenance drugs. In this case you will be responsible for the difference in price. Your *Pharmacy Directory* tells you which pharmacies in our network can give you a long-term supply of maintenance drugs. You can also call Customer Service for more information (phone numbers are printed on the back cover of this booklet).

2. For certain kinds of drugs, you can use the plan's network **mail-order services**. The drugs available through our plan's mail-order service are marked as "**MO**" ("**mail-order**") **drugs** in our Drug List. Our plan's mail-order service requires you to order at least a 30-day supply of the drug and no more than a 90-day supply. See Section 2.3 for more information about using our mail-order services.

Section 2.5 When can you use a pharmacy that is not in the plan's network?

Your prescription may be covered in certain situations

Generally, we cover drugs filled at an out-of-network pharmacy *only* when you are not able to use a network pharmacy. To help you, we have network pharmacies outside of our service area where you can get your prescriptions filled as a member of our plan. If you cannot use a network pharmacy, here are the circumstances when we would cover prescriptions filled at an out-of-network pharmacy:

- If you are traveling outside the plan's service area and you run out of or lose your covered Part D drug(s), and you cannot access a network pharmacy (for information about the plan's service area, see Chapter 1, Section 2.3 of this booklet);
- If you are traveling outside the plan's service area and you become ill and need a covered Part D drug, and you cannot access a network pharmacy (for information on the plan's service area, see Chapter 1, Section 2.3 of this booklet);
- If you fill a prescription for a covered Part D drug in a timely manner, and that particular covered Part D drug (for example, a specialty drug typically shipped directly from manufacturers or special vendors) is not regularly stocked at accessible network retail or mail-order pharmacies;
- If you are provided a covered Part D drug(s) dispensed by an out-of-network, institution-based pharmacy while you are a patient in an emergency department, provider-based clinic, outpatient surgery or other outpatient setting, and as a result you cannot get your medications filled at a network pharmacy;
- If there is a Federal disaster declaration or other public health emergency declaration in which you are evacuated or otherwise displaced from your place of residence and you cannot reasonably be expected to obtain covered Part D drugs at a network pharmacy;
- If you are getting a vaccine that is medically necessary but not covered by Medicare Part B, or some covered drugs that are administered in your doctor's office;

In these situations, **please check first with Customer Service** to see if there is a network pharmacy nearby. (Phone numbers for Customer Service are printed on the back cover of this booklet.) You may be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost that we would cover at an in-network pharmacy.

How do you ask for reimbursement from the plan?

If you must use an out-of-network pharmacy, you will generally have to pay the full cost (rather than your normal share of the cost) at the time you fill your prescription. You can ask us to reimburse you for our share of the cost. (Chapter 7, Section 2.1 explains how to ask the plan to pay you back.)

SECTION 3 Your drugs need to be on the plan's "Drug List"

Section 3.1 The "Drug List" tells which Part D drugs are covered

The plan has a "*List of Covered Drugs (Formulary).*" In this *Evidence of Coverage*, **we call it the "Drug List" for short.**

The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved the plan's Drug List.

The drugs on the Drug List are only those covered under Medicare Part D (earlier in this chapter, Section 1.1 explains about Part D drugs).

We will generally cover a drug on the plan's Drug List as long as you follow the other coverage rules explained in this chapter and the use of the drug is a medically accepted indication. A "medically accepted indication" is a use of the drug that is *either*:

- approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
- -- *or* -- supported by certain reference books. (These reference books are the American Hospital Formulary Service Drug Information; the DRUGDEX Information System; Lexi-Drugs; and the USPDI or its successor; and, for cancer, the National Comprehensive Cancer Network and Clinical Pharmacology or their successors.)

The Drug List includes both brand name and generic drugs

A generic drug is a prescription drug that has the same active ingredients as the brand name drug. Generally, it works just as well as the brand name drug and usually costs less. There are generic drug substitutes available for many brand name drugs.

What is *not* on the Drug List?

The plan does not cover all prescription drugs.

- In some cases, the law does not allow any Medicare plan to cover certain types of drugs (for more information about this, see Section 7.1 in this chapter).
- In other cases, we have decided not to include a particular drug on the Drug List.

Section 3.2 There are "cost-sharing tiers" for drugs on the Drug List

You receive prescription drug benefits through your employer. The information below may not apply to you. To see how many tiers are on your employer plan's Drug List, please see your Cost Sharing Guide or call Customer Service (the number is on the back of this booklet). Your employer may offer extra coverage on some prescription drugs not normally covered in a Medicare Prescription Drug Plan (non-Part D supplemental drugs). Please see your Cost Sharing Guide for more information.

If your employer's prescription drug coverage has 5 Tiers, please see below: Every drug on the plan's Drug List is in one of five cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug:

- Tier 1 –Preferred Generic Drugs (lowest tier)
- Tier 2 - Generic Drugs
- Tier 3 – Preferred Brand Drugs
- Tier 4 – Non-Preferred Drugs
- Tier 5 – Specialty Drugs (highest tier)

If your employer's prescription drug coverage has 4 Tiers, please see below: Every drug on the plan's Drug List is in one of four cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug:

- Tier 1 – Preferred Generic Drugs (lowest tier)
- Tier 2 – Preferred Brand Drugs
- Tier 3 – Non-Preferred Drugs
- Tier 4 – Specialty Drugs (highest tier)

If your employer's prescription drug coverage has 3 Tiers, please see below: Every drug on the plan's Drug List is in one of three cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug:

- Tier 1 – Preferred Generic Drugs (lowest tier)

- Tier 2 – Preferred Brand Drugs
- Tier 3 – Non-formulary

To find out which cost-sharing tier your drug is in, look it up in the plan's Drug List.

The amount you pay for drugs in each cost-sharing tier is shown in Chapter 6 (*What you pay for your Part D prescription drugs*).

Section 3.3 How can you find out if a specific drug is on the Drug List?

You have three ways to find out:

1. Check the most recent Drug List we : provided electronically.
2. Visit the plan's website (www.emblemhealth.com/medicare). The Drug List on the website is always the most current.
3. Call Customer Service to find out if a particular drug is on the plan's Drug List or to ask for a copy of the list. (Phone numbers for Customer Service are printed on the back cover of this booklet.)

SECTION 4 There are restrictions on coverage for some drugs

Section 4.1 Why do some drugs have restrictions?

For certain prescription drugs, special rules restrict how and when the plan covers them. A team of doctors and pharmacists developed these rules to help our members use drugs in the most effective ways. These special rules also help control overall drug costs, which keeps your drug coverage more affordable.

In general, our rules encourage you to get a drug that works for your medical condition and is safe and effective. Whenever a safe, lower-cost drug will work just as well medically as a higher-cost drug, the plan's rules are designed to encourage you and your provider to use that lower-cost option. We also need to comply with Medicare's rules and regulations for drug coverage and cost-sharing.

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. If you want us to waive the restriction for you, you will need to use the coverage decision process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See Chapter 9, Section 6.2 for information about asking for exceptions.)

Please note that sometimes a drug may appear more than once in our drug list. This is because different restrictions or cost-sharing may apply based on factors such as the strength, amount, or

form of the drug prescribed by your health care provider (for instance, 10 mg versus 100 mg; one per day versus two per day; tablet versus liquid).

Section 4.2 What kinds of restrictions?

Our plan uses different types of restrictions to help our members use drugs in the most effective ways. The sections below tell you more about the types of restrictions we use for certain drugs. Restricting brand name drugs when a generic version is available

Generally, a "generic" drug works the same as a brand name drug and usually costs less. **In most cases, when a generic version of a brand name drug is available, our network pharmacies will provide you the generic version.** We usually will not cover the brand name drug when a generic version is available. However, if your provider has told us the medical reason that the generic drug will not work for you, then we will cover the brand name drug. (Your share of the cost may be greater for the brand name drug than for the generic drug.)

Getting plan approval in advance

For certain drugs, you or your provider need to get approval from the plan before we will agree to cover the drug for you. This is called "**prior authorization**." Sometimes the requirement for getting approval in advance helps guide appropriate use of certain drugs. If you do not get this approval, your drug might not be covered by the plan.

Trying a different drug first

This requirement encourages you to try less costly but just as effective drugs before the plan covers another drug. For example, if Drug A and Drug B treat the same medical condition, the plan may require you to try Drug A first. If Drug A does not work for you, the plan will then cover Drug B. This requirement to try a different drug first is called "**step therapy**."

Quantity limits

For certain drugs, we limit the amount of the drug that you can have by limiting how much of a drug you can get each time you fill your prescription. For example, if it is normally considered safe to take only one pill per day for a certain drug, we may limit coverage for your prescription to no more than one pill per day.

Section 4.3 Do any of these restrictions apply to your drugs?

The plan's Drug List includes information about the restrictions described above. To find out if any of these restrictions apply to a drug you take or want to take, check the Drug List. For the most up-to-date information, call Customer Service (phone numbers are printed on the back cover of this booklet) or check our website (www.emblemhealth.com/medicare).

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. If there is a restriction on the drug you want to take, you should contact Customer Service to learn what you or your provider would need to do to get coverage for the drug. If you want us to waive the restriction for you, you will need to use the coverage decision process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See Chapter 9, Section 6.2 for information about asking for exceptions.)

SECTION 5 What if one of your drugs is not covered in the way you'd like it to be covered?

Section 5.1 There are things you can do if your drug is not covered in the way you'd like it to be covered

We hope that your drug coverage will work well for you. But it's possible that there could be a prescription drug you are currently taking, or one that you and your provider think you should be taking that is not on our formulary or is on our formulary with restrictions. For example:

- The drug might not be covered at all. Or maybe a generic version of the drug is covered but the brand name version you want to take is not covered.
- The drug is covered, but there are extra rules or restrictions on coverage for that drug. As explained in Section 4, some of the drugs covered by the plan have extra rules to restrict their use. For example, you might be required to try a different drug first, to see if it will work, before the drug you want to take will be covered for you. Or there might be limits on what amount of the drug (number of pills, etc.) is covered during a particular time period. In some cases, you may want us to waive the restriction for you.
- The drug is covered, but it is in a cost-sharing tier that makes your cost-sharing more expensive than you think it should be. The plan puts each covered drug into one of the different cost-sharing tiers. The number of tiers is listed in your Cost Sharing Guide. How much you pay for your prescription depends in part on which cost-sharing tier your drug is in.

There are things you can do if your drug is not covered in the way that you'd like it to be covered. Your options depend on what type of problem you have:

- If your drug is not on the Drug List or if your drug is restricted, go to Section 5.2 to learn what you can do.
- If your drug is in a cost-sharing tier that makes your cost more expensive than you think it should be, go to Section 5.3 to learn what you can do.

Section 5.2 What can you do if your drug is not on the Drug List or if the drug is restricted in some way?

If your drug is not on the Drug List or is restricted, here are things you can do:

- You may be able to get a temporary supply of the drug (only members in certain situations can get a temporary supply). This will give you and your provider time to change to another drug or to file a request to have the drug covered.
- You can change to another drug.
- You can request an exception and ask the plan to cover the drug or remove restrictions from the drug.

You may be able to get a temporary supply

Under certain circumstances, the plan can offer a temporary supply of a drug to you when your drug is not on the Drug List or when it is restricted in some way. Doing this gives you time to talk with your provider about the change in coverage and figure out what to do.

To be eligible for a temporary supply, you must meet the two requirements below:

1. The change to your drug coverage must be one of the following types of changes:

- The drug you have been taking is **no longer on the plan's Drug List**.
- or -- the drug you have been taking is **now restricted in some way** (Section 4 in this chapter tells about restrictions).

2. You must be in one of the situations described below:

- **For those members who are new or who were in the plan last year:**

  We will cover a temporary supply of your drug **during the first 90 days of your membership in the plan if you were new and during the first 90 days of the calendar year if you were in the plan last year**. This temporary supply will be for a maximum of a 30-day supply. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of a 30-day supply of medication. The prescription must be filled at a network pharmacy. (Please note that the long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)
- **For those members who have been in the plan for more than 90 days and reside in a long-term care (LTC) facility and need a supply right away:**

  We will cover one a 31-day supply of a particular drug, or less if your prescription is written for fewer days. This is in addition to the above temporary supply situation.
- If you are outside of your transition window and try to fill a prescription for a drug that is transition eligible, the claim will be flagged to indicate to the

pharmacist to inquire about level of care changes. Once a level of care change has been confirmed, the pharmacist will be provided an override to allow a one-time transition supply.

To ask for a temporary supply, call Customer Service (phone numbers are printed on the back cover of this booklet).

During the time when you are getting a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug. The sections below tell you more about these options.

You can change to another drug

Start by talking with your provider. Perhaps there is a different drug covered by the plan that might work just as well for you. You can call Customer Service to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you. (Phone numbers for Customer Service are printed on the back cover of this booklet.)

You can ask for an exception

You and your provider can ask the plan to make an exception for you and cover the drug in the way you would like it to be covered. If your provider says that you have medical reasons that justify asking us for an exception, your provider can help you request an exception to the rule. For example, you can ask the plan to cover a drug even though it is not on the plan's Drug List. Or you can ask the plan to make an exception and cover the drug without restrictions.

If you are a current member and a drug you are taking will be removed from the formulary or restricted in some way for next year, we will allow you to request a formulary exception in advance for next year. We will tell you about any change in the coverage for your drug for next year. You can ask for an exception before next year and we will give you an answer within 72 hours after we receive your request (or your prescriber's supporting statement). If we approve your request, we will authorize the coverage before the change takes effect.

If you and your provider want to ask for an exception, Chapter 9, Section 6.4 tells what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

Section 5.3 What can you do if your drug is in a cost-sharing tier you think is too high?

If your drug is in a cost-sharing tier you think is too high, here are things you can do:

You can change to another drug

If your drug is in a cost-sharing tier you think is too high, start by talking with your provider. Perhaps there is a different drug in a lower cost-sharing tier that might work just as well for you. You can call Customer Service to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you. (Phone numbers for Customer Service are printed on the back cover of this booklet.)

You can ask for an exception

You and your provider can ask the plan to make an exception in the cost-sharing tier for the drug so that you pay less for it. If your provider says that you have medical reasons that justify asking us for an exception, your provider can help you request an exception to the rule.

If you and your provider want to ask for an exception, Chapter 9, Section 6.4 tells what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

Specialty Drugs that are listed in your Drug List as "LDS" – limited day supply are not eligible for this type of exception. We do not lower the cost-sharing amount for drugs in this tier.

SECTION 6 What if your coverage changes for one of your drugs?

Section 6.1 The Drug List can change during the year

Most of the changes in drug coverage happen at the beginning of each year (January 1). However, during the year, the plan might make changes to the Drug List. For example, the plan might:

- **Add or remove drugs from the Drug List**. New drugs become available, including new generic drugs. Perhaps the government has given approval to a new use for an existing drug. Sometimes, a drug gets recalled and we decide not to cover it. Or we might remove a drug from the list because it has been found to be ineffective.
- **Move a drug to a higher or lower cost-sharing tier**.
- **Add or remove a restriction on coverage for a drug** (for more information about restrictions to coverage, see Section 4 in this chapter).
- **Replace a brand name drug with a generic drug.**

We must follow Medicare requirements before we change the plan's Drug List.

Section 6.2 What happens if coverage changes for a drug you are taking?

Information on changes to drug coverage

When changes to the Drug List occur during the year, we post information on our website about those changes. We will update our online Drug List on a regularly scheduled basis to include any changes that have occurred after the last update. Below we point out the times that you would get direct notice if changes are made to a drug that you are then taking. You can also call Customer Service for more information (phone numbers are printed on the back cover of this booklet).

Do changes to your drug coverage affect you right away?

Changes that can affect you this year: In the below cases, you will be affected by the coverage changes during the current year:

- **A new generic drug replaces a brand name drug on the Drug List (or we change the cost-sharing tier or add new restrictions to the brand name drug or both)**
    - We may immediately remove a brand name drug on our Drug List if we are replacing it with a new generic drug that will appear on the same or lower cost sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the brand name drug on our Drug List, but immediately move it to a different cost-sharing tier or add new restrictions.
    - We may not tell you in advance before we make that change—even if you are currently taking the brand name drug
    - You or your prescriber can ask us to make an exception and continue to cover the brand name drug for you. For information on how to ask for an exception, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints).*
    - If you are taking the brand name drug at the time we make the change, we will provide you with information about the specific change(s) we made. This will also include information on the steps you may take to request an exception to cover the brand name drug. You may not get this notice before we make the change.
- **Unsafe drugs and other drugs on the Drug List that are withdrawn from the market**
    - Once in a while, a drug may be suddenly withdrawn because it has been found to be unsafe or removed from the market for another reason. If this happens, we will immediately remove the drug from the Drug List. If you are taking that drug, we will let you know of this change right away.
    - Your prescriber will also know about this change and can work with you to find another drug for your condition.
- **Other changes to drugs on the Drug List**

- We may make other changes once the year has started that affect drugs you are taking. For instance, we might add a generic drug that is not new to the market to replace a brand name drug or change the cost-sharing tier or add new restrictions to the brand name drug or both. We also might make changes based on FDA boxed warnings or new clinical guidelines recognized by Medicare. We must give you at least 30 days' notice or give you a 30-day refill of the drug you are taking at a network pharmacy.
- During this 30-day period, you should be working with your prescriber to switch to a different drug that we cover.
- Or you or your prescriber can ask us to make an exception and continue to cover the drug for you. For information on how to ask for an exception, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints).*

Changes to drugs on the Drug List that will not affect people currently taking the drug: For changes to the Drug List that are not described above, if you are currently taking the drug, the following types of changes will not affect you until January 1 of the next year if you stay in the plan:

- If we move your drug into a higher cost-sharing tier.
- If we put a new restriction on your use of the drug.
- If we remove your drug from the Drug List

If any of these changes happen for a drug you are taking (but not because of a market withdrawal, a generic drug replacing a brand name drug, or other change noted in the sections above), then the change won't affect your use or what you pay as your share of the cost until January 1 of the next year. Until that date, you probably won't see any increase in your payments or any added restriction to your use of the drug. You will not get direct notice this year about changes that do not affect you. However, on January 1 of the next year, the changes will affect you, and it is important to check the Drug List in the new benefit year or any changes to drugs.

SECTION 7 What types of drugs are *not* covered by the plan?

Section 7.1 Types of drugs we do not cover

This section tells you what kinds of prescription drugs are "excluded." This means Medicare does not pay for these drugs.

If you get drugs that are excluded, you must pay for them yourself. We won't pay for the drugs that are listed in this section. The only exception: If the requested drug is found upon appeal to be a drug that is not excluded under Part D and we should have paid for or covered it because of

your specific situation. (For information about appealing a decision we have made to not cover a drug, go to Chapter 9, Section 6.5 in this booklet.)

Here are three general rules about drugs that Medicare drug plans will not cover under Part D:

- Our plan's Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.
- Our plan cannot cover a drug purchased outside the United States and its territories.
- Our plan usually cannot cover off-label use. "Off-label use" is any use of the drug other than those indicated on a drug's label as approved by the Food and Drug Administration.
    - Generally, coverage for "off-label use" is allowed only when the use is supported by certain reference books. These reference books are the American Hospital Formulary Service Drug Information; the DRUGDEX Information System; Lexi-Drugs; and for cancer, the National Comprehensive Cancer Network and Clinical Pharmacology, or their successors. If the use is not supported by any of these reference books, then our plan cannot cover its "off-label use."

Also, by law, these categories of drugs are not covered by Medicare drug plans:

- Non-prescription drugs (also called over-the-counter drugs)
- Drugs when used to promote fertility
- Drugs when used for the relief of cough or cold symptoms
- Drugs when used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs when used for the treatment of sexual or erectile dysfunction
- Drugs when used for treatment of anorexia, weight loss, or weight gain
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale

If you receive "Extra Help" paying for your drugs, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Please contact your state Medicaid program to determine what drug coverage may be available to you. (You can find phone numbers and contact information for Medicaid in Chapter 2, Section 6.)

SECTION 8 Show your plan membership card when you fill a prescription

Section 8.1 Show your membership card

To fill your prescription, show your plan membership card at the network pharmacy you choose. When you show your plan membership card, the network pharmacy will automatically bill the plan for *our* share of your covered prescription drug cost. You will need to pay the pharmacy *your* share of the cost when you pick up your prescription.

Section 8.2 What if you don't have your membership card with you?

If you don't have your plan membership card with you when you fill your prescription, ask the pharmacy to call the plan to get the necessary information.

If the pharmacy is not able to get the necessary information, **you may have to pay the full cost of the prescription when you pick it up**. (You can then **ask us to reimburse you** for our share. See Chapter 7, Section 2.1 for information about how to ask the plan for reimbursement.)

SECTION 9 Part D drug coverage in special situations

Section 9.1 What if you're in a hospital or a skilled nursing facility for a stay that is covered by the plan?

If you are admitted to a hospital or to a skilled nursing facility for a stay covered by the plan, we will generally cover the cost of your prescription drugs during your stay. Once you leave the hospital or skilled nursing facility, the plan will cover your drugs as long as the drugs meet all of our rules for coverage. See the previous parts of this section that tell about the rules for getting drug coverage. Chapter 6 (*What you pay for your Part D prescription drugs*) gives more information about drug coverage and what you pay.

Please note: When you enter, live in, or leave a skilled nursing facility, you are entitled to a Special Enrollment Period. During this time period, you can switch plans or change your coverage. (Chapter 10, *Ending your membership in the plan*, tells when you can leave our plan and join a different Medicare plan.)

Section 9.2 What if you're a resident in a long-term care (LTC) facility?

Usually, a long-term care (LTC) facility (such as a nursing home) has its own pharmacy, or a pharmacy that supplies drugs for all of its residents. If you are a resident of a long-term care facility, you may get your prescription drugs through the facility's pharmacy as long as it is part of our network.

Check your *Pharmacy Directory* to find out if your long-term care facility's pharmacy is part of our network. If it isn't, or if you need more information, please contact Customer Service (phone numbers are printed on the back cover of this booklet).

What if you're a resident in a long-term care (LTC) facility and become a new member of the plan?

If you need a drug that is not on our Drug List or is restricted in some way, the plan will cover a **temporary supply** of your drug during the first 90 days of your membership. The total supply will be for a maximum of 30-days, or less if your prescription is written for fewer days. (Please note that the long-term care (LTC) pharmacy may provide the drug in smaller amounts at a time to prevent waste.) If you have been a member of the plan for more than 90 days and need a drug that is not on our Drug List or if the plan has any restriction on the drug's coverage, we will cover one 31-day supply, or less if your prescription is written for fewer days.

During the time when you are getting a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. Perhaps there is a different drug covered by the plan that might work just as well for you. Or you and your provider can ask the plan to make an exception for you and cover the drug in the way you would like it to be covered. If you and your provider want to ask for an exception, Chapter 9, Section 6.4 tells what to do.

Section 9.3 What if you're also getting drug coverage from an employer or retiree group plan?

Do you currently have other prescription drug coverage through your (or your spouse's) employer or retiree group? If so, please contact **that group's benefits administrator.** He or she can help you determine how your current prescription drug coverage will work with our plan.

In general, if you are currently employed, the prescription drug coverage you get from us will be *secondary* to your employer or retiree group coverage. That means your group coverage would pay first.

Special note about 'creditable coverage':

Each year your employer or retiree group should send you a notice that tells if your prescription drug coverage for the next calendar year is "creditable" and the choices you have for drug coverage.

If the coverage from the group plan is "**creditable**," it means that the plan has drug coverage that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.

Keep these notices about creditable coverage, because you may need them later. If you enroll in a Medicare plan that includes Part D drug coverage, you may need these notices to show that

you have maintained creditable coverage. If you didn't get a notice about creditable coverage from your employer or retiree group plan, you can get a copy from your employer or retiree plan's benefits administrator or the employer or union.

Section 9.4 What if you're in Medicare-certified hospice?

Drugs are never covered by both hospice and our plan at the same time. If you are enrolled in Medicare hospice and require an anti-nausea, laxative, pain medication or antianxiety drug that is not covered by your hospice because it is unrelated to your terminal illness and related conditions, our plan must receive notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug. To prevent delays in receiving any unrelated drugs that should be covered by our plan, you can ask your hospice provider or prescriber to make sure we have the notification that the drug is unrelated before you ask a pharmacy to fill your prescription.

In the event you either revoke your hospice election or are discharged from hospice our plan should cover all your drugs. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, you should bring documentation to the pharmacy to verify your revocation or discharge. See the previous parts of this section that tell about the rules for getting drug coverage under Part D. Chapter 6 (*What you pay for your Part D prescription drugs*) gives more information about drug coverage and what you pay.

SECTION 10 Programs on drug safety and managing medications

Section 10.1 Programs to help members use drugs safely

We conduct drug use reviews for our members to help make sure that they are getting safe and appropriate care. These reviews are especially important for members who have more than one provider who prescribes their drugs.

We do a review each time you fill a prescription. We also review our records on a regular basis. During these reviews, we look for potential problems such as:

- Possible medication errors
- Drugs that may not be necessary because you are taking another drug to treat the same medical condition
- Drugs that may not be safe or appropriate because of your age or gender
- Certain combinations of drugs that could harm you if taken at the same time
- Prescriptions written for drugs that have ingredients you are allergic to
- Possible errors in the amount (dosage) of a drug you are taking

If we see a possible problem in your use of medications, we will work with your provider to correct the problem.

Section 10.2 Drug Management Program (DMP) to help members safely use their opioid medications

We have a program that can help make sure our members safely use their prescription opioid medications, and other medications that are frequently abused. This program is called a Drug Management Program (DMP). If you use opioid medications that you get from several doctors or pharmacies, we may talk to your doctors to make sure your use of opioid medications is appropriate and medically necessary. Working with your doctors, if we decide your use of prescription opioid or benzodiazepine medications is not safe, we may limit how you can get those medications. The limitations may be:

- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from a certain pharmacy
- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from a certain doctor
- Limiting the amount of opioid benzodiazepine medications we will cover for you

If we think that one or more of these limitations should apply to you, we will send you a letter in advance. The letter will have information explaining the limitations with think should apply to you. You will also have an opportunity to tell us which doctors or pharmacies you prefer to use, and about any other information you think is important for us to know. After you've had the opportunity to respond, if we decide to limit your coverage for these medications, we will send you another letter confirming the limitation. If you think we made a mistake or you disagree with our determination that you are at-risk for prescription drug misuse or with the limitation, you and your prescriber have the right to ask us for an appeal. If you choose to appeal, we will review your case and give you a decision. If we continue to deny any part of your request related to the limitations that apply to your access to medications, we will automatically send your case to an independent reviewer outside of our plan. See Chapter 9 for information about how to ask for an appeal.

The DMP may not apply to you if you have certain medical conditions, such as cancer, or you are receiving hospice care or live in a long-term care facility.

Section 10.3 Medication Therapy Management (MTM) program to help members manage their medications

We have a program a program that can help our members with complex health needs. For example, some members have several medical conditions, take different drugs at the same time, and have high drug costs.

This program is voluntary and free to members. A team of pharmacists and doctors developed the program for us. This program can help make sure that our members get the most benefit from the drugs they take. Our program is called a Medication Therapy Management (MTM) program.

Some members who take medications for different medical conditions and have high drug costs may be able to get services through an MTM program. A pharmacist or other health professional will give you a comprehensive review of all your medications. You can talk about how best to take your medications, your costs, and any problems or questions you have about your prescription and over-the-counter medications. You'll get a written summary of this discussion. The summary has a medication action plan that recommends what you can do to make the best use of your medications, with space for you to take notes or write down any follow-up questions. You'll also get a personal medication list that will include all the medications you're taking and why you take them.

It's a good idea to have your medication review before your yearly "Wellness" visit, so you can talk to your doctor about your action plan and medication list. Bring your action plan and medication list with you to your visit or anytime you talk with your doctors, pharmacists, and other health care providers. Also, keep your medication list with you (for example, with your ID) in case you go to the hospital or emergency room.

If we have a program that fits your needs, we will automatically enroll you in the program and send you information. If you decide not to participate, please notify us and we will withdraw you from the program. If you have any questions about these programs, please contact Customer Service (phone numbers are printed on the back cover of this booklet).

CHAPTER 6

What you pay for your Part D prescription drugs

Chapter 6. What you pay for your Part D prescription drugs

Did you know there are programs to help people pay for their drugs?

There are programs to help people with limited resources pay for their drugs. These include "Extra Help" and State Pharmaceutical Assistance Programs. For more information, see Chapter 2, Section 7.

Are you currently getting help to pay for your drugs?

If you are in a program that helps pay for your drugs, **some information in this *Evidence of Coverage* about the costs for Part D prescription drugs may not apply to you.** We sent you a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also known as the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug coverage. If you don't have this insert, please call Customer Service and ask for the "LIS Rider." (Phone numbers for Customer Service are printed on the back cover of this booklet.)

SECTION 1 Introduction

Section 1.1 Use this chapter together with other materials that explain your drug coverage

This chapter focuses on what you pay for your Part D prescription drugs. To keep things simple, we use "drug" in this chapter to mean a Part D prescription drug. As explained in Chapter 5, not all drugs are Part D drugs – some drugs are covered under Medicare Part A or Part B and other drugs are excluded from Medicare coverage by law.

To understand the payment information, we give you in this chapter, you need to know the basics of what drugs are covered, where to fill your prescriptions, and what rules to follow when you get your covered drugs. Here are materials that explain these basics:

- **The plan's *List of Covered Drugs (Formulary).*** To keep things simple, we call this the "Drug List."
  - This Drug List tells which drugs are covered for you.
  - It also tells which of the "cost-sharing tiers" the drug is in and whether there are any restrictions on your coverage for the drug.
  - If you need a copy of the Drug List, call Customer Service (phone numbers are printed on the back cover of this booklet). You can also find the Drug List on our website at www.emblemhealth.com/medicare. The Drug List on the website is always the most current.
- **Chapter 5 of this booklet.** Chapter 5 gives the details about your prescription drug coverage, including rules you need to follow when you get your covered drugs. Chapter 5 also tells which types of prescription drugs are not covered by our plan.

- **The plan's *Pharmacy Directory.*** In most situations you must use a network pharmacy to get your covered drugs (see Chapter 5 for the details). The *Pharmacy Directory* has a list of pharmacies in the plan's network. It also tells you which pharmacies in our network can give you a long-term supply of a drug (such as filling a prescription for a three-month's supply).

Section 1.2 Types of out-of-pocket costs you may pay for covered drugs

To understand the payment information we give you in this chapter, you need to know about the types of out-of-pocket costs you may pay for your covered services. The amount that you pay for a drug is called "cost-sharing" and there are three ways you may be asked to pay.

- The **"deductible"** is the amount you must pay for drugs before our plan begins to pay its share.
- **"Copayment"** means that you pay a fixed amount each time you fill a prescription.
- **"Coinsurance"** means that you pay a percent of the total cost of the drug each time you fill a prescription.

SECTION 2 What you pay for a drug depends on which "drug payment stage" you are in when you get the drug

Section 2.1 What are the drug payment stages for EmblemHealth VIP Premier (HMO) - Group members?

As shown in the table below, there are "drug payment stages" for your prescription drug coverage under EmblemHealth VIP Premier (HMO) - Group How much you pay for a drug depends on which of these stages you are in at the time you get a prescription filled or refilled. Keep in mind you are always responsible for the plan's monthly premium regardless of the drug payment stage.

Stage 1 *Yearly Deductible Stage*	**Stage 2** *Initial Coverage Stage*	**Stage 3** *Coverage Gap Stage*	**Stage 4** *Catastrophic Coverage Stage*
Because there is no deductible for the plan, this payment stage does not apply to you (Details are in Section 4 of this chapter.)	You begin in this stage when you fill your first prescription of the year. During this stage, the plan pays its share of the cost of your drugs and you pay your share of the cost. You stay in this stage until your year-to-date "total drug costs" (your payments plus any Part D plan's payments) reach the Initial Coverage Limit amount. We will send you a Cost Sharing Guide under separate cover that tells you what your Initial Coverage Limit amount will be for 2021. Or, you can call your benefits administrator for this information. (Details are in Section 5 of this chapter.)	During this stage, you pay 25% of the price for brand name drugs (plus a portion of the dispensing fee) and 25% of the price for generic drugs. You stay in this stage until your year-to-date "out-of-pocket costs" (your payments) reach your Out-of-Pocket Limit amount. This amount and rules for counting costs toward this amount have been set by Medicare. We will send you a Cost Sharing Guide under separate cover that tells you what your Out-of-Pocket Limit amount will be for 2021. Or, you can call your benefits administrator for this information. (Details are in Section 6 of this chapter.)	During this stage, **the plan will pay most of the cost** of your drugs for the rest of the calendar year (through December 31, 2021). (Details are in Section 7 of this chapter.)

SECTION 3 We send you reports that explain payments for your drugs and which payment stage you are in

Section 3.1 We send you a monthly report called the "Part D Explanation of Benefits" (the "Part D EOB")

Our plan keeps track of the costs of your prescription drugs and the payments you have made when you get your prescriptions filled or refilled at the pharmacy. This way, we can tell you when you have moved from one drug payment stage to the next. In particular, there are two types of costs we keep track of:

- We keep track of how much you have paid. This is called your "**out-of-pocket**" cost.
- We keep track of your "**total drug costs**." This is the amount you pay out-of-pocket or others pay on your behalf plus the amount paid by the plan.

Our plan will prepare a written report called the *Part D Explanation of Benefits* (it is sometimes called the "Part D EOB") when you have had one or more prescriptions filled through the plan during the previous month. The Part D EOB provides more information about the drugs you take, such as increases in price and other drugs with lower cost sharing that may be available. You should consult with your prescriber about these lower cost options. It includes:

- **Information for that month**. This report gives the payment details about the prescriptions you have filled during the previous month. It shows the total drug costs, what the plan paid, and what you and others on your behalf paid.
- **Totals for the year since January 1.** This is called "year-to-date" information. It shows you the total drug costs and total payments for your drugs since the year began.
- **Drug price information.** This information will display cumulative percentage increases for each prescription claim.
- **Available lower cost alternative prescriptions**. This will include information about other drugs with lower cost sharing for each prescription claim that may be available.

Section 3.2 Help us keep our information about your drug payments up to date

To keep track of your drug costs and the payments you make for drugs, we use records we get from pharmacies. Here is how you can help us keep your information correct and up to date:

- **Show your membership card when you get a prescription filled.** To make sure we know about the prescriptions you are filling and what you are paying, show your plan membership card every time you get a prescription filled.

- **Make sure we have the information we need.** There are times you may pay for prescription drugs when we will not automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track of your out-of-pocket costs, you may give us copies of receipts for drugs that you have purchased. (If you are billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions on how to do this, go to Chapter 7, Section 2 of this booklet.) Here are some types of situations when you may want to give us copies of your drug receipts to be sure we have a complete record of what you have spent for your drugs:
    - When you purchase a covered drug at a network pharmacy at a special price or using a discount card that is not part of our plan's benefit.
    - When you made a copayment for drugs that are provided under a drug manufacturer patient assistance program.
    - Any time you have purchased covered drugs at out-of-network pharmacies or other times you have paid the full price for a covered drug under special circumstances.
- **Send us information about the payments others have made for you.** Payments made by certain other individuals and organizations also count toward your out-of-pocket costs and help qualify you for catastrophic coverage. For example, payments made by a State Pharmaceutical Assistance Program, an AIDS drug assistance program (ADAP), the Indian Health Service, and most charities count toward your out-of-pocket costs. You should keep a record of these payments and send them to us so we can track your costs.
- **Check the written report we send you.** When you receive a *Part D Explanation of Benefits* (a "Part D EOB") in the mail, please look it over to be sure the information is complete and correct. If you think something is missing from the report, or you have any questions, please call us at Customer Service (phone numbers are printed on the back cover of this booklet). Be sure to keep these reports. They are an important record of your drug expenses.

SECTION 4 THERE IS NO DEDUCTIBLE FOR EMBLEMHEALTH VIP PREMIER (HMO) - Group

Section 4.1 You do not pay a deductible for your Part D

There is no deductible for EmblemHealth VIP Premier (HMO) - Group. You begin in the Initial Coverage Stage when you fill your first prescription of the year. See Section 5 for information about your coverage in the Initial Coverage Stage.

SECTION 5 During the Initial Coverage Stage, the plan pays its share of your drug costs and you pay your share

Section 5.1 What you pay for a drug depends on the drug and where you fill your prescription

During the Initial Coverage Stage, the plan pays its share of the cost of your covered prescription drugs, and you pay your share (your copayment or coinsurance amount). Your share of the cost will vary depending on the drug and where you fill your prescription.

The plan has cost-sharing tiers

You receive prescription drug benefits through your employer. The information below may not apply to you. To see how many tiers are on your employer plan's Drug List, please see your Cost Sharing Guide or call Customer Service (the number is on the back of this booklet). Your employer may offer extra coverage on some prescription drugs not normally covered in a Medicare Prescription Drug Plan (non-Part D supplemental drugs). Please see your Cost Sharing Guide for more information.

If your employer's prescription drug coverage has 5 Tiers, please see below: Every drug on the plan's Drug List is in one of five cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug:

- Tier 1 –Preferred Generic Drugs (lowest tier)
- Tier 2 - Generic Drugs
- Tier 3 – Preferred Brand Drugs
- Tier 4 – Non-Preferred Drugs
- Tier 5 – Specialty Drugs (highest tier)

If your employer's prescription drug coverage has 4 Tiers, please see below: Every drug on the plan's Drug List is in one of four cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug:

- Tier 1 – Preferred Generic Drugs (lowest tier)
- Tier 2 – Preferred Brand Drugs
- Tier 3 – Non-Preferred Drugs
- Tier 4 – Specialty Drugs (highest tier)

If your employer's prescription drug coverage has 3 Tiers, please see below: Every drug on the plan's Drug List is in one of three cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug:

- Tier 1 – Preferred Generic Drugs (lowest tier)
- Tier 2 – Preferred Brand Drugs
- Tier 3 – Non-formulary

To find out which cost-sharing tier your drug is in, look it up in the plan's Drug List.

Your pharmacy choices

How much you pay for a drug depends on whether you get the drug from:

- A network retail pharmacy that offers standard cost-sharing
- A network retail pharmacy that offers preferred cost-sharing
- A pharmacy that is not in the plan's network
- The plan's mail-order pharmacy

For more information about these pharmacy choices and filling your prescriptions, see Chapter 5 in this booklet and the plan's Pharmacy Directory.

Generally, we will cover your prescriptions only if they are filled at one of our network pharmacies. Some of our network pharmacies also offer preferred cost-sharing. You may go to either network pharmacies that offer preferred cost-sharing or other network pharmacies that offer standard cost-sharing to receive your covered prescription drugs. Your costs may be less at pharmacies that offer preferred cost-sharing

Section 5.2 Your costs for a *one-month* supply of a drug

During the Initial Coverage Stage, your share of the cost of a covered drug will be either a copayment or coinsurance.

- **"Copayment"** means that you pay a fixed amount each time you fill a prescription.
- **"Coinsurance"** means that you pay a percent of the total cost of the drug each time you fill a prescription.

As shown in the table below, the amount of the copayment or coinsurance depends on which cost-sharing tier your drug is in. Please note:

- If your covered drug costs less than the copayment amount listed in the chart, you will pay that lower price for the drug. You pay *either* the full price of the drug *or* the copayment amount, *whichever is lower*.

- We cover prescriptions filled at out-of-network pharmacies in only limited situations. Please see Chapter 5, Section 2.5 for information about when we will cover a prescription filled at an out-of-network pharmacy.

We will send you a Cost Sharing Guide under separate cover that tells you what your drug costs will be for 2021. Or, you can call your benefits administrator for this information.

Section 5.3 If your doctor prescribes less than a full month's supply, you may not have to pay the cost of the entire month's supply

Typically, the amount you pay for a prescription drug covers a full month's supply of a covered drug. However, your doctor can prescribe less than a month's supply of drugs. There may be times when you want to ask your doctor about prescribing less than a month's supply of a drug (for example, when you are trying a medication for the first time that is known to have serious side effects). If your doctor prescribes less than a full month's supply, you will not have to pay for the full month's supply for certain drugs.

The amount you pay when you get less than a full month's supply will depend on whether you are responsible for paying coinsurance (a percentage of the total cost) or a copayment (a flat dollar amount).

- If you are responsible for coinsurance, you pay a percentage of the total cost of the drug. You pay the same percentage regardless of whether the prescription is for a full month's supply or for fewer days. However, because the entire drug cost will be lower if you get less than a full month's supply, the amount you pay will be less.
- If you are responsible for a copayment for the drug, your copay will be based on the number of days of the drug that you receive. We will calculate the amount you pay per day for your drug (the "daily cost-sharing rate") and multiply it by the number of days of the drug you receive.
    - Here's an example: Let's say the copay for your drug for a full month's supply (a 30-day supply) is $30. This means that the amount you pay per day for your drug is $1. If you receive a 7 days' supply of the drug, your payment will be $1 per day multiplied by 7 days, for a total payment of $7.

Daily cost-sharing allows you to make sure a drug works for you before you have to pay for an entire month's supply. You can also ask your doctor to prescribe, and your pharmacist to dispense, less than a full month's supply of a drug or drugs, if this will help you better plan refill dates for different prescriptions so that you can take fewer trips to the pharmacy. The amount you pay will depend upon the days' supply you receive.

Section 5.4 A table that shows your costs for a long-term 90-day supply of a drug

For some drugs, you can get a long-term supply (also called an "extended supply") when you fill your prescription. A long-term supply is a 90 day-day supply. (For details on where and how to get a long-term supply of a drug, see Chapter 5, Section 2.4.)

The table below shows what you pay when you get a long-term (90-day) supply of a drug.

- Please note: If your covered drug costs are less than the copayment amount listed in the chart, you will pay that lower price for the drug. You pay *either* the full price of the drug *or* the copayment amount, whichever is lower.

We will send you a Cost Sharing Guide under separate cover that tells you what your drug costs will be for 2021. Or, you can call your benefits administrator for this information.

Section 5.5 You stay in the Initial Coverage Stage until your total drug costs for the year reach the Initial Coverage Limit amount

You stay in the Initial Coverage Stage until the total amount for the prescription drugs you have filled and refilled reaches the limit for the Initial Coverage Stage.

Your total drug cost is based on adding together what you have paid and what any Part D plan has paid:

- **What <u>you</u> have paid** for all the covered drugs you have gotten since you started with your first drug purchase of the year. (See Section 6.2 for more information about how Medicare calculates your out-of-pocket costs.) This includes:
    - The total you paid as your share of the cost for your drugs during the Initial Coverage Stage.
- **What the <u>plan</u> has paid** as its share of the cost for your drugs during the Initial Coverage Stage. (If you were enrolled in a different Part D plan at any time during 2021, the amount that plan paid during the Initial Coverage Stage also counts toward your total drug costs.)

We will send you a Cost Sharing Guide under separate cover that tells you what your drug costs will be for 2021. Or, you can call your benefits administrator for this information.

The *Part D Explanation of Benefits* (Part D EOB) that we send to you will help you keep track of how much you and the plan, as well as any third parties, have spent on your behalf during the year. Many people do not reach the Initial Coverage Limit in a year.

We will let you know if you reach the Initial Coverage Limit amount. If you do reach this amount, you will leave the Initial Coverage Stage and move on to the Coverage Gap Stage.

SECTION 6 During the Coverage Gap Stage, you receive a discount on brand name drugs and pay no more than 25% of the costs of generic drugs

Section 6.1 You stay in the Coverage Gap Stage until your out-of-pocket costs reach your out-of-pocket Limit amount

When you are in the Coverage Gap Stage, the Medicare Coverage Gap Discount Program provides manufacturer discounts on brand name drugs. You pay 25% of the negotiated price and a portion of the dispensing fee for brand name drugs. Both the amount you pay and the amount discounted by the manufacturer count toward your out-of-pocket costs as if you had paid them and moves you through the coverage gap.

You also receive some coverage for generic drugs. You pay no more than 37% of the cost for generic drugs and the plan pays the rest. For generic drugs, the amount paid by the plan (63%) does not count toward your out-of-pocket costs. Only the amount you pay counts and moves you through the coverage gap.

You continue paying the discounted price for brand name drugs and no more than 37% of the costs of generic drugs until your yearly out-of-pocket payments reach a maximum amount that Medicare has set.

Medicare has rules about what counts and what does *not* count as your out-of-pocket costs.

We will send you a Cost Sharing Guide under separate cover that tells you if your plan has gap coverage, and what your Out-of-Pocket Limit amount will be for 2021. Or, you can call your benefits administrator for this information.

When you reach an out-of-pocket limit, you leave the Coverage Gap Stage and move on to the Catastrophic Coverage Stage.

Section 6.2 How Medicare calculates your out-of-pocket costs for prescription drugs

Here are Medicare's rules that we must follow when we keep track of your out-of-pocket costs for your drugs.

These payments <u>are included</u> in your out-of-pocket costs

When you add up your out-of-pocket costs, **<u>you can include</u>** the payments listed below (as long as they are for Part D covered drugs and you followed the rules for drug coverage that are explained in Chapter 5 of this booklet):

- The amount you pay for drugs when you are in any of the following drug payment stages:
  - The Deductible Stage
  - The Initial Coverage Stage
  - The Coverage Gap Stage
- Any payments you made during this calendar year as a member of a different Medicare prescription drug plan before you joined our plan.

It matters who pays:

- If you make these payments **yourself**, they are included in your out-of-pocket costs.
- These payments are *also included* if they are made on your behalf by **certain other individuals or organizations.** This includes payments for your drugs made by a friend or relative, by most charities, by AIDS drug assistance programs, by a State Pharmaceutical Assistance Program that is qualified by Medicare, or by the Indian Health Service. Payments made by Medicare's "Extra Help" Program are also included.
- Some of the payments made by the Medicare Coverage Gap Discount Program are included. The amount the manufacturer pays for your brand name drugs is included. But the amount the plan pays for your generic drugs is not included.

Moving on to the Catastrophic Coverage Stage:

When you (or those paying on your behalf) have spent Out-of-Pocket Limit amount within the calendar year, you will move from the Coverage Gap Stage to the Catastrophic Coverage Stage. We will send you a Cost Sharing Guide under separate cover that tells what your Out-of-Pocket Limit amount will be for 2021.

These payments <u>are not included</u> in your out-of-pocket costs

When you add up your out-of-pocket costs, you are **<u>not</u> allowed to include** any of these types of payments for prescription drugs:

- The amount you pay for your monthly premium.
- Drugs you buy outside the United States and its territories.
- Drugs that are not covered by our plan.
- Drugs you get at an out-of-network pharmacy that do not meet the plan's requirements for out-of-network coverage.
- Non-Part D drugs, including prescription drugs covered by Part A or Part B and other drugs excluded from coverage by Medicare.
- Payments made by the plan for your brand or generic drugs while in the Coverage Gap.

- Payments for your drugs that are made by group health plans including employer health plans.
- Payments for your drugs that are made by certain insurance plans and government-funded health programs such as TRICARE and the Veterans Affairs.
- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, Workers' Compensation).

Reminder: If any other organization such as the ones listed above pays part or all of your out-of-pocket costs for drugs, you are required to tell our plan. Call Customer Service to let us know (phone numbers are printed on the back cover of this booklet).

How can you keep track of your out-of-pocket total?

- **We will help you.** The *Part D Explanation of Benefits* (Part D EOB) report we send to you includes the current amount of your out-of-pocket costs (Section 3 in this chapter tells about this report). When you reach your out-of-pocket Limit amount for the year, this report will tell you that you have left the Coverage Gap Stage and have moved on to the Catastrophic Coverage Stage. We will send you a Cost Sharing Guide under separate cover that tells what your Out-of-Pocket Limit amount will be for 2021. Or, you can call your benefits administrator for this information.
- **Make sure we have the information we need**. Section 3.2 tells what you can do to help make sure that our records of what you have spent are complete and up to date.

SECTION 7 During the Catastrophic Coverage Stage, the plan pays most of the cost for your drugs

Section 7.1 Once you are in the Catastrophic Coverage Stage, you will stay in this stage for the rest of the year

You qualify for the Catastrophic Coverage Stage when your out-of-pocket costs have reached the out of pocket limit amount for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year. We will send you a Cost Sharing Guide under separate cover that tells what your Out-of-Pocket Limit amount will be for 2021. Or, you can call your benefits administrator for this information.

During this stage, the plan will pay most of the cost for your drugs.

- **Your share** of the cost for a covered drug will be either coinsurance or a copayment, whichever is the *larger* amount:
    - – *either* – coinsurance of 5% of the cost of the drug

- *–or –* $3.70 for a generic drug or a drug that is treated like a generic and $ 9.20 for all other drugs.

- **Our plan pays the rest** of the cost.

SECTION 8 What you pay for vaccinations covered by Part D depends on how and where you get them

Section 8.1 Our plan may have separate coverage for the Part D vaccine medication itself and for the cost of giving you the vaccine

Our plan provides coverage for a number of Part D vaccines. We also cover vaccines that are considered medical benefits. You can find out about coverage of these vaccines by going to the Medical Benefits Chart in Chapter 4, Section 2.1.

There are two parts to our coverage of Part D vaccinations:

- The first part of coverage is the cost of **the vaccine medication itself**. The vaccine is a prescription medication.
- The second part of coverage is for the cost of **giving you the vaccine**. (This is sometimes called the "administration" of the vaccine.)

What do you pay for a Part D vaccination?

What you pay for a Part D vaccination depends on three things:

1. **The type of vaccine** (what you are being vaccinated for).
   - Some vaccines are considered medical benefits. You can find out about your coverage of these vaccines by going to Chapter 4, *Medical Benefits Chart (what is covered and what you pay).*
   - Other vaccines are considered Part D drugs. You can find these vaccines listed in the plan's *List of Covered Drugs (Formulary).*
2. **Where you get the vaccine medication.**
3. **Who gives you the vaccine.**

What you pay at the time you get the Part D vaccination can vary depending on the circumstances. For example:

- Sometimes when you get your vaccine, you will have to pay the entire cost for both the vaccine medication and for getting the vaccine. You can ask our plan to pay you back for our share of the cost.

- Other times, when you get the vaccine medication or the vaccine, you will pay only your share of the cost.

To show how this works, here are three common ways you might get a Part D vaccine. Remember you are responsible for all of the costs associated with vaccines (including their administration) during the Deductible and Coverage Gap Stage of your benefit.

Situation 1: You buy the Part D vaccine at the pharmacy and you get your vaccine at the network pharmacy. (Whether you have this choice depends on where you live. Some states do not allow pharmacies to administer a vaccination.)

- You will have to pay the pharmacy the amount of your coinsurance for the vaccine and the cost of giving you the vaccine.
- Our plan will pay the remainder of the costs.

Situation 2: You get the Part D vaccination at your doctor's office.

- When you get the vaccination, you will pay for the entire cost of the vaccine and its administration.
- You can then ask our plan to pay our share of the cost by using the procedures that are described in Chapter 7 of this booklet (*Asking us to pay our share of a bill you have received for covered medical services or drugs*).
- You will be reimbursed the amount you paid less your normal coinsurance for the vaccine (including administration) .

Situation 3: You buy the Part D vaccine at your pharmacy, and then take it to your doctor's office where they give you the vaccine.

- You will have to pay the pharmacy the amount of your coinsurance for the vaccine itself.
- When your doctor gives you the vaccine, you will pay the entire cost for this service. You can then ask our plan to pay our share of the cost by using the procedures described in Chapter 7 of this booklet.
- You will be reimbursed the amount charged by the doctor for administering the vaccine.

Section 8.2 You may want to call us at Customer Service before you get a vaccination

The rules for coverage of vaccinations are complicated. We are here to help. We recommend that you call us first at Customer Service whenever you are planning to get a vaccination. (Phone numbers for Customer Service are printed on the back cover of this booklet.)

- We can tell you about how your vaccination is covered by our plan and explain your share of the cost.
- We can tell you how to keep your own cost down by using providers and pharmacies in our network.
- If you are not able to use a network provider and pharmacy, we can tell you what you need to do to get payment from us for our share of the cost.

CHAPTER 7

Asking us to pay our share of a bill you have received for covered medical services or drugs

Chapter 7. Asking us to pay our share of a bill you have received for covered medical services or drugs

SECTION 1 Situations in which you should ask us to pay our share of the cost of your covered services or drugs

Section 1.1 If you pay our plan's share of the cost of your covered services or drugs, or if you receive a bill, you can ask us for payment

Sometimes when you get medical care or a prescription drug, you may need to pay the full cost right away. Other times, you may find that you have paid more than you expected under the coverage rules of the plan. In either case, you can ask our plan to pay you back (paying you back is often called "reimbursing" you). It is your right to be paid back by our plan whenever you've paid more than your share of the cost for medical services or drugs that are covered by our plan.

There may also be times when you get a bill from a provider for the full cost of medical care you have received. In many cases, you should send this bill to us instead of paying it. We will look at the bill and decide whether the services should be covered. If we decide they should be covered, we will pay the provider directly.

Here are examples of situations in which you may need to ask our plan to pay you back or to pay a bill you have received:

1. When you've received emergency or urgently needed medical care from a provider who is not in our plan's network

You can receive emergency services from any provider, whether or not the provider is a part of our network. When you receive emergency or urgently needed services from a provider who is not part of our network, you are only responsible for paying your share of the cost, not for the entire cost. You should ask the provider to bill the plan for our share of the cost.

- If you pay the entire amount yourself at the time you receive the care, you need to ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you have made.
- At times you may get a bill from the provider asking for payment that you think you do not owe. Send us this bill, along with documentation of any payments you have already made.
    - If the provider is owed anything, we will pay the provider directly.
    - If you have already paid more than your share of the cost of the service, we will determine how much you owed and pay you back for our share of the cost.

2. When a network provider sends you a bill you think you should not pay

Network providers should always bill the plan directly, and ask you only for your share of the cost. But sometimes they make mistakes, and ask you to pay more than your share.

- You only have to pay your cost-sharing amount when you get services covered by our plan. We do not allow providers to add additional separate charges, called "balance billing." This protection (that you never pay more than your cost-sharing amount) applies even if we pay the provider less than the provider charges for a service and even if there is a dispute and we don't pay certain provider charges. For more information about "balance billing," go to Chapter 4, Section 1.3.
- Whenever you get a bill from a network provider that you think is more than you should pay, send us the bill. We will contact the provider directly and resolve the billing problem.
- If you have already paid a bill to a network provider, but you feel that you paid too much, send us the bill along with documentation of any payment you have made and ask us to pay you back the difference between the amount you paid and the amount you owed under the plan.

3. If you are retroactively enrolled in our plan

Sometimes a person's enrollment in the plan is retroactive. (Retroactive means that the first day of their enrollment has already passed. The enrollment date may even have occurred last year.)

If you were retroactively enrolled in our plan and you paid out-of-pocket for any of your covered services or drugs after your enrollment date, you can ask us to pay you back for our share of the costs. You will need to submit paperwork for us to handle the reimbursement.

Please call Customer Service for additional information about how to ask us to pay you back and deadlines for making your request. (Phone numbers for Customer Service are printed on the back cover of this booklet.)

4. When you use an out-of-network pharmacy to get a prescription filled

If you go to an out-of-network pharmacy and try to use your membership card to fill a prescription, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription. (We cover prescriptions filled at out-of-network pharmacies only in a few special situations. Please go to Chapter 5, Section 2.5 to learn more.)

Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost.

5. When you pay the full cost for a prescription because you don't have your plan membership card with you

If you do not have your plan membership card with you, you can ask the pharmacy to call the plan or to look up your plan enrollment information. However, if the pharmacy cannot get the enrollment information they need right away, you may need to pay the full cost of the prescription yourself.

Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost.

6. When you pay the full cost for a prescription in other situations

You may pay the full cost of the prescription because you find that the drug is not covered for some reason.

- For example, the drug may not be on the plan's *List of Covered Drugs (Formulary)*; or it could have a requirement or restriction that you didn't know about or don't think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it.
- Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor in order to pay you back for our share of the cost.

All of the examples above are types of coverage decisions. This means that if we deny your request for payment, you can appeal our decision. Chapter 9 of this booklet (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) has information about how to make an appeal.

SECTION 2 How to ask us to pay you back or to pay a bill you have received

Section 2.1 How and where to send us your request for payment

Send us your request for payment, along with your bill and documentation of any payment you have made. It's a good idea to make a copy of your bill and receipts for your records.

To make sure you are giving us all the information we need to make a decision, you can fill out our claim form to make your request for payment.

- You don't have to use the form, but it will help us process the information faster.
- Either download a copy of the form from our website (**www.emblemhealth.com/medicare**) or call Customer Service and ask for the form. The phone numbers for Customer Service are printed on the back cover of this booklet.

Mail your request for payment together with any bills or receipts to us at this address:

For payment requests for medical care:
EmblemHealth Claims
PO Box 2845
New York, NY 10116-2845

For payment requests for Part D drugs:
EmblemHealth Medicare HMO
PO Box 1520 JAF Station
New York, NY 10116-1520

Contact Customer Service if you have any questions (phone numbers are printed on the back cover of this booklet). If you don't know what you should have paid, or you receive bills and you don't know what to do about those bills, we can help. You can also call if you want to give us more information about a request for payment you have already sent to us.

SECTION 3 We will consider your request for payment and say yes or no

Section 3.1 We check to see whether we should cover the service or drug and how much we owe

When we receive your request for payment, we will let you know if we need any additional information from you. Otherwise, we will consider your request and make a coverage decision.

- If we decide that the medical care or drug is covered and you followed all the rules for getting the care or drug, we will pay for our share of the cost. If you have already paid for the service or drug, we will mail your reimbursement of our share of the cost to you. If you have not paid for the service or drug yet, we will mail the payment directly to the provider. (Chapter 3 explains the rules you need to follow for getting your medical services covered. Chapter 5 explains the rules you need to follow for getting your Part D prescription drugs covered.)
- If we decide that the medical care or drug is *not* covered, or you did *not* follow all the rules, we will not pay for our share of the cost. Instead, we will send you a letter that explains the reasons why we are not sending the payment you have requested and your rights to appeal that decision.

Section 3.2 If we tell you that we will not pay for all or part of the medical care or drug, you can make an appeal

If you think we have made a mistake in turning down your request for payment or you don't agree with the amount we are paying, you can make an appeal. If you make an appeal, it means

you are asking us to change the decision we made when we turned down your request for payment.

For the details on how to make this appeal, go to Chapter 9 of this booklet *(What to do if you have a problem or complaint (coverage decisions, appeals, complaints))*. The appeals process is a formal process with detailed procedures and important deadlines. If making an appeal is new to you, you will find it helpful to start by reading Section 4 of Chapter 9. Section 4 is an introductory section that explains the process for coverage decisions and appeals and gives definitions of terms such as "appeal." Then after you have read Section 4, you can go to the section in Chapter 9 that tells what to do for your situation:

- If you want to make an appeal about getting paid back for a medical service, go to Section 5.3 in Chapter 9.
- If you want to make an appeal about getting paid back for a drug, go to Section 6.5 of Chapter 9.

SECTION 4 Other situations in which you should save your receipts and send copies to us

Section 4.1 In some cases, you should send copies of your receipts to us to help us track your out-of-pocket drug costs

There are some situations when you should let us know about payments you have made for your drugs. In these cases, you are not asking us for payment. Instead, you are telling us about your payments so that we can calculate your out-of-pocket costs correctly. This may help you to qualify for the Catastrophic Coverage Stage more quickly.

Here are two situations when you should send us copies of receipts to let us know about payments you have made for your drugs:

1. When you buy the drug for a price that is lower than our price

Sometimes when you are in the Coverage Gap Stage you can buy your drug **at a network pharmacy** for a price that is lower than our price.

- For example, a pharmacy might offer a special price on the drug. Or you may have a discount card that is outside our benefit that offers a lower price.
- Unless special conditions apply, you must use a network pharmacy in these situations and your drug must be on our Drug List.
- Save your receipt and send a copy to us so that we can have your out-of-pocket expenses count toward qualifying you for the Catastrophic Coverage Stage.

- **Please note:** If you are in the Coverage Gap Stage, we will not pay for any share of these drug costs. But sending a copy of the receipt allows us to calculate your out-of-pocket costs correctly and may help you qualify for the Catastrophic Coverage Stage more quickly.

2. When you get a drug through a patient assistance program offered by a drug manufacturer

Some members are enrolled in a patient assistance program offered by a drug manufacturer that is outside the plan benefits. If you get any drugs through a program offered by a drug manufacturer, you may pay a copayment to the patient assistance program.

- Save your receipt and send a copy to us so that we can have your out-of-pocket expenses count toward qualifying you for the Catastrophic Coverage Stage.
- **Please note:** Because you are getting your drug through the patient assistance program and not through the plan's benefits, we will not pay for any share of these drug costs. But sending a copy of the receipt allows us to calculate your out-of-pocket costs correctly and may help you qualify for the Catastrophic Coverage Stage more quickly.

Since you are not asking for payment in the two cases described above, these situations are not considered coverage decisions. Therefore, you cannot make an appeal if you disagree with our decision.

CHAPTER 8

Your rights and responsibilities

Chapter 8. Your rights and responsibilities

SECTION 1 Our plan must honor your rights as a member of the plan

Section 1.1 We must provide information in a way that works for you (in languages other than English, in braille, in large print, or other alternate formats, etc.)

To get information from us in a way that works for you, please call Customer Service (phone numbers are printed on the back cover of this booklet).

Our plan has people and free interpreter services available to answer questions from disabled and non-English speaking members. Information is available for free in other languages. We can also give you information in braille, in large print, or other alternate formats at no cost if you need it. We are required to give you information about the plan's benefits in a format that is accessible and appropriate for you. To get information from us in a way that works for you, please call Customer Service (phone numbers are printed on the back cover of this booklet) or contact EmblemHealth's Civil Rights Coordinator.

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, please call to file a grievance with Customer Service (phone numbers are printed on the back cover of this booklet). You may also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights. Contact information is included in this Evidence of Coverage or with this mailing, or you may contact our plan's Customer Service for additional information.

Sección 1.1 Nosotros debemos proporcionar información en una forma conveniente para usted (en idiomas aparte del inglés, en sistema braille, en letras grandes u otros formatos alternativos, etc.)

Para obtener información de nosotros en una forma conveniente para usted, por favor llame a Servicio al Cliente (los números de teléfono están impresos en la contraportada de este folleto).

Nuestro plan tiene personas y servicios de interpretación gratis disponibles para contestar preguntas de los miembros discapacitados y no inglés. Información está disponible de forma gratuita en otros idiomas. Podemos también darle información en braille, en letra grande, u otros formatos alternativos sin costo si lo necesita. Estamos obligados a darle información sobre los beneficios del plan en un formato accesible y apropiado para usted. Para obtener información de nosotros de una manera que funciona para usted, por favor llame a servicio al cliente (teléfono números están impresos en la contraportada de este folleto) o póngase en contacto con el Coordinador de derechos civiles EmblemHealth.

Si tienes cualquier problema obtener información de nuestro plan en un formato accesible y apropiado para usted, por favor, llame a presentar una queja con el servicio al cliente (números

de teléfono aparecen en la contraportada de este folleto). También puede presentar una queja con Medicare llamando al 1-800-MEDICARE (1-800-633-4227) o directamente con la oficina de derechos civiles. La información de contacto está incluida en esta Evidencia de cobertura o con este envío por correo, o puede comunicarse con el Servicio al cliente de nuestro plan para obtener información adicional.

Section 1.2 We must ensure that you get timely access to your covered services and drugs

As a member of our plan, you have the right to choose a primary care provider (PCP) in the plan's network to provide and arrange for your covered services (Chapter 3 explains more about this). Call Customer Service to learn which doctors are accepting new patients (phone numbers are printed on the back cover of this booklet). You also have the right to go to a women's health specialist (such as a gynecologist) without a referral.

As a plan member, you have the right to get appointments and covered services from the plan's network of providers *within a reasonable amount of time*. This includes the right to get timely services from specialists when you need that care. You also have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays.

If you think that you are not getting your medical care or Part D drugs within a reasonable amount of time, Chapter 9, Section 10 of this booklet tells what you can do. (If we have denied coverage for your medical care or drugs and you don't agree with our decision, Chapter 9, Section 4 tells what you can do.)

Section 1.3 We must protect the privacy of your personal health information

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

- Your "personal health information" includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information.
- The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We give you a written notice, called a "Notice of Privacy Practice," that tells about these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.
- In most situations, if we give your health information to anyone who isn't providing your care or paying for your care, *we are required to get written permission from you first.*

Written permission can be given by you or by someone you have given legal power to make decisions for you.

- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
    - For example, we are required to release health information to government agencies that are checking on quality of care.
    - Because you are a member of our plan through Medicare, we are required to give Medicare your health information including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations.

You can see the information in your records and know how it has been shared with others

You have the right to look at your medical records held at the plan, and to get a copy of your records. We are allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will work with your healthcare provider to decide whether the changes should be made.

You have the right to know how your health information has been shared with others for any purposes that are not routine.

If you have questions or concerns about the privacy of your personal health information, please call Customer Service (phone numbers are printed on the back cover of this booklet).

Section 1.4 We must give you information about the plan, its network of providers, and your covered services

As a member of EmblemHealth VIP Premier (HMO) - Group, you have the right to get several kinds of information from us. (As explained above in Section 1.1, you have the right to get information from us in a way that works for you. This includes getting the information in languages other than English and in large print or other alternate formats.)

If you want any of the following kinds of information, please call Customer Service (phone numbers are printed on the back cover of this booklet):

- **Information about our plan**. This includes, for example, information about the plan's financial condition. It also includes information about the number of appeals made by members and the plan's performance ratings, including how it has been rated by plan members and how it compares to other Medicare health plans.

- **Information about our network providers including our network pharmacies.**
    - For example, you have the right to get information from us about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.
    - For a list of the providers in the plan's network, see the Provider Directory.
    - For a list of the pharmacies in the plan's network, see the Pharmacy Directory.
    - For more detailed information about our providers or pharmacies, you can call Customer Service (phone numbers are printed on the back cover of this booklet) or visit our website atwww.emblemhealth.com/medicare**.**
- **Information about your coverage and the rules you must follow when using your coverage.**
    - In Chapters 3 and 4 of this booklet, we explain what medical services are covered for you, any restrictions to your coverage, and what rules you must follow to get your covered medical services.
    - To get the details on your Part D prescription drug coverage, see Chapters 5 and 6 of this booklet plus the plan's *List of Covered Drugs (Formulary).* These chapters, together with the *List of Covered Drugs (Formulary)*, tell you what drugs are covered and explain the rules you must follow and the restrictions to your coverage for certain drugs.
    - If you have questions about the rules or restrictions, please call Customer Service (phone numbers are printed on the back cover of this booklet).
- **Information about why something is not covered and what you can do about it.**
    - If a medical service or Part D drug is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the medical service or drug from an out-of-network provider or pharmacy.
    - If you are not happy or if you disagree with a decision we make about what medical care or Part D drug is covered for you, you have the right to ask us to change the decision. You can ask us to change the decision by making an appeal. For details on what to do if something is not covered for you in the way you think it should be covered, see Chapter 9 of this booklet. It gives you the details about how to make an appeal if you want us to change our decision. (Chapter 9 also tells about how to make a complaint about quality of care, waiting times, and other concerns.)
    - If you want to ask our plan to pay our share of a bill you have received for medical care or a Part D prescription drug, see Chapter 7 of this booklet.

Section 1.5 We must support your right to make decisions about your care

You have the right to know your treatment options and participate in decisions about your health care

You have the right to get full information from your doctors and other health care providers when you go for medical care. Your providers must explain your medical condition and your treatment choices *in a way that you can understand*.

You also have the right to participate fully in decisions about your health care. To help you make decisions with your doctors about what treatment is best for you, your rights include the following:

- **To know about all of your choices.** This means that you have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.
- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- **The right to say "no.**" You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. You also have the right to stop taking your medication. Of course, if you refuse treatment or stop taking medication, you accept full responsibility for what happens to your body as a result.
- **To receive an explanation if you are denied coverage for care.** You have the right to receive an explanation from us if a provider has denied care that you believe you should receive. To receive this explanation, you will need to ask us for a coverage decision. Chapter 9 of this booklet tells how to ask the plan for a coverage decision.

You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself

Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you are in this situation. This means that, *if you want to*, you can:

- Fill out a written form to give **someone the legal authority to make medical decisions for you** if you ever become unable to make decisions for yourself.
- **Give your doctors written instructions** about how you want them to handle your medical care if you become unable to make decisions for yourself.

The legal documents that you can use to give your directions in advance in these situations are called "**advance directives**." There are different types of advance directives and different names for them. Documents called "**living will**" and "**power of attorney for health care**" are examples of advance directives.

If you want to use an "advance directive" to give your instructions, here is what to do:

- **Get the form.** If you want to have an advance directive, you can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare.*:* You can also contact Customer Service to ask for the forms (phone numbers are printed on the back cover of this booklet).
- **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well. Be sure to keep a copy at home.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, **take a copy with you to the hospital**.

- If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you.
- If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is your choice whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive.

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with the New York State Department of Health. If you wish to file a complaint about a hospital, you should call **1-800-804-5447. If you wish file a complaint about a doctor, you should call 1-800-663-6114.**

Section 1.6 You have the right to make complaints and to ask us to reconsider decisions we have made

If you have any problems or concerns about your covered services or care, Chapter 9 of this booklet tells what you can do. It gives the details about how to deal with all types of problems and complaints. What you need to do to follow up on a problem or concern depends on the

situation. You might need to ask our plan to make a coverage decision for you, make an appeal to us to change a coverage decision, or make a complaint. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – **we are required to treat you fairly**.

You have the right to get a summary of information about the appeals and complaints that other members have filed against our plan in the past. To get this information, please call Customer Service (phone numbers are printed on the back cover of this booklet).

Section 1.7 What can you do if you believe you are being treated unfairly or your rights are not being respected?

If it is about discrimination, call the Office for Civil Rights

If you believe you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, you should call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 or TTY 1-800-537-7697, or call your local Office for Civil Rights.

Is it about something else?

If you believe you have been treated unfairly or your rights have not been respected, *and* it's *not* about discrimination, you can get help dealing with the problem you are having:

- You can **call Customer Service** (phone numbers are printed on the back cover of this booklet).
- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- Or, **you can call Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Section 1.8 How to get more information about your rights

There are several places where you can get more information about your rights:

- You can **call Customer Service** (phone numbers are printed on the back cover of this booklet).
- You can **call the SHIP**. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- You can contact **Medicare**.
    - You can visit the Medicare website to read or download the publication "Your Medicare Rights & Protections." (The publication is available at: www.medicare.gov/Pubs/pdf/11534.pdf.)

- Or, you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

SECTION 2 You have some responsibilities as a member of the plan

Section 2.1 What are your responsibilities?

Things you need to do as a member of the plan are listed below. If you have any questions, please call Customer Service (phone numbers are printed on the back cover of this booklet). We're here to help.

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this *Evidence of Coverage* booklet to learn what is covered for you and the rules you need to follow to get your covered services.
  - Chapters 3 and 4 give the details about your medical services, including what is covered, what is not covered, rules to follow, and what you pay.
  - Chapters 5 and 6 give the details about your coverage for Part D prescription drugs.
- If you have any other health insurance coverage or prescription drug coverage in addition to our plan, you are required to tell us. Please call Customer Service to let us know (phone numbers are printed on the back cover of this booklet).
  - We are required to follow rules set by Medicare to make sure that you are using all of your coverage in combination when you get your covered services from our plan. This is called "**coordination of benefits**" because it involves coordinating the health and drug benefits you get from our plan with any other health and drug benefits available to you. We'll help you coordinate your benefits. (For more information about coordination of benefits, go to Chapter 1, Section 10.)
- **Tell your doctor and other health care providers that you are enrolled in our plan.** Show your plan membership card whenever you get your medical care or Part D prescription drugs.
- Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.
  - To help your doctors and other health providers give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.
  - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.

  - If you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don't understand the answer you are given, ask again.

- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- **Pay what you owe.** As a plan member, you are responsible for these payments:
  - You must pay your plan premiums to continue being a member of our plan.
  - In order to be eligible for our plan, you must have Medicare Part A and Medicare Part B. Some plan members must pay a premium for Medicare Part A. Most plan members must pay a premium for Medicare Part B to remain a member of the plan.
  - For most of your medical services or drugs covered by the plan, you must pay your share of the cost when you get the service or drug. This will be a copayment (a fixed amount) or coinsurance (a percentage of the total cost). Chapter 4 tells what you must pay for your medical services. Chapter 6 tells what you must pay for your Part D prescription drugs.
  - If you get any medical services or drugs that are not covered by our plan or by other insurance you may have, you must pay the full cost.
    - If you disagree with our decision to deny coverage for a service or drug, you can make an appeal. Please see Chapter 9 of this booklet for information about how to make an appeal.
  - If you are required to pay a late enrollment penalty, you must pay the penalty to keep your prescription drug coverage.
  - If you are required to pay the extra amount for Part D because of your yearly income, you must pay the extra amount directly to the government to remain a member of the plan.
- **Tell us if you move.** If you are going to move, it's important to tell us right away. Call Customer Service (phone numbers are printed on the back cover of this booklet).
- **If you move *outside* of our plan service area, you cannot remain a member of our plan.** (Chapter 1 tells about our service area.) We can help you figure out whether you are moving outside our service area. If you are leaving our service area, you will have a Special Enrollment Period when you can join any Medicare plan available in your new area. We can let you know if we have a plan in your new area.
  - **If you move *within* our service area, we still need to know** so we can keep your membership record up to date and know how to contact you.
  - If you move, it is also important to tell Social Security (or the Railroad Retirement Board). You can find phone numbers and contact information for these organizations in Chapter 2.

- **Call Customer Service for help if you have questions or concerns.** We also welcome any suggestions you may have for improving our plan.
    - Phone numbers and calling hours for Customer Service are printed on the back cover of this booklet.
    - For more information on how to reach us, including our mailing address, please see Chapter 2.

CHAPTER 9

What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Chapter 9. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

BACKGROUND

SECTION 1 Introduction

Section 1.1 What to do if you have a problem or concern

This chapter explains two types of processes for handling problems and concerns:

- For some types of problems, you need to use the **process for coverage decisions and appeals**.
- For other types of problems, you need to use the **process for making complaints**.

Both of these processes have been approved by Medicare. To ensure fairness and prompt handling of your problems, each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

Which one do you use? That depends on the type of problem you are having. The guide in Section 3 will help you identify the right process to use.

Section 1.2 What about the legal terms?

There are technical legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people and can be hard to understand.

To keep things simple, this chapter explains the legal rules and procedures using simpler words in place of certain legal terms. For example, this chapter generally says “making a complaint” rather than “filing a grievance,” “coverage decision” rather than “organization determination,” or “coverage determination” or “at-risk determination,” and “Independent Review Organization” instead of “Independent Review Entity.” It also uses abbreviations as little as possible.

However, it can be helpful – and sometimes quite important – for you to know the correct legal terms for the situation you are in. Knowing which terms to use will help you communicate more clearly and accurately when you are dealing with your problem and get the right help or information for your situation. To help you know which terms to use, we include legal terms when we give the details for handling specific types of situations.

SECTION 2 You can get help from government organizations that are not connected with us

Section 2.1 Where to get more information and personalized assistance

Sometimes it can be confusing to start or follow through the process for dealing with a problem. This can be especially true if you do not feel well or have limited energy. Other times, you may not have the knowledge you need to take the next step.

Get help from an independent government organization

We are always available to help you. But in some situations you may also want help or guidance from someone who is not connected with us. You can always contact your **State Health Insurance Assistance Program (SHIP)**. This government program has trained counselors in every state. The program is not connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you are having. They can also answer your questions, give you more information, and offer guidance on what to do.

The services of SHIP counselors are free. You will find phone numbers in Chapter 2, Section 3 of this booklet.

You can also get help and information from Medicare

For more information and help in handling a problem, you can also contact Medicare. Here are two ways to get information directly from Medicare:

- You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- You can visit the Medicare website (www.medicare.gov).

SECTION 3 To deal with your problem, which process should you use?

Section 3.1 Should you use the process for coverage decisions and appeals? Or should you use the process for making complaints?

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. The guide that follows will help.

To figure out which part of this chapter will help with your specific problem or concern, **START HERE**

Is your problem or concern about your benefits or coverage?

(This includes problems about whether particular medical care or prescription drugs are covered or not, the way in which they are covered, and problems related to payment for medical care or prescription drugs.)

Yes. My problem is about benefits or coverage.

Go on to the next section of this chapter, **Section 4, "A guide to the basics of coverage decisions and appeals."**

No. My problem is not about benefits or coverage.

Skip ahead to **Section 10** at the end of this chapter: **"How to make a complaint about quality of care, waiting times, Customer Service or other concerns."**

COVERAGE DECISIONS AND APPEALS

SECTION 4 A guide to the basics of coverage decisions and appeals

Section 4.1 Asking for coverage decisions and making appeals: the big picture

The process for coverage decisions and appeals deals with problems related to your benefits and coverage for medical services and prescription drugs, including problems related to payment. This is the process you use for issues such as whether something is covered or not and the way in which something is covered.

Asking for coverage decisions

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services or drugs. For example, your plan network doctor makes a (favorable) coverage decision for you whenever you receive medical care from him or her or if your network doctor refers you to a medical specialist. You or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we will cover a particular

medical service or refuses to provide medical care you think that you need. In other words, if you want to know if we will cover a medical service before you receive it, you can ask us to make a coverage decision for you.

We are making a coverage decision for you whenever we decide what is covered for you and how much we pay. In some cases we might decide a service or drug is not covered or is no longer covered by Medicare for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

If we make a coverage decision and you are not satisfied with this decision, you can "appeal" the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made.

When you appeal a decision for the first time, this is called a Level 1 Appeal. In this appeal, we review the coverage decision we made to check to see if we were following all of the rules properly. Your appeal is handled by different reviewers than those who made the original unfavorable decision. When we have completed the review we give you our decision. Under certain circumstances, which we discuss later, you can request an expedited or "fast coverage decision" or fast appeal of a coverage decision.

If we say no to all or part of your Level 1 Appeal, you can go on to a Level 2 Appeal. The Level 2 Appeal is conducted by an Independent Review Organization that is not connected to us. (In some situations, your case will be automatically sent to the Independent Review Organization for a Level 2 Appeal. In other situations, you will need to ask for a Level 2 Appeal.) If you are not satisfied with the decision at the Level 2 Appeal, you may be able to continue through additional levels of appeal.

Section 4.2 How to get help when you are asking for a coverage decision or making an appeal

Would you like some help? Here are resources you may wish to use if you decide to ask for any kind of coverage decision or appeal a decision:

- You **can call us at Customer Service** (phone numbers are printed on the back cover of this booklet).
- You **can get free help from** your State Health Insurance Assistance Program (see Section 2 of this chapter).
- **Your doctor can make a request for you.**
    - For medical care or Part B prescription drugs, your doctor can request a coverage decision or a Level 1 Appeal on your behalf. If your appeal is denied at Level 1, it

will be automatically forwarded to Level 2. To request any appeal after Level 2, your doctor must be appointed as your representative.

- For Part D prescription drugs, your doctor or other prescriber can request a coverage decision or a Level 1 or Level 2 Appeal on your behalf. To request any appeal after Level 2, your doctor or other prescriber must be appointed as your representative.

- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your "representative" to ask for a coverage decision or make an appeal.
  - There may be someone who is already legally authorized to act as your representative under State law.
  - If you want a friend, relative, your doctor or other provider, or other person to be your representative, call Customer Service (phone numbers are printed on the back cover of this booklet) and ask for the "Appointment of Representative" form. (The form is also available on Medicare's website at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at www.emblemhealth.com/medicare .) The form gives that person permission to act on your behalf. It must be signed by you and by the person who you would like to act on your behalf. You must give us a copy of the signed form.
- **You also have the right to hire a lawyer to act for you.** You may contact your own lawyer or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Section 4.3 Which section of this chapter gives the details for your situation?

There are four different types of situations that involve coverage decisions and appeals. Since each situation has different rules and deadlines, we give the details for each one in a separate section:

- **Section 5** of this chapter: "Your medical care: How to ask for a coverage decision or make an appeal"
- **Section 6** of this chapter: "Your Part D prescription drugs: How to ask for a coverage decision or make an appeal"
- **Section 7** of this chapter: "How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon"

- **Section 8** of this chapter: "How to ask us to keep covering certain medical services if you think your coverage is ending too soon" (*Applies to these services only*: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services)

If you're not sure which section you should be using, please call Customer Service (phone numbers are printed on the back cover of this booklet). You can also get help or information from government organizations such as your SHIP (Chapter 2, Section 3, of this booklet has the phone numbers for this program).

SECTION 5 Your medical care: How to ask for a coverage decision or make an appeal

Have you read Section 4 of this chapter (*A guide to "the basics" of coverage decisions and appeals*)? If not, you may want to read it before you start this section.

Section 5.1 This section tells what to do if you have problems getting coverage for medical care or if you want us to pay you back for our share of the cost of your care

This section is about your benefits for medical care and services. These benefits are described in Chapter 4 of this booklet: *Medical Benefits Chart (what is covered and what you pay)*. To keep things simple, we generally refer to "medical care coverage" or "medical care" in the rest of this section, instead of repeating "medical care or treatment or services" every time. The term "medical care" includes medical items and services as well as Medicare Part B prescription drugs. In some cases, different rules apply to a request for a Part B prescription drug. In those cases, we will explain how the rules for Part B prescription drugs are different from the rules for medical items and services.

This section tells what you can do if you are in any of the five following situations:

1. You are not getting certain medical care you want, and you believe that this care is covered by our plan.

2. Our plan will not approve the medical care your doctor or other medical provider wants to give you, and you believe that this care is covered by the plan.

3. You have received medical care that you believe should be covered by the plan, but we have said we will not pay for this care.

4. You have received and paid for medical care that you believe should be covered by the plan, and you want to ask our plan to reimburse you for this care.

5. You are being told that coverage for certain medical care you have been getting that we previously approved will be reduced or stopped, and you believe that reducing or stopping this care could harm your health.

   NOTE: **If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services**, you need to read a separate section of this chapter because special rules apply to these types of care. Here's what to read in those situations:

   - Chapter 9, Section 7: How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon.
   - Chapter 9, Section 8: How to ask us to keep covering certain medical services if you think your coverage is ending too soon. This section is about three services only: home health care, skilled nursing facility care, and CORF services.

   For *all other* situations that involve being told that medical care you have been getting will be stopped, use this section (Section 5) as your guide for what to do.

Which of these situations are you in?

If you are in this situation:	This is what you can do:
To find out whether we will cover the medical care or services you want.	You can ask us to make a coverage decision for you. Go to the next section of this chapter, **Section 5.2**.
If we already told you that we will not cover or pay for a medical service in the way that you want it to be covered or paid for.	You can make an **appeal**. (This means you are asking us to reconsider.) Skip ahead to **Section 5.3** of this chapter.
If you want to ask us to pay you back for medical care you have already received and paid for.	You can send us the bill. Skip ahead to **Section 5.5** of this chapter.

Section 5.2 Step-by-step: How to ask for a coverage decision (how to ask our plan to authorize or provide the medical care coverage you want)

Legal Terms
When a coverage decision involves your medical care, it is called an **"organization determination."**

Step 1: You ask our plan to make a coverage decision on the medical care you are requesting. If your health requires a quick response, you should ask us to make a **"fast coverage decision."**

Legal Terms
A "fast coverage decision" is called an **"expedited determination."**

How to request coverage for the medical care you want

- Start by calling, writing, or faxing our plan to make your request for us to authorize or provide coverage for the medical care you want. You, your doctor, or your representative can do this.
- For the details on how to contact us, go to Chapter 2, Section 1 and look for the section called, How to contact us when you are asking for a coverage decision about your medical care.

Generally we use the standard deadlines for giving you our decision

When we give you our decision, we will use the "standard" deadlines unless we have agreed to use the "fast" deadlines. **A standard coverage decision means we will give you an answer within 14 calendar days** after we receive your request for a medical item or service. If your request is for a Medicare Part B prescription drug, we will give you an answer within 72 hours after we receive your request.

- **However, for a request for a medical item or service we can take up to 14 more calendar days** if you ask for more time, or if we need information (such as medical records from out-of-network providers) that may benefit you. If we decide to take extra days to make the decision, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

- If you believe we should *not* take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, including fast complaints, see Section 10 of this chapter.)

If your health requires it, ask us to give you a "fast coverage decision"

- **A fast coverage decision means we will answer within 72 hours if your request is for a medical item or service. If your request is for a Medicare Part B prescription drug, we will answer within 24 hours.**

- **However, for a request for a medical item or service we can take up to 14 more calendar days** if we find that some information that may benefit you is missing (such as medical records from out-of-network providers), or if you need time to get information to us for the review. If we decide to take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we should *not* take extra days, you can file a "fast complaint" about our decision to take extra days. (For more information about the process for making complaints, including fast complaints, see Section 10 of this chapter.) We will call you as soon as we make the decision.
- **To get a fast coverage decision, you must meet two requirements:**
  - You can get a fast coverage decision *only* if you are asking for coverage for medical care *you have not yet received*. (You cannot ask for a fast coverage decision if your request is about payment for medical care you have already received.)
  - You can get a fast coverage decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function.*
- **If your doctor tells us that your health requires a "fast coverage decision," we will automatically agree to give you a fast coverage decision.**
- If you ask for a fast coverage decision on your own, without your doctor's support, we will decide whether your health requires that we give you a fast coverage decision.
  - If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will send you a letter that says so (and we will use the standard deadlines instead).
  - This letter will tell you that if your doctor asks for the fast coverage decision, we will automatically give a fast coverage decision.
  - The letter will also tell how you can file a "fast complaint" about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. (For more information about the process for making complaints, including fast complaints, see Section 10 of this chapter.)

Step 2: We consider your request for medical care coverage and give you our answer.

Deadlines for a "fast coverage decision"

- Generally, for a fast coverage decision on a request for a medical item or service, we will give you our answer within **72 hours**. If your request is for a Medicare Part B prescription drug, we will answer **within 24 hours**.

- As explained above, we can take up to 14 more calendar days under certain circumstances. If we decide to take extra days to make the coverage decision, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we should *not* take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 10 of this chapter.)
- If we do not give you our answer within 72 hours (or if there is an extended time period, by the end of that period), or 24 hours if your request is for a Part B prescription drug, you have the right to appeal. Section 5.3 below tells how to make an appeal.

- **If our answer is no to part or all of what you requested,** we will send you a detailed written explanation as to why we said no.

Deadlines for a "standard coverage decision"

- Generally, for a standard coverage decision on a request for a medical item or service, we will give you our answer **within 14 calendar days of receiving your request**. If your request is for a Medicare Part B prescription drug, we will give you an answer **within 72 hours** of receiving your request.
  - For a request for a medical item or service, we can take up to 14 more calendar days ("an extended time period") under certain circumstances. If we decide to take extra days to make the coverage decision, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
  - If you believe we should *not* take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 10 of this chapter.)
  - If we do not give you our answer within 14 calendar days (or if there is an extended time period, by the end of that period), or 72 hours if your request is for a Part B prescription drug, you have the right to appeal. Section 5.3 below tells how to make an appeal.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

Step 3: If we say no to your request for coverage for medical care, you decide if you want to make an appeal.

- If we say no, you have the right to ask us to reconsider – and perhaps change – this decision by making an appeal. Making an appeal means making another try to get the medical care coverage you want.
- If you decide to make an appeal, it means you are going on to Level 1 of the appeals process (see Section 5.3 below).

Section 5.3 Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a medical care coverage decision made by our plan)

Legal Terms
An appeal to the plan about a medical care coverage decision is called a plan **"reconsideration."**

Step 1: You contact us and make your appeal. If your health requires a quick response, you must ask for a **"fast appeal."**

What to do

- **To start an appeal you, your doctor, or your representative, must contact us.** For details on how to reach us for any purpose related to your appeal, go to Chapter 2, Section 1 and look for the section called *How to contact us when you are making an appeal about your medical care.*
- **If you are asking for a standard appeal, make your standard appeal in writing by submitting a request.** You may also ask for an appeal by calling us at the phone number shown in Chapter 2, Section 1 (*How to contact us when you are making an appeal about your medical care*).
    - If you have someone appealing our decision for you other than your doctor, your appeal must include an Appointment of Representative form authorizing this person to represent you. To get the form, call Customer Service (phone numbers are printed on the back cover of this booklet) and ask for the "Appointment of Representative" form. It is also available on Medicare's website at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at www.emblemhealth.com/medicare . While we can accept an appeal request without the form, we cannot begin or complete our review until we receive it. If we do not receive the form within 44 calendar days after receiving your

appeal request (our deadline for making a decision on your appeal), your appeal request will be dismissed. If this happens, we will send you a written notice explaining your right to ask the Independent Review Organization to review our decision to dismiss your appeal.

- **If you are asking for a fast appeal, make your appeal in writing or call us** at the phone number shown in Chapter 2, Section 1 (*How to contact us when you are making an appeal about your medical care*).
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information regarding your medical decision and add more information to support your appeal.**
  - You have the right to ask us for a copy of the information regarding your appeal. We are allowed to charge a fee for copying and sending this information to you.
  - If you wish, you and your doctor may give us additional information to support your appeal.

If your health requires it, ask for a "fast appeal" (you can make a request by calling us)

Legal Terms
A "fast appeal" is also called an **"expedited reconsideration."**

- If you are appealing a decision we made about coverage for care that you have not yet received, you and/or your doctor will need to decide if you need a "fast appeal."
- The requirements and procedures for getting a "fast appeal" are the same as those for getting a "fast coverage decision." To ask for a fast appeal, follow the instructions for asking for a fast coverage decision. (These instructions are given earlier in this section.)
- If your doctor tells us that your health requires a "fast appeal," we will give you a fast appeal.

Step 2: We consider your appeal and we give you our answer.

- When our plan is reviewing your appeal, we take another careful look at all of the information about your request for coverage of medical care. We check to see if we were following all the rules when we said no to your request.
- We will gather more information if we need it. We may contact you or your doctor to get more information.

Deadlines for a "fast appeal"

- When we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires us to do so.
    - However, if you ask for more time, or if we need to gather more information that may benefit you, we **can take up to 14 more calendar days** if your request is for a medical item or service. If we decide to take extra days to make the decision, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
    - If we do not give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we are required to automatically send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we tell you about this organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested,** we will automatically send your appeal to the Independent Review Organization for a Level 2 Appeal.

Deadlines for a "standard appeal"

- If we are using the standard deadlines, we must give you our answer on a request for a medical item or service **within 30 calendar days** after we receive your appeal if your appeal is about coverage for services you have not yet received. If your request is for a Medicare Part B prescription drug you have not yet received, we will give you our answer within 7 calendar days after we receive your appeal. We will give you our decision sooner if your health condition requires us to.
    - However, if you ask for more time, or if we need to gather more information that may benefit you, **we can take up to 14 more calendar days.** If we decide to take extra days to make the decision, we will tell you in writing.
    - If you believe we should *not* take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information

about the process for making complaints, including fast complaints, see Section 10 of this chapter.)

- If we do not give you an answer by the applicable deadline above (or by the end of the extended time period if we took extra days on your request for a medical item or service), we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we talk about this review organization and explain what happens at Level 2 of the appeals process.

- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage we have agreed to provide within 30 calendar days if your request is for a medical item or service, or within 7 calendar days if your request is for a Medicare Part B prescription drug.
- **If our answer is no to part or all of what you requested**, we will automatically send your appeal to the Independent Review Organization for a Level 2 Appeal.

Step 3: If our plan says no to part or all of your appeal, your case will *automatically* be sent on to the next level of the appeals process.

- To make sure we were following all the rules when we said no to your appeal, **we are required to send your appeal to the "Independent Review Organization."** When we do this, it means that your appeal is going on to the next level of the appeals process, which is Level 2.

Section 5.4 Step-by-step: How a Level 2 Appeal is done

If we say no to your Level 1 Appeal, your case will *automatically* be sent on to the next level of the appeals process. During the Level 2 Appeal, the **Independent Review Organization** reviews our decision for your first appeal. This organization decides whether the decision we made should be changed.

Legal Terms
The formal name for the "Independent Review Organization" is the **"Independent Review Entity."** It is sometimes called the **"IRE."**

Step 1: The Independent Review Organization reviews your appeal.

- **The Independent Review Organization is an independent organization that is hired by Medicare**. This organization is not connected with us and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.

- We will send the information about your appeal to this organization. This information is called your "case file." **You have the right to ask us for a copy of your case file**. We are allowed to charge you a fee for copying and sending this information to you.
- You have a right to give the Independent Review Organization additional information to support your appeal.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.

If you had a "fast appeal" at Level 1, you will also have a "fast appeal" at Level 2

- If you had a fast appeal to our plan at Level 1, you will automatically receive a fast appeal at Level 2. The review organization must give you an answer to your Level 2 Appeal within 72 hours of when it receives your appeal.
- However, if your request is for a medical item or service and the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days.** The Independent Review Organization can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

If you had a "standard appeal" at Level 1, you will also have a "standard appeal" at Level 2

- If you had a standard appeal to our plan at Level 1, you will automatically receive a standard appeal at Level 2. If your request is for a medical item or service, the review organization must give you an answer to your Level 2 Appeal **within 30 calendar days** of when it receives your appeal. If your request is for a Medicare Part B prescription drug, the review organization must give you an answer to your Level 2 Appeal **within 7 calendar days** of when it receives your appeal.
- However, if the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The Independent Review Organization can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

Step 2: The Independent Review Organization gives you their answer.

The Independent Review Organization will tell you its decision in writing and explain the reasons for it.

- **If the review organization says yes to part or all of a request for a medical item or service,** we must authorize the medical care coverage within **72 hours** or provide the service **within 14 calendar days** after we receive the decision from the review organization for **standard requests** or within **72 hours** from the date we receive the decision from the review organization for **expedited requests**.
- **If the review organization says yes to part or all of a request for a Medicare Part B prescription drug,** we must authorize or provide the Part B prescription drug

under dispute **within 72 hours** after we receive the decision from the review organization for **standard requests** or within **24 hours** from the date we receive the decision from the review organization for **expedited requests**.

- **If this organization says no to part or all of your appeal**, it means they agree with us that your request (or part of your request) for coverage for medical care should not be approved. (This is called "upholding the decision." It is also called "turning down your appeal.")
    - If the Independent Review Organization "upholds the decision" you have the right to a Level 3 Appeal. However, to make another appeal at Level 3, the dollar value of the medical care coverage you are requesting must meet a certain minimum. If the dollar value of the coverage you are requesting is too low, you cannot make another appeal, which means that the decision at Level 2 is final. The written notice you get from the Independent Review Organization will tell you how to find out the dollar amount to continue the appeals process.

Step 3: If your case meets the requirements, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. The details on how to do this are in the written notice you got after your Level 2 Appeal.
- The Level 3 Appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 5.5 What if you are asking us to pay you for our share of a bill you have received for medical care?

If you want to ask us for payment for medical care, start by reading Chapter 7 of this booklet: *Asking us to pay our share of a bill you have received for covered medical services or drugs*. Chapter 7 describes the situations in which you may need to ask for reimbursement or to pay a bill you have received from a provider. It also tells how to send us the paperwork that asks us for payment.

Asking for reimbursement is asking for a coverage decision from us

If you send us the paperwork that asks for reimbursement, you are asking us to make a coverage decision (for more information about coverage decisions, see Section 4.1 of this chapter). To make this coverage decision, we will check to see if the medical care you paid for is a covered service (see Chapter 4: *Medical Benefits Chart (what is covered and what you pay)*). We will

also check to see if you followed all the rules for using your coverage for medical care (these rules are given in Chapter 3 of this booklet: *Using the plan's coverage for your medical services*).

We will say yes or no to your request

- If the medical care you paid for is covered and you followed all the rules, we will send you the payment for our share of the cost of your medical care within 60 calendar days after we receive your request. Or, if you haven't paid for the services, we will send the payment directly to the provider. When we send the payment, it's the same as saying *yes* to your request for a coverage decision.)
- If the medical care is *not* covered, or you did *not* follow all the rules, we will not send payment. Instead, we will send you a letter that says we will not pay for the services and the reasons why in detail. (When we turn down your request for payment, it's the same as saying *no* to your request for a coverage decision.)

What if you ask for payment and we say that we will not pay?

If you do not agree with our decision to turn you down, **you can make an appeal**. If you make an appeal, it means you are asking us to change the coverage decision we made when we turned down your request for payment.

To make this appeal, follow the process for appeals that we describe in Section 5.3. Go to this section for step-by-step instructions. When you are following these instructions, please note:

- If you make an appeal for reimbursement, we must give you our answer within 60 calendar days after we receive your appeal. (If you are asking us to pay you back for medical care you have already received and paid for yourself, you are not allowed to ask for a fast appeal.)
- If the Independent Review Organization reverses our decision to deny payment, we must send the payment you have requested to you or to the provider within 30 calendar days. If the answer to your appeal is yes at any stage of the appeals process after Level 2, we must send the payment you requested to you or to the provider within 60 calendar days.

SECTION 6 Your Part D prescription drugs: How to ask for a coverage decision or make an appeal

Have you read Section 4 of this chapter (*A guide to "the basics" of coverage decisions and appeals*)? If not, you may want to read it before you start this section.

Section 6.1 This section tells you what to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your benefits as a member of our plan include coverage for many prescription drugs. Please refer to our plan's *List of Covered Drugs (Formulary)*. To be covered, the drug must be used for a medically accepted indication. (A "medically accepted indication" is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. See Chapter 5, Section 3 for more information about a medically accepted indication.)

- **This section is about your Part D drugs only.** To keep things simple, we generally say "drug" in the rest of this section, instead of repeating "covered outpatient prescription drug" or "Part D drug" every time.
- For details about what we mean by Part D drugs, the *List of Covered Drugs (Formulary)*, rules and restrictions on coverage, and cost information, see Chapter 5 (*Using our plan's coverage for your Part D prescription drugs*) and Chapter 6 (*What you pay for your Part D prescription drugs*).

Part D coverage decisions and appeals

As discussed in Section 4 of this chapter, a coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your drugs.

Legal Terms
An initial coverage decision about your Part D drugs is called a **"coverage determination."**

Here are examples of coverage decisions you ask us to make about your Part D drugs:

- You ask us to make an exception, including:
  - Asking us to cover a Part D drug that is not on the plan's *List of Covered Drugs (Formulary)*
  - Asking us to waive a restriction on the plan's coverage for a drug (such as limits on the amount of the drug you can get)
  - Asking to pay a lower cost-sharing amount for a covered drug on a higher cost-sharing tier
- You ask us whether a drug is covered for you and whether you satisfy any applicable coverage rules. (For example, when your drug is on the plan's *List of Covered Drugs (Formulary)* but we require you to get approval from us before we will cover it for you.)

  - *Please note:* If your pharmacy tells you that your prescription cannot be filled as written, the pharmacy will give you a written notice explaining how to contact us to ask for a coverage decision.
- You ask us to pay for a prescription drug you already bought. This is a request for a coverage decision about payment.

If you disagree with a coverage decision we have made, you can appeal our decision.

This section tells you both how to ask for coverage decisions and how to request an appeal. Use the chart below to help you determine which part has information for your situation:

Which of these situations are you in?

If you are in this situation:	This is what you can do:
If you need a drug that isn't on our Drug List or need us to waive a rule or restriction on a drug we cover.	You can ask us to make an exception. (This is a type of coverage decision.) Start with Section **6.2** of this chapter.
If you want us to cover a drug on our Drug List and you believe you meet any plan rules or restrictions (such as getting approval in advance) for the drug you need.	You can ask us for a drug you coverage decision. Skip ahead to Section **6.4** of this chapter.
If you want to ask us to pay you back for a drug you have already received and paid for.	You can ask us to pay you back. (This is a type of coverage decision.) Skip ahead to Section **6.4** of this chapter.
If we already told you that we will not cover or pay for a drug in the way that you want it to be covered or paid for.	You can make an appeal. (This means you are asking us to reconsider.) Skip ahead to Section **6.5** of this chapter.

Section 6.2 What is an exception?

If a drug is not covered in the way you would like it to be covered, you can ask us to make an "exception." An exception is a type of coverage decision. Similar to other types of coverage decisions, if we turn down your request for an exception, you can appeal our decision.

When you ask for an exception, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. We will then consider your request. Here are three examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. **Covering a Part D drug for you that is not on our *List of Covered Drugs (Formulary).*** (We call it the "Drug List" for short.)

Legal Terms
Asking for coverage of a drug that is not on the Drug List is sometimes called asking for a **"formulary exception."**

   - If we agree to make an exception and cover a drug that is not on the Drug List, you will need to pay the cost-sharing amount that applies to Specialty Drugs. These drugs are listed on your Drug List as "LDS"- Limited day Supply. You cannot ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.

2. **Removing a restriction on our coverage for a covered drug**. There are extra rules or restrictions that apply to certain drugs on our *List of Covered Drugs (Formulary)* (for more information, go to Chapter 5 and look for Section 4).

Legal Terms
Asking for removal of a restriction on coverage for a drug is sometimes called asking for a **"formulary exception."**

   - The extra rules and restrictions on coverage for certain drugs include:
     - *Being required to use the generic version* of a drug instead of the brand name drug.
     - *Getting plan approval in advance* before we will agree to cover the drug for you. (This is sometimes called "prior authorization.")
     - *Being required to try a different drug first* before we will agree to cover the drug you are asking for. (This is sometimes called "step therapy.")
     - *Quantity limits*. For some drugs, there are restrictions on the amount of the drug you can have.
   - If we agree to make an exception and waive a restriction for you, you can ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.

3. **Changing coverage of a drug to a lower cost-sharing tier.** Every drug on our Drug List is in one of the cost-sharing tiers. The number of tiers is listed in your Cost Sharing Guide. In general, the lower the cost-sharing tier number, the less you will pay as your share of the cost of the drug.

Legal Terms
Asking to pay a lower price for a covered non-preferred drug is sometimes called asking for a **"tiering exception."**

- If our drug list contains alternative drug(s) for treating your medical condition that are in a lower cost-sharing tier than your drug, you can ask us to cover your drug at the cost-sharing amount that applies to the alternative drug(s). This would lower your share of the cost for the drug.
    - If the drug you're taking is a brand name drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains brand name alternatives for treating your condition.
    - If the drug you're taking is a generic drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains either brand or generic alternatives for treating your condition.
- You cannot ask us to change the cost-sharing tier for any Specialty Drugs. These drugs are listed on your Drug List as "LDS"- Limited day Supply.
- If we approve your request for a tiering exception and there is more than one lower cost-sharing tier with alternative drugs you can't take, you will usually pay the lowest amount.

Section 6.3 Important things to know about asking for exceptions

Your doctor must tell us the medical reasons

Your doctor or other prescriber must give us a statement that explains the medical reasons for requesting an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Typically, our Drug List includes more than one drug for treating a particular condition. These different possibilities are called "alternative" drugs. If an alternative drug would be just as effective as the drug you are requesting and would not cause more side effects or other health problems, we will generally *not* approve your request for an exception. If you ask us for a tiering exception, we will generally *not* approve your request for an exception unless all the alternative drugs in the lower cost-sharing tier(s) won't work as well for you or are likely to cause an adverse reaction or other harm.

We can say yes or no to your request

- If we approve your request for an exception, our approval usually is valid until the end of the plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.

- If we say no to your request for an exception, you can ask for a review of our decision by making an appeal. Section 6.5 tells how to make an appeal if we say no.

The next section tells you how to ask for a coverage decision, including an exception.

Section 6.4 Step-by-step: How to ask for a coverage decision, including an exception

Step 1: You ask us to make a coverage decision about the drug(s) or payment you need. If your health requires a quick response, you must ask us to make a "fast coverage decision." You cannot ask for a fast coverage decision if you are asking us to pay you back for a drug you already bought.

What to do

- **Request the type of coverage decision you want.** Start by calling, writing, or faxing us to make your request. You, your representative, or your doctor (or other prescriber) can do this. You can also access the coverage decision process through our website. For the details, go to Chapter 2, Section 1 and look for the section called, *How to contact us when you are asking for a coverage decision about your Part D prescription drugs*. Or if you are asking us to pay you back for a drug, go to the section called, *Where to send a request asking us to pay for our share of the cost for medical care or a drug you have received.*
- **You or your doctor or someone else who is acting on your behalf** can ask for a coverage decision. Section 4 of this chapter tells how you can give written permission to someone else to act as your representative. You can also have a lawyer act on your behalf.
- **If you want to ask us to pay you back for a drug,** start by reading Chapter 7 of this booklet: *Asking us to pay our share of a bill you have received for covered medical services or drugs.* Chapter 7 describes the situations in which you may need to ask for reimbursement. It also tells how to send us the paperwork that asks us to pay you back for our share of the cost of a drug you have paid for.
- **If you are requesting an exception, provide the "supporting statement."** Your doctor or other prescriber must give us the medical reasons for the drug exception you are requesting. (We call this the "supporting statement.") Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary. See Sections 6.2 and 6.3 for more information about exception requests.
- **We must accept any written request,** including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website.

Legal Terms
A "fast coverage decision" is called an **"expedited coverage determination."**

If your health requires it, ask us to give you a "fast coverage decision"

- When we give you our decision, we will use the "standard" deadlines unless we have agreed to use the "fast" deadlines. A standard coverage decision means we will give you an answer within 72 hours after we receive your doctor's statement. A fast coverage decision means we will answer within 24 hours after we receive your doctor's statement.
- **To get a fast coverage decision, you must meet two requirements:**
    - You can get a fast coverage decision *only* if you are asking for a *drug you have not yet received*. (You cannot ask for a fast coverage decision if you are asking us to pay you back for a drug you have already bought.)
    - You can get a fast coverage decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function.*
- **If your doctor or other prescriber tells us that your health requires a "fast coverage decision," we will automatically agree to give you a fast coverage decision.**
- If you ask for a fast coverage decision on your own (without your doctor's or other prescriber's support), we will decide whether your health requires that we give you a fast coverage decision.
    - If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will send you a letter that says so (and we will use the standard deadlines instead).
    - This letter will tell you that if your doctor or other prescriber asks for the fast coverage decision, we will automatically give a fast coverage decision.
    - The letter will also tell how you can file a complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. It tells how to file a "fast complaint," which means you would get our answer to your complaint within 24 hours of receiving the complaint. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, see Section 10 of this chapter.)

Step 2: We consider your request and we give you our answer.

Deadlines for a "fast coverage decision"

- If we are using the fast deadlines, we must give you our answer **within 24 hours**.
    - Generally, this means within 24 hours after we receive your request. If you are requesting an exception, we will give you our answer within 24 hours after we

receive your doctor's statement supporting your request. We will give you our answer sooner if your health requires us to.

- If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.

- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 24 hours after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

Deadlines for a "standard coverage decision" about a drug you have not yet received

- If we are using the standard deadlines, we must give you our answer **within 72 hours.**
  - Generally, this means within 72 hours after we receive your request. If you are requesting an exception, we will give you our answer within 72 hours after we receive your doctor's statement supporting your request. We will give you our answer sooner if your health requires us to.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested –**
  - If we approve your request for coverage, we must **provide the coverage** we have agreed to provide **within 72 hours** after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how to appeal.

Deadlines for a "standard coverage decision" about payment for a drug you have already bought

- We must give you our answer **within 14 calendar days** after we receive your request.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested,** we are also required to make payment to you within 14 calendar days after we receive your request.

- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

Step 3: If we say no to your coverage request, you decide if you want to make an appeal.

- If we say no, you have the right to request an appeal. Requesting an appeal means asking us to reconsider – and possibly change – the decision we made.

Section 6.5 Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a coverage decision made by our plan)

Legal Terms
An appeal to the plan about a Part D drug coverage decision is called a plan **"redetermination."**

Step 1: You contact us and make your Level 1 Appeal. If your health requires a quick response, you must ask for a **"fast appeal."**

What to do

- **To start your appeal, you (or your representative or your doctor or other prescriber) must contact us.**
    - For details on how to reach us by phone, fax, or mail, or on our website, for any purpose related to your appeal, go to Chapter 2, Section 1, and look for the section called, (*How to contact us when you are making an appeal about your Part D prescription drugs).*
- **If you are asking for a standard appeal, make your appeal by submitting a written request.** You may also ask for an appeal by calling us at the phone number shown in Chapter 2, Section 1 (*How to contact us when you are making an appeal about your Part D prescription drugs*).
- **If you are asking for a fast appeal, you may make your appeal in writing or you may call us at the phone number shown in Chapter 2, Section 1** *(How to contact us when you are making an appeal about your Part D prescription drugs).*
- **We must accept any written request,** including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website.
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time

to make your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.

- **You can ask for a copy of the information in your appeal and add more information.**
    - You have the right to ask us for a copy of the information regarding your appeal. We are allowed to charge a fee for copying and sending this information to you.
    - If you wish, you and your doctor or other prescriber may give us additional information to support your appeal.

Legal Terms
A "fast appeal" is also called an **"expedited redetermination."**

If your health requires it, ask for a "fast appeal"

- If you are appealing a decision we made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a "fast appeal."
- The requirements for getting a "fast appeal" are the same as those for getting a "fast coverage decision" in Section 6.4 of this chapter.

Step 2: We consider your appeal and we give you our answer.

- When we are reviewing your appeal, we take another careful look at all of the information about your coverage request. We check to see if we were following all the rules when we said no to your request. We may contact you or your doctor or other prescriber to get more information.

Deadlines for a "fast appeal"

- If we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires it.
    - If we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we talk about this review organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no and how you can appeal our decision.

Deadlines for a "standard appeal"

- If we are using the standard deadlines, we must give you our answer **within 7 calendar days** after we receive your appeal for a drug you have not received yet. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so. If you believe your health requires it, you should ask for "fast appeal."
    - If we do not give you a decision within 7 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we talk about this review organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested –**
    - If we approve a request for coverage, we must **provide the coverage** we have agreed to provide as quickly as your health requires, but **no later than 7 calendar days** after we receive your appeal.
    - If we approve a request to pay you back for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we receive your appeal request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no and how to appeal our decision.
- If you are requesting that we pay you back for a drug you have already bought, we must give you our answer **within 14 calendar days** after we receive your request.
    - If we do not give you a decision within 14 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested,** we are also required to make payment to you within 30 calendar days after we receive your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how you can appeal our decision.

<u>Step 3:</u> If we say no to your appeal, you decide if you want to continue with the appeals process and make *another* appeal.

- If we say no to your appeal, you then choose whether to accept this decision or continue by making another appeal.
- If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process (see below).

Section 6.6 Step-by-step: How to make a Level 2 Appeal

If we say no to your appeal, you then choose whether to accept this decision or continue by making another appeal. If you decide to go on to a Level 2 Appeal, the **Independent Review Organization** reviews the decision we made when we said no to your first appeal. This organization decides whether the decision we made should be changed.

Legal Terms
The formal name for the "Independent Review Organization" is the **"Independent Review Entity."** It is sometimes called the **"IRE."**

Step 1: To make a Level 2 Appeal, you (or your representative or your doctor or other prescriber) must contact the Independent Review Organization and ask for a review of your case.

- If we say no to your Level 1 Appeal, the written notice we send you will include **instructions on how to make a Level 2 Appeal** with the Independent Review Organization. These instructions will tell who can make this Level 2 Appeal, what deadlines you must follow, and how to reach the review organization.
- When you make an appeal to the Independent Review Organization, we will send the information we have about your appeal to this organization. This information is called your "case file." **You have the right to ask us for a copy of your case file**. We are allowed to charge you a fee for copying and sending this information to you.
- You have a right to give the Independent Review Organization additional information to support your appeal.

Step 2: The Independent Review Organization does a review of your appeal and gives you an answer.

- **The Independent Review Organization is an independent organization that is hired by Medicare**. This organization is not connected with us and it is not a government agency. This organization is a company chosen by Medicare to review our decisions about your Part D benefits with us.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal. The organization will tell you its decision in writing and explain the reasons for it.

Deadlines for "fast appeal" at Level 2

- If your health requires it, ask the Independent Review Organization for a "fast appeal."

- If the review organization agrees to give you a "fast appeal," the review organization must give you an answer to your Level 2 Appeal **within 72 hours** after it receives your appeal request.
- **If the Independent Review Organization says yes to part or all of what you requested,** we must provide the drug coverage that was approved by the review organization **within 24 hours** after we receive the decision from the review organization.

Deadlines for "standard appeal" at Level 2

- If you have a standard appeal at Level 2, the review organization must give you an answer to your Level 2 Appeal **within 7 calendar days** after it receives your appeal if it is for a drug you have not received yet. If you are requesting that we pay you back for a drug you have already bought, the review organization must give you an answer to your level 2 appeal within 14 calendar days after it receives your request.
  - **If the Independent Review Organization says yes to part or all of what you requested –**
    - If the Independent Review Organization approves a request for coverage, we must **provide the drug coverage** that was approved by the review organization **within 72 hours** after we receive the decision from the review organization.
    - If the Independent Review Organization approves a request to pay you back for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we receive the decision from the review organization.

What if the review organization says no to your appeal?

If this organization says no to your appeal, it means the organization agrees with our decision not to approve your request. (This is called "upholding the decision." It is also called "turning down your appeal.")

If the Independent Review Organization "upholds the decision" you have the right to a Level 3 Appeal. However, to make another appeal at Level 3, the dollar value of the drug coverage you are requesting must meet a minimum amount. If the dollar value of the drug coverage you are requesting is too low, you cannot make another appeal and the decision at Level 2 is final. The notice you get from the Independent Review Organization will tell you the dollar value that must be in dispute to continue with the appeals process.

Step 3: If the dollar value of the coverage you are requesting meets the requirement, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a

third appeal. If you decide to make a third appeal, the details on how to do this are in the written notice you got after your second appeal.

- The Level 3 Appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 7 How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon

When you are admitted to a hospital, you have the right to get all of your covered hospital services that are necessary to diagnose and treat your illness or injury. For more information about our coverage for your hospital care, including any limitations on this coverage, see Chapter 4 of this booklet: *Medical Benefits Chart (what is covered and what you pay)*.

During your covered hospital stay, your doctor and the hospital staff will be working with you to prepare for the day when you will leave the hospital. They will also help arrange for care you may need after you leave.

- The day you leave the hospital is called your "**discharge date**."
- When your discharge date has been decided, your doctor or the hospital staff will let you know.
- If you think you are being asked to leave the hospital too soon, you can ask for a longer hospital stay and your request will be considered. This section tells you how to ask.

Section 7.1 During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights

During your covered hospital stay, you will be given a written notice called *An Important Message from Medicare about Your Rights.* Everyone with Medicare gets a copy of this notice whenever they are admitted to a hospital. Someone at the hospital (for example, a caseworker or nurse) must give it to you within two days after you are admitted. If you do not get the notice, ask any hospital employee for it. If you need help, please call Customer Service (phone numbers are printed on the back cover of this booklet). You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

1. **Read this notice carefully and ask questions if you don't understand it.** It tells you about your rights as a hospital patient, including:
   - Your right to receive Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.

- Your right to be involved in any decisions about your hospital stay, and your right to know who will pay for it.
- Where to report any concerns you have about quality of your hospital care.
- Your right to appeal your discharge decision if you think you are being discharged from the hospital too soon.

Legal Terms
The written notice from Medicare tells you how you can **"request an immediate review."** Requesting an immediate review is a formal, legal way to ask for a delay in your discharge date so that we will cover your hospital care for a longer time. (Section 7.2 below tells you how you can request an immediate review.)

2. **You will be asked to sign the written notice to show that you received it and understand your rights.**
   - You or someone who is acting on your behalf will be asked to sign the notice. (Section 4 of this chapter tells how you can give written permission to someone else to act as your representative.)
   - Signing the notice shows *only* that you have received the information about your rights. The notice does not give your discharge date (your doctor or hospital staff will tell you your discharge date). Signing the notice **does *not* mean** you are agreeing on a discharge date.

3. **Keep your copy** of the notice so you will have the information about making an appeal (or reporting a concern about quality of care) handy if you need it.
   - If you sign the notice more than two days before the day you leave the hospital, you will get another copy before you are scheduled to be discharged.
   - To look at a copy of this notice in advance, you can call Customer Service (phone numbers are printed on the back cover of this booklet) or 1-800 MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. You can also see the notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html.

Section 7.2 Step-by-step: How to make a Level 1 Appeal to change your hospital discharge date

If you want to ask for your inpatient hospital services to be covered by us for a longer time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do.
- **Ask for help if you need it**. If you have questions or need help at any time, please call Customer Service (phone numbers are printed on the back cover of this booklet). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Section 2 of this chapter).

During a Level 1 Appeal, the Quality Improvement Organization reviews your appeal. It checks to see if your planned discharge date is medically appropriate for you.

Step 1: Contact the Quality Improvement Organization for your state and ask for a "fast review" of your hospital discharge. You must act quickly.

What is the Quality Improvement Organization?

- This organization is a group of doctors and other health care professionals who are paid by the Federal government. These experts are not part of our plan. This organization is paid by Medicare to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare.

How can you contact this organization?

- The written notice you received (*An Important Message from Medicare About Your Rights*) tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2, Section 4, of this booklet.)

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and **no later than midnight the day of your discharge date.** (Your "planned discharge date" is the date that has been set for you to leave the hospital.)
    - If you meet this deadline, you are allowed to stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision on your appeal from the Quality Improvement Organization.
    - If you do *not* meet this deadline, and you decide to stay in the hospital after your planned discharge date, *you may have to pay all of the costs* for hospital care you receive after your planned discharge date.
- If you miss the deadline for contacting the Quality Improvement Organization and you still wish to appeal, you must make an appeal directly to our plan instead. For details about this other way to make your appeal, see Section 7.4.

Ask for a "fast review":

- You must ask the Quality Improvement Organization for a **"fast review"** of your discharge. Asking for a "fast review" means you are asking for the organization to use the "fast" deadlines for an appeal instead of using the standard deadlines.

Legal Terms
A "**fast review**" is also called an "**immediate review**" or an "**expedited review**."

Step 2: The Quality Improvement Organization conducts an independent review of your case.

What happens during this review?

- Health professionals at the Quality Improvement Organization (we will call them "the reviewers" for short) will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.
- The reviewers will also look at your medical information, talk with your doctor, and review information that the hospital and we have given to them.
- By noon of the day after the reviewers informed our plan of your appeal, you will also get a written notice that gives your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

Legal Terms
This written explanation is called the "**Detailed Notice of Discharge."** You can get a sample of this notice by calling Customer Service (phone numbers are printed on the back cover of this booklet) or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.) Or you can see a sample notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html

Step 3: Within one full day after it has all the needed information, the Quality Improvement Organization will give you its answer to your appeal.

What happens if the answer is yes?

- If the review organization says *yes* to your appeal, **we must keep providing your covered inpatient hospital services for as long as these services are medically necessary.**

- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered hospital services. (See Chapter 4 of this booklet).

What happens if the answer is no?

- If the review organization says *no* to your appeal, they are saying that your planned discharge date is medically appropriate. If this happens, **our coverage for your inpatient hospital services will end** at noon on the day *after* the Quality Improvement Organization gives you its answer to your appeal.
- If the review organization says *no* to your appeal and you decide to stay in the hospital, then **you may have to pay the full cost** of hospital care you receive after noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

Step 4: If the answer to your Level 1 Appeal is no, you decide if you want to make another appeal.

- If the Quality Improvement Organization has turned down your appeal, *and* you stay in the hospital after your planned discharge date, then you can make another appeal. Making another appeal means you are going on to "Level 2" of the appeals process.

Section 7.3 Step-by-step: How to make a Level 2 Appeal to change your hospital discharge date

If the Quality Improvement Organization has turned down your appeal, *and* you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your first appeal. If the Quality Improvement Organization turns down your Level 2 Appeal, you may have to pay the full cost for your stay after your planned discharge date.

Here are the steps for Level 2 of the appeal process:

Step 1: You contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 calendar days** after the day the Quality Improvement Organization said *no* to your Level 1 Appeal. You can ask for this review only if you stay in the hospital after the date that your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

Step 3: Within 14 calendar days of receipt of your request for a second review, the Quality Improvement Organization reviewers will decide on your appeal and tell you their decision.

If the review organization says yes:

- **We must reimburse you** for our share of the costs of hospital care you have received since noon on the day after the date your first appeal was turned down by the Quality Improvement Organization. **We must continue providing coverage for your inpatient hospital care for as long as it is medically necessary**.
- You must continue to pay your share of the costs and coverage limitations may apply.

If the review organization says no:

- It means they agree with the decision they made on your Level 1 Appeal and will not change it. This is called "upholding the decision."
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by an Administrative Law Judge or attorney adjudicator.

Step 4: If the answer is no, you will need to decide whether you want to take your appeal further by going on to Level 3.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If the review organization turns down your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by an Administrative Law Judge or attorney adjudicator.
- Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 7.4 What if you miss the deadline for making your Level 1 Appeal?

You can appeal to us instead

As explained above in Section 7.2, you must act quickly to contact the Quality Improvement Organization to start your first appeal of your hospital discharge. ("Quickly" means before you leave the hospital and no later than your planned discharge date, whichever comes first.) If you miss the deadline for contacting this organization, there is another way to make your appeal.

If you use this other way of making your appeal, *the first two levels of appeal are different.*

Step-by-Step: How to make a Level 1 *Alternate* Appeal

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a "fast review." A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

Legal Terms
A "fast review" (or "fast appeal") is also called an **"expedited appeal."**

Step 1: Contact us and ask for a "fast review."

- For details on how to contact us, go to Chapter 2, Section 1 and look for the section called, *How to contact us when you are making an appeal about your medical care*.
- **Be sure to ask for a "fast review**." This means you are asking us to give you an answer using the "fast" deadlines rather than the "standard" deadlines.

Step 2: We do a "fast review" of your planned discharge date, checking to see if it was medically appropriate.

- During this review, we take a look at all of the information about your hospital stay. We check to see if your planned discharge date was medically appropriate. We will check to see if the decision about when you should leave the hospital was fair and followed all the rules.
- In this situation, we will use the "fast" deadlines rather than the standard deadlines for giving you the answer to this review.

Step 3: We give you our decision within 72 hours after you ask for a "fast review" ("fast appeal").

- **If we say yes to your fast appeal,** it means we have agreed with you that you still need to be in the hospital after the discharge date, and will keep providing your covered inpatient hospital services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If we say no to your fast appeal,** we are saying that your planned discharge date was medically appropriate. Our coverage for your inpatient hospital services ends as of the day we said coverage would end.
    - If you stayed in the hospital *after* your planned discharge date, then **you may have to pay the full cost** of hospital care you received after the planned discharge date.

Step 4: If we say *no* to your fast appeal, your case will *automatically* be sent on to the next level of the appeals process.

- To make sure we were following all the rules when we said no to your fast appeal, **we are required to send your appeal to the "Independent Review Organization."** When we do this, it means that you are *automatically* going on to Level 2 of the appeals process.

Step-by-Step: Level 2 *Alternate* Appeal Process

During the Level 2 Appeal, an **Independent Review Organization** reviews the decision we made when we said no to your "fast appeal." This organization decides whether the decision we made should be changed.

Legal Terms
The formal name for the "Independent Review Organization" is the **"Independent Review Entity."** It is sometimes called the **"IRE."**

Step 1: We will automatically forward your case to the Independent Review Organization.

- We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeal process. Section 10 of this chapter tells how to make a complaint.)

Step 2: The Independent Review Organization does a "fast review" of your appeal. The reviewers give you an answer within 72 hours.

- **The Independent Review Organization is an independent organization that is hired by Medicare**. This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal of your hospital discharge.
- **If this organization says *yes* to your appeal,** then we must reimburse you (pay you back) for our share of the costs of hospital care you have received since the date of your planned discharge. We must also continue the plan's coverage of your inpatient hospital services for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.

- **If this organization says *no* to your appeal,** it means they agree with us that your planned hospital discharge date was medically appropriate.
    - The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal, which is handled by an Administrative Law Judge or attorney adjudicator.

Step 3: If the Independent Review Organization turns down your appeal, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If reviewers say no to your Level 2 Appeal, you decide whether to accept their decision or go on to Level 3 and make a third appeal.
- Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 8 How to ask us to keep covering certain medical services if you think your coverage is ending too soon

Section 8.1 *This section is about three services only:* Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services

This section is about the following types of care *only*:

- **Home health care services** you are getting.
- **Skilled nursing care** you are getting as a patient in a skilled nursing facility. (To learn about requirements for being considered a "skilled nursing facility," see Chapter 12, *Definitions of important words*.)
- **Rehabilitation care** you are getting as an outpatient at a Medicare-approved Comprehensive Outpatient Rehabilitation Facility (CORF). Usually, this means you are getting treatment for an illness or accident, or you are recovering from a major operation. (For more information about this type of facility, see Chapter 12, *Definitions of important words*.)

When you are getting any of these types of care, you have the right to keep getting your covered services for that type of care for as long as the care is needed to diagnose and treat your illness or injury. For more information on your covered services, including your share of the cost and any limitations to coverage that may apply, see Chapter 4 of this booklet: *Medical Benefits Chart (what is covered and what you pay)*.

When we decide it is time to stop covering any of the three types of care for you, we are required to tell you in advance. When your coverage for that care ends, *we will stop paying our share of the cost for your care.*

If you think we are ending the coverage of your care too soon, **you can appeal our decision**. This section tells you how to ask for an appeal.

Section 8.2 We will tell you in advance when your coverage will be ending

1. **You receive a notice in writing.** At least two days before our plan is going to stop covering your care, you will receive a notice.
   - The written notice tells you the date when we will stop covering the care for you.
   - The written notice also tells what you can do if you want to ask our plan to change this decision about when to end your care, and keep covering it for a longer period of time.

Legal Terms
In telling you what you can do, the written notice is telling how you can request a **"fast-track appeal."** Requesting a fast-track appeal is a formal, legal way to request a change to our coverage decision about when to stop your care. (Section 7.3 below tells how you can request a fast-track appeal.) The written notice is called the "**Notice of Medicare Non-Coverage."**

2. **You will be asked to sign the written notice to show that you received it.**
   - You or someone who is acting on your behalf will be asked to sign the notice. (Section 4 tells how you can give written permission to someone else to act as your representative.)
   - Signing the notice shows *only* that you have received the information about when your coverage will stop. **Signing it does <u>not</u> mean you agree** with the plan that it's time to stop getting the care.

Section 8.3 Step-by-step: How to make a Level 1 Appeal to have our plan cover your care for a longer time

If you want to ask us to cover your care for a longer period of time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.

- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do. There are also deadlines our plan must follow. (If you think we are not meeting our deadlines, you can file a complaint. Section 10 of this chapter tells you how to file a complaint.)
- **Ask for help if you need it**. If you have questions or need help at any time, please call Customer Service (phone numbers are printed on the back cover of this booklet). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Section 2 of this chapter).

If you ask for a Level 1 Appeal on time, the Quality Improvement Organization reviews your appeal and decides whether to change the decision made by our plan.

Step 1: Make your Level 1 Appeal: contact the Quality Improvement Organization for your state and ask for a review. You must act quickly.

What is the Quality Improvement Organization?

- This organization is a group of doctors and other health care experts who are paid by the Federal government. These experts are not part of our plan. They check on the quality of care received by people with Medicare and review plan decisions about when it's time to stop covering certain kinds of medical care.

How can you contact this organization?

- The written notice you received tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2, Section 4, of this booklet.)

What should you ask for?

- Ask this organization for a "fast-track appeal" (to do an independent review) of whether it is medically appropriate for us to end coverage for your medical services.

Your deadline for contacting this organization.

- You must contact the Quality Improvement Organization to start your appeal by noon of the day before the effective date on the Notice of Medicare Non-Coverage.
- If you miss the deadline for contacting the Quality Improvement Organization and you still wish to file an appeal, you must make an appeal directly to us instead. For details about this other way to make your appeal, see Section 8.5.

Step 2: The Quality Improvement Organization conducts an independent review of your case.

What happens during this review?

- Health professionals at the Quality Improvement Organization (we will call them "the reviewers" for short) will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.
- The review organization will also look at your medical information, talk with your doctor, and review information that our plan has given to them.
- By the end of the day the reviewers inform us of your appeal, and you will also get a written notice from us that explains in detail our reasons for ending our coverage for your services.

Legal Terms
This notice of explanation is called the "**Detailed Explanation of Non-Coverage.**"

Step 3: Within one full day after they have all the information they need, the reviewers will tell you their decision.

What happens if the reviewers say yes to your appeal?

- If the reviewers say *yes* to your appeal, then **we must keep providing your covered services for as long as it is medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered services (see Chapter 4 of this booklet).

What happens if the reviewers say no to your appeal?

- If the reviewers say *no* to your appeal, then **your coverage will end on the date we have told you.** We will stop paying our share of the costs of this care on the date listed on the notice.
- If you decide to keep getting the home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* this date when your coverage ends, then **you will have to pay the full cost** of this care yourself.

Step 4: If the answer to your Level 1 Appeal is no, you decide if you want to make another appeal.

- This first appeal you make is "Level 1" of the appeals process. If reviewers say *no* to your Level 1 Appeal – and you choose to continue getting care after your coverage for the care has ended – then you can make another appeal.
- Making another appeal means you are going on to "Level 2" of the appeals process.

Section 8.4 Step-by-step: How to make a Level 2 Appeal to have our plan cover your care for a longer time

If the Quality Improvement Organization has turned down your appeal and you choose to continue getting care after your coverage for the care has ended, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your first appeal. If the Quality Improvement Organization turns down your Level 2 Appeal, you may have to pay the full cost for your home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end.

Here are the steps for Level 2 of the appeal process:

Step 1: You contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 days** after the day when the Quality Improvement Organization said *no* to your Level 1 Appeal. You can ask for this review only if you continued getting care after the date that your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

Step 3: Within 14 days of receipt of your appeal request, reviewers will decide on your appeal and tell you their decision.

What happens if the review organization says yes to your appeal?

- **We must reimburse you** for our share of the costs of care you have received since the date when we said your coverage would end. **We must continue providing coverage** for the care for as long as it is medically necessary.
- You must continue to pay your share of the costs and there may be coverage limitations that apply.

What happens if the review organization says no?

- It means they agree with the decision we made to your Level 1 Appeal and will not change it.
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by an Administrative Law Judge or attorney adjudicator.

Step 4: If the answer is no, you will need to decide whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers turn down your Level 2 Appeal, you can choose whether to accept that decision or to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by an Administrative Law Judge or attorney adjudicator.
- Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 8.5 What if you miss the deadline for making your Level 1 Appeal?

You can appeal to us instead

As explained above in Section 8.3, you must act quickly to contact the Quality Improvement Organization to start your first appeal (within a day or two, at the most). If you miss the deadline for contacting this organization, there is another way to make your appeal. If you use this other way of making your appeal, *the first two levels of appeal are different.*

Step-by-Step: How to make a Level 1 *Alternate* Appeal

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a "fast review." A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

Here are the steps for a Level 1 Alternate Appeal:

Legal Terms
A "fast review" (or "fast appeal") is also called an **"expedited appeal."**

Step 1: Contact us and ask for a "fast review."

- For details on how to contact us, go to Chapter 2, Section 1 and look for the section called, *How to contact us when you are making an appeal about your medical care*.

- **Be sure to ask for a "fast review**." This means you are asking us to give you an answer using the "fast" deadlines rather than the "standard" deadlines.

Step 2: We do a "fast review" of the decision we made about when to end coverage for your services.

- During this review, we take another look at all of the information about your case. We check to see if we were following all the rules when we set the date for ending the plan's coverage for services you were receiving.
- We will use the "fast" deadlines rather than the standard deadlines for giving you the answer to this review.

Step 3: We give you our decision within 72 hours after you ask for a "fast review" ("fast appeal").

- **If we say yes to your fast appeal,** it means we have agreed with you that you need services longer, and will keep providing your covered services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If we say no to your fast appeal,** then your coverage will end on the date we told you and we will not pay any share of the costs after this date.
- If you continued to get home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end, then **you will have to pay the full cost** of this care yourself.

Step 4: If we say *no* to your fast appeal, your case will *automatically* go on to the next level of the appeals process.

- To make sure we were following all the rules when we said no to your fast appeal, **we are required to send your appeal to the "Independent Review Organization."** When we do this, it means that you are *automatically* going on to Level 2 of the appeals process.

Step-by-Step: Level 2 *Alternate* Appeal Process

During the Level 2 Appeal, the **Independent Review Organization** reviews the decision we made when we said no to your "fast appeal." This organization decides whether the decision we made should be changed.

Legal Terms
The formal name for the "Independent Review Organization" is the **"Independent Review Entity."** It is sometimes called the **"IRE."**

Step 1: We will automatically forward your case to the Independent Review Organization.

- We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeal process. Section 10 of this chapter tells how to make a complaint.)

Step 2: The Independent Review Organization does a "fast review" of your appeal. The reviewers give you an answer within 72 hours.

- **The Independent Review Organization is an independent organization that is hired by Medicare**. This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.
- **If this organization says *yes* to your appeal,** then we must reimburse you (pay you back) for our share of the costs of care you have received since the date when we said your coverage would end. We must also continue to cover the care for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says *no* to your appeal,** it means they agree with the decision our plan made to your first appeal and will not change it.
    - The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal.

Step 3: If the Independent Review Organization turns down your appeal, you choose whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers say no to your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by an Administrative Law Judge or attorney adjudicator.
- Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 9 Taking your appeal to Level 3 and beyond

Section 9.1 Appeal Levels 3, 4, and 5 for Medical Service Requests

This section may be appropriate for you if you have made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down.

If the dollar value of the item or medical service you have appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, the written response you receive to your Level 2 Appeal will explain who to contact and what to do to ask for a Level 3 Appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 Appeal: **A judge (called an Administrative Law Judge) or an attorney adjudicator who works for the Federal government** will review your appeal and give you an answer.

- **If the Administrative Law Judge or attorney adjudicator says yes to your appeal, the appeals process *may* or *may not* be over** - We will decide whether to appeal this decision to Level 4. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 3 decision that is favorable to you.
    - If we decide *not* to appeal the decision, we must authorize or provide you with the service within 60 calendar days after receiving the Administrative Law Judge's or attorney adjudicator's decision.
    - If we decide to appeal the decision, we will send you a copy of the Level 4 Appeal request with any accompanying documents. We may wait for the Level 4 Appeal decision before authorizing or providing the service in dispute.
- **If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process *may* or *may not* be over**.

- If you decide to accept this decision that turns down your appeal, the appeals process is over.
- If you do not want to accept the decision, you can continue to the next level of the review process. If the Administrative Law Judge or attorney adjudicator says no to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal.

Level 4 Appeal: The Medicare **Appeals Council** (Council) will review your appeal and give you an answer. The Council is part of the Federal government.

- If the answer is yes, or if the Council denies our request to review a favorable Level 3 Appeal decision, the appeals process *may* or *may not* be over - We will decide whether to appeal this decision to Level 5. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 4 decision that is favorable to you if the value of the item or medical service meets the required dollar value.
  - If we decide *not* to appeal the decision, we must authorize or provide you with the service within 60 calendar days after receiving the Council's decision.
  - If we decide to appeal the decision, we will let you know in writing.
- **If the answer is no or if the Council denies the review request, the appeals process *may* or *may not* be over**.
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Council says no to your appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

Level 5 Appeal: A judge at the **Federal District Court** will review your appeal.

- This is the last step of the appeals process.

Section 9.2 Appeal Levels 3, 4, and 5 for Part D Drug Requests

This section may be appropriate for you if you have made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down.

If the value of the drug you have appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. If the dollar amount is less, you cannot appeal any further. The written response you receive to your Level 2 Appeal will explain who to contact and what to do to ask for a Level 3 Appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 Appeal:	**A judge (called an Administrative Law Judge) or an attorney adjudicator who works for the Federal government** will review your appeal and give you an answer.

- **If the answer is yes, the appeals process is over**. What you asked for in the appeal has been approved. We must **authorize or provide the drug coverage** that was approved by the Administrative Law Judge or attorney adjudicator **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the answer is no, the appeals process *may* or *may not* be over**.
    - If you decide to accept this decision that turns down your appeal, the appeals process is over.
    - If you do not want to accept the decision, you can continue to the next level of the review process. If the Administrative Law Judge or attorney adjudicator says no to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal.

Level 4 Appeal	The Medicare **Appeals Council** (Council) will review your appeal and give you an answer. The Council is part of the Federal government.

- **If the answer is yes, the appeals process is over**. What you asked for in the appeal has been approved. We must **authorize or provide the drug coverage** that was approved by the Council **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the answer is no, the appeals process *may* or *may not* be over**.
    - If you decide to accept this decision that turns down your appeal, the appeals process is over.
    - If you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Council says no to your appeal or denies your request to review the appeal, the notice you get will tell you whether the rules allow you to go on to Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

Level 5 Appeal	A judge at the **Federal District Court** will review your appeal.

- This is the last step of the appeals process.

MAKING COMPLAINTS

SECTION 10 How to make a complaint about quality of care, waiting times, Customer Service, or other concerns

If your problem is about decisions related to benefits, coverage, or payment, then this section is *not for you*. Instead, you need to use the process for coverage decisions and appeals. Go to Section 4 of this chapter.

Section 10.1 What kinds of problems are handled by the complaint process?

This section explains how to use the process for making complaints. The complaint process is used for certain types of problems *only.* This includes problems related to quality of care, waiting times, and the Customer Service you receive. Here are examples of the kinds of problems handled by the complaint process.

If you have any of these kinds of problems, you can "make a complaint"

Complaint	Example
Quality of your medical care	• Are you unhappy with the quality of the care you have received (including care in the hospital)?
Respecting your privacy	• Do you believe that someone did not respect your right to privacy or shared information about you that you feel should be confidential?
Disrespect, poor Customer Service, or other negative behaviors	• Has someone been rude or disrespectful to you? • Are you unhappy with how our Customer Service has treated you? • Do you feel you are being encouraged to leave the plan?
Waiting times	• Are you having trouble getting an appointment, or waiting too long to get it? • Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by our Customer Service or other staff at the plan? o Examples include waiting too long on the phone, in the waiting room, when getting a prescription, or in the exam room.

Complaint	Example
Cleanliness	• Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
Information you get from us	• Do you believe we have not given you a notice that we are required to give? • Do you think written information we have given you is hard to understand?
Timeliness (These types of complaints are all related to the timeliness of our actions related to coverage decisions and appeals)	The process of asking for a coverage decision and making appeals is explained in Sections 4-9 of this chapter. If you are asking for a coverage decision or making an appeal, you use that process, not the complaint process. However, if you have already asked us for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can also make a complaint about our slowness. Here are examples: • If you have asked us to give you a "fast coverage decision" or a "fast appeal," and we have said we will not, you can make a complaint. • If you believe we are not meeting the deadlines for giving you a coverage decision or an answer to an appeal you have made, you can make a complaint. • When a coverage decision we made is reviewed and we are told that we must cover or reimburse you for certain medical services or drugs, there are deadlines that apply. If you think we are not meeting these deadlines, you can make a complaint. • When we do not give you a decision on time, we are required to forward your case to the Independent Review Organization. If we do not do that within the required deadline, you can make a complaint.

Section 10.2 The formal name for "making a complaint" is "filing a grievance"

Legal Terms

- What this section calls a **"complaint"** is also called a **"grievance."**
- Another term for **"making a complaint"** is **"filing a grievance."**
- Another way to say "**using the process for complaints"** is "**using the process for filing a grievance."**

Section 10.3 Step-by-step: Making a complaint

Step 1: Contact us promptly – either by phone or in writing.

- **Usually, calling Customer Service is the first step.** If there is anything else you need to do Customer Service will let you know. Our phone number and hours of operation are 1-877-344-7364, 7 days a week 8:00 am to 8:00 pm, (TTY: 711).
- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we will respond to your complaint in writing.

- A member grievance (complaint) must be filed within 60 days of the date of the incident causing the complaint by writing to:

  EmblemHealth Medicare HMO
  ATTN: Grievance and Appeals
  PO Box 2807
  New York, NY 10116-2807

  or in person at:
  EmblemHealth Medicare HMO
  55 Water Street
  New York, NY 10041

  The hours of operation are Monday-Friday, 8:30 am - 5:00 pm. No appointment is necessary.

  or by calling Customer Service at:
  1-877-447-1199

TDD/TTY users may call 711

The hours of operation are Monday through Sunday, 8:00 am – 8:00 pm.

If you have someone filing a grievance for you, your grievance must include an " Appointment of Representative Form" authorizing the person to represent you. To get the form, call Customer Service (phone numbers are listed above) and ask for the " Appointment of Representative Form." It is also available on Medicare's website at https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at www.emblemhealth.com/medicare. While we can accept a grievance without the form, we cannot complete our review until we receive it. If we do not receive the form within 44 days after receiving your grievance request (our deadline for responding to your grievance), your grievance request will be closed.

A written acknowledgement will be sent to you within 15 days after the date the grievance was received by EmblemHealth Medicare. It will include a request for any additional information needed to resolve the grievance and will identify the name, address and phone number of the department which has been designated to respond to it.

We will investigate your grievance, and notify you of our decision as quickly as your case requires based on your health status, but no later than 30 calendar days after receiving your grievance. We may extend the time frame by up to 14 calendar days if you request an extension, or if we justify a need for additional information and the delay is in your best interest. We will notify you if an extension is needed.

If you request an expedited organization determination, expedited coverage determination, expedited reconsideration or expedited redetermination, we may decide your request does not meet the criteria to expedite, and therefore will process your request using the timeframes for a standard request. If we decide not to expedite your request, or decide to take an extension on your request, you may request an expedited grievance. EmblemHealth must respond to your expedited grievance within 24 hours of the request.

- **Whether you call or write, you should contact Customer Service right away.** The complaint must be made within 60 calendar days after you had the problem you want to complain about.
- **If you are making a complaint because we denied your request for a "fast coverage decision" or a "fast appeal," we will automatically give you a "fast complaint."** If you have a "fast complaint," it means we will give you **an answer within 24 hours**.

Legal Terms
What this section calls a **"fast complaint"** is also called an **"expedited grievance."**

Step 2: We look into your complaint and give you our answer.

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.
- **Most complaints are answered within 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. If we decide to take extra days, we will tell you in writing.
- **If we do not agree** with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not.

Section 10.4 You can also make complaints about quality of care to the Quality Improvement Organization

You can make your complaint about the quality of care you received to us by using the step-by-step process outlined above.

When your complaint is about *quality of care*, you also have two extra options:

- **You can make your complaint to the Quality Improvement Organization**. If you prefer, you can make your complaint about the quality of care you received directly to this organization (*without* making the complaint to us).
    - The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients.
    - To find the name, address, and phone number of the Quality Improvement Organization for your state, look in Chapter 2, Section 4, of this booklet. If you make a complaint to this organization, we will work with them to resolve your complaint.
- **Or you can make your complaint to both at the same time**. If you wish, you can make your complaint about quality of care to us and also to the Quality Improvement Organization.

Section 10.5 You can also tell Medicare about your complaint

You can submit a complaint about EmblemHealth VIP Premier (HMO) - Group plan directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the plan is not addressing your issue, please call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048.

CHAPTER 10

Ending your membership in the plan

Chapter 10. Ending your membership in the plan

SECTION 1 Introduction

Section 1.1 This chapter focuses on ending your membership in our plan

Ending your membership in EmblemHealth VIP Premier (HMO) - Group may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you have decided that you *want* to leave.
  - There are only certain times during the year, or certain situations, when you may voluntarily end your membership in the plan. Section 2 tells you *when* you can end your membership in the plan.
  - The process for voluntarily ending your membership varies depending on what type of new coverage you are choosing. Section 3 tells you *how* to end your membership in each situation.
- There are also limited situations where you do not choose to leave, but we are required to end your membership. Section 5 tells you about situations when we must end your membership.

If you are leaving our plan, you must continue to get your medical care through our plan until your membership ends.

SECTION 2 When can you end your membership in our plan?

You may end your membership in our plan only during certain times of the year, known as enrollment periods. All members have the opportunity to leave the plan during the Annual Enrollment Period and during the Medicare Advantage Open Enrollment Period. In certain situations, you may also be eligible to leave the plan at other times of the year.

Section 2.1 You can end your membership during the Annual Enrollment Period

You can end your membership during the **Annual Enrollment Period** (also known as the "Annual Open Enrollment Period"). This is the time when you should review your health and drug coverage and make a decision about your coverage for the upcoming year.

- **When is the Annual Enrollment Period?** This happens from October 15 to December 7.

Note: If you're in a drug management program, you may not be able to change plans. Chapter 5, Section 10 tells you more about drug management programs.

- **What type of plan can you switch to during the Annual Enrollment Period?** You can choose to keep your current coverage or make changes to your coverage for the upcoming year. If you decide to change to a new plan, you can choose any of the following types of plans:
    - Another Medicare health plan. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)
    - Original Medicare *with* a separate Medicare prescription drug plan.
    - *– or –* Original Medicare *without* a separate Medicare prescription drug plan.
        - **If you receive "Extra Help" from Medicare to pay for your prescription drugs:** If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

    Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for 63 or more days in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later. ("Creditable" coverage means the coverage is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) See Chapter 1, Section 5 for more information about the late enrollment penalty.
- **When will your membership end?** Your membership will end when your new plan's coverage begins on January 1.

Section 2.2 You can end your membership during the Medicare Advantage Open Enrollment Period

You have the opportunity to make *one* change to your health coverage during the **Medicare Advantage Open Enrollment Period**.

- **When is the annual Medicare Advantage Open Enrollment Period?** This happens every year from January 1 to March 31.
- **What type of plan can you switch to during the annual Medicare Advantage Open Enrollment Period?** During this time, you can:
    - Switch to another Medicare Advantage Plan. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)
    - Disenroll from our plan and obtain coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time.
- **When will your membership end?** Your membership will end on the first day of the month after you enroll in a different Medicare Advantage plan or we get your request to switch to Original Medicare. If you also choose to enroll in a Medicare prescription drug

plan, your membership in the drug plan will begin the first day of the month after the drug plan gets your enrollment request.

Section 2.3 In certain situations, you can end your membership during a Special Enrollment Period

In certain situations, members of EmblemHealth VIP Premier (HMO) - Group may be eligible to end their membership at other times of the year. This is known as a **Special Enrollment Period**.

- **Who is eligible for a Special Enrollment Period?** If any of the following situations apply to you, you may be eligible to end your membership during a Special Enrollment Period. These are just examples, for the full list you can contact the plan, call Medicare, or visit the Medicare website (www.medicare.gov):
  - Usually, when you have moved.
  - If you have Medicaid.
  - If you are eligible for "Extra Help" with paying for your Medicare prescriptions.
  - If we violate our contract with you.
  - If you are getting care in an institution, such as a nursing home or long-term care (LTC) hospital.
  - If you enroll in the Program of All-inclusive Care for the Elderly (PACE).
- **When are Special Enrollment Periods?** The enrollment periods vary depending on your situation.
- **What can you do?** To find out if you are eligible for a Special Enrollment Period, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048. If you are eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. This means you can choose any of the following types of plans:
  - Another Medicare health plan. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)
  - Original Medicare *with* a separate Medicare prescription drug plan.
  - – *or* – Original Medicare *without* a separate Medicare prescription drug plan.
    - **If you receive "Extra Help" from Medicare to pay for your prescription drugs:** If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

    Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for a continuous period of 63 days or more, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later. ("Creditable" coverage means the coverage is expected to pay, on

average, at least as much as Medicare's standard prescription drug coverage.) See Chapter 1, Section 5 for more information about the late enrollment penalty.

- **When will your membership end?** Your membership will usually end on the first day of the month after your request to change your plan is received.

Section 2.4 Where can you get more information about when you can end your membership?

If you have any questions or would like more information on when you can end your membership:

- You can **call Customer Service** (phone numbers are printed on the back cover of this booklet).
- You can find the information in the ***Medicare & You 2021*** Handbook.
  - Everyone with Medicare receives a copy of *Medicare & You* each fall. Those new to Medicare receive it within a month after first signing up.
  - You can also download a copy from the Medicare website (www.medicare.gov). Or, you can order a printed copy by calling Medicare at the number below.
- You can contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

SECTION 3 How do you end your membership in our plan?

Section 3.1 Usually, you end your membership by enrolling in another plan

Usually, to end your membership in our plan, you simply enroll in another Medicare plan during one of the enrollment periods (see Section 2 in this chapter for information about the enrollment periods). However, if you want to switch from our plan to Original Medicare *without* a Medicare prescription drug plan, you must ask to be disenrolled from our plan. There are two ways you can ask to be disenrolled:

- You can make a request in writing to us. Contact Customer Service if you need more information on how to do this (phone numbers are printed on the back cover of this booklet).
- --*or*--You can contact Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for a continuous period of 63 days or more, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later. ("Creditable"

coverage means the coverage is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) See Chapter 1, Section 5 for more information about the late enrollment penalty.

The table below explains how you should end your membership in our plan.

If you would like to switch from our plan to:	**This is what you should do:**
• Another Medicare health plan.	• Enroll in the new Medicare health plan. You will automatically be disenrolled from EmblemHealth VIP Premier (HMO) - Group when your new plan's coverage begins.
• Original Medicare *with* a separate Medicare prescription drug plan.	• Enroll in the new Medicare prescription drug plan. You will automatically be disenrolled from EmblemHealth VIP Premier (HMO) - Group your new plan's coverage begins.
• Original Medicare *without* a separate Medicare prescription drug plan. o **Note:** If you disenroll from a Medicare prescription drug plan and go without creditable prescription drug coverage for 63 days or more in a row, you may have to pay a late enrollment penalty if you join a Medicare drug plan later. See Chapter 1, Section 5 for more information about the late enrollment penalty.	• **Send us a written request to disenroll.** Contact Customer Service if you need more information on how to do this (phone numbers are printed on the back cover of this booklet). • You can also contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048. • You will be disenrolled from EmblemHealth VIP Premier (HMO) - Group when your coverage in Original Medicare begins.

SECTION 4 Until your membership ends, you must keep getting your medical services and drugs through our plan

Section 4.1 Until your membership ends, you are still a member of our plan

If you leave EmblemHealth VIP Premier (HMO) - Group, it may take time before your membership ends and your new Medicare coverage goes into effect. (See Section 2 for information on when your new coverage begins.) During this time, you must continue to get your medical care and prescription drugs through our plan.

- **You should continue to use our network pharmacies to get your prescriptions filled until your membership in our plan ends.** Usually, your prescription drugs are only covered if they are filled at a network pharmacy*:* including through our mail-order pharmacy services.
- **If you are hospitalized on the day that your membership ends, your hospital stay will usually be covered by our plan until you are discharged** (even if you are discharged after your new health coverage begins).

SECTION 5 EmblemHealth VIP Premier (HMO) - Group must end your membership in the plan in certain situations

Section 5.1 When must we end your membership in the plan?

EmblemHealth VIP Premier (HMO) - Group must end your membership in the plan if any of the following happen:

- If you no longer have Medicare Part A and Part B.
- If you move out of our service area.
- If you are away from our service area for more than six months.
    - If you move or take a long trip, you need to call Customer Service to find out if the place you are moving or traveling to is in our plan's area. (Phone numbers for Customer Service are printed on the back cover of this booklet.)
- If you become incarcerated (go to prison).
- If you are not a United States citizen or lawfully present in the United States.
- If you lie about or withhold information about other insurance you have that provides prescription drug coverage.

- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get medical care. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
    - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- If you are required to pay the extra Part D amount because of your income and you do not pay it, Medicare will disenroll you from our plan and you will lose prescription drug coverage.

Where can you get more information?

If you have questions or would like more information on when we can end your membership:

- You can call **Customer Service** for more information (phone numbers are printed on the back cover of this booklet).

Section 5.2 We cannot ask you to leave our plan for any reason related to your health

Our plan is not allowed to ask you to leave our plan for any reason related to your health.

What should you do if this happens?

If you feel that you are being asked to leave our plan because of a health-related reason, you should call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may call 24 hours a day, 7 days a week.

Section 5.3 You have the right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership. You can look in Chapter 9, Section 10 for information about how to make a complaint.

CHAPTER 11

Legal notices

Chapter 11. Legal notices

SECTION 1 Notice about governing law

Many laws apply to this *Evidence of Coverage* and some additional provisions may apply because they are required by law. This may affect your rights and responsibilities even if the laws are not included or explained in this document. The principal law that applies to this document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS. In addition, other Federal laws may apply and, under certain circumstances, the laws of the state you live in.

SECTION 2 Notice about non-discrimination

We don’t discriminate based on race, ethnicity, national origin, color, religion, sex, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location. All organizations that provide Medicare Advantage plans, like our plan, must obey Federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, EmblemHealth as a Medicare Advantage Organization, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any State laws.

In some situations, other parties should pay for your medical care before your Medicare Advantage (MA) health plan. In those situations, your Medicare Advantage plan may pay, but have the right to get the payments back from these other parties. Medicare Advantage plans may not be the primary payer for medical care you receive. These situations include those in which the Federal Medicare Program is considered a secondary payer under the Medicare Secondary Payer laws. For information on the Federal Medicare Secondary Payer program, Medicare has written a booklet with general information about what happens when people with Medicare have additional insurance. It's called Medicare and Other Health Benefits: Your Guide to Who Pays First (publication number 02179). You can get a copy by calling 1-800-MEDICARE, 24 hours a day, 7 days a week, or by visiting the www.medicare.gov website.

The plan's rights to recover in these situations are based on the terms of this health plan contract, as well as the provisions of the Federal statutes governing the Medicare Program. Your MA plan coverage is always secondary to any payment made or reasonably expected to be made under:

A workers compensation law or plan of the United States or a State, any non-fault based insurance, including automobile and non-automobile no-fault and medical payments insurance, any liability insurance policy or plan (including a self-insured plan) issued under an automobile or other type of policy or coverage, and any automobile insurance policy or plan (including a self-insured plan), including, but not limited to, uninsured and underinsured motorist coverages.

Since your MA plan is always secondary to any automobile no-fault (Personal Injury Protection) or medical payments coverage, you should review your automobile insurance policies to ensure that appropriate policy provisions have been selected to make your automobile coverage primary for your medical treatment arising from an automobile accident.

As outlined herein, in these situations, your MA plan may make payments on your behalf for this medical care, subject to the conditions set forth in this provision for the plan to recover these payments from you or from other parties. Immediately upon making any conditional payment, your MA plan shall be subrogated to (stand in the place of) all rights of recovery you have against any person, entity or insurer responsible for causing your injury, illness or condition or against any person, entity or insurer listed as a primary payer above.

In addition, if you receive payment from any person, entity or insurer responsible for causing your injury, illness or condition or you receive payment from any person, entity or insurer listed as a primary payer above, your MA plan has the right to recover from, and be reimbursed by you for all conditional payments the plan has made or will make as a result of that injury, illness or condition.

Your MA plan will automatically have a lien, to the extent of benefits it paid for the treatment of the injury, illness or condition, upon any recovery whether by settlement, judgment or otherwise. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the Plan including, but not limited to, you, your representatives or agents, any person, entity or insurer responsible for causing your injury, illness or condition or any person, entity or insurer listed as a primary payer above.

By accepting benefits (whether the payment of such benefits is made to you or made on your behalf to any health care provider) from your MA plan, you acknowledge that the plan's recovery rights are a first priority claim and are to be paid to the plan before any other claim for your damages. The plan shall be entitled to full reimbursement on a first-dollar basis from any payments, even if such payment to the plan will result in a recovery to you which is insufficient to make you whole or to compensate you in part or in whole for the damages you sustained. Your MA plan is not required to participate in or pay court costs or attorney fees to any attorney hired by you to pursue your damage claims.

Your MA plan is entitled to full recovery regardless of whether any liability for payment is admitted by any person, entity or insurer responsible for causing your injury, illness or condition or by any person, entity or insurer listed as a primary payer above. The plan is entitled to full recovery regardless of whether the settlement or judgment received by you identifies the medical benefits the plan provided or purports to allocate any portion of such settlement or judgment to

payment of expenses other than medical expenses. The MA plan is entitled to recover from any and all settlements or judgments, even those designated as for pain and suffering, non-economic damages and/or general damages only.

You, and your legal representatives, shall fully cooperate with the plan's efforts to recover its benefits paid. It is your duty to notify the plan within 30 days of the date when notice is given to any party, including an insurance company or attorney, of your intention to pursue or investigate a claim to recover damages or obtain compensation due to your injury, illness or condition. You and your agents or representatives shall provide all information requested by the plan or its representatives. You shall do nothing to prejudice your MA plan's subrogation or recovery interest or to prejudice the plan's ability to enforce the terms of this provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the plan.

Failure to provide requested information or failure to assist your MA plan in pursuit of its subrogation or recovery rights may result in you being personally responsible for reimbursing the plan for benefits paid relating to the injury, illness or condition as well as for the plan's reasonable attorney fees and costs incurred in obtaining reimbursement from you.

CHAPTER 12

Definitions of important words

Chapter 12. Definitions of important words

Ambulatory Surgical Center – An Ambulatory Surgical Center is an entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization and whose expected stay in the center does not exceed 24 hours.

Annual Enrollment Period – A set time each fall when members can change their health or drug plans or switch to Original Medicare. The Annual Enrollment Period is from October 15 until December 7.

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or prescription drugs or payment for services or drugs you already received. You may also make an appeal if you disagree with our decision to stop services that you are receiving. For example, you may ask for an appeal if we don't pay for a drug, item, or service you think you should be able to receive. Chapter 9 explains appeals, including the process involved in making an appeal.

Balance Billing – When a provider (such as a doctor or hospital) bills a patient more than the plan's allowed cost-sharing amount. As a member of our plan, you only have to pay our plan's cost-sharing amounts when you get services covered by our plan. We do not allow providers to "balance bill" or otherwise charge you more than the amount of cost-sharing your plan says you must pay.

Benefit Period –The way that both our plan and Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. For Skilled Nursing Facility stays a benefit period begins the day you are admitted as an inpatient in a SNF. The benefit period ends when you haven't received any inpatient hospital care or skilled care in a SNF for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. For inpatient hospital stays, a benefit period begins when you are admitted to the hospital and ends when you are discharged from the hospital. If you are admitted to the hospital after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

Brand Name Drug – A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand name drug has expired.

Catastrophic Coverage Stage – The stage in the Part D Drug Benefit where you pay a low copayment or coinsurance for your drugs after you or other qualified parties on your behalf have spent Catastrophic Coverage limit in covered drugs during the covered year.

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that administers Medicare. Chapter 2 explains how to contact CMS.

Coinsurance – An amount you may be required to pay as your share of the cost for services or prescription drugs ,Coinsurance is usually a percentage (for example, 20%).

Complaint - The formal name for "making a complaint" is "filing a grievance." The complaint process is used for certain types of problems *only.* This includes problems related to quality of care, waiting times, and the Customer Service you receive. See also "Grievance," in this list of definitions.

Comprehensive Outpatient Rehabilitation Facility (CORF) – A facility that mainly provides rehabilitation services after an illness or injury, and provides a variety of services including physical therapy, social or psychological services, respiratory therapy, occupational therapy and speech-language pathology services, and home environment evaluation services.

Copayment (or "copay") – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or a prescription drug. A copayment is a set amount, rather than a percentage. For example, you might pay $10 or $20 for a doctor's visit or prescription drug.

Cost-Sharing – Cost-sharing refers to amounts that a member has to pay when services or drugs are received. (This is in addition to the plan's monthly premium.) Cost-sharing includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before services or drugs are covered; (2) any fixed "copayment" amount that a plan requires when a specific service or drug is received; or (3) any "coinsurance" amount, a percentage of the total amount paid for a service or drug, that a plan requires when a specific service or drug is received. A "daily cost-sharing rate" may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you are required to pay a copayment.

Cost-Sharing Tier – Every drug on the list of covered drugs is in one of the cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug. The number of tiers may be different for your employer.

Coverage Determination – A decision about whether a drug prescribed for you is covered by the plan and the amount, if any, you are required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn't covered under your plan, that isn't a coverage determination. You need to call or write to your plan to ask for a formal decision about the coverage. Coverage determinations are called "coverage decisions" in this booklet. Chapter 9 explains how to ask us for a coverage decision.

Covered Drugs – The term we use to mean all of the prescription drugs covered by our plan.

Covered Services – The general term we use to mean all of the health care services and supplies that are covered by our plan.

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible

for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

Custodial Care – Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you do not need skilled medical care or skilled nursing care. Custodial care is personal care that can be provided by people who don't have professional skills or training, such as help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn't pay for custodial care.

Customer Service – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See Chapter 2 for information about how to contact Customer Service.

Daily cost-sharing rate – A "daily cost-sharing rate" may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you are required to pay a copayment. A daily cost-sharing rate is the copayment divided by the number of days in a month's supply. Here is an example: If your copayment for a one-month supply of a drug is $30, and a one-month's supply in your plan is 30 days, then your "daily cost-sharing rate" is $1 per day. This means you pay $1 for each day's supply when you fill your prescription.

Deductible – The amount you must pay for health care or prescriptions before our plan begins to pay.

Disenroll or **Disenrollment** – The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

Dispensing Fee – A fee charged each time a covered drug is dispensed to pay for the cost of filling a prescription. The dispensing fee covers costs such as the pharmacist's time to prepare and package the prescription.

Durable Medical Equipment (DME) – Certain medical equipment that is ordered by your doctor for medical reasons. Examples include walkers, wheelchairs, crutches, powered mattress systems, diabetic supplies, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, or hospital beds ordered by a provider for use in the home.

Emergency – A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

Emergency Care – Covered services that are: 1) rendered by a provider qualified to furnish emergency services; and 2) needed to treat, evaluate, or stabilize an emergency medical condition.

Evidence of Coverage (EOC) and Disclosure Information – This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

Exception – A type of coverage decision that, if approved, allows you to get a drug that is not on your plan sponsor's formulary (a formulary exception), or get a non-preferred drug at a lower cost-sharing level (a tiering exception). You may also request an exception if your plan sponsor requires you to try another drug before receiving the drug you are requesting, or the plan limits the quantity or dosage of the drug you are requesting (a formulary exception).

Extra Help – A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

Generic Drug – A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand name drug. Generally, a "generic" drug works the same as a brand name drug and usually costs less.

Grievance - A type of complaint you make about us or pharmacies, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes.

Home Health Aide – A home health aide provides services that don't need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides do not have a nursing license or provide therapy.

Hospice - A member who has 6 months or less to live has the right to elect hospice. We, your plan, must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums you are still a member of our plan. You can still obtain all medically necessary services as well as the supplemental benefits we offer. The hospice will provide special treatment for your state.

Hospital Inpatient Stay – A hospital stay when you have been formally admitted to the hospital for skilled medical services. Even if you stay in the hospital overnight, you might still be considered an "outpatient."

Income Related Monthly Adjustment Amount (IRMAA) – If your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain amount, you'll pay the standard premium amount and an Income Related Monthly Adjustment Amount, also known as IRMAA. IRMAA is an extra charge added to your premium. Less than 5% of people with Medicare are affected, so most people will not pay a higher premium.

Initial Coverage Limit – The maximum limit of coverage under the Initial Coverage Stage.

Initial Coverage Stage – This is the stage before your total drug costs including amounts you have paid and what your plan has paid on your behalf for the year have reached Initial Coverage Limit.

Initial Enrollment Period – When you are first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. For example, if you're eligible for Medicare when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

Institutional Special Needs Plan (SNP) – A Special Needs Plan that enrolls eligible individuals who continuously reside or are expected to continuously reside for 90 days or longer in a long-term care (LTC) facility. These LTC facilities may include a skilled nursing facility (SNF), nursing facility (NF), (SNF/NF), an intermediate care facility for the mentally retarded (ICF/MR), and/or an inpatient psychiatric facility. An institutional Special Needs Plan to serve Medicare residents of LTC facilities must have a contractual arrangement with (or own and operate) the specific LTC facility(ies).

Institutional Equivalent Special Needs Plan (SNP) – An institutional Special Needs Plan that enrolls eligible individuals living in the community but requiring an institutional level of care based on the State assessment. The assessment must be performed using the same respective State level of care assessment tool and administered by an entity other than the organization offering the plan. This type of Special Needs Plan may restrict enrollment to individuals that reside in a contracted assisted living facility (ALF) if necessary to ensure uniform delivery of specialized care.

List of Covered Drugs (Formulary or "Drug List") – A list of prescription drugs covered by the plan. The drugs on this list are selected by the plan with the help of doctors and pharmacists. The list includes both brand name and generic drugs.

Low Income Subsidy (LIS) – See "Extra Help."

Maximum Out-of-Pocket Amount – The most that you pay out-of-pocket during the calendar year for in-network covered Part A and Part B services. Amounts you pay for your plan premiums, Medicare Part A and Part B premiums, and prescription drugs do not count toward the maximum out-of-pocket amount. See Chapter 4, Section 1 for information about your maximum out-of-pocket amount.

Medicaid (or Medical Assistance) – A joint Federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid. See Chapter 2, Section 6 for information about how to contact Medicaid in your state.

Medically Accepted Indication – A use of a drug that is either approved by the Food and Drug Administration or supported by certain reference books. See Chapter 5, Section 3 for more information about a medically accepted indication.

Medically Necessary – Services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

Medicare –The Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare a Medicare Cost Plan, a PACE plan or a Medicare Advantage Plan.

Medicare Advantage Open Enrollment Period – A set time each year when members in a Medicare Advantage plan can cancel their plan enrollment and switch to another Medicare Advantage plan, or obtain coverage through Original Medicare. If you choose to switch to Original Medicare furing this period, you can also join a separate Medicare prescription drug plan at that time. The Open Enrollment Period is from January 1 until March 31, and is also available for a 3-month period after an individual is first eligible for Medicare.

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be an HMO, PPO, a Private Fee-for-Service (PFFS) plan, or a Medicare Medical Savings Account (MSA) plan. When you are enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan, and are not paid for under Original Medicare. In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**. Everyone who has Medicare Part A and Part B is eligible to join any Medicare health plan that is offered in their area, except people with End-Stage Renal Disease (unless certain exceptions apply).

Medicare Cost Plan – A Medicare Cost Plan is a plan operated by a Health Maintenance Organization (HMO) or Competitive Medical Plan (CMP) in accordance with a cost-reimbursed contract under section 1876(h) of the Act.

Medicare Coverage Gap Discount Program – A program that provides discounts on most covered Part D brand name drugs to Part D members who have reached the Coverage Gap Stage and who are not already receiving "Extra Help." Discounts are based on agreements between the Federal government and certain drug manufacturers. For this reason, most, but not all, brand name drugs are discounted.

Medicare-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans, including our plan, must cover all of the services that are covered by Medicare Part A and B.

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

Medicare Prescription Drug Coverage (Medicare Part D) – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

"Medigap" (Medicare Supplement Insurance) Policy – Medicare supplement insurance sold by private insurance companies to fill "gaps" in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage Plan is not a Medigap policy.)

Member (Member of our Plan, or "Plan Member") – A person with Medicare who is eligible to get covered services, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Network Pharmacy – A network pharmacy is a pharmacy where members of our plan can get their prescription drug benefits. We call them "network pharmacies" because they contract with our plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Network Provider – "Provider" is the general term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services. We call them "**network providers**" when they have an agreement with our plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our plan. Our plan pays network providers based on the agreements it has with the providers or if the providers agree to provide you with plan-covered services. Network providers may also be referred to as "plan providers."

Optional Supplemental Benefits – Non-Medicare-covered benefits that can be purchased for an additional premium and are not included in your package of benefits. If you choose to have optional supplemental benefits, you may have to pay an additional premium. You must voluntarily elect Optional Supplemental Benefits in order to get them.

Organization Determination – The Medicare Advantage plan has made an organization determination when it makes a decision about whether items or services are covered or how much you have to pay for covered items or services. Organization determinations are called "coverage decisions" in this booklet. Chapter 9 explains how to ask us for a coverage decision.

Original Medicare ("Traditional Medicare" or "Fee-for-service" Medicare) – Original Medicare is offered by the government, and not a private health plan like Medicare Advantage Plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Network Pharmacy – A pharmacy that doesn't have a contract with our plan to coordinate or provide covered drugs to members of our plan. As explained in this Evidence of

Coverage, most drugs you get from out-of-network pharmacies are not covered by our plan unless certain conditions apply.

Out-of-Network Provider or Out-of-Network Facility – A provider or facility with which we have not arranged to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that are not employed, owned, or operated by our plan or are not under contract to deliver covered services to you. Using out-of-network providers or facilities is explained in this booklet in Chapter 3.

Out-of-Pocket Costs – See the definition for "cost-sharing" above. A member's cost-sharing requirement to pay for a portion of services or drugs received is also referred to as the member's "out-of-pocket" cost requirement.

PACE plan – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term care (LTC) services for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible, while getting the high-quality care they need. People enrolled in PACE plans receive both their Medicare and Medicaid benefits through the plan.

Part C – see "Medicare Advantage (MA) Plan."

Part D – The voluntary Medicare Prescription Drug Benefit Program. (For ease of reference, we will refer to the prescription drug benefit program as Part D.)

Part D Drugs – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. (See your formulary for a specific list of covered drugs.) Certain categories of drugs were specifically excluded by Congress from being covered as Part D drugs.

Part D Late Enrollment Penalty – An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that is expected to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more after you are first eligible to join a Part D plan. You pay this higher amount as long as you have a Medicare drug plan. There are some exceptions. For example, if you receive "Extra Help" from Medicare to pay your prescription drug plan costs, you will not pay a late enrollment penalty.

Preferred Provider Organization (PPO) Plan – A Preferred Provider Organization plan is a Medicare Advantage Plan that has a network of contracted providers that have agreed to treat plan members for a specified payment amount. A PPO plan must cover all plan benefits whether they are received from network or out-of-network providers. Member cost-sharing will generally be higher when plan benefits are received from out-of-network providers. PPO plans have an annual limit on your out-of-pocket costs for services received from network (preferred) providers and a higher limit on your total combined out-of-pocket costs for services from both network (preferred) and out-of-network (non-preferred) providers.

Premium – The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Primary Care Provider (PCP) – Your primary care provider is the doctor or other provider you see first for most health problems. He or she makes sure you get the care you need to keep you healthy. He or she also may talk with other doctors and health care providers about your care and refer you to them. In many Medicare health plans, you must see your primary care provider before you see any other health care provider. See Chapter 3, Section 2.1 for information about Primary Care Providers.

Prior Authorization – Approval in advance to get services or certain drugs that may or may not be on our formulary. Some in-network medical services are covered only if your doctor or other network provider gets "prior authorization" from our plan. Covered services that need prior authorization are marked in the Benefits Chart in Chapter 4. Some drugs are covered only if your doctor or other network provider gets "prior authorization" from us. Covered drugs that need prior authorization are marked in the formulary.

Prosthetics and Orthotics – These are medical devices ordered by your doctor or other health care provider. Covered items include, but are not limited to, arm, back and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients. See Chapter 2, Section 4 for information about how to contact the QIO for your state.

Quantity Limits – A management tool that is designed to limit the use of selected drugs for quality, safety, or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

Rehabilitation Services – These services include physical therapy, speech and language therapy, and occupational therapy.

Service Area – A geographic area where a health plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (non-emergency) services. The plan may disenroll you if you permanently move out of the plan's service area.

Skilled Nursing Facility (SNF) Care – Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Special Enrollment Period – A set time when members can change their health or drug plans or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the service area, if you are getting "Extra Help" with your prescription drug costs, if you move into a nursing home, or if we violate our contract with you.

Special Needs Plan – A special type of Medicare Advantage Plan that provides more focused health care for specific groups of people, such as those who have both Medicare and Medicaid, who reside in a nursing home, or who have certain chronic medical conditions.

Standard Cost-Sharing– Standard cost-sharing is cost-sharing other than preferred cost-sharing offered at a network pharmacy.

Step Therapy – A utilization tool that requires you to first try another drug to treat your medical condition before we will cover the drug your physician may have initially prescribed.

Supplemental Security Income (SSI) – A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

Urgently Needed Services – Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible.

EmblemHealth VIP Premier (HMO) – Group Customer Service

Method	Customer Service – Contact Information
CALL	**1-877-344-7364** Calls to this number are free. Hours of operation: 8:00 a.m. – 8:00 p.m., seven days a week Customer Service also has free language interpreter services available for non-English speakers.
TTY	**711** (New York State Relay Service) This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Hours of operation: 8:00 a.m. – 8:00 p.m., seven days a week
FAX	1-212-510-5373
WRITE	EmblemHealth Medicare HMO ATTN: Customer Service 55 Water Street New York, NY 10041-8190
WEBSITE	**emblemhealth.com/medicare**

Health Insurance Information Counseling and Assistance Program (HIICAP) (New York's SHIP)

HIICAP is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

Method	Contact Information
CALL	1-800-701-0501
TTY	711 (New York State Relay Service) This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	New York State Office for the Aging 2 Empire State Plaza Albany, New York 12223-1251
WEBSITE	http://www.aging.ny.gov

PRA Disclosure Statement *According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1051. If you have comments or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.*

Medicare Evidence of Coverage without Rx

Provided on the following pages is our Medicare Evidence of Coverage without prescription drug coverage. Note that we are submitting both versions since there are minor differences, such as chapter numbers, between both files beyond the prescription drug coverage section.

EmblemHealth

January 1 – December 31, 2021

Evidence of Coverage:

Your Medicare Health Benefits and Services as a Member of EmblemHealth VIP Rx Carveout (HMO) - Group

This booklet gives you the details about your Medicare health care coverage from January 1 – December 31, 2021. It explains how to get coverage for the health care services you need.
This is an important legal document. Please keep it in a safe place.

This plan, EmblemHealth VIP Rx Carveout (HMO) Group, is offered by HIP Health Insurance Plan of Greater New York (HIP)/EmblemHealth. When this *Evidence of Coverage* says "we," "us," or "our," it means HIP/EmblemHealth. When it says "plan" or "our plan," it means EmblemHealth VIP Rx Carveout (HMO) Group.

HIP Health Plan of New York (HIP) is a HMO plan with a Medicare contract. Enrollment in HIP depends on contract renewal. HIP is an EmblemHealth company.

This document is available for free in Spanish.

Please contact our Customer Service number at **1-877-344-7364** for additional information. (TTY users should call 711.) Hours are 7 days a week, 8:00 am to 8:00 pm.

This information is also available in alternate formats such as large print and braille. Please call Customer Service at the above numbers for more information.

ATTENTION: If you speak other languages, language assistance services, free of charge, are available to you. Call 877-344-7364 (TTY 711).

ATENCIÓN: Si usted habla español, tiene a su disposición, gratis, servicios de ayuda para idiomas. Llame al 877-344-7364 (TTY 711).

Benefits, premium, deductible, and/or copayments/coinsurance may change on January 1, 2022.

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

H3330_127362_C Group

2021 Evidence of Coverage

Table of Contents

This list of chapters and page numbers is your starting point. For more help in finding information you need, go to the first page of a chapter. **You will find a detailed list of topics at the beginning of each chapter.**

CHAPTER 1

Getting started as a member

Chapter 1. Getting started as a member

SECTION 1 Introduction

Section 1.1 You are enrolled in EmblemHealth VIP Rx Carveout (HMO) Group, which is a Medicare HMO

You are covered by Medicare, and you have chosen to get your Medicare health care through our plan, EmblemHealth VIP Rx Carveout (HMO) Group.

There are different types of Medicare health plans. EmblemHealth VIP Rx Carveout (HMO) Group is a Medicare Advantage HMO Plan (HMO stands for Health Maintenance Organization) approved by Medicare and run by a private company. EmblemHealth VIP Rx Carveout (HMO) Group does not include Part D prescription drug coverage.

Coverage under this Plan qualifies as Qualifying Health Coverage (QHC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at: www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

Section 1.2 What is the *Evidence of Coverage* booklet about?

This *Evidence of Coverage* booklet tells you how to get your Medicare medical care covered through our plan. This booklet explains your rights and responsibilities, what is covered, and what you pay as a member of the plan.

The word "coverage" and "covered services" refers to the medical care and services available to you as a member of EmblemHealth VIP Rx Carveout (HMO) Group.

It's important for you to learn what the plan's rules are and what services are available to you. We encourage you to set aside some time to look through this *Evidence of Coverage* booklet.

If you are confused or concerned or just have a question, please contact our plan's Customer Service (phone numbers are printed on the back cover of this booklet).

Section 1.3 Legal information about the *Evidence of Coverage*

It's part of our contract with you

This *Evidence of Coverage* is part of our contract with you about how *our* plan covers your care. Other parts of this contract include your enrollment form, and any notices you receive from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called "riders" or "amendments."

The contract is in effect for months in which you are enrolled in *our* plan between January 1, 2021 and December 31, 2021.

Each calendar year, Medicare allows us to make changes to the plans that we offer. This means we can change the costs and benefits of *our* plan after December 31, 2021. We can also choose to stop offering the plan, or to offer it in a different service area, after December 31, 2021.

Medicare must approve our plan each year

Medicare (the Centers for Medicare & Medicaid Services) must approve our plan each year. You can continue to get Medicare coverage as a member of our plan as long as we choose to continue to offer the plan and Medicare renews its approval of the plan.

SECTION 2 What makes you eligible to be a plan member?

Section 2.1 Your eligibility requirements

You are eligible for membership in our plan as long as:

- You have both Medicare Part A and Medicare Part B (Section 2.2 tells you about Medicare Part A and Medicare Part B)
- -- *and* -- you live in our geographic service area (Section 2.3 below describes our service area).
- -- *and* -- you are a United States citizen or are lawfully present in the United States
- -- *and* -- you do not have End-Stage Renal Disease (ESRD), with limited exceptions, such as if you develop ESRD when you are already a member of a plan that we offer, or you were a member of a different Medicare Advantage plan that was terminated.

Section 2.2 What are Medicare Part A and Medicare Part B?

When you first signed up for Medicare, you received information about what services are covered under Medicare Part A and Medicare Part B. Remember:

- Medicare Part A generally helps cover services provided by hospitals (for inpatient services, skilled nursing facilities, or home health agencies).
- Medicare Part B is for most other medical services (such as physician's services and other outpatient services) and certain items (such as durable medical equipment (DME) and supplies).

Section 2.3 Here is the plan service area for our plan

Although Medicare is a Federal program, *our* plan is available only to individuals who live in our plan service area. To remain a member of our plan, you must continue to reside in the plan service area. The service area is described below.

Our service area includes these counties in New York State:

New York, Bronx, Queens, Kings, Richmond, Nassau, Suffolk and Westchester.

If you plan to move out of the service area, please contact Customer Service (phone numbers are printed on the back cover of this booklet). When you move, you will have a Special Enrollment Period that will allow you to switch to Original Medicare or enroll in a Medicare health or drug plan that is available in your new location.

It is also important that you call Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

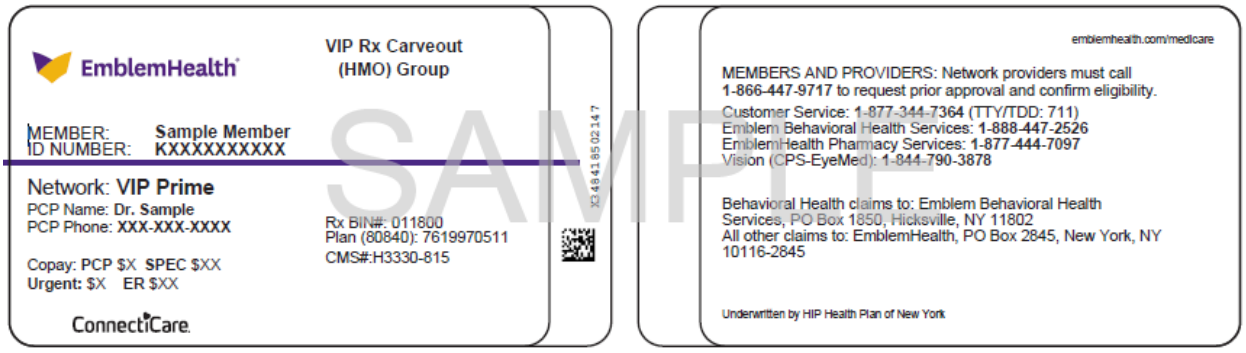
Section 2.4 U.S. Citizen or Lawful Presence

A member of a Medicare health plan must be a U.S. citizen or lawfully present in the United States. Medicare (the Centers for Medicare & Medicaid Services) will notify our plan if you are not eligible to remain a member on this basis. We must disenroll you if you do not meet this requirement.

SECTION 3 What other materials will you get from us?

Section 3.1 Your plan membership card – Use it to get all covered care

While you are a member of our plan, you must use your membership card for our plan whenever you get any services covered by this plan. You should also show the provider your Medicaid card, if applicable. Here's a sample membership card to show you what yours will look like:



As long as you are a member of our plan, in most cases, DO NOT use your new red, white, and blue Medicare card for covered medical services while you are a member of this plan. If you use your Medicare card instead of your EmblemHealth VIP Rx Carveout (HMO) –Group membership card, you may have to pay the full cost of medical services yourself. Keep your Medicare card in a safe place. You may be asked to show it if you need hospital services, hospice services, or participate in routine research studies.

Here's why this is so important: If you get covered services using your new red, white, and blue Medicare card instead of using your EmblemHealth VIP Rx Carveout (HMO) –Group membership card while you are a plan member, you may have to pay the full cost yourself.

If your plan membership card is damaged, lost, or stolen, call Customer Service right away and we will send you a new card. (Phone numbers for Customer Service are printed on the back cover of this booklet.)

Section 3.2 The *Provider Directory*: Your guide to all providers in the plan's network

The *Provider Directory* lists our network providers and durable medical equipment suppliers.

What are "network providers"?

Network providers are the doctors and other health care professionals, medical groups, durable medical equipment suppliers, hospitals, and other health care facilities that have an agreement with us to accept our payment and any plan cost-sharing as payment in full. We have arranged for these providers to deliver covered services to members in our plan. The most recent list of providers and suppliers is available on our website at www.emblemhealth.com/medicare .

Why do you need to know which providers are part of our network?

It is important to know which providers are part of our network because, with limited exceptions, while you are a member of our plan you must use network providers to get your medical care and services. The only exceptions are emergencies, urgently needed services when the network is not available (generally, when you are out of the area), out-of-area dialysis services, and cases in which *our* plan authorizes use of out-of-network providers. See Chapter 3 (*Using the plan's coverage for your medical services*) for more specific information about emergency, out-of-network, and out-of-area coverage.

If you don't have your copy of the *Provider Directory*, you can request a copy from Customer Service (phone numbers are printed on the back cover of this booklet). You may ask Customer Service for more information about our network providers, including their qualifications. You can also see the Provider Directory at www.emblemhealth.com/medicare, or download it from this website. Both Customer Service and the website can give you the most up-to-date information about changes in our network providers.

SECTION 4 Your monthly premium for our plan

Section 4.1 How much is your plan premium?

Your coverage is provided through contract with your current employer or former employer or union. Please contact the employer's or union's benefits administrator or see your Cost Sharing Guide for information about your plan premium.

Section 4.2 There are several ways you can pay your plan premium

There are four ways you can pay your plan premium. They are listed below. Please contact Customer Service at the number listed in this booklet to tell us what option you choose. You can change your premium payment option at any time by calling our Customer Service. It may take us a few weeks to process your request. If you do not make a selection, you will be sent a monthly premium invoice.

If you decide to change the way you pay your premium, it can take up to three months for your new payment method to take effect. While we are processing your request for a new payment method, you are responsible for making sure that your plan premium is paid on time.

Option 1: You can pay by check

You will receive a monthly bill from us approximately two weeks before the month the premium is due. Your premium payment by check is due the first day of each month. For example, you will receive a monthly bill in February. We must receive your check by March 1. Checks should be made payable to EmblemHealth, not CMS. You can arrange to be billed monthly, quarterly or annually.

You can mail your premium to:
EmblemHealth-HIP
Box 9221, G.P.O.
New York, NY 10087

Or you can drop off your premium payment at:
EmblemHealth
55 Water Street
New York, NY 10041-8190

Hours are Monday to Friday, 8:30 am to 5:00 pm

Option 2: Web Pay

You can pay your premium on the Web using EmblemHealth's secure online payment system. To do so, sign into your EmblemHealth website account and select "Pay My Bill." You will be

transferred to our banking partner payment system, where you can make one-time or recurring payments utilizing options for e-check, Visa, MasterCard or debit card at your convenience. Online access is available 24 hours a day, 7 days a week. Please note that our plan is prohibited from furnishing discounts for enrollees who use the Web to pay their plan premiums.

Option 3: EmblemHealth's secure automated phone system

You can pay your premium over the phone using EmblemHealth's secure automated phone system, or EmblemHealth Interactive Voice Response (EIVR). Contact Customer Service and you will hear a prompt to check your account balance and make a payment. You will be transferred to our secure banking partner payment system and may use your checking or savings account, VISA or MasterCard to make a payment. There is no fee for these transactions. The EIVR payment option is available 24 hours a day, 7 days a week. (Phone numbers for Customer Service are printed on the back cover of this booklet.)

Option 4: You can have the plan premium taken out of your monthly Social Security check

You can have the plan premium taken out of your monthly Social Security check. Contact Customer Service for more information on how to pay your plan premium this way. We will be happy to help you set this up. (Phone numbers for Customer Service are printed on the back cover of this booklet.)

What to do if you are having trouble paying your plan premium

Your plan premium is due in our office by the first day of each month. If we have not received your premium payment by the 10th day of the month, we will send you a notice telling you that your plan membership will end if we do not receive your premium within 3 months. If you are required to pay a Part D late enrollment penalty, you must pay the penalty to keep your prescription drug coverage.

If you are having trouble paying your premium on time, please contact Customer Service to see if we can direct you to programs that will help with your premium. (Phone numbers for Customer Service are printed on the back cover of this booklet.)

If we end your membership because you did not pay your premium, you will have health coverage under Original Medicare.

At the time we end your membership, you may still owe us for premiums you have not paid. We have the right to pursue collection of the premiums you owe. In the future, if you want to enroll again in our plan (or another plan that we offer), you will need to pay the amount you owe before you can enroll. If you think we have wrongfully ended your membership, you have a right to ask us to reconsider this decision by making a complaint. Chapter 7, Section 9 of this booklet tells how to make a complaint. If you had an emergency circumstance that was out of your control and it caused you to not be able to pay your premiums within our grace period, you can ask us to reconsider this decision by calling 1-877-344-7364 between 8:00 am to 8:00 pm 7 days a week.

TTY users should call 711. You must make your request no later than 60 days after the date your membership ends.

Section 4.3 Can we change your monthly plan premium during the year?

No. We are not allowed to change the amount we charge for the plan's monthly plan premium during the year. If the monthly plan premium changes for next year we will tell you in September and the change will take effect on January 1.

SECTION 5 Please keep your plan membership record up to date

Section 5.1 How to help make sure that we have accurate information about you

Your membership record has information from your enrollment form, including your address and telephone number. It shows your specific plan coverage including your Primary Care Provider.

The doctors, hospitals, and other providers in the plan's network need to have correct information about you. **These network providers use your membership record to know what services are covered and the cost-sharing amounts for you**. Because of this, it is very important that you help us keep your information up to date.

Let us know about these changes:

- Changes to your name, your address, or your phone number
- Changes in any other health insurance coverage you have (such as from your employer, your spouse's employer, workers' compensation, or Medicaid)
- If you have any liability claims, such as claims from an automobile accident
- If you have been admitted to a nursing home
- If you receive care in an out-of-area or out-of-network hospital or emergency room
- If your designated responsible party (such as a caregiver) changes
- If you are participating in a clinical research study

If any of this information changes, please let us know by calling Customer Service (phone numbers are printed on the back cover of this booklet).

It is also important to contact Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

Read over the information we send you about any other insurance coverage you have

Medicare requires that we collect information from you about any other medical or drug insurance coverage that you have. That's because we must coordinate any other coverage you have with your benefits under our plan. (For more information about how our coverage works when you have other insurance, see Section 7 in this chapter.)

Once each year, we will send you a letter that lists any other medical or drug insurance coverage that we know about. Please read over this information carefully. If it is correct, you don't need to do anything. If the information is incorrect, or if you have other coverage that is not listed, please call Customer Service (phone numbers are printed on the back cover of this booklet).

SECTION 6 We protect the privacy of your personal health information

Section 6.1 We make sure that your health information is protected

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

For more information about how we protect your personal health information, please go to Chapter 6, Section 1.3 of this booklet.

SECTION 7 How other insurance works with our plan

Section 7.1 Which plan pays first when you have other insurance?

When you have other insurance (like employer group health coverage), there are rules set by Medicare that decide whether our plan or your other insurance pays first. The insurance that pays first is called the "primary payer" and pays up to the limits of its coverage. The one that pays second, called the "secondary payer," only pays if there are costs left uncovered by the primary coverage. The secondary payer may not pay all of the uncovered costs.

These rules apply for employer or union group health plan coverage:

- If you have retiree coverage, Medicare pays first.
- If your group health plan coverage is based on your or a family member's current employment, who pays first depends on your age, the number of people employed by your employer, and whether you have Medicare based on age, disability, or End-Stage Renal Disease (ESRD):

  - If you're under 65 and disabled and you or your family member are still working, your group health plan pays first if the employer has 100 or more employees or at least one employer in a multiple employer plan that has more than 100 employees.
  - If you're over 65 and you or your spouse are still working, your group health plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan that has more than 20 employees.
- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

These types of coverage usually pay first for services related to each type:

- No-fault insurance (including automobile insurance)
- Liability (including automobile insurance)
- Black lung benefits
- Workers' compensation

Medicaid and TRICARE never pay first for Medicare-covered services. They only pay after Medicare, employer group health plans, and/or Medigap have paid.

If you have other insurance, tell your doctor, hospital, and pharmacy. If you have questions about who pays first, or you need to update your other insurance information, call Customer Service (phone numbers are printed on the back cover of this booklet). You may need to give your plan member ID number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.

CHAPTER 2

Important phone numbers and resources

Chapter 2. Important phone numbers and resources

SECTION 1 Our plan contacts
(how to contact us, including how to reach Customer Service at the plan)

How to contact our plan's Customer Service

For assistance with claims, billing, or member card questions, please call or write to EmblemHealth VIP Rx Carveout (HMO) – Group Customer Service. We will be happy to help you.

Method	Customer Service – Contact Information
CALL	1-877-344-7364 Calls to this number are free. 7 days a week, 8:00 am to 8:00 pm. Customer Service also has free language interpreter services available for non-English speakers.
TTY	711 (New York State Relay Service) Calls to this number are free. 7 days a week, 8:00 am to 8:00 pm.
FAX	1-212-510-5373
WRITE	EmblemHealth Medicare HMO ATTN: Customer Service 55 Water Street New York, NY 10041-8190
WEBSITE	www.emblemhealth.com/medicare

How to contact us when you are asking for a coverage decision about your medical care

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services. For more information on asking for coverage decisions about your medical care, see Chapter 7. (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints*).

You may call us if you have questions about our coverage decision process.

Method	Coverage Decisions for Medical Care – Contact Information
CALL	1-877-344-7364 Calls to this number are free. 7 days a week, 8:00 am to 8:00 pm.
TTY	711 (New York State Relay Service) Calls to this number are free 7 days a week, 8:00 am to 8:00 pm.
FAX	1-866-215-2928
WRITE	EmblemHealth Medicare HMO ATTN: Utilization Management 55 Water Street New York, NY 10041
WEBSITE	www.emblemhealth.com/medicare

How to contact us when you are making an appeal about your medical care

An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on making an appeal about your medical care, see Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints*).

Method	Appeals for Medical Care – Contact Information
CALL	1-877-344-7364 Calls to this number are free 7 days a week, 8:00 am to 8:00 pm For expedited appeals: 1-888-447-6855
TTY	711 (New York State Relay Service) Calls to this number are free 7 days a week, 8:00 am to 8:00 pm For expedited appeals: 711
FAX	1-212-510-5320 For expedited appeals: 1-866-350-2168
WRITE	EmblemHealth Grievance and Appeal Department P.O. Box 2807 New York, NY 10116-2807
WEBSITE	www.emblemhealth.com/medicare

How to contact us when you are making a complaint about your medical care

You can make a complaint about us or one of our network providers, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. (If your problem is about the plan's coverage or payment, you should look at the section above about making an appeal.) For more information on making a complaint about your medical care, see Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints*).

Method	Complaints About Medical Care – Contact Information
CALL	1-877-344-7364 Calls to this number are free. 7 days a week, 8:00 am to 8:00 pm
TTY	711 (New York State Relay Service) Calls to this number are free. 7 days a week, 8:00 am to 8:00 pm
FAX	1-212-510-5320 For expedited appeals: 1-866-350-2168
WRITE	EmblemHealth Grievance and Appeal Department P.O. Box 2807 New York, NY 10116-2807
MEDICARE WEBSITE	You can submit a complaint about our plan directly to Medicare. To submit an online complaint to Medicare go to www.medicare.gov/MedicareComplaintForm/home.aspx.

Where to send a request asking us to pay for our share of the cost for medical care you have received

For more information on situations in which you may need to ask us for reimbursement or to pay a bill you have received from a provider, see Chapter 5 (*Asking us to pay our share of a bill you have received for covered medical services or drugs*).

Please note: If you send us a payment request and we deny any part of your request, you can appeal our decision. See Chapter 7 *(What to do if you have a problem or complaint (coverage decisions, appeals, complaints))* for more information.

Method	Medicare Payment Request – Contact Information
WRITE	EmblemHealth Claims P.O. Box 2845 New York, NY 10116-2845
WEBSITE	**www.emblemhealth.com/medicare**

SECTION 2 Medicare
(how to get help and information directly from the Federal Medicare program)

Medicare is the Federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

The Federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (sometimes called "CMS"). This agency contracts with Medicare Advantage organizations including us.

Method	Medicare – Contact Information
CALL	1-800-MEDICARE, or 1-800-633-4227 Calls to this number are free. 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.

Method	Medicare – Contact Information
WEBSITE	www.medicare.gov This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes booklets you can print directly from your computer. You can also find Medicare contacts in your state. The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools: • **Medicare Eligibility Tool:** Provides Medicare eligibility status information. • **Medicare Plan Finder:** Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an *estimate* of what your out-of-pocket costs might be in different Medicare plans. You can also use the website to tell Medicare about any complaints you have about EmblemHealth VIP Rx Carveout (HMO) Group: • **Tell Medicare about your complaint:** You can submit a complaint about *our plan)* directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program. If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare and tell them what information you are looking for. They will find the information on the website, print it out, and send it to you. (You can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)

SECTION 3 State Health Insurance Assistance Program (free help, information, and answers to your questions about Medicare)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In New York State, the SHIP is called the Health Insurance Information Counseling and Assistance Program (HIICAP).

HIICAP is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

HIICAP counselors can help you with your Medicare questions or problems. They can help you understand your Medicare rights, help you make complaints about your medical care or treatment, and help you straighten out problems with your Medicare bills. HIICAP counselors can also help you understand your Medicare plan choices and answer questions about switching plans.

Method	Health Insurance Information Counseling and Assistance Program (HIICAP) (New York's SHIP)
CALL	1-800-701-0501
TTY	711 (New York State Relay Service)
WRITE	New York State Office for the Aging 2 Empire State Plaza Albany, New York 12223-1251
WEBSITE	www.aging.ny.gov/

SECTION 4 Quality Improvement Organization (paid by Medicare to check on the quality of care for people with Medicare)

There is a designated Quality Improvement Organization for serving Medicare beneficiaries in each state. For New York State, the Quality Improvement Organization is called Livanta.

Livanta has a group of doctors and other health care professionals who are paid by the Federal government. This organization is paid by Medicare to check on and help improve the quality of care for people with Medicare. Livanta is an independent organization. It is not connected with our plan.

You should contact Livanta in any of these situations:

- You have a complaint about the quality of care you have received.
- You think coverage for your hospital stay is ending too soon.
- You think coverage for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon.

Method	LIVANTA (New York State's Quality Improvement Organization) Contact Information
CALL	1-866-815-5440
TTY	1-866-868-2289
FAX	1-855-236-2423 (for appeals) 1-844-420-6671 (for all other reviews)
WRITE	Livanta BFCC-QIO Program 9090 Junction Drive, Suite 10 Annapolis Junction, MD 20701
WEBSITE	www.Livanta.com

SECTION 5 Social Security

Social Security is responsible for determining eligibility and handling enrollment for Medicare. U.S. citizens and lawful permanent residents who are 65 or older, or who have a disability or End-Stage Renal Disease and meet certain conditions, are eligible for Medicare. If you are already getting Social Security checks, enrollment into Medicare is automatic. If you are not getting Social Security checks, you have to enroll in Medicare. Social Security handles the enrollment process for Medicare. To apply for Medicare, you can call Social Security or visit your local Social Security office.

If you move or change your mailing address, it is important that you contact Social Security to let them know.

Method	**Social Security– Contact Information**
CALL	1-800-772-1213 Calls to this number are free. Available 7:00 am to 7:00 pm, Monday through Friday. You can use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	1-800-325-0778 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 7:00 am to 7:00 pm, Monday through Friday.
WEBSITE	www.ssa.gov

SECTION 6 Medicaid
(a joint Federal and state program that helps with medical costs for some people with limited income and resources)

Medicaid is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid.

In addition, there are programs offered through Medicaid that help people with Medicare pay their Medicare costs, such as their Medicare premiums. These "Medicare Savings Programs" help people with limited income and resources save money each year:

- **Qualified Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums, and other cost-sharing (like deductibles, coinsurance, and copayments). (Some people with QMB are also eligible for full Medicaid benefits (QMB+).)
- **Specified Low-Income Medicare Beneficiary (SLMB):** Helps pay Part B premiums. (Some people with SLMB are also eligible for full Medicaid benefits (SLMB+).)
- **Qualified Individual (QI):** Helps pay Part B premiums.
- Qualified Disabled & Working Individuals (QDWI): Helps pay Part A premiums.

To find out more about Medicaid and its programs, contact the New York State Department of Health.

Method	New York State Department of Health (New York's Medicaid program – Contact Information
CALL	1-800-541-2831
TTY	711 (New York State Relay Service)
WRITE	New York State Department of Health Corning Tower Empire State Plaza, Albany, NY 12237
WEBSITE	www.health.ny.gov/health_care/medicaid

SECTION 7 How to contact the Railroad Retirement Board

The Railroad Retirement Board is an independent Federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you have questions regarding your benefits from the Railroad Retirement Board, contact the agency.

If you receive your Medicare through the Railroad Retirement Board, it is important that you let them know if you move or change your mailing address.

Method	Railroad Retirement Board – Contact Information
CALL	1-877-772-5772 Calls to this number are free. Available 9:00 am to 3:30 pm, Monday through Friday. If you have a touch-tone telephone, recorded information and automated services are available 24 hours a day, including weekends and holidays.
TTY	1-312-751-4701 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are *not* free.
WEBSITE	rrb.gov

SECTION 8 Do you have "group insurance" or other health insurance from an employer?

If you (or your spouse) get benefits from your (or your spouse's) employer or retiree group as part of this plan, you may call the employer/union benefits administrator or Customer Service if you have any questions. You can ask about your (or your spouse's) employer or retiree health benefits, premiums, or the enrollment period. (Phone numbers for Customer Service are printed on the back cover of this booklet.) You may also call 1-800-MEDICARE (1-800-633-4227; TTY: 1-877-486-2048) with questions related to your Medicare coverage under this plan.

CHAPTER 3

Using the plan's coverage for your medical services

Chapter 3. Using the plan's coverage for your medical services

SECTION 1 Things to know about getting your medical care covered as a member of our plan

This chapter explains what you need to know about using the plan to get your medical care covered. It gives definitions of terms and explains the rules you will need to follow to get the medical treatments, services, and other medical care that are covered by the plan.

For the details on what medical care is covered by our plan and how much you pay when you get this care, use the benefits chart in the next chapter, Chapter 4 (*Medical Benefits Chart, what is covered and what you pay*).

Section 1.1 What are "network providers" and "covered services"?

Here are some definitions that can help you understand how you get the care and services that are covered for you as a member of our plan:

- **"Providers"** are doctors and other health care professionals licensed by the state to provide medical services and care. The term "providers" also includes hospitals and other health care facilities.
- **"Network providers"** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and your cost-sharing amount as payment in full. We have arranged for these providers to deliver covered services to members in our plan. The providers in our network bill us directly for care they give you. When you see a network provider, you pay only your share of the cost for their services.
- **"Covered services"** include all the medical care, health care services, supplies, and equipment that are covered by our plan. Your covered services for medical care are listed in the benefits chart in Chapter 4.

Section 1.2 Basic rules for getting your medical care covered by the plan

As a Medicare health plan, our plan must cover all services covered by Original Medicare and must follow Original Medicare's coverage rules.

Our plan will generally cover your medical care as long as:

- **The care you receive is included in the plan's Medical Benefits Chart** (this chart is in Chapter 4 of this booklet).
- **The care you receive is considered medically necessary**. "Medically necessary" 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.

- **You have a network primary care provider (a PCP) who is providing and overseeing your care.** As a member of our plan, you must choose a network PCP (for more information about this, see Section 2.1 in this chapter).
    - In most situations, your network PCP must give you approval in advance before you can use other providers in the plan's network, such as specialists, hospitals, skilled nursing facilities, or home health care agencies. This is called giving you a "referral." For more information about this, see Section 2.3 of this chapter.
    - Referrals from your PCP are not required for emergency care or urgently needed services. There are also some other kinds of care you can get without having approval in advance from your PCP (for more information about this, see Section 2.2 of this chapter).
- **You must receive your care from a network provider** (for more information about this, see Section 2 in this chapter). In most cases, care you receive from an out-of-network provider (a provider who is not part of our plan's network) will not be covered. *Here are three exceptions:*
    - The plan covers emergency care or urgently needed services that you get from an out-of-network provider. For more information about this, and to see what emergency or urgently needed services means, see Section 3 in this chapter.
    - If you need medical care that Medicare requires our plan to cover and the providers in our network cannot provide this care, you can get this care from an out-of-network provider. Authorization should be obtained from the plan prior to seeking care. In this situation, you will pay the same as you would pay if you got the care from a network provider. For information about getting approval to see an out-of-network doctor, see Section 2.4 in this chapter.
    - The plan covers kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area.

SECTION 2 Use providers in the plan's network to get your medical care

Section 2.1 You must choose a Primary Care Provider (PCP) to provide and oversee your medical care

What is a "PCP" and what does the PCP do for you?

When you become a member of our plan, you must choose a network provider to be your Primary Care Provider, or PCP. The name and office telephone number of your PCP is printed on your Member ID card. Your PCP can be a family practice or internal medicine physician, nurse practitioner, geriatrician or other health care professional who meets state requirements and is trained to give you basic medical care. Usually, you will get most of your routine or basic care from your PCP. Your PCP will coordinate the rest of the covered services you get as a plan

member and will give you the referrals to see other providers, like specialists. The services your PCP will coordinate for you include, but are not limited to:

- X-rays and laboratory tests
- Therapies and specialist visits.

In some cases, your PCP will need to get prior authorization (prior approval) from the plan for other services. Chapter 4 has more information on which services require prior authorization.

Call your PCP to make an appointment. When you change your PCP, ask your doctors to send your medical record to your new PCP. It will help your PCP understand your medical history and coordinate your care better

How do you choose your PCP?

You may choose your PCP by using our Provider Directory or getting help from Customer Service. You can also get most up-to-date list by going to our website at www.emblemhealth.com/medicare.

Changing your PCP

You may change your PCP for any reason, at any time. Also, it's possible that your PCP might leave our plan's network of providers and you would have to find a new PCP. Your new PCP will be effective on the day that you make the change.

You may change your PCP online at www.emblemhealth.com/medicare or call Customer Service. Be sure to tell Customer Service if you are seeing specialists that need your PCP's approval. They will help make sure you can continue with the specialty care and other services you have been getting when you change your PCP.

Section 2.2 What kinds of medical care can you get without getting approval in advance from your PCP?

You can get the services listed below without getting approval in advance from your PCP.

- Routine women's health care, which includes breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams*:* as long as you get them from a network provider.
- Flu shots, Hepatitis B vaccinations, and pneumonia vaccinations as long as you get them from a network provider.
- Emergency services from network providers or from out-of-network providers.
- Urgently needed services from network providers or from out-of-network providers when network providers are temporarily unavailable or inaccessible (e.g., when you are temporarily outside of the plan's service area).

- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area. (If possible, please call Customer Service before you leave the service area so we can help arrange for you to have maintenance dialysis while you are away. Phone numbers for Customer Service are printed on the back cover of this booklet.)
- All preventive services like annual wellness visit, breast cancer screening, colorectal cancer screening and many others. You will see this apple next to the preventive services listed in the Medical benefits chart in Chapter 4 of this booklet. These services do not require a referral or prior authorization.

Section 2.3 How to get care from specialists and other network providers

A specialist is a doctor who provides health care services for a specific disease or part of the body. There are many kinds of specialists. Here are a few examples:

- Oncologists care for patients with cancer.
- Cardiologists care for patients with heart conditions.
- Orthopedists care for patients with certain bone, joint, or muscle conditions.

Your PCP will give you a referral to see specialists and other providers. Where your provider gets a referral or prior authorization depends on the type of service. Please see medical benefits chart in Chapter 4, Section 2.1 for more information. The services listed in the benefits chart indicate if prior approval is required and who can provide it. Your provider may contact our plan to obtain authorization. If you are a member of a medical group, they will generally give you a referral to a specialist who also belongs to that medical group, but you are not limited to that specialist.

What if a specialist or another network provider leaves our plan?

We may make changes to the hospitals, doctors, and specialists (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan, but if your doctor or specialist does leave your plan you have certain rights and protections that are summarized below:

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.

- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider to manage your care.

If you need assistance or have questions about seeing a specialist, please contact our Customer Service (phone numbers are on the back cover of this booklet).

Section 2.4 How to get care from out-of-network providers

Generally, you must get all of your covered services from in-network providers. In some cases you can get services from out-of-network providers without prior approval from the plan. For example, you can get emergency and urgent care, and out-of-area dialysis from out-of-network providers. If you get routine care from out-of-network providers without prior approval, you will be responsible for the costs. Call Customer Service at the number listed on your booklet to find a provider near you. If you need specialized care and we do not have a network provider available, let us know and request an authorization by calling 1-877-344-7364 (TTY 711), 7 days a week 8 am to 8 pm. See the Medical Benefits Chart in Chapter 4, Section 2.1 for more information about what services require authorization.

SECTION 3 How to get covered services when you have an emergency or urgent need for care or during a disaster

Section 3.1 Getting care if you have a medical emergency

What is a "medical emergency" and what should you do if you have one?

A **"medical emergency"** is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You do *not* need to get approval or a referral first from your PCP.

- **As soon as possible, make sure that our plan has been told about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. Call Customer Service at 1-877-344-7364, 7 days a week from 8:00 am to 8:00 pm, or 711 for TTY.

What is covered if you have a medical emergency?

You may get covered emergency medical care whenever you need it, anywhere in the United States or its territories. Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. For more information, see the Medical Benefits Chart in Chapter 4 of this booklet.

Our plan covers emergency medical care anywhere in the world. For more information, see the Medical Benefits Chart in Chapter 4 of this booklet.

If you have an emergency, we will talk with the doctors who are giving you emergency care to help manage and follow up on your care. The doctors who are giving you emergency care will decide when your condition is stable and the medical emergency is over.

After the emergency is over you are entitled to follow-up care to be sure your condition continues to be stable. Your follow-up care will be covered by our plan. If your emergency care is provided by out-of-network providers, we will try to arrange for network providers to take over your care as soon as your medical condition and the circumstances allow.

What if it wasn't a medical emergency?

Sometimes it can be hard to know if you have a medical emergency. For example, you might go in for emergency care – thinking that your health is in serious danger – and the doctor may say that it wasn't a medical emergency after all. If it turns out that it was not an emergency, as long as you reasonably thought your health was in serious danger, we will cover your care.

However, after the doctor has said that it was *not* an emergency, we will cover additional care *only* if you get the additional care in one of these two ways:

- You go to a network provider to get the additional care.
- – *or* – The additional care you get is considered "urgently needed services" and you follow the rules for getting this urgently needed services (for more information about this, see Section 3.2 below).

Section 3.2 Getting care when you have an urgent need for services

What are "urgently needed services"?

"Urgently needed services" are non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network

providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible. The unforeseen condition could, for example, be an unforeseen flare-up of a known condition that you have.

What if you are in the plan's service area when you have an urgent need for care?

You should always try to obtain urgently needed services from network providers. However, if providers are temporarily unavailable or inaccessible and it is not reasonable to wait to obtain care from your network provider when the network becomes available, we will cover urgently needed services that you get from an out-of-network provider.

You may have an injury or an illness that is not an emergency but still needs prompt care. To locate a network urgent care center near you, visit our website at www.emblemhealth.com. On holidays, urgent care center hours of operation are subject to change. Please call the urgent care center nearest you to confirm its hours. You can also contact Customer Service for assistance (phone numbers are printed on the back cover of this booklet).

What if you are outside the plan's service area when you have an urgent need for care?

When you are outside the service area and cannot get care from a network provider, our plan will cover urgently needed services that you get from any provider.

Our plan covers urgently needed care anywhere in the world.

Section 3.3 Getting care during a disaster

If the Governor of your state, the U.S. Secretary of Health and Human Services, or the President of the United States declares a state of disaster or emergency in your geographic area, you are still entitled to care from your plan.

Please visit the following website: www.emblemhealth.com/Our-Plans/Medicare/Contact-us for information on how to obtain needed care during a disaster.

Generally, if you cannot use a network provider during a disaster, your plan will allow you to obtain care from out-of-network providers at in-network cost-sharing.

SECTION 4 What if you are billed directly for the full cost of your covered services?

Section 4.1 You can ask us to pay our share of the cost of covered services

If you have paid more than your share for covered services, or if you have received a bill for the full cost of covered medical services, go to Chapter 5 (Asking us to pay our share of a bill you have received for covered medical services) for information about what to do.

Section 4.2 If services are not covered by our plan, you must pay the full cost

Our Plan covers all medical services that are medically necessary, these services are listed in the plan's Medical Benefits Chart (this chart is in Chapter 4 of this booklet) and are obtained consistent with plan rules. You are responsible for paying the full cost of services that aren't covered by our plan, either because they are not plan covered services, or they were obtained out-of-network and were not authorized.

If you have any questions about whether we will pay for any medical service or care that you are considering, you have the right to ask us whether we will cover it before you get it. You also have the right to ask for this in writing. If we say we will not cover your services, you have the right to appeal our decision not to cover your care.

Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) has more information about what to do if you want a coverage decision from us or want to appeal a decision we have already made. You may also call Customer Service to get more information (phone numbers are printed on the back cover of this booklet).

For covered services that have a benefit limitation, you pay the full cost of any services you get after you have used up your benefit for that type of covered service. The amount you pay for services after you have used up your benefit for that type of covered service will not count toward an out of pocket maximum. You can call Customer Service when you want to know how much of your benefit limit you have already used.

SECTION 5 How are your medical services covered when you are in a "clinical research study"?

Section 5.1 What is a "clinical research study"?

A clinical research study (also called a "clinical trial") is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. They test new medical care

procedures or drugs by asking for volunteers to help with the study. This kind of study is one of the final stages of a research process that helps doctors and scientists see if a new approach works and if it is safe.

Not all clinical research studies are open to members of our plan. Medicare first needs to approve the research study. If you participate in a study that Medicare has *not* approved, *you will be responsible for paying all costs for your participation in the study*.

Once Medicare approves the study, someone who works on the study will contact you to explain more about the study and see if you meet the requirements set by the scientists who are running the study. You can participate in the study as long as you meet the requirements for the study *and* you have a full understanding and acceptance of what is involved if you participate in the study.

If you participate in a Medicare-approved study, Original Medicare pays most of the costs for the covered services you receive as part of the study. When you are in a clinical research study, you may stay enrolled in our plan and continue to get the rest of your care (the care that is not related to the study) through our plan.

If you want to participate in a Medicare-approved clinical research study, you do *not* need to get approval from us or your PCP. The providers that deliver your care as part of the clinical research study do *not* need to be part of our plan's network of providers.

Although you do not need to get our plan's permission to be in a clinical research study, **you do need to tell us before you start participating in a clinical research study.**

If you plan on participating in a clinical research study, contact Customer Service (phone numbers are printed on the back cover of this booklet) to let them know that you will be participating in a clinical trial and to find out more specific details about what your plan will pay.

Section 5.2 When you participate in a clinical research study, who pays for what?

Once you join a Medicare-approved clinical research study, you are covered for routine items and services you receive as part of the study, including:

- Room and board for a hospital stay that Medicare would pay for even if you weren't in a study.
- An operation or other medical procedure if it is part of the research study.
- Treatment of side effects and complications of the new care.

Original Medicare pays most of the cost of the covered services you receive as part of the study. After Medicare has paid its share of the cost for these services, our plan will also pay for part of the costs. We will pay the difference between the cost-sharing in Original Medicare and your

cost-sharing as a member of our plan. This means you will pay the same amount for the services you receive as part of the study as you would if you received these services from our plan.

> *Here's an example of how the cost-sharing works:* Let's say that you have a lab test that costs $100 as part of the research study. Let's also say that your share of the costs for this test is $20 under Original Medicare, but the test would be $10 under our plan's benefits. In this case, Original Medicare would pay $80 for the test and we would pay another $10. This means that you would pay $10, which is the same amount you would pay under our plan's benefits.

In order for us to pay for our share of the costs, you will need to submit a request for payment. With your request, you will need to send us a copy of your Medicare Summary Notices or other documentation that shows what services you received as part of the study and how much you owe. Please see Chapter 5 for more information about submitting requests for payment.

When you are part of a clinical research study, **neither Medicare nor our plan will pay for any of the following:**

- Generally, Medicare will *not* pay for the new item or service that the study is testing unless Medicare would cover the item or service even if you were *not* in a study.
- Items and services the study gives you or any participant for free.
- Items or services provided only to collect data, and not used in your direct health care. For example, Medicare would not pay for monthly CT scans done as part of the study if your medical condition would normally require only one CT scan.

Do you want to know more?

You can get more information about joining a clinical research study by reading the publication "Medicare and Clinical Research Studies" on the Medicare website (www.medicare.gov).

You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

SECTION 6 Rules for getting care covered in a "religious non-medical health care institution"

Section 6.1 What is a religious non-medical health care institution?

A religious non-medical health care institution is a facility that provides care for a condition that would ordinarily be treated in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against a member's religious beliefs, we will instead provide coverage for care in a religious non-medical health care institution. You may choose to pursue medical care at any time for any reason. This benefit is provided only for Part A inpatient

services (non-medical health care services). Medicare will only pay for non-medical health care services provided by religious non-medical health care institutions.

Section 6.2 Receiving Care from a Religious Non-Medical Health Care Institution

To get care from a religious non-medical health care institution, you must sign a legal document that says you are conscientiously opposed to getting medical treatment that is "non-excepted."

- "Non-excepted" medical care or treatment is any medical care or treatment that is *voluntary* and *not required* by any federal, state, or local law.
- "Excepted" medical treatment is medical care or treatment that you get that is *not* voluntary or *is required* under federal, state, or local law.

To be covered by our plan, the care you get from a religious non-medical health care institution must meet the following conditions:

- The facility providing the care must be certified by Medicare.
- Our plan's coverage of services you receive is limited to *non-religious* aspects of care.
- If you get services from this institution that are provided to you in a facility, the following conditions apply:
  - You must have a medical condition that would allow you to receive covered services for inpatient hospital care or skilled nursing facility care.
  - – *and* – you must get approval in advance from our plan before you are admitted to the facility or your stay will not be covered.

Please see the description of your inpatient hospital benefit in the Benefits Chart located in Chapter 4 of this booklet.

There is no limit to the number of days covered by the plan for each benefit period.

SECTION 7 Rules for ownership of durable medical equipment

Section 7.1 Will you own the durable medical equipment after making a certain number of payments under our plan?

Durable medical equipment (DME) includes items such as oxygen equipment and supplies, wheelchairs, walkers, powered mattress systems, crutches, diabetic supplies, speech generating devices, IV infusion pumps, nebulizers, and hospital beds ordered by a provider for use in the home. The member always owns certain items, such as prosthetics. In this section, we discuss other types of DME that you must rent.

In Original Medicare, people who rent certain types of DME own the equipment after paying copayments for the item for 13 months. As a member of our plan, however, you usually will not acquire ownership of rented DME items no matter how many copayments you make for the item while a member of our plan. Under certain limited circumstances we will transfer ownership of the durable medical equipment item. Call Customer Service (phone numbers are printed on the back cover of this booklet) to find out about the requirements you must meet and the documentation you need to provide.

What happens to payments you made for durable medical equipment if you switch to Original Medicare?

If you did not acquire ownership of the DME item while in our plan, you will have to make 13 new consecutive payments after you switch to Original Medicare in order to own the item. Payments you made while in our plan do not count toward these 13 consecutive payments.

If you made fewer than 13 payments for the DME item under Original Medicare before you joined our plan, your previous payments also do not count toward the 13 consecutive payments. You will have to make 13 new consecutive payments after you return to Original Medicare in order to own the item. There are no exceptions to this case when you return to Original Medicare.

SECTION 8 Rules for oxygen equipment, supplies and maintenance

Section 8.1 What oxygen benefits are you entitled to?

If you qualify for Medicare oxygen equipment coverage, then for as long as you are enrolled, EmblemHealth VIP Rx Carveout (HMO) – Group will cover:

- Rental of oxygen equipment
- Delivery of oxygen and oxygen contents
- Tubing and related oxygen accessories for the delivery of oxygen and oxygen contents
- Maintenance and repairs of oxygen equipment

If you leave EmblemHealth VIP Rx Carveout (HMO) – Group or no longer medically require oxygen equipment, then the oxygen equipment must be returned to the owner.

Section 8.2 What is your cost sharing? Will it change after 36 months?

For your cost sharing for Medicare oxygen equipment coverage per month please contact your benefits administrator or see your Cost Sharing Guide. Your cost sharing will not change after being enrolled for 36 months in EmblemHealth VIP Rx Carveout (HMO) – Group.

If prior to enrolling in EmblemHealth VIP Rx Carveout (HMO) – Group you had made 36 months of rental payment for oxygen equipment coverage, please contact your benefits administrator or see your Cost Sharing Guide for your cost share in EmblemHealth VIP Rx Carveout (HMO) – Group

Section 8.3 What happens if you leave your plan and return to Original Medicare?

If you return to Original Medicare, then you start a new 36-month cycle which renews every five years. For example, if you had paid rentals for oxygen equipment for 36 months prior to joining EmblemHealth VIP Rx Carveout (HMO) – Group, join EmblemHealth VIP Rx Carveout (HMO) – Group for 12 months, and then return to Original Medicare, you will pay full cost sharing for oxygen equipment coverage.

Similarly, if you made payments for 36 months while enrolled in EmblemHealth VIP Rx Carveout (HMO) – Group and then return to Original Medicare, you will pay full cost sharing for oxygen equipment coverage.

CHAPTER 4

Medical Benefits Chart (what is covered and what you pay)

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

SECTION 1 Understanding your out-of-pocket costs for covered services

This chapter focuses on your covered services and what you pay for your medical benefits. It includes a Medical Benefits Chart that lists your covered services and shows how much you will pay for each covered service as a member of our plan. Later in this chapter, you can find information about medical services that are not covered. It also explains limits on certain services.

Section 1.1 Types of out-of-pocket costs you may pay for your covered services

To understand the payment information we give you in this chapter, you need to know about the types of out-of-pocket costs you may pay for your covered services.

- The **"deductible"** is the amount you must pay for medical services before our plan begins to pay its share.
- A **"copayment"** is the fixed amount you pay each time you receive certain medical services. You pay a copayment at the time you get the medical service. (The Medical Benefits Chart in Section 2 tells you more about your copayments.)
- **"Coinsurance"** is the percentage you pay of the total cost of certain medical services. You pay a coinsurance at the time you get the medical service. (The Medical Benefits Chart in Section 2 tells you more about your coinsurance.)

Most people who qualify for Medicaid or for the Qualified Medicare Beneficiary (QMB) program should never pay deductibles, copayments or coinsurance. Be sure to show your proof of Medicaid or QMB eligibility to your provider, if applicable. If you think that you are being asked to pay improperly, contact Customer Service.

Section 1.2 What is the most you will pay for Medicare Part A and Part B covered medical services?

Because you are enrolled in a Medicare Advantage Plan, there is a limit to how much you have to pay out-of-pocket each year for in-network medical services that are covered under Medicare Part A and Part B (see the Medical Benefits Chart in Section 2, below). This limit is called the maximum out-of-pocket amount for medical services.

As a member of *our plan,* the most you will have to pay out-of-pocket for in-network covered Part A and Part B services in 2021. The amounts you pay for copayments, and coinsurance for in-network covered services count toward this maximum out-of-pocket amount. (The amounts you pay for your plan premiums and for your Part D prescription drugs do not count toward your maximum out-of-pocket amount. In addition, amounts you pay for some services do not count

toward your maximum out-of-pocket amount. These services are marked with an asterisk in the Medical Benefits Chart. If you reach the maximum out-of-pocket amount, you will not have to pay any out-of-pocket costs for the rest of the year for in-network covered Part A and Part B services. However, you must continue to pay your plan premium and the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party). We will send you a Cost Sharing Guide under separate cover that tells you what your maximum out-of-pocket amount will be for 2021. Or, you can call your benefits administrator for this information.

Section 1.3 Our plan does not allow providers to "balance bill" you

As a member of our plan, an important protection for you is that you only have to pay your cost-sharing amount when you get services covered by our plan. We do not allow providers to add additional separate charges, called "balance billing." This protection (that you never pay more than your cost-sharing amount) applies even if we pay the provider less than the provider charges for a service and even if there is a dispute and we don't pay certain provider charges.

Here is how this protection works.

- If your cost-sharing is a copayment (a set amount of dollars, for example, $15.00), then you pay only that amount for any covered services from a network provider.
- If your cost-sharing is a coinsurance (a percentage of the total charges), then you never pay more than that percentage. However, your cost depends on which type of provider you see:
  - If you receive the covered services from a network provider, you pay the coinsurance percentage multiplied by the plan's reimbursement rate (as determined in the contract between the provider and the plan).
  - If you receive the covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers. (Remember, the plan covers services from out-of-network providers only in certain situations, such as when you get a referral.)
  - If you receive the covered services from an out-of-network provider who does not participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers. (Remember, the plan covers services from out-of-network providers only in certain situations, such as when you get a referral.)
- If you believe a provider has "balance billed" you, call Customer Service (phone numbers are printed on the back cover of this booklet).

SECTION 2 Use the *Medical Benefits Chart* to find out what is covered for you and how much you will pay

Section 2.1 Your medical benefits and costs as a member of the plan

The Medical Benefits Chart on the following pages lists the services our plan covers and what you pay out-of-pocket for each service. Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts. The services listed in the Medical Benefits Chart are covered only when the following coverage requirements are met:

- Your Medicare covered services must be provided according to the coverage guidelines established by Medicare.
- Your services (including medical care, services, supplies, and equipment) *must* be medically necessary. "Medically necessary" 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.
- You receive your care from a network provider. In most cases, care you receive from an out-of-network provider will not be covered. Chapter 3 provides more information about requirements for using network providers and the situations when we will cover services from an out-of-network provider.
- You have a primary care provider (a PCP) who is providing and overseeing your care. In most situations, your PCP must give you approval in advance before you can see other providers in the plan's network. This is called giving you a "referral." Chapter 3 provides more information about getting a referral and the situations when you do not need a referral.
- Some of the services listed in the Medical Benefits Chart are covered only if your doctor or other network provider gets approval in advance (sometimes called "prior authorization") from us. Covered services that need approval in advance are marked in the Medical Benefits Chart by an asterisk.

Other important things to know about our coverage:

- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay *more* in our plan than you would in Original Medicare. For others, you pay *less.* (If you want to know more about the coverage and costs of Original Medicare, look in your *Medicare & You 2021* Handbook. View it online at www.medicare.gov or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)
- For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you also are treated or monitored for an

existing medical condition during the visit when you receive the preventive service, a copayment will apply for the care received for the existing medical condition.

- Sometimes, Medicare adds coverage under Original Medicare for new services during the year. If Medicare adds coverage for any services during 2021, either Medicare or our plan will cover those services.

You will see this apple next to the preventive services in the benefits chart.

Medical Benefits Chart

Services that are covered for you	**What you must pay** when you get these services
Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.
Acupuncture 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: • Lasting 12 weeks or longer; • nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious, etc. disease); • not associated with surgery; and • 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. Treatment must be discontinued if the patient is not improving or is regressing. **PRIOR AUTHORIZATION IS REQURED FOR SOME SERVICES**	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts

Services that are covered for you	**What you must pay** when you get these services
Ambulance services • Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care if they 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. Non-emergency 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. **PRIOR AUTHORIZATION REQUIRED FOR NON-EMERGENT AMBULANCE SERVICES**	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.
Annual wellness visit If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months. **Note**: Your first annual wellness visit can't take place within 12 months of your "Welcome to Medicare" preventive visit. However, you don't need to have had a "Welcome to Medicare" visit to be covered for annual wellness visits after you've had Part B for 12 months.	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.
Bone mass measurement For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.

Services that are covered for you	**What you must pay** when you get these services
Breast cancer screening (mammograms) Covered services include: • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for women age 40 and older • Clinical breast exams once every 24 months	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.
Cardiac rehabilitation services Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs. **PRIOR AUTHORIZATION REQUIRED.**	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.
Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.

Services that are covered for you	**What you must pay** when you get these services
Cervical and vaginal cancer screening Covered services include: • For all women: Pap tests and pelvic exams are covered once every 24 months • If you are at high risk of cervical or vaginal cancer or you are of childbearing age and have had an abnormal Pap test within the past 3 years: one Pap test every 12 months	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.
Chiropractic services Covered services include: • We cover only Manual manipulation of the spine to correct subluxation **PRIOR AUTHORIZATION REQUIRED FROM PALLADIAN (1-877-774-7693)**	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.
Colorectal cancer screening For people 50 and older, the following are covered: • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months One of the following every 12 months: • Guaiac-based fecal occult blood test (gFOBT) • Fecal immunochemical test (FIT) DNA based colorectal screening every 3 years For people at high risk of colorectal cancer, we cover: • Screening colonoscopy (or screening barium enema as an alternative) every 24 months For people not at high risk of colorectal cancer, we cover: • Screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.

Services that are covered for you	**What you must pay** when you get these services
Dental services In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare.	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.
Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.
Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.

Services that are covered for you	**What you must pay** when you get these services
Diabetes self-management training, diabetic services and supplies For all people who have diabetes (insulin and non-insulin users). Covered services include: • Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors • For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting. • Diabetes self-management training is covered under certain conditions	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.
Durable medical equipment (DME) and related supplies (For a definition of "durable medical equipment," see Chapter 12 of this booklet.) Covered items include, but are not limited to: wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers. We cover all medically necessary DME covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you. The most recent list of suppliers is available on our website at www.emblemhealth.com/medicare . **PRIOR AUTHORIZATION REQUIRED.**	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.

Services that are covered for you	**What you must pay** when you get these services
Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse. Cost sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network. * Emergency care is covered worldwide as described above and includes emergency transportation. * Worldwide Emergency/Urgent coverage includes emergency ground transportation to the nearest hospital when outside the United States and with the purpose of stabilizing an emergency medical condition.	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts. If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must have your inpatient care at the out-of-network hospital authorized by the plan and your cost is the cost-sharing you would pay at a network hospital.

Services that are covered for you	**What you must pay** when you get these services
Health and wellness education programs • **Health Education** - Provides education to improve outcomes for members with Diabetes, Congestive Heart Failure (CHF), Coronary Artery Disease (CAD), Asthma or Chronic Obstructive Pulmonary Disease (COPD) as well as Depression and Hypertension as co-morbid conditions. Offered to targeted groups of enrollees based on specific disease conditions. Includes interaction with a certified health educator or other qualified health professional. One-on-one instruction and or telephone-based coaching provided.	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.
• **Nursing Hotline** - 24 Hour, 7 day a week service. Members can speak confidentially, one-on-one with a registered nurse at any time. Nurses are trained in telephone triage and will provide clinical support for everyday health issues and questions. The number is 1-877-444-7988.	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.
• **Enhanced Disease Management** - Provides education, health support and disease management services to improve outcomes for members in poorest health with Diabetes, Congestive Heart Failure (CHF), Coronary Artery Disease (CAD) or Chronic Obstructive Pulmonary Disease (COPD) as well as Depression and Hypertension as co-morbid conditions. Enrollees in the target group are assigned to qualified case managers with specialized knowledge about the disease(s) who contact the enrollee to provide additional case management and monitoring services. Educational activities are provided by certified or licensed professionals that are focused on the specific disease/condition. Routine monitoring is conducted of measures, signs and symptoms, applicable to the specific disease(s)/condition(s) of the enrollee.	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.

Services that are covered for you	**What you must pay** when you get these services
Hearing services Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider. Covered supplemental services include: One routine hearing exam per year One evaluation and fitting of hearing aids per year Hearing Aids	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.
HIV screening For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover: • One screening exam every 12 months For women who are pregnant, we cover: • Up to three screening exams during a pregnancy	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.

Services that are covered for you	**What you must pay** when you get these services
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 health care 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 therapy • Medical and social services • Medical equipment and supplies **PRIOR AUTHORIZATION REQUIRED**	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.
Hospice care You may receive care from any Medicare-certified hospice program. You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: • Drugs for symptom control and pain relief • Short-term respite care • Home care	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not our plan. Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.

Services that are covered for you	**What you must pay** when you get these services
Hospice care (continued) For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis: Original Medicare (rather than our plan) will pay for your hospice services and any Part A and Part B services related to your terminal prognosis. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for. For services that are covered by Medicare Part A or B and are not related to your terminal prognosis: If you need non-emergency, non-urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network: • If you obtain the covered services from a network provider, you only pay the plan cost-sharing amount for in-network services • If you obtain the covered services from an out-of-network provider, you pay the cost-sharing under Fee-for-Service Medicare (Original Medicare) For services that are covered by our plan but are not covered by Medicare Part A or B: our plan will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal prognosis. You pay your plan cost-sharing amount for these services. **Note:** If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services. Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.

Services that are covered for you	**What you must pay** when you get these services
Immunizations Covered Medicare Part B services include: • Pneumonia vaccine • Flu shots, 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 • Other vaccines if you are at risk and they meet Medicare Part B coverage rules	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.
Inpatient hospital care Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day. * Prior authorization required for non-emergent in-network hospital care. Except in an emergency, your doctor must tell the plan that you are going to the hospital to be admitted to the hospital. There is no limit to the number of days covered by the plan. Covered services include but are not limited to: • Semi-private room (or a private room if medically necessary) • Meals including special diets • Regular nursing services • Costs of special care units (such as intensive care or coronary care units) • Drugs and medications • Lab tests • X-rays and other radiology services • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical, occupational, and speech language therapy • Inpatient substance abuse services	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts. A benefit period begins when you are admitted to the hospital and ends when you are discharged. There's no limit to the number of benefit periods.

Services that are covered for you	**What you must pay** when you get these services
Inpatient hospital care (continued) • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If our plan provides transplant services at a location outside the pattern of care for transplants in your community and you chose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. • Blood - Including storage and administration. Coverage of whole blood and packed red cells begins with the first pint used. • Physician services **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at www.medicare.gov/Pubs/pdf/11435.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	If you get*:* authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at a network hospital.

Services that are covered for you	**What you must pay** when you get these services
Inpatient mental health care * Prior authorization required through Emblem Behavioral Health Services (1-888-447-2526). Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. Covered services include mental health care services that require a hospital stay. Covered services include mental health care services that require a hospital stay. There is a 190-day lifetime limit for inpatient services in a psychiatric hospital. The 190-day limit does not apply to Mental Health services provided in a psychiatric unit of a general hospital.	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts. A benefit period begins when you are admitted to the hospital and ends when you are discharged
Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay If you have exhausted your inpatient benefits or if the inpatient stay is not reasonable and necessary, we will not cover your inpatient stay. However, in some cases, we will cover certain services you receive while you are in the hospital or the skilled nursing facility (SNF). Covered services include, but are not limited to: • Physician services • Diagnostic tests (like lab tests) • X-ray, radium, and isotope therapy including technician materials and services • Surgical dressings • Splints, casts and other devices used to reduce fractures and dislocations • Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices • Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition • Physical therapy, speech therapy, and occupational therapy	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.

Services that are covered for you	**What you must pay** when you get these services
Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor. We cover 3 hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician's order. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year.	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.
Medicare Diabetes Prevention Program (MDPP) MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans. MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.

Services that are covered for you	**What you must pay** when you get these services
Medicare Part B prescription drugs **Part B to B step therapy applies.** These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include: • Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services • Drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan • Clotting factors you give yourself by injection if you have hemophilia • Immunosuppressive Drugs, if you were enrolled in Medicare Part A at the time of the organ transplant • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug • Antigens • Certain oral anti-cancer drugs and anti-nausea drugs • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases **PRIOR AUTHORIZATION REQUIRED**	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.
Obesity screening and therapy to promote sustained weight loss If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.

Services that are covered for you	**What you must pay** when you get these services
Opioid treatment program services Opioid use disorder treatment services are covered under Part B of Original Medicare. Members of our plan receive coverage for these services through our plan. Covered services include: • FDA-approved opioid agonist and antagonist treatment medications and the dispensing and administration of such medications, if applicable • Substance use counseling • Individual and group therapy • Toxicology testing **PRIOR AUTHORIZATION IS REQUIRED**	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts
Outpatient diagnostic tests and therapeutic services and supplies * Prior authorization required for all services Covered services include, but are not limited to: • X-rays • Radiation (radium and isotope) therapy including technician materials and supplies • Surgical supplies, such as dressings • Splints, casts and other devices used to reduce fractures and dislocations • Laboratory tests • Blood - Including storage and administration. Coverage of whole blood and packed red cells begins with the first pint used. • Other outpatient diagnostic tests (including but not limited to EKG, PET, MRI, MRA, CT scan, nuclear medicine imaging, molecular diagnostics and genetic testing).	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.

Services that are covered for you	**What you must pay** when you get these services
Outpatient hospital observation Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must meet the Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at www.medicare.gov/sites/default/files/2018-09/11435-Are-You-an-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week. **PRIOR AUTHORIZATION IS REQURED FOR SOME SERVICES**	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.

Services that are covered for you	**What you must pay** when you get these services
Outpatient hospital services * Prior authorization required for some services We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include, but are not limited to: • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery • Laboratory and diagnostic tests billed by the hospital • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it • X-rays and other radiology services billed by the hospital • Medical supplies such as splints and casts • Certain drugs and biologicals that you can't give yourself **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at www.medicare.gov/Pubs/pdf/11435.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.

Services that are covered for you	**What you must pay** when you get these services
Outpatient mental health care * Prior authorization through Emblem Behavioral Health Services (1-888-447-2526) Covered services include: 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 health care professional as allowed under applicable state laws.	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.
Outpatient rehabilitation services * Prior authorization required through Palladian (1-877-774-7693) for physical therapy and occupational therapy only. Covered services include: physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.
Outpatient substance abuse services * Prior authorization through Emblem Behavioral Health Services (1-888-447-2526) Outpatient mental health care for the diagnosis of, treatment for, and counseling for substance abuse.	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.

Services that are covered for you	**What you must pay** when you get these services
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers * Prior authorization required For surgical procedures, your provider is allowed to bill you a separate copayment for professional services. **Note:** If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an "outpatient."	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.
Partial hospitalization services *Prior authorization through Emblem Behavioral Health Services (1-888-447-2526) "Partial hospitalization" is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center, that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.

Services that are covered for you	**What you must pay** when you get these services
Physician/Practitioner services, including doctor's office visits Covered services include: • Medically-necessary medical care or surgery services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location • Consultation, diagnosis, and treatment by a specialist • Basic hearing and balance exams performed by your specialist, if your doctor orders it to see if you need medical treatment • Certain additional telehealth services including consultation, diagnosis, and treatment by a physician or practitioner for patients in certain rural areas or other locations approved by Medicare • Certain additional telehealth services, including those for: Primary Care Physician visits, Specialist visits, Individual Mental Health visits, individual Psychiatric visits, or individual Substance Abuse visits. o You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth. • Brief virtual check-ins • Remote evaluation of pre-recorded video and/or images sent to your doctor • Consultation your doctor has with other doctors by phone, internet, or electronic health record assessment—<u>if</u> you're not a new patient • Second opinion by another network provider prior to surgery • Non-routine 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) **REFERRAL REQUIRED FOR SPECIALISTS**	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.

Services that are covered for you	**What you must pay** when you get these services
Podiatry services Covered services include: • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs) • Routine foot care for members with certain medical conditions affecting the lower limbs Covered supplemental services include: • Routine podiatry benefit includes removal of calluses, corns and trimming of nails. Limited to four visits per year. **REFERRAL REQUIRED**	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.
Prostate cancer screening exams For men age 50 and older, covered services include the following - once every 12 months: • Digital rectal exam • Prostate Specific Antigen (PSA) test	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.
Prosthetic devices and related supplies Devices (other than dental) that replace all or part of a body part or function. These include, but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see "Vision Care" later in this section for more detail. **PRIOR AUTHORIZATION IS REQUIRED FOR SOME SUPPLIES/DEVICES**	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.

Services that are covered for you	**What you must pay** when you get these services
Pulmonary rehabilitation services Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease. **PRIOR AUTHORIZATION IS REQUIRED**	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.
Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.

Services that are covered for you	**What you must pay** when you get these services
Screening for lung cancer with low dose computed tomography (LDCT) For qualified individuals, a LDCT is covered every 12 months. **Eligible members are**: people aged 55 – 77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 30 pack-years and who currently smoke or have quit smoking within the last 15 years, who receive a written order for LDCT during a lung cancer screening counseling and shared decision making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner. For LDCT lung cancer screenings after the initial LDCT screening*:* the members must receive a written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision-making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy. We also cover up to 2 individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.
Services to treat kidney disease Covered services include:	

Services that are covered for you	**What you must pay** when you get these services
• Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3) • Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and supplies • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B Drugs, please go to the section, "Medicare Part B prescription drugs."	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts. Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.
Skilled nursing facility (SNF) care (For a definition of "skilled nursing facility care," see Chapter 12 of this booklet. Skilled nursing facilities are sometimes called "SNFs.") Coverage is limited to the first 100 days of a stay in a skilled nursing facility per Medicare defined benefit period. Covered services include but are not limited to: • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services • Physical therapy, occupational therapy, and speech 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. Coverage of whole blood and packed red cells begins with the first pint of blood used. • Medical and surgical supplies ordinarily provided by SNFs	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts. A benefit period begins the day you are admitted as an inpatient in a skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care or skilled care in a SNF for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a

Services that are covered for you	**What you must pay** when you get these services
• Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/Practitioner services Generally, you will get your SNF care from network facilities. However, under certain conditions listed below, you may be able to pay in-network cost-sharing for a facility that isn't a network provider, if the facility accepts our plan's amounts for payment. • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care) • A SNF where your spouse is living at the time you leave the hospital **PRIOR AUTHORIZATION IS REQUIRED FOR ELECTIVE ADMISSIONS**	new benefit period begins. There is no limit to the number of benefit periods.
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) If you use tobacco, but do not have signs or symptoms of tobacco-related disease: We cover two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits. If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: We cover cessation counseling services. We cover two counseling quit attempts within a 12-month period, however, you will pay the applicable cost-sharing. Each counseling attempt includes up to four face-to-face visits.	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.

Services that are covered for you	**What you must pay** when you get these services
Supervised Exercise Therapy (SET) ***** Prior authorization required. SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment. Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must: • Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication • Be conducted in a hospital outpatient setting or a physician's office • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD • Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider.	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.
Urgently needed services Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible. Cost sharing for necessary urgently needed services furnished out-of-network is the same as for such services furnished in-network. **Covered supplemental services include:** ***** World Wide Coverage	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.

Services that are covered for you	**What you must pay** when you get these services
Vision care Covered services include: • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts • For people who are at high risk of glaucoma, we will cover one glaucoma screening each year. People at high risk of glaucoma include: people with a family history of glaucoma, people with diabetes, African-Americans who are age 50 and older and Hispanic Americans who are 65 or older • For people with diabetes, screening for diabetic retinopathy is covered once per year • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.) Covered supplemental services include: • One routine eye exam per year • One pair of eyeglasses or contact lenses per year. For a complete listing of eyewear providers that participate with your plan, please see your EmblemHealth Medicare HMO Provider Directory. If you do not have a directory, you can contact Customer Service at 1-877-344-7364; TTY call 711 during the hours of 8:00 am to 8:00 pm, 7 days a week, or visit the plan website at www.emblemhealth.com/medicare.	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.

Services that are covered for you	**What you must pay** when you get these services
"Welcome to Medicare" preventive visit The plan covers the one-time "Welcome to Medicare" preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed. **Important:** We cover the "Welcome to Medicare" preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you would like to schedule your "Welcome to Medicare" preventive visit.	Please contact your benefits administrator or see your Cost Sharing Guide for benefit details and cost sharing amounts.

SECTION 3 What services are not covered by the plan?

Section 3.1 Services we do *not* cover (exclusions)

This section tells you what services are "excluded" from Medicare coverage and therefore, are not covered by this plan. If a service is "excluded," it means that this plan doesn't cover the service.

The chart below lists services and items that either are not covered under any condition or are covered only under specific conditions.

If you get services that are excluded (not covered), you must pay for them yourself. We won't pay for the excluded medical services listed in the chart below except under the specific conditions listed. The only exception: we will pay if a service in the chart below is found upon appeal to be a medical service that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a medical service, go to Chapter 7, Section 5.3 in this booklet.)

All exclusions or limitations on services are described in the Benefits Chart or in the chart below.

Even if you receive the excluded services at an emergency facility, the excluded services are still not covered and our plan will not pay for them.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Services considered not reasonable and necessary, according to the standards of Original Medicare	✓	
Experimental medical and surgical procedures, equipment and medications. Experimental procedures and items are those items and procedures determined by our plan and Original Medicare to not be generally accepted by the medical community.		✓ May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan. (See Chapter 3, Section 5 for more information on clinical research studies.)
Private room in a hospital.		✓ Covered only when medically necessary.
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television.	✓	
Full-time nursing care in your home.	✓	
*Custodial care is care provided in a nursing home, hospice, or other facility setting when you do not require skilled medical care or skilled nursing care.	✓	
Homemaker services include basic household assistance, including light housekeeping or light meal preparation.	✓	
Fees charged for care by your immediate relatives or members of your household.	✓	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Cosmetic surgery or procedures		✓ • Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member. • Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
Routine dental care, such as cleanings, fillings or dentures.	✓	
Non-routine dental care		✓ Dental care required to treat illness or injury may be covered as inpatient or outpatient care.
Routine chiropractic care		✓ Manual manipulation of the spine to correct a subluxation is covered.
Routine foot care		✓ Some limited coverage provided according to Medicare guidelines (e.g., if you have diabetes). You are covered 4 routine footcare visits per year. Routine footcare includes removal of calluses, corns and trimming of nails.
Home-delivered meals	✓	
Orthopedic shoes		✓ If shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease.
Supportive devices for the feet		✓ Orthopedic or therapeutic shoes for people with diabetic foot disease.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Routine hearing exams, hearing aids, or exams to fit hearing aids.		✓
Routine eye examinations, eyeglasses, radial keratotomy, LASIK surgery and other low vision aids.		✓ Eye exam and one pair of eyeglasses (or contact lenses) are covered for people after cataract surgery. You have supplemental vision care benefit. Please see Medical Benefits Chart for more information.
Reversal of sterilization procedures and or non-prescription contraceptive supplies.	✓	
Naturopath services (uses natural or alternative treatments).	✓	
Acupuncture		✓
Services provided to veterans in Veterans Affairs (VA) facilities		✓ When emergency services are received at VA hospital and the VA cost-sharing is more than the cost-sharing under our plan, we will reimburse veterans for the difference. Members are still responsible for our cost-sharing amounts.

*Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing.

CHAPTER 5

Asking us to pay our share of a bill you have received for covered medical services

Chapter 5. Asking us to pay our share of a bill you have received for covered medical services

SECTION 1 Situations in which you should ask us to pay our share of the cost of your covered services

Section 1.1 If you pay our plan's share of the cost of your covered services, or if you receive a bill, you can ask us for payment

Sometimes when you get medical care, you may need to pay the full cost right away. Other times, you may find that you have paid more than you expected under the coverage rules of the plan. In either case, you can ask our plan to pay you back (paying you back is often called "reimbursing" you). It is your right to be paid back by our plan whenever you've paid more than your share of the cost for medical services that are covered by our plan.

There may also be times when you get a bill from a provider for the full cost of medical care you have received. In many cases, you should send this bill to us instead of paying it. We will look at the bill and decide whether the services should be covered. If we decide they should be covered, we will pay the provider directly.

Here are examples of situations in which you may need to ask our plan to pay you back or to pay a bill you have received:

1. When you've received emergency or urgently needed medical care from a provider who is not in our plan's network

You can receive emergency services from any provider, whether or not the provider is a part of our network. When you receive emergency or urgently needed services from a provider who is not part of our network, you are only responsible for paying your share of the cost, not for the entire cost. You should ask the provider to bill the plan for our share of the cost.

- If you pay the entire amount yourself at the time you receive the care, you need to ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you have made.
- At times you may get a bill from the provider asking for payment that you think you do not owe. Send us this bill, along with documentation of any payments you have already made.
    - If the provider is owed anything, we will pay the provider directly.
    - If you have already paid more than your share of the cost of the service, we will determine how much you owed and pay you back for our share of the cost.

2. When a network provider sends you a bill you think you should not pay

Network providers should always bill the plan directly and ask you only for your share of the cost. But sometimes they make mistakes and ask you to pay more than your share.

- You only have to pay your cost-sharing amount when you get services covered by our plan. We do not allow providers to add additional separate charges, called "balance billing." This protection (that you never pay more than your cost-sharing amount) applies even if we pay the provider less than the provider charges for a service and even if there is a dispute and we don't pay certain provider charges. For more information about "balance billing," go to Chapter 4, Section 1.3.
- Whenever you get a bill from a network provider that you think is more than you should pay, send us the bill. We will contact the provider directly and resolve the billing problem.
- If you have already paid a bill to a network provider, but you feel that you paid too much, send us the bill along with documentation of any payment you have made and ask us to pay you back the difference between the amount you paid and the amount you owed under the plan.

3. If you are retroactively enrolled in our plan

Sometimes a person's enrollment in the plan is retroactive. (Retroactive means that the first day of their enrollment has already passed. The enrollment date may even have occurred last year.)

If you were retroactively enrolled in our plan and you paid out-of-pocket for any of your covered services after your enrollment date, you can ask us to pay you back for our share of the costs. You will need to submit paperwork for us to handle the reimbursement.

Please call Customer Service for additional information about how to ask us to pay you back and deadlines for making your request. (Phone numbers for Customer Service are printed on the back cover of this booklet.)

SECTION 2 How to ask us to pay you back or to pay a bill you have received

Section 2.1 How and where to send us your request for payment

Send us your request for payment, along with your bill and documentation of any payment you have made. It's a good idea to make a copy of your bill and receipts for your records.

To make sure you are giving us all the information we need to make a decision, you can fill out our claim form to make your request for payment.

- You don't have to use the form, but it will help us process the information faster.

- Either download a copy of the form from our website (**www.emblemhealth.com/medicare**) or call Customer Service and ask for the form. The phone numbers for Customer Service are printed on the back cover of this booklet.

Mail your request for payment together with any bills or receipts to us at this address:

For payment requests for medical care:
EmblemHealth Claims
PO Box 2845
New York, NY 10116-2845

Contact Customer Service if you have any questions (phone numbers are printed on the back cover of this booklet). If you don't know what you should have paid, or you receive bills and you don't know what to do about those bills, we can help. You can also call if you want to give us more information about a request for payment you have already sent to us.

SECTION 3 We will consider your request for payment and say yes or no

Section 3.1 We check to see whether we should cover the service and how much we owe

When we receive your request for payment, we will let you know if we need any additional information from you. Otherwise, we will consider your request and make a coverage decision.

- If we decide that the medical care is covered and you followed all the rules for getting the care, we will pay for our share of the cost. If you have already paid for the service, we will mail your reimbursement of our share of the cost to you. If you have not paid for the service yet, we will mail the payment directly to the provider. (Chapter 3 explains the rules you need to follow for getting your medical services covered.)
- If we decide that the medical care is *not* covered, or you did *not* follow all the rules, we will not pay for our share of the cost. Instead, we will send you a letter that explains the reasons why we are not sending the payment you have requested and your rights to appeal that decision.

Section 3.2 If we tell you that we will not pay for all or part of the medical care, you can make an appeal

If you think we have made a mistake in turning down your request for payment or you don't agree with the amount we are paying, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment.

For the details on how to make this appeal, go to Chapter 7 of this booklet *(What to do if you have a problem or complaint (coverage decisions, appeals, complaints))*. The appeals process is a formal process with detailed procedures and important deadlines. If making an appeal is new to you, you will find it helpful to start by reading Section 4 of Chapter 7. Section 4 is an introductory section that explains the process for coverage decisions and appeals and gives definitions of terms such as "appeal." Then after you have read Section 4, you can go to Section 5.3 to learn how to make an appeal about getting paid back for a medical service.

Chapter 6

Your rights and responsibilities

Chapter 6. Your rights and responsibilities

SECTION 1 Our plan must honor your rights as a member of the plan

Section 1.1 We must provide information in a way that works for you (in languages other than English, in braille, in large print, or other alternate formats, etc.)

To get information from us in a way that works for you, please call Customer Service (phone numbers are printed on the back cover of this booklet).

Our plan has people and free interpreter services available to answer questions from disabled and non-English speaking members. Information is available for free in other languages. We can also give you information in braille, in large print, or other alternate formats at no cost if you need it. We are required to give you information about the plan's benefits in a format that is accessible and appropriate for you. To get information from us in a way that works for you, please call Customer Service (phone numbers are printed on the back cover of this booklet) or contact EmblemHealth's Civil Rights Coordinator.

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, please call to file a grievance with Customer Service (phone numbers are printed on the back cover of this booklet). You may also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights. Contact information is included in this Evidence of Coverage or with this mailing, or you may contact our plan's Customer Service for additional information.

Sección 1.1 Nosotros debemos proporcionar información en una forma conveniente para usted (en idiomas aparte del inglés, en sistema braille, en letras grandes u otros formatos alternativos, etc.)

Para obtener información de nosotros en una forma conveniente para usted, por favor llame a Servicio al Cliente (los números de teléfono están impresos en la contraportada de este folleto).

Nuestro plan tiene personas y servicios de interpretación gratis disponibles para contestar preguntas de los miembros discapacitados y no inglés. Información está disponible de forma gratuita en otros idiomas. Podemos también darle información en braille, en letra grande, u otros formatos alternativos sin costo si lo necesita. Estamos obligados a darle información sobre los beneficios del plan en un formato accesible y apropiado para usted. Para obtener información de nosotros de una manera que funciona para usted, por favor llame a servicio al cliente (teléfono números están impresos en la contraportada de este folleto) o póngase en contacto con el Coordinador de derechos civiles EmblemHealth.

Si tienes cualquier problema obtener información de nuestro plan en un formato accesible y apropiado para usted, por favor, llame a presentar una queja con el servicio al cliente (números

de teléfono aparecen en la contraportada de este folleto). También puede presentar una queja con Medicare llamando al 1-800-MEDICARE (1-800-633-4227) o directamente con la oficina de derechos civiles. La información de contacto está incluida en esta Evidencia de cobertura o con este envío por correo, o puede comunicarse con el Servicio al cliente de nuestro plan para obtener información adicional.

Section 1.2 We must ensure that you get timely access to your covered services

As a member of our plan, you have the right to choose a primary care provider (PCP) in the plan's network to provide and arrange for your covered services (Chapter 3 explains more about this). Call Customer Service to learn which doctors are accepting new patients (phone numbers are printed on the back cover of this booklet). You also have the right to go to a women's health specialist (such as a gynecologist) without a referral.

As a plan member, you have the right to get appointments and covered services from the plan's network of providers *within a reasonable amount of time*. This includes the right to get timely services from specialists when you need that care.

If you think that you are not getting your medical care within a reasonable amount of time, Chapter 7, Section 9 of this booklet tells what you can do. (If we have denied coverage for your medical care and you don't agree with our decision, Chapter 7, Section 4 tells what you can do.)

Section 1.3 We must protect the privacy of your personal health information

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

- Your "personal health information" includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information.
- The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We give you a written notice, called a "Notice of Privacy Practice," that tells about these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.
- In most situations, if we give your health information to anyone who isn't providing your care or paying for your care, *we are required to get written permission from you first.* Written permission can be given by you or by someone you have given legal power to make decisions for you.

- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
    - For example, we are required to release health information to government agencies that are checking on quality of care.
    - Because you are a member of our plan through Medicare, we are required to give Medicare your health information. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations.

You can see the information in your records and know how it has been shared with others

You have the right to look at your medical records held at the plan, and to get a copy of your records. We are allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will work with your healthcare provider to decide whether the changes should be made.

You have the right to know how your health information has been shared with others for any purposes that are not routine.

If you have questions or concerns about the privacy of your personal health information, please call Customer Service (phone numbers are printed on the back cover of this booklet).

Section 1.4 We must give you information about the plan, its network of providers, and your covered services

As a member of EmblemHealth VIP Rx Carveout (HMO) - Group, you have the right to get several kinds of information from us. (As explained above in Section 1.1, you have the right to get information from us in a way that works for you. This includes getting the information in languages other than English and in large print or other alternate formats.)

If you want any of the following kinds of information, please call Customer Service (phone numbers are printed on the back cover of this booklet):

- **Information about our plan**. This includes, for example, information about the plan's financial condition. It also includes information about the number of appeals made by members and the plan's performance ratings, including how it has been rated by plan members and how it compares to other Medicare health plans.
- **Information about our network providers.**
    - For example, you have the right to get information from us about the qualifications of the providers in our network and how we pay the providers in our network.
    - For a list of the providers in the plan's network, see the Provider Directory.

  - For more detailed information about our providers or pharmacies, you can call Customer Service (phone numbers are printed on the back cover of this booklet) or visit our website atwww.emblemhealth.com/medicare**.**

- **Information about your coverage and the rules you must follow when using your coverage.**
  - In Chapters 3 and 4 of this booklet, we explain what medical services are covered for you, any restrictions to your coverage, and what rules you must follow to get your covered medical services.
  - If you have questions about the rules or restrictions, please call Customer Service (phone numbers are printed on the back cover of this booklet).
- **Information about why something is not covered and what you can do about it.**
  - If a medical service is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the medical service from an out-of-network provider.
  - If you are not happy or if you disagree with a decision we make about what medical care is covered for you, you have the right to ask us to change the decision. You can ask us to change the decision by making an appeal. For details on what to do if something is not covered for you in the way you think it should be covered, see Chapter 7 of this booklet. It gives you the details about how to make an appeal if you want us to change our decision. (Chapter 7 also tells about how to make a complaint about quality of care, waiting times, and other concerns.)
  - If you want to ask our plan to pay our share of a bill you have received for medical care, see Chapter 5 of this booklet.

Section 1.5 We must support your right to make decisions about your care

You have the right to know your treatment options and participate in decisions about your health care

You have the right to get full information from your doctors and other health care providers when you go for medical care. Your providers must explain your medical condition and your treatment choices *in a way that you can understand*.

You also have the right to participate fully in decisions about your health care. To help you make decisions with your doctors about what treatment is best for you, your rights include the following:

- **To know about all of your choices.** This means that you have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan.

- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- **The right to say "no.**" You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. Of course, if you refuse treatment, you accept full responsibility for what happens to your body as a result.
- **To receive an explanation if you are denied coverage for care.** You have the right to receive an explanation from us if a provider has denied care that you believe you should receive. To receive this explanation, you will need to ask us for a coverage decision. Chapter 7 of this booklet tells how to ask the plan for a coverage decision.

You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself

Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you are in this situation. This means that, *if you want to*, you can:

- Fill out a written form to give **someone the legal authority to make medical decisions for you** if you ever become unable to make decisions for yourself.
- **Give your doctors written instructions** about how you want them to handle your medical care if you become unable to make decisions for yourself.

The legal documents that you can use to give your directions in advance in these situations are called "**advance directives**." There are different types of advance directives and different names for them. Documents called "**living will**" and "**power of attorney for health care**" are examples of advance directives.

If you want to use an "advance directive" to give your instructions, here is what to do:

- **Get the form.** If you want to have an advance directive, you can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. You can also contact Customer Service to ask for the forms (phone numbers are printed on the back cover of this booklet).
- **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well. Be sure to keep a copy at home.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, **take a copy with you to the hospital**.

- If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you.
- If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is your choice whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive.

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with the New York State Department of Health. If you wish to file a complaint about a hospital, you should call **1-800-804-5447. If you wish file a complaint about a doctor, you should call 1-800-663-6114.**

Section 1.6 You have the right to make complaints and to ask us to reconsider decisions we have made

If you have any problems or concerns about your covered services or care, Chapter 7 of this booklet tells what you can do. It gives the details about how to deal with all types of problems and complaints. What you need to do to follow up on a problem or concern depends on the situation. You might need to ask our plan to make a coverage decision for you, make an appeal to us to change a coverage decision, or make a complaint. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – **we are required to treat you fairly**.

You have the right to get a summary of information about the appeals and complaints that other members have filed against our plan in the past. To get this information, please call Customer Service (phone numbers are printed on the back cover of this booklet).

Section 1.7 What can you do if you believe you are being treated unfairly or your rights are not being respected?

If it is about discrimination, call the Office for Civil Rights

If you believe you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, you should call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 or TTY 1-800-537-7697 or call your local Office for Civil Rights.

Is it about something else?

If you believe you have been treated unfairly or your rights have not been respected, *and* it's *not* about discrimination, you can get help dealing with the problem you are having:

- You can **call Customer Service** (phone numbers are printed on the back cover of this booklet).
- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- Or, **you can call Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Section 1.8 How to get more information about your rights

There are several places where you can get more information about your rights:

- You can **call Customer Service** (phone numbers are printed on the back cover of this booklet).
- You can **call the SHIP**. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- You can contact **Medicare**.
  - You can visit the Medicare website to read or download the publication "Your Medicare Rights & Protections." (The publication is available at: www.medicare.gov/Pubs/pdf/11534.pdf.)
  - Or, you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

SECTION 2 You have some responsibilities as a member of the plan

Section 2.1 What are your responsibilities?

Things you need to do as a member of the plan are listed below. If you have any questions, please call Customer Service (phone numbers are printed on the back cover of this booklet). We're here to help.

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this *Evidence of Coverage* booklet to learn what is covered for you and the rules you need to follow to get your covered services.

  - Chapters 3 and 4 give the details about your medical services, including what is covered, what is not covered, rules to follow, and what you pay.

- If you have any other health insurance coverage or prescription drug coverage in addition to our plan, you are required to tell us. Please call Customer Service to let us know (phone numbers are printed on the back cover of this booklet).
  - We are required to follow rules set by Medicare to make sure that you are using all of your coverage in combination when you get your covered services from our plan. This is called "**coordination of benefits**" because it involves coordinating the health benefits you get from our plan with any other benefits available to you. We'll help you coordinate your benefits. (For more information about coordination of benefits, go to Chapter 1, Section 7.)
- **Tell your doctor and other health care providers that you are enrolled in our plan.** Show your plan membership card whenever you get your medical care.
- Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.
  - To help your doctors and other health providers give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.
  - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
  - If you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don't understand the answer you are given, ask again.
- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- **Pay what you owe.** As a plan member, you are responsible for these payments:
  - You must pay your plan premiums to continue being a member of our plan.
  - In order to be eligible for our plan, you must have Medicare Part A and Medicare Part B. Some plan members must pay a premium for Medicare Part A. Most plan members must pay a premium for Medicare Part B to remain a member of the plan.
  - For most of your medical services covered by the plan, you must pay your share of the cost when you get the service. This will be a copayment (a fixed amount) or coinsurance (a percentage of the total cost). Chapter 4 tells what you must pay for your medical services.
  - If you get any medical services that are not covered by our plan or by other insurance you may have, you must pay the full cost.

  - If you disagree with our decision to deny coverage for a service, you can make an appeal. Please see Chapter 7 of this booklet for information about how to make an appeal.

- **Tell us if you move**. If you are going to move, it's important to tell us right away. Call Customer Service (phone numbers are printed on the back cover of this booklet).
  - **If you move outside of our plan service area, you cannot remain a member of our plan.** (Chapter 1 tells about our service area.) We can help you figure out whether you are moving outside our service area. If you are leaving our service area, you will have a Special Enrollment Period when you can join any Medicare plan available in your new area. We can let you know if we have a plan in your new area.
  - **If you move *within* our service area, we still need to know** so we can keep your membership record up to date and know how to contact you.
  - If you move, it is also important to tell Social Security (or the Railroad Retirement Board). You can find phone numbers and contact information for these organizations in Chapter 2.
- **Call Customer Service for help if you have questions or concerns.** We also welcome any suggestions you may have for improving our plan.
  - Phone numbers and calling hours for Customer Service are printed on the back cover of this booklet.
  - For more information on how to reach us, including our mailing address, please see Chapter 2.

CHAPTER 7

What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

BACKGROUND

SECTION 1 Introduction

Section 1.1 What to do if you have a problem or concern

This chapter explains two types of processes for handling problems and concerns:

- For some types of problems, you need to use the **process for coverage decisions and appeals**.
- For other types of problems, you need to use the **process for making complaints**.

Both of these processes have been approved by Medicare. To ensure fairness and prompt handling of your problems, each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

Which one do you use? That depends on the type of problem you are having. The guide in Section 3 will help you identify the right process to use.

Section 1.2 What about the legal terms?

There are technical legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people and can be hard to understand.

To keep things simple, this chapter explains the legal rules and procedures using simpler words in place of certain legal terms. For example, this chapter generally says “making a complaint” rather than “filing a grievance,” “coverage decision” rather than “organization determination,” or “coverage determination” or “at-risk determination,” and “Independent Review Organization” instead of “Independent Review Entity.” It also uses abbreviations as little as possible.

However, it can be helpful – and sometimes quite important – for you to know the correct legal terms for the situation you are in. Knowing which terms to use will help you communicate more clearly and accurately when you are dealing with your problem and get the right help or information for your situation. To help you know which terms to use, we include legal terms when we give the details for handling specific types of situations.

SECTION 2 You can get help from government organizations that are not connected with us

Section 2.1 Where to get more information and personalized assistance

Sometimes it can be confusing to start or follow through the process for dealing with a problem. This can be especially true if you do not feel well or have limited energy. Other times, you may not have the knowledge you need to take the next step.

Get help from an independent government organization

We are always available to help you. But in some situations you may also want help or guidance from someone who is not connected with us. You can always contact your **State Health Insurance Assistance Program (SHIP)**. This government program has trained counselors in every state. The program is not connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you are having. They can also answer your questions, give you more information, and offer guidance on what to do.

The services of SHIP counselors are free. You will find phone numbers in Chapter 2, Section 3 of this booklet.

You can also get help and information from Medicare

For more information and help in handling a problem, you can also contact Medicare. Here are two ways to get information directly from Medicare:

- You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- You can visit the Medicare website (www.medicare.gov).

SECTION 3 To deal with your problem, which process should you use?

Section 3.1 Should you use the process for coverage decisions and appeals? Or should you use the process for making complaints?

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. The guide that follows will help.

To figure out which part of this chapter will help with your specific problem or concern, **START HERE**

Is your problem or concern about your benefits or coverage?

(This includes problems about whether particular medical care or prescription drugs are covered or not, the way in which they are covered, and problems related to payment for medical care or prescription drugs.)

Yes. My problem is about benefits or coverage.

Go on to the next section of this chapter, **Section 4, "A guide to the basics of coverage decisions and appeals."**

No. My problem is not about benefits or coverage.

Skip ahead to **Section 9** at the end of this chapter: **"How to make a complaint about quality of care, waiting times, Customer Service or other concerns."**

COVERAGE DECISIONS AND APPEALS

SECTION 4 A guide to the basics of coverage decisions and appeals

Section 4.1 Asking for coverage decisions and making appeals: the big picture

The process for coverage decisions and appeals deals with problems related to your benefits and coverage for medical services, including problems related to payment. This is the process you use for issues such as whether something is covered or not and the way in which something is covered.

Asking for coverage decisions

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services. For example, your plan network doctor makes a (favorable) coverage decision for you whenever you receive medical care from him or her or if your network doctor refers you to a medical specialist. You or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we will cover a particular

medical service or refuses to provide medical care you think that you need. In other words, if you want to know if we will cover a medical service before you receive it, you can ask us to make a coverage decision for you.

We are making a coverage decision for you whenever we decide what is covered for you and how much we pay. In some cases we might decide a service is not covered or is no longer covered by Medicare for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

If we make a coverage decision and you are not satisfied with this decision, you can "appeal" the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made.

When you appeal a decision for the first time, this is called a Level 1 Appeal. In this appeal, we review the coverage decision we made to check to see if we were following all of the rules properly. Your appeal is handled by different reviewers than those who made the original unfavorable decision. When we have completed the review we give you our decision. Under certain circumstances, which we discuss later, you can request an expedited or "fast coverage decision" or fast appeal of a coverage decision.

If we say no to all or part of your Level 1 Appeal, you can go on to a Level 2 Appeal. The Level 2 Appeal is conducted by an Independent Review Organization that is not connected to us. (In some situations, your case will be automatically sent to the Independent Review Organization for a Level 2 Appeal. In other situations, you will need to ask for a Level 2 Appeal.) If you are not satisfied with the decision at the Level 2 Appeal, you may be able to continue through additional levels of appeal.

Section 4.2 How to get help when you are asking for a coverage decision or making an appeal

Would you like some help? Here are resources you may wish to use if you decide to ask for any kind of coverage decision or appeal a decision:

- You **can call us at Customer Service** (phone numbers are printed on the back cover of this booklet).
- You **can get free help from** your State Health Insurance Assistance Program (see Section 2 of this chapter).
- **Your doctor can make a request for you.**
    - For medical care or Part B prescription drugs, your doctor can request a coverage decision or a Level 1 Appeal on your behalf. If your appeal is denied at Level 1, it

will be automatically forwarded to Level 2. To request any appeal after Level 2, your doctor must be appointed as your representative.

- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your "representative" to ask for a coverage decision or make an appeal.
  - There may be someone who is already legally authorized to act as your representative under State law.
  - If you want a friend, relative, your doctor or other provider, or other person to be your representative, call Customer Service (phone numbers are printed on the back cover of this booklet) and ask for the "Appointment of Representative" form. (The form is also available on Medicare's website at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at www.emblemhealth.com/medicare .) The form gives that person permission to act on your behalf. It must be signed by you and by the person who you would like to act on your behalf. You must give us a copy of the signed form.
- **You also have the right to hire a lawyer to act for you.** You may contact your own lawyer or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Section 4.3 Which section of this chapter gives the details for your situation?

There are three different types of situations that involve coverage decisions and appeals. Since each situation has different rules and deadlines, we give the details for each one in a separate section:

- **Section 5** of this chapter: "Your medical care: How to ask for a coverage decision or make an appeal"
- **Section 6** of this chapter: "How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon"
- **Section 7** of this chapter: "How to ask us to keep covering certain medical services if you think your coverage is ending too soon" (*Applies to these services only*: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services)

If you're not sure which section you should be using, please call Customer Service (phone numbers are printed on the back cover of this booklet). You can also get help or information from government organizations such as your SHIP (Chapter 2, Section 3, of this booklet has the phone numbers for this program).

SECTION 5 Your medical care: How to ask for a coverage decision or make an appeal

Have you read Section 4 of this chapter (*A guide to "the basics" of coverage decisions and appeals*)? If not, you may want to read it before you start this section.

Section 5.1 This section tells what to do if you have problems getting coverage for medical care or if you want us to pay you back for our share of the cost of your care

This section is about your benefits for medical care and services. These benefits are described in Chapter 4 of this booklet: *Medical Benefits Chart (what is covered and what you pay)*. To keep things simple, we generally refer to "medical care coverage" or "medical care" in the rest of this section, instead of repeating "medical care or treatment or services" every time. The term "medical care" includes medical items and services as well as Medicare Part B prescription drugs. In some cases, different rules apply to a request for a Part B prescription drug. In those cases, we will explain how the rules for Part B prescription drugs are different from the rules for medical items and services.

This section tells what you can do if you are in any of the five following situations:

1. You are not getting certain medical care you want, and you believe that this care is covered by our plan.

2. Our plan will not approve the medical care your doctor or other medical provider wants to give you, and you believe that this care is covered by the plan.

3. You have received medical care that you believe should be covered by the plan, but we have said we will not pay for this care.

4. You have received and paid for medical care that you believe should be covered by the plan, and you want to ask our plan to reimburse you for this care.

5. You are being told that coverage for certain medical care you have been getting that we previously approved will be reduced or stopped, and you believe that reducing or stopping this care could harm your health.

   NOTE: **If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services**, you need to read a separate section of this chapter because special rules apply to these types of care. Here's what to read in those situations:

- Chapter 7, Section 6: How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon.
- Chapter 7, Section 7: How to ask us to keep covering certain medical services if you think your coverage is ending too soon. This section is about three services only: home health care, skilled nursing facility care, and CORF services.

For *all other* situations that involve being told that medical care you have been getting will be stopped, use this section (Section 5) as your guide for what to do.

Which of these situations are you in?

If you are in this situation:	This is what you can do:
To find out whether we will cover the medical care or services you want.	You can ask us to make a coverage decision for you. Go to the next section of this chapter, **Section 5.2**.
If we already told you that we will not cover or pay for a medical service in the way that you want it to be covered or paid for.	You can make an **appeal**. (This means you are asking us to reconsider.) Skip ahead to **Section 5.3** of this chapter.
If you want to ask us to pay you back for medical care you have already received and paid for.	You can send us the bill. Skip ahead to **Section 5.5** of this chapter.

Section 5.2 Step-by-step: How to ask for a coverage decision (how to ask our plan to authorize or provide the medical care coverage you want)

Legal Terms
When a coverage decision involves your medical care, it is called an **"organization determination."**

Step 1: You ask our plan to make a coverage decision on the medical care you are requesting. If your health requires a quick response, you should ask us to make a **"fast coverage decision."**

Legal Terms
A "fast coverage decision" is called an **"expedited determination."**

How to request coverage for the medical care you want

- Start by calling, writing, or faxing our plan to make your request for us to authorize or provide coverage for the medical care you want. You, your doctor, or your representative can do this.
- For the details on how to contact us, go to Chapter 2, Section 1 and look for the section called, How to contact us when you are asking for a coverage decision about your medical care.

Generally we use the standard deadlines for giving you our decision

When we give you our decision, we will use the "standard" deadlines unless we have agreed to use the "fast" deadlines. **A standard coverage decision means we will give you an answer within 14 calendar days** after we receive your request for a medical item or service. If your request is for a Medicare Part B prescription drug, we will give you an answer within 72 hours after we receive your request.

- **However, for a request for a medical item or service we can take up to 14 more calendar days** if you ask for more time, or if we need information (such as medical records from out-of-network providers) that may benefit you. If we decide to take extra days to make the decision, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

- If you believe we should *not* take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.)

If your health requires it, ask us to give you a "fast coverage decision"

- **A fast coverage decision means we will answer within 72 hours if your request is for a medical item or service. If your request is for a Medicare Part B prescription drug, we will answer within 24 hours.**
- **However, for a request for a medical item or service we can take up to 14 more calendar days** if we find that some information that may benefit you is missing (such as medical records from out-of-network providers), or if you need time to get information to us for the review. If we decide to take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we should *not* take extra days, you can file a "fast complaint" about our decision to take extra days. (For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.) We will call you as soon as we make the decision.

- **To get a fast coverage decision, you must meet two requirements:**
  - You can get a fast coverage decision *only* if you are asking for coverage for medical care *you have not yet received*. (You cannot ask for a fast coverage decision if your request is about payment for medical care you have already received.)
  - You can get a fast coverage decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function.*
- **If your doctor tells us that your health requires a "fast coverage decision," we will automatically agree to give you a fast coverage decision.**
- If you ask for a fast coverage decision on your own, without your doctor's support, we will decide whether your health requires that we give you a fast coverage decision.
  - If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will send you a letter that says so (and we will use the standard deadlines instead).
  - This letter will tell you that if your doctor asks for the fast coverage decision, we will automatically give a fast coverage decision.
  - The letter will also tell how you can file a "fast complaint" about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. (For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.)

Step 2: We consider your request for medical care coverage and give you our answer.

Deadlines for a "fast coverage decision"

- Generally, for a fast coverage decision on a request for a medical item or service, we will give you our answer within **72 hours**. If your request is for a Medicare Part B prescription drug, we will answer **within 24 hours**.
  - As explained above, we can take up to 14 more calendar days under certain circumstances. If we decide to take extra days to make the coverage decision, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
  - If you believe we should *not* take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.)

- If we do not give you our answer within 72 hours (or if there is an extended time period, by the end of that period), or 24 hours if your request is for a Part B prescription drug, you have the right to appeal. Section 5.3 below tells how to make an appeal.

- **If our answer is no to part or all of what you requested,** we will send you a detailed written explanation as to why we said no.

Deadlines for a "standard coverage decision"

- Generally, for a standard coverage decision on a request for a medical item or service, we will give you our answer **within 14 calendar days of receiving your request**. If your request is for a Medicare Part B prescription drug, we will give you an answer **within 72 hours** of receiving your request.
  - For a request for a medical item or service, we can take up to 14 more calendar days ("an extended time period") under certain circumstances. If we decide to take extra days to make the coverage decision, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
  - If you believe we should *not* take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.)
  - If we do not give you our answer within 14 calendar days (or if there is an extended time period, by the end of that period), or 72 hours if your request is for a Part B prescription drug, you have the right to appeal. Section 5.3 below tells how to make an appeal.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

<u>Step 3:</u> If we say no to your request for coverage for medical care, you decide if you want to make an appeal.

- If we say no, you have the right to ask us to reconsider – and perhaps change – this decision by making an appeal. Making an appeal means making another try to get the medical care coverage you want.
- If you decide to make an appeal, it means you are going on to Level 1 of the appeals process (see Section 5.3 below).

Section 5.3 Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a medical care coverage decision made by our plan)

Legal Terms
An appeal to the plan about a medical care coverage decision is called a plan **"reconsideration."**

Step 1: You contact us and make your appeal. If your health requires a quick response, you must ask for a **"fast appeal."**

What to do

- **To start an appeal you, your doctor, or your representative, must contact us.** For details on how to reach us for any purpose related to your appeal, go to Chapter 2, Section 1 and look for the section called *How to contact us when you are making an appeal about your medical care.*
- **If you are asking for a standard appeal, make your standard appeal in writing by submitting a request.** You may also ask for an appeal by calling us at the phone number shown in Chapter 2, Section 1 (*How to contact us when you are making an appeal about your medical care*).
    - If you have someone appealing our decision for you other than your doctor, your appeal must include an Appointment of Representative form authorizing this person to represent you. To get the form, call Customer Service (phone numbers are printed on the back cover of this booklet) and ask for the "Appointment of Representative" form. It is also available on Medicare's website at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at www.emblemhealth.com/medicare . While we can accept an appeal request without the form, we cannot begin or complete our review until we receive it. If we do not receive the form within 44 calendar days after receiving your appeal request (our deadline for making a decision on your appeal), your appeal request will be dismissed. If this happens, we will send you a written notice explaining your right to ask the Independent Review Organization to review our decision to dismiss your appeal.
- **If you are asking for a fast appeal, make your appeal in writing or call us** at the phone number shown in Chapter 2, Section 1 (*How to contact us when you are making an appeal about your medical care*).
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer to your request for a coverage

decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.

- **You can ask for a copy of the information regarding your medical decision and add more information to support your appeal.**
  - You have the right to ask us for a copy of the information regarding your appeal. We are allowed to charge a fee for copying and sending this information to you.
  - If you wish, you and your doctor may give us additional information to support your appeal.

If your health requires it, ask for a "fast appeal" (you can make a request by calling us)

Legal Terms
A "fast appeal" is also called an **"expedited reconsideration."**

- If you are appealing a decision we made about coverage for care that you have not yet received, you and/or your doctor will need to decide if you need a "fast appeal."
- The requirements and procedures for getting a "fast appeal" are the same as those for getting a "fast coverage decision." To ask for a fast appeal, follow the instructions for asking for a fast coverage decision. (These instructions are given earlier in this section.)
- If your doctor tells us that your health requires a "fast appeal," we will give you a fast appeal.

Step 2: We consider your appeal and we give you our answer.

- When our plan is reviewing your appeal, we take another careful look at all of the information about your request for coverage of medical care. We check to see if we were following all the rules when we said no to your request.
- We will gather more information if we need it. We may contact you or your doctor to get more information.

Deadlines for a "fast appeal"

- When we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires us to do so.

- However, if you ask for more time, or if we need to gather more information that may benefit you, we **can take up to 14 more calendar days** if your request is for a medical item or service. If we decide to take extra days to make the decision, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If we do not give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we are required to automatically send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we tell you about this organization and explain what happens at Level 2 of the appeals process.

- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested,** we will automatically send your appeal to the Independent Review Organization for a Level 2 Appeal.

Deadlines for a "standard appeal"

- If we are using the standard deadlines, we must give you our answer on a request for a medical item or service **within 30 calendar days** after we receive your appeal if your appeal is about coverage for services you have not yet received. If your request is for a Medicare Part B prescription drug you have not yet received, we will give you our answer within 7 calendar days after we receive your appeal. We will give you our decision sooner if your health condition requires us to.
  - However, if you ask for more time, or if we need to gather more information that may benefit you, **we can take up to 14 more calendar days.** If we decide to take extra days to make the decision, we will tell you in writing.
  - If you believe we should *not* take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.)
  - If we do not give you an answer by the applicable deadline above (or by the end of the extended time period if we took extra days on your request for a medical item or service), we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we talk about this review organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage we have agreed to provide within 30 calendar days if your request is for a medical item or service, or within 7 calendar days if your request is for a Medicare Part B prescription drug.

- **If our answer is no to part or all of what you requested**, we will automatically send your appeal to the Independent Review Organization for a Level 2 Appeal.

Step 3: If our plan says no to part or all of your appeal, your case will *automatically* be sent on to the next level of the appeals process.

- To make sure we were following all the rules when we said no to your appeal, **we are required to send your appeal to the "Independent Review Organization."** When we do this, it means that your appeal is going on to the next level of the appeals process, which is Level 2.

Section 5.4 Step-by-step: How a Level 2 Appeal is done

If we say no to your Level 1 Appeal, your case will *automatically* be sent on to the next level of the appeals process. During the Level 2 Appeal, the **Independent Review Organization** reviews our decision for your first appeal. This organization decides whether the decision we made should be changed.

Legal Terms
The formal name for the "Independent Review Organization" is the **"Independent Review Entity."** It is sometimes called the **"IRE."**

Step 1: The Independent Review Organization reviews your appeal.

- **The Independent Review Organization is an independent organization that is hired by Medicare**. This organization is not connected with us and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- We will send the information about your appeal to this organization. This information is called your "case file." **You have the right to ask us for a copy of your case file**. We are allowed to charge you a fee for copying and sending this information to you.
- You have a right to give the Independent Review Organization additional information to support your appeal.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.

If you had a "fast appeal" at Level 1, you will also have a "fast appeal" at Level 2

- If you had a fast appeal to our plan at Level 1, you will automatically receive a fast appeal at Level 2. The review organization must give you an answer to your Level 2 Appeal within 72 hours of when it receives your appeal.

- However, if your request is for a medical item or service and the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days.** The Independent Review Organization can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

If you had a "standard appeal" at Level 1, you will also have a "standard appeal" at Level 2

- If you had a standard appeal to our plan at Level 1, you will automatically receive a standard appeal at Level 2. If your request is for a medical item or service, the review organization must give you an answer to your Level 2 Appeal **within 30 calendar days** of when it receives your appeal. If your request is for a Medicare Part B prescription drug, the review organization must give you an answer to your Level 2 Appeal **within 7 calendar days** of when it receives your appeal.
- However, if the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The Independent Review Organization can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

Step 2: The Independent Review Organization gives you their answer.

The Independent Review Organization will tell you its decision in writing and explain the reasons for it.

- **If the review organization says yes to part or all of a request for a medical item or service,** we must authorize the medical care coverage within **72 hours** or provide the service **within 14 calendar days** after we receive the decision from the review organization for **standard requests** or within **72 hours** from the date we receive the decision from the review organization for **expedited requests**.
- **If the review organization says yes to part or all of a request for a Medicare Part B prescription drug,** we must authorize or provide the Part B prescription drug under dispute **within 72 hours** after we receive the decision from the review organization for **standard requests** or within **24 hours** from the date we receive the decision from the review organization for **expedited requests**.
- **If this organization says no to part or all of your appeal**, it means they agree with us that your request (or part of your request) for coverage for medical care should not be approved. (This is called "upholding the decision." It is also called "turning down your appeal.")
    - If the Independent Review Organization "upholds the decision" you have the right to a Level 3 Appeal. However, to make another appeal at Level 3, the dollar value of the medical care coverage you are requesting must meet a certain minimum. If the dollar value of the coverage you are requesting is too low, you cannot make another appeal, which means that the decision at Level 2 is final. The written

notice you get from the Independent Review Organization will tell you how to find out the dollar amount to continue the appeals process.

Step 3: If your case meets the requirements, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. The details on how to do this are in the written notice you got after your Level 2 Appeal.
- The Level 3 Appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 5.5 What if you are asking us to pay you for our share of a bill you have received for medical care?

If you want to ask us for payment for medical care, start by reading Chapter 5 of this booklet: *Asking us to pay our share of a bill you have received for covered medical services*. Chapter 5 describes the situations in which you may need to ask for reimbursement or to pay a bill you have received from a provider. It also tells how to send us the paperwork that asks us for payment.

Asking for reimbursement is asking for a coverage decision from us

If you send us the paperwork that asks for reimbursement, you are asking us to make a coverage decision (for more information about coverage decisions, see Section 4.1 of this chapter). To make this coverage decision, we will check to see if the medical care you paid for is a covered service (see Chapter 4: *Medical Benefits Chart (what is covered and what you pay)*). We will also check to see if you followed all the rules for using your coverage for medical care (these rules are given in Chapter 3 of this booklet: *Using the plan's coverage for your medical services*).

We will say yes or no to your request

- If the medical care you paid for is covered and you followed all the rules, we will send you the payment for our share of the cost of your medical care within 60 calendar days after we receive your request. Or, if you haven't paid for the services, we will send the payment directly to the provider. When we send the payment, it's the same as saying *yes* to your request for a coverage decision.)
- If the medical care is *not* covered, or you did *not* follow all the rules, we will not send payment. Instead, we will send you a letter that says we will not pay for the services and

the reasons why in detail. (When we turn down your request for payment, it's the same as saying *no* to your request for a coverage decision.)

What if you ask for payment and we say that we will not pay?

If you do not agree with our decision to turn you down, **you can make an appeal**. If you make an appeal, it means you are asking us to change the coverage decision we made when we turned down your request for payment.

To make this appeal, follow the process for appeals that we describe in Section 5.3. Go to this section for step-by-step instructions. When you are following these instructions, please note:

- If you make an appeal for reimbursement, we must give you our answer within 60 calendar days after we receive your appeal. (If you are asking us to pay you back for medical care you have already received and paid for yourself, you are not allowed to ask for a fast appeal.)
- If the Independent Review Organization reverses our decision to deny payment, we must send the payment you have requested to you or to the provider within 30 calendar days. If the answer to your appeal is yes at any stage of the appeals process after Level 2, we must send the payment you requested to you or to the provider within 60 calendar days.

SECTION 6 How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon

When you are admitted to a hospital, you have the right to get all of your covered hospital services that are necessary to diagnose and treat your illness or injury. For more information about our coverage for your hospital care, including any limitations on this coverage, see Chapter 4 of this booklet: *Medical Benefits Chart (what is covered and what you pay)*.

During your covered hospital stay, your doctor and the hospital staff will be working with you to prepare for the day when you will leave the hospital. They will also help arrange for care you may need after you leave.

- The day you leave the hospital is called your "**discharge date**."
- When your discharge date has been decided, your doctor or the hospital staff will let you know.
- If you think you are being asked to leave the hospital too soon, you can ask for a longer hospital stay and your request will be considered. This section tells you how to ask.

Section 6.1 During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights

During your covered hospital stay, you will be given a written notice called *An Important Message from Medicare about Your Rights.* Everyone with Medicare gets a copy of this notice whenever they are admitted to a hospital. Someone at the hospital (for example, a caseworker or nurse) must give it to you within two days after you are admitted. If you do not get the notice, ask any hospital employee for it. If you need help, please call Customer Service (phone numbers are printed on the back cover of this booklet). You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

1. **Read this notice carefully and ask questions if you don't understand it.** It tells you about your rights as a hospital patient, including:
   - Your right to receive Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
   - Your right to be involved in any decisions about your hospital stay, and your right to know who will pay for it.
   - Where to report any concerns you have about quality of your hospital care.
   - Your right to appeal your discharge decision if you think you are being discharged from the hospital too soon.

Legal Terms
The written notice from Medicare tells you how you can **"request an immediate review."** Requesting an immediate review is a formal, legal way to ask for a delay in your discharge date so that we will cover your hospital care for a longer time. (Section 7.2 below tells you how you can request an immediate review.)

2. **You will be asked to sign the written notice to show that you received it and understand your rights.**
   - You or someone who is acting on your behalf will be asked to sign the notice. (Section 4 of this chapter tells how you can give written permission to someone else to act as your representative.)
   - Signing the notice shows *only* that you have received the information about your rights. The notice does not give your discharge date (your doctor or hospital staff will tell you your discharge date). Signing the notice **does *not* mean** you are agreeing on a discharge date.

3. **Keep your copy** of the notice so you will have the information about making an appeal (or reporting a concern about quality of care) handy if you need it.

- If you sign the notice more than two days before the day you leave the hospital, you will get another copy before you are scheduled to be discharged.
- To look at a copy of this notice in advance, you can call Customer Service (phone numbers are printed on the back cover of this booklet) or 1-800 MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. You can also see the notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html.

Section 6.2 Step-by-step: How to make a Level 1 Appeal to change your hospital discharge date

If you want to ask for your inpatient hospital services to be covered by us for a longer time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do.
- **Ask for help if you need it**. If you have questions or need help at any time, please call Customer Service (phone numbers are printed on the back cover of this booklet). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Section 2 of this chapter).

During a Level 1 Appeal, the Quality Improvement Organization reviews your appeal. It checks to see if your planned discharge date is medically appropriate for you.

Step 1: Contact the Quality Improvement Organization for your state and ask for a "fast review" of your hospital discharge. You must act quickly.

What is the Quality Improvement Organization?

- This organization is a group of doctors and other health care professionals who are paid by the Federal government. These experts are not part of our plan. This organization is paid by Medicare to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare.

How can you contact this organization?

- The written notice you received (*An Important Message from Medicare About Your Rights*) tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2, Section 4, of this booklet.)

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and **no later than midnight the day of your discharge date.** (Your "planned discharge date" is the date that has been set for you to leave the hospital.)
  - If you meet this deadline, you are allowed to stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision on your appeal from the Quality Improvement Organization.
  - If you do *not* meet this deadline, and you decide to stay in the hospital after your planned discharge date, *you may have to pay all of the costs* for hospital care you receive after your planned discharge date.
  - If you miss the deadline for contacting the Quality Improvement Organization and you still wish to appeal, you must make an appeal directly to our plan instead. For details about this other way to make your appeal, see Section 7.4.

Ask for a "fast review":

- You must ask the Quality Improvement Organization for a **"fast review"** of your discharge. Asking for a "fast review" means you are asking for the organization to use the "fast" deadlines for an appeal instead of using the standard deadlines.

Legal Terms
A "**fast review**" is also called an "**immediate review**" or an "**expedited review**."

<u>Step 2:</u> The Quality Improvement Organization conducts an independent review of your case.

What happens during this review?

- Health professionals at the Quality Improvement Organization (we will call them "the reviewers" for short) will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.
- The reviewers will also look at your medical information, talk with your doctor, and review information that the hospital and we have given to them.
- By noon of the day after the reviewers informed our plan of your appeal, you will also get a written notice that gives your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

Legal Terms
This written explanation is called the "**Detailed Notice of Discharge."** You can get a sample of this notice by calling Customer Service (phone numbers are printed on the back cover of this booklet) or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.) Or you can see a sample notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html

Step 3: Within one full day after it has all the needed information, the Quality Improvement Organization will give you its answer to your appeal.

What happens if the answer is yes?

- If the review organization says *yes* to your appeal, **we must keep providing your covered inpatient hospital services for as long as these services are medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered hospital services. (See Chapter 4 of this booklet).

What happens if the answer is no?

- If the review organization says *no* to your appeal, they are saying that your planned discharge date is medically appropriate. If this happens, **our coverage for your inpatient hospital services will end** at noon on the day *after* the Quality Improvement Organization gives you its answer to your appeal.
- If the review organization says *no* to your appeal and you decide to stay in the hospital, then **you may have to pay the full cost** of hospital care you receive after noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

Step 4: If the answer to your Level 1 Appeal is no, you decide if you want to make another appeal.

- If the Quality Improvement Organization has turned down your appeal, *and* you stay in the hospital after your planned discharge date, then you can make another appeal. Making another appeal means you are going on to "Level 2" of the appeals process.

Section 6.3 Step-by-step: How to make a Level 2 Appeal to change your hospital discharge date

If the Quality Improvement Organization has turned down your appeal, *and* you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision

they made on your first appeal. If the Quality Improvement Organization turns down your Level 2 Appeal, you may have to pay the full cost for your stay after your planned discharge date.

Here are the steps for Level 2 of the appeal process:

Step 1: You contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 calendar days** after the day the Quality Improvement Organization said *no* to your Level 1 Appeal. You can ask for this review only if you stay in the hospital after the date that your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

Step 3: Within 14 calendar days of receipt of your request for a second review, the Quality Improvement Organization reviewers will decide on your appeal and tell you their decision.

If the review organization says yes:

- **We must reimburse you** for our share of the costs of hospital care you have received since noon on the day after the date your first appeal was turned down by the Quality Improvement Organization. **We must continue providing coverage for your inpatient hospital care for as long as it is medically necessary**.
- You must continue to pay your share of the costs and coverage limitations may apply.

If the review organization says no:

- It means they agree with the decision they made on your Level 1 Appeal and will not change it. This is called "upholding the decision."
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by an Administrative Law Judge or attorney adjudicator.

Step 4: If the answer is no, you will need to decide whether you want to take your appeal further by going on to Level 3.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If the review organization turns down your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by an Administrative Law Judge or attorney adjudicator.

- Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 6.4 What if you miss the deadline for making your Level 1 Appeal?

You can appeal to us instead

As explained above in Section 6.2, you must act quickly to contact the Quality Improvement Organization to start your first appeal of your hospital discharge. ("Quickly" means before you leave the hospital and no later than your planned discharge date, whichever comes first.) If you miss the deadline for contacting this organization, there is another way to make your appeal.

If you use this other way of making your appeal, *the first two levels of appeal are different.*

Step-by-Step: How to make a Level 1 *Alternate* Appeal

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a "fast review." A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

Legal Terms
A "fast review" (or "fast appeal") is also called an **"expedited appeal."**

Step 1: Contact us and ask for a "fast review."

- For details on how to contact us, go to Chapter 2, Section 1 and look for the section called, *How to contact us when you are making an appeal about your medical care*.
- **Be sure to ask for a "fast review**." This means you are asking us to give you an answer using the "fast" deadlines rather than the "standard" deadlines.

Step 2: We do a "fast review" of your planned discharge date, checking to see if it was medically appropriate.

- During this review, we take a look at all of the information about your hospital stay. We check to see if your planned discharge date was medically appropriate. We will check to see if the decision about when you should leave the hospital was fair and followed all the rules.
- In this situation, we will use the "fast" deadlines rather than the standard deadlines for giving you the answer to this review.

Step 3: We give you our decision within 72 hours after you ask for a "fast review" ("fast appeal").

- **If we say yes to your fast appeal,** it means we have agreed with you that you still need to be in the hospital after the discharge date, and will keep providing your covered inpatient hospital services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If we say no to your fast appeal,** we are saying that your planned discharge date was medically appropriate. Our coverage for your inpatient hospital services ends as of the day we said coverage would end.
    - If you stayed in the hospital *after* your planned discharge date, then **you may have to pay the full cost** of hospital care you received after the planned discharge date.

Step 4: If we say *no* to your fast appeal, your case will *automatically* be sent on to the next level of the appeals process.

- To make sure we were following all the rules when we said no to your fast appeal, **we are required to send your appeal to the "Independent Review Organization."** When we do this, it means that you are *automatically* going on to Level 2 of the appeals process.

Step-by-Step: Level 2 *Alternate* Appeal Process

During the Level 2 Appeal, an **Independent Review Organization** reviews the decision we made when we said no to your "fast appeal." This organization decides whether the decision we made should be changed.

Legal Terms
The formal name for the "Independent Review Organization" is the **"Independent Review Entity."** It is sometimes called the **"IRE."**

Step 1: We will automatically forward your case to the Independent Review Organization.

- We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeal process. Section 9 of this chapter tells how to make a complaint.)

Step 2: The Independent Review Organization does a "fast review" of your appeal. The reviewers give you an answer within 72 hours.

- **The Independent Review Organization is an independent organization that is hired by Medicare**. This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal of your hospital discharge.
- **If this organization says *yes* to your appeal,** then we must reimburse you (pay you back) for our share of the costs of hospital care you have received since the date of your planned discharge. We must also continue the plan's coverage of your inpatient hospital services for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says *no* to your appeal,** it means they agree with us that your planned hospital discharge date was medically appropriate.
    - The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal, which is handled by an Administrative Law Judge or attorney adjudicator.

Step 3: If the Independent Review Organization turns down your appeal, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If reviewers say no to your Level 2 Appeal, you decide whether to accept their decision or go on to Level 3 and make a third appeal.
- Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 7 How to ask us to keep covering certain medical services if you think your coverage is ending too soon

Section 7.1 *This section is about three services only:* Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services

This section is about the following types of care *only*:

- **Home health care services** you are getting.
- **Skilled nursing care** you are getting as a patient in a skilled nursing facility. (To learn about requirements for being considered a "skilled nursing facility," see Chapter 10, *Definitions of important words*.)
- **Rehabilitation care** you are getting as an outpatient at a Medicare-approved Comprehensive Outpatient Rehabilitation Facility (CORF). Usually, this means you are getting treatment for an illness or accident, or you are recovering from a major operation. (For more information about this type of facility, see Chapter 10, *Definitions of important words*.)

When you are getting any of these types of care, you have the right to keep getting your covered services for that type of care for as long as the care is needed to diagnose and treat your illness or injury. For more information on your covered services, including your share of the cost and any limitations to coverage that may apply, see Chapter 4 of this booklet: *Medical Benefits Chart (what is covered and what you pay)*.

When we decide it is time to stop covering any of the three types of care for you, we are required to tell you in advance. When your coverage for that care ends, *we will stop paying our share of the cost for your care.*

If you think we are ending the coverage of your care too soon, **you can appeal our decision**. This section tells you how to ask for an appeal.

Section 7.2 We will tell you in advance when your coverage will be ending

1. **You receive a notice in writing.** At least two days before our plan is going to stop covering your care, you will receive a notice.
   - The written notice tells you the date when we will stop covering the care for you.
   - The written notice also tells what you can do if you want to ask our plan to change this decision about when to end your care, and keep covering it for a longer period of time.

Legal Terms
In telling you what you can do, the written notice is telling how you can request a **"fast-track appeal."** Requesting a fast-track appeal is a formal, legal way to request a change to our coverage decision about when to stop your care. (Section 7.3 below tells how you can request a fast-track appeal.) The written notice is called the "**Notice of Medicare Non-Coverage."**

2. **You will be asked to sign the written notice to show that you received it.**
   - You or someone who is acting on your behalf will be asked to sign the notice. (Section 4 tells how you can give written permission to someone else to act as your representative.)
   - Signing the notice shows *only* that you have received the information about when your coverage will stop. **Signing it does not mean you agree** with the plan that it's time to stop getting the care.

Section 7.3 Step-by-step: How to make a Level 1 Appeal to have our plan cover your care for a longer time

If you want to ask us to cover your care for a longer period of time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do. There are also deadlines our plan must follow. (If you think we are not meeting our deadlines, you can file a complaint. Section 9 of this chapter tells you how to file a complaint.)
- **Ask for help if you need it**. If you have questions or need help at any time, please call Customer Service (phone numbers are printed on the back cover of this booklet). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Section 2 of this chapter).

If you ask for a Level 1 Appeal on time, the Quality Improvement Organization reviews your appeal and decides whether to change the decision made by our plan.

Step 1: Make your Level 1 Appeal: contact the Quality Improvement Organization for your state and ask for a review. You must act quickly.

What is the Quality Improvement Organization?

- This organization is a group of doctors and other health care experts who are paid by the Federal government. These experts are not part of our plan. They check on the quality of care received by people with Medicare and review plan decisions about when it's time to stop covering certain kinds of medical care.

How can you contact this organization?

- The written notice you received tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2, Section 4, of this booklet.)

What should you ask for?

- Ask this organization for a "fast-track appeal" (to do an independent review) of whether it is medically appropriate for us to end coverage for your medical services.

Your deadline for contacting this organization.

- You must contact the Quality Improvement Organization to start your appeal by noon of the day before the effective date on the Notice of Medicare Non-Coverage.
- If you miss the deadline for contacting the Quality Improvement Organization and you still wish to file an appeal, you must make an appeal directly to us instead. For details about this other way to make your appeal, see Section 7.5.

Step 2: The Quality Improvement Organization conducts an independent review of your case.

What happens during this review?

- Health professionals at the Quality Improvement Organization (we will call them "the reviewers" for short) will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.
- The review organization will also look at your medical information, talk with your doctor, and review information that our plan has given to them.
- By the end of the day the reviewers inform us of your appeal, and you will also get a written notice from us that explains in detail our reasons for ending our coverage for your services.

Legal Terms
This notice of explanation is called the "**Detailed Explanation of Non-Coverage.**"

Step 3: Within one full day after they have all the information they need, the reviewers will tell you their decision.

What happens if the reviewers say yes to your appeal?

- If the reviewers say *yes* to your appeal, then **we must keep providing your covered services for as long as it is medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered services (see Chapter 4 of this booklet).

What happens if the reviewers say no to your appeal?

- If the reviewers say *no* to your appeal, then **your coverage will end on the date we have told you.** We will stop paying our share of the costs of this care on the date listed on the notice.
- If you decide to keep getting the home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* this date when your coverage ends, then **you will have to pay the full cost** of this care yourself.

Step 4: If the answer to your Level 1 Appeal is no, you decide if you want to make another appeal.

- This first appeal you make is "Level 1" of the appeals process. If reviewers say *no* to your Level 1 Appeal – and you choose to continue getting care after your coverage for the care has ended – then you can make another appeal.
- Making another appeal means you are going on to "Level 2" of the appeals process.

Section 7.4 Step-by-step: How to make a Level 2 Appeal to have our plan cover your care for a longer time

If the Quality Improvement Organization has turned down your appeal and you choose to continue getting care after your coverage for the care has ended, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your first appeal. If the Quality Improvement Organization turns down your Level 2 Appeal, you may have to pay the full cost for your home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end.

Here are the steps for Level 2 of the appeal process:

Step 1: You contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 days** after the day when the Quality Improvement Organization said *no* to your Level 1 Appeal. You can ask for this review only if you continued getting care after the date that your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

Step 3: Within 14 days of receipt of your appeal request, reviewers will decide on your appeal and tell you their decision.

What happens if the review organization says yes to your appeal?

- **We must reimburse you** for our share of the costs of care you have received since the date when we said your coverage would end. **We must continue providing coverage** for the care for as long as it is medically necessary.
- You must continue to pay your share of the costs and there may be coverage limitations that apply.

What happens if the review organization says no?

- It means they agree with the decision we made to your Level 1 Appeal and will not change it.
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by an Administrative Law Judge or attorney adjudicator.

Step 4: If the answer is no, you will need to decide whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers turn down your Level 2 Appeal, you can choose whether to accept that decision or to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by an Administrative Law Judge or attorney adjudicator.
- Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 7.5 What if you miss the deadline for making your Level 1 Appeal?

You can appeal to us instead

As explained above in Section 7.3, you must act quickly to contact the Quality Improvement Organization to start your first appeal (within a day or two, at the most). If you miss the deadline for contacting this organization, there is another way to make your appeal. If you use this other way of making your appeal, *the first two levels of appeal are different.*

Step-by-Step: How to make a Level 1 *Alternate* Appeal

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a "fast review." A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

Here are the steps for a Level 1 Alternate Appeal:

Legal Terms
A "fast review" (or "fast appeal") is also called an **"expedited appeal**."

Step 1: Contact us and ask for a "fast review."

- For details on how to contact us, go to Chapter 2, Section 1 and look for the section called, *How to contact us when you are making an appeal about your medical care*.
- **Be sure to ask for a "fast review**." This means you are asking us to give you an answer using the "fast" deadlines rather than the "standard" deadlines.

Step 2: We do a "fast review" of the decision we made about when to end coverage for your services.

- During this review, we take another look at all of the information about your case. We check to see if we were following all the rules when we set the date for ending the plan's coverage for services you were receiving.
- We will use the "fast" deadlines rather than the standard deadlines for giving you the answer to this review.

Step 3: We give you our decision within 72 hours after you ask for a "fast review" ("fast appeal").

- **If we say yes to your fast appeal,** it means we have agreed with you that you need services longer, and will keep providing your covered services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If we say no to your fast appeal,** then your coverage will end on the date we told you and we will not pay any share of the costs after this date.
- If you continued to get home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end, then **you will have to pay the full cost** of this care yourself.

Step 4: If we say *no* to your fast appeal, your case will *automatically* go on to the next level of the appeals process.

- To make sure we were following all the rules when we said no to your fast appeal, **we are required to send your appeal to the "Independent Review Organization."** When we do this, it means that you are *automatically* going on to Level 2 of the appeals process.

Step-by-Step: Level 2 *Alternate* Appeal Process

During the Level 2 Appeal, the **Independent Review Organization** reviews the decision we made when we said no to your "fast appeal." This organization decides whether the decision we made should be changed.

Legal Terms
The formal name for the "Independent Review Organization" is the **"Independent Review Entity."** It is sometimes called the **"IRE."**

Step 1: We will automatically forward your case to the Independent Review Organization.

- We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeal process. Section 9 of this chapter tells how to make a complaint.)

Step 2: The Independent Review Organization does a "fast review" of your appeal. The reviewers give you an answer within 72 hours.

- **The Independent Review Organization is an independent organization that is hired by Medicare**. This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.
- **If this organization says *yes* to your appeal,** then we must reimburse you (pay you back) for our share of the costs of care you have received since the date when we said your coverage would end. We must also continue to cover the care for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says *no* to your appeal,** it means they agree with the decision our plan made to your first appeal and will not change it.
    - The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal.

Step 3: If the Independent Review Organization turns down your appeal, you choose whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers say no to your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by an Administrative Law Judge or attorney adjudicator.
- Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 8 Taking your appeal to Level 3 and beyond

Section 8.1 Appeal Levels 3, 4, and 5 for Medical Service Requests

This section may be appropriate for you if you have made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down.

If the dollar value of the item or medical service you have appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, the written response you receive to your Level 2 Appeal will explain who to contact and what to do to ask for a Level 3 Appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 Appeal: **A judge (called an Administrative Law Judge) or an attorney adjudicator who works for the Federal government** will review your appeal and give you an answer.

- **If the Administrative Law Judge or attorney adjudicator says yes to your appeal, the appeals process *may* or *may not* be over** - We will decide whether to appeal this decision to Level 4. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 3 decision that is favorable to you.
  - If we decide *not* to appeal the decision, we must authorize or provide you with the service within 60 calendar days after receiving the Administrative Law Judge's or attorney adjudicator's decision.
  - If we decide to appeal the decision, we will send you a copy of the Level 4 Appeal request with any accompanying documents. We may wait for the Level 4 Appeal decision before authorizing or providing the service in dispute.
- **If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process *may* or *may not* be over**.

- If you decide to accept this decision that turns down your appeal, the appeals process is over.
- If you do not want to accept the decision, you can continue to the next level of the review process. If the Administrative Law Judge or attorney adjudicator says no to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal.

Level 4 Appeal: The Medicare **Appeals Council** (Council) will review your appeal and give you an answer. The Council is part of the Federal government.

- If the answer is yes, or if the Council denies our request to review a favorable Level 3 Appeal decision, the appeals process *may* or *may not* be over - We will decide whether to appeal this decision to Level 5. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 4 decision that is favorable to you if the value of the item or medical service meets the required dollar value.
  - If we decide *not* to appeal the decision, we must authorize or provide you with the service within 60 calendar days after receiving the Council's decision.
  - If we decide to appeal the decision, we will let you know in writing.
- **If the answer is no or if the Council denies the review request, the appeals process *may* or *may not* be over**.
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Council says no to your appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

Level 5 Appeal: A judge at the **Federal District Court** will review your appeal.

- This is the last step of the appeals process.

MAKING COMPLAINTS

SECTION 9 How to make a complaint about quality of care, waiting times, Customer Service, or other concerns

If your problem is about decisions related to benefits, coverage, or payment, then this section is *not for you*. Instead, you need to use the process for coverage decisions and appeals. Go to Section 4 of this chapter.

Section 9.1 What kinds of problems are handled by the complaint process?

This section explains how to use the process for making complaints. The complaint process is used for certain types of problems *only.* This includes problems related to quality of care, waiting times, and the Customer Service you receive. Here are examples of the kinds of problems handled by the complaint process.

If you have any of these kinds of problems, you can "make a complaint"

Complaint	Example
Quality of your medical care	• Are you unhappy with the quality of the care you have received (including care in the hospital)?
Respecting your privacy	• Do you believe that someone did not respect your right to privacy or shared information about you that you feel should be confidential?
Disrespect, poor Customer Service, or other negative behaviors	• Has someone been rude or disrespectful to you? • Are you unhappy with how our Customer Service has treated you? • Do you feel you are being encouraged to leave the plan?
Waiting times	• Are you having trouble getting an appointment, or waiting too long to get it? • Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by our Customer Service or other staff at the plan? o Examples include waiting too long on the phone, in the waiting room, when getting a prescription, or in the exam room.

Complaint	Example
Cleanliness	• Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
Information you get from us	• Do you believe we have not given you a notice that we are required to give? • Do you think written information we have given you is hard to understand?
Timeliness (These types of complaints are all related to the timeliness of our actions related to coverage decisions and appeals)	The process of asking for a coverage decision and making appeals is explained in Sections 4-8 of this chapter. If you are asking for a coverage decision or making an appeal, you use that process, not the complaint process. However, if you have already asked us for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can also make a complaint about our slowness. Here are examples: • If you have asked us to give you a "fast coverage decision" or a "fast appeal," and we have said we will not, you can make a complaint. • If you believe we are not meeting the deadlines for giving you a coverage decision or an answer to an appeal you have made, you can make a complaint. • When a coverage decision we made is reviewed and we are told that we must cover or reimburse you for certain medical services, there are deadlines that apply. If you think we are not meeting these deadlines, you can make a complaint. • When we do not give you a decision on time, we are required to forward your case to the Independent Review Organization. If we do not do that within the required deadline, you can make a complaint.

Section 9.2 The formal name for "making a complaint" is "filing a grievance"

Legal Terms

- What this section calls a **"complaint"** is also called a **"grievance."**
- Another term for **"making a complaint"** is **"filing a grievance."**
- Another way to say "**using the process for complaints"** is "**using the process for filing a grievance."**

Section 9.3 Step-by-step: Making a complaint

Step 1: Contact us promptly – either by phone or in writing.

- **Usually, calling Customer Service is the first step.** If there is anything else you need to do Customer Service will let you know. Our phone number and hours of operation are 1-877-344-7364, 7 days a week 8:00 am to 8:00 pm, (TTY: 711).
- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we will respond to your complaint in writing.

- A member grievance (complaint) must be filed within 60 days of the date of the incident causing the complaint by writing to:

  EmblemHealth Medicare HMO
  ATTN: Grievance and Appeals
  PO Box 2807
  New York, NY 10116-2807

  or in person at:
  EmblemHealth Medicare HMO
  55 Water Street
  New York, NY 10041

  The hours of operation are Monday-Friday, 8:30 am - 5:00 pm. No appointment is necessary.

  or by calling Customer Service at:
  1-877-447-1199

TDD/TTY users may call 711

The hours of operation are Monday through Sunday, 8:00 am – 8:00 pm.

If you have someone filing a grievance for you, your grievance must include an "Appointment of Representative Form" authorizing the person to represent you. To get the form, call Customer Service (phone numbers are listed above) and ask for the "Appointment of Representative Form." It is also available on Medicare's website at https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at www.emblemhealth.com/medicare. While we can accept a grievance without the form, we cannot complete our review until we receive it. If we do not receive the form within 44 days after receiving your grievance request (our deadline for responding to your grievance), your grievance request will be closed.

A written acknowledgement will be sent to you within 15 days after the date the grievance was received by EmblemHealth Medicare. It will include a request for any additional information needed to resolve the grievance and will identify the name, address and phone number of the department which has been designated to respond to it.

We will investigate your grievance, and notify you of our decision as quickly as your case requires based on your health status, but no later than 30 calendar days after receiving your grievance. We may extend the time frame by up to 14 calendar days if you request an extension, or if we justify a need for additional information and the delay is in your best interest. We will notify you if an extension is needed.

If you request an expedited organization determination, expedited coverage determination, expedited reconsideration or expedited redetermination, we may decide your request does not meet the criteria to expedite, and therefore will process your request using the timeframes for a standard request. If we decide not to expedite your request, or decide to take an extension on your request, you may request an expedited grievance. EmblemHealth must respond to your expedited grievance within 24 hours of the request.

- **Whether you call or write, you should contact Customer Service right away.** The complaint must be made within 60 calendar days after you had the problem you want to complain about.
- **If you are making a complaint because we denied your request for a "fast coverage decision" or a "fast appeal," we will automatically give you a "fast complaint."** If you have a "fast complaint," it means we will give you **an answer within 24 hours**.

Legal Terms
What this section calls a **"fast complaint"** is also called an **"expedited grievance."**

Step 2: We look into your complaint and give you our answer.

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.
- **Most complaints are answered within 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. If we decide to take extra days, we will tell you in writing.
- **If we do not agree** with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not.

Section 9.4 You can also make complaints about quality of care to the Quality Improvement Organization

You can make your complaint about the quality of care you received to us by using the step-by-step process outlined above.

When your complaint is about *quality of care*, you also have two extra options:

- **You can make your complaint to the Quality Improvement Organization**. If you prefer, you can make your complaint about the quality of care you received directly to this organization (*without* making the complaint to us).
  - The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients.
  - To find the name, address, and phone number of the Quality Improvement Organization for your state, look in Chapter 2, Section 4, of this booklet. If you make a complaint to this organization, we will work with them to resolve your complaint.
- **Or you can make your complaint to both at the same time**. If you wish, you can make your complaint about quality of care to us and also to the Quality Improvement Organization.

Section 9.5 You can also tell Medicare about your complaint

You can submit a complaint about EmblemHealth VIP Rx Carveout (HMO) - Group plan directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the plan is not addressing your issue, please call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048.

CHAPTER 8

Ending your membership in the plan

Chapter 8. Ending your membership in the plan

SECTION 1 Introduction

Section 1.1 This chapter focuses on ending your membership in our plan

Ending your membership in EmblemHealth VIP Rx Carveout (HMO) - Group may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you have decided that you *want* to leave.
  - There are only certain times during the year, or certain situations, when you may voluntarily end your membership in the plan. Section 2 tells you *when* you can end your membership in the plan.
  - The process for voluntarily ending your membership varies depending on what type of new coverage you are choosing. Section 3 tells you *how* to end your membership in each situation.
- There are also limited situations where you do not choose to leave, but we are required to end your membership. Section 5 tells you about situations when we must end your membership.

If you are leaving our plan, you must continue to get your medical care through our plan until your membership ends.

SECTION 2 When can you end your membership in our plan?

You may end your membership in our plan only during certain times of the year, known as enrollment periods. All members have the opportunity to leave the plan during the Annual Enrollment Period and during the Medicare Advantage Open Enrollment Period. In certain situations, you may also be eligible to leave the plan at other times of the year.

Section 2.1 You can end your membership during the Annual Enrollment Period

You can end your membership during the **Annual Enrollment Period** (also known as the "Annual Open Enrollment Period"). This is the time when you should review your health and drug coverage and make a decision about your coverage for the upcoming year.

- **When is the Annual Enrollment Period?** This happens from October 15 to December 7.
- **What type of plan can you switch to during the Annual Enrollment Period?** You can choose to keep your current coverage or make changes to your coverage for the upcoming year. If you decide to change to a new plan, you can choose any of the following types of plans:

- Another Medicare health plan. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)
- Original Medicare *with* a separate Medicare prescription drug plan.
- – *or* – Original Medicare *without* a separate Medicare prescription drug plan.

- **When will your membership end?** Your membership will end when your new plan's coverage begins on January 1.

Section 2.2 You can end your membership during the Medicare Advantage Open Enrollment Period

You have the opportunity to make *one* change to your health coverage during the **Medicare Advantage Open Enrollment Period**.

- **When is the annual Medicare Advantage Open Enrollment Period?** This happens every year from January 1 to March 31.
- **What type of plan can you switch to during the annual Medicare Advantage Open Enrollment Period?** During this time, you can:
  - Switch to another Medicare Advantage Plan. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)
  - Disenroll from our plan and obtain coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time.
- **When will your membership end?** Your membership will end on the first day of the month after you enroll in a different Medicare Advantage plan or we get your request to switch to Original Medicare. If you also choose to enroll in a Medicare prescription drug plan, your membership in the drug plan will begin the first day of the month after the drug plan gets your enrollment request.

Section 2.3 In certain situations, you can end your membership during a Special Enrollment Period

In certain situations, members of EmblemHealth VIP Rx Carveout (HMO) - Group may be eligible to end their membership at other times of the year. This is known as a **Special Enrollment Period**.

- **Who is eligible for a Special Enrollment Period?** If any of the following situations apply to you, you may be eligible to end your membership during a Special Enrollment Period. These are just examples, for the full list you can contact the plan, call Medicare, or visit the Medicare website (www.medicare.gov):

- Usually, when you have moved.
- If you have Medicaid.
- If we violate our contract with you.
- If you are getting care in an institution, such as a nursing home or long-term care (LTC) hospital.
- If you enroll in the Program of All-inclusive Care for the Elderly (PACE).

- **When are Special Enrollment Periods?** The enrollment periods vary depending on your situation.
- **What can you do?** To find out if you are eligible for a Special Enrollment Period, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048. If you are eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. This means you can choose any of the following types of plans:
  - Another Medicare health plan. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)
  - Original Medicare *with* a separate Medicare prescription drug plan.
  - – *or* – Original Medicare *without* a separate Medicare prescription drug plan.
- **When will your membership end?** Your membership will usually end on the first day of the month after your request to change your plan is received.

Section 2.4 Where can you get more information about when you can end your membership?

If you have any questions or would like more information on when you can end your membership:

- You can **call Customer Service** (phone numbers are printed on the back cover of this booklet).
- You can find the information in the ***Medicare & You 2021*** Handbook.
  - Everyone with Medicare receives a copy of *Medicare & You* each fall. Those new to Medicare receive it within a month after first signing up.
  - You can also download a copy from the Medicare website (www.medicare.gov). Or, you can order a printed copy by calling Medicare at the number below.
- You can contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

SECTION 3 How do you end your membership in our plan?

Section 3.1 Usually, you end your membership by enrolling in another plan

Usually, to end your membership in our plan, you simply enroll in another Medicare plan during one of the enrollment periods (see Section 2 in this chapter for information about the enrollment periods). However, if you want to switch from our plan to Original Medicare *without* a Medicare prescription drug plan, you must ask to be disenrolled from our plan. There are two ways you can ask to be disenrolled:

- You can make a request in writing to us. Contact Customer Service if you need more information on how to do this (phone numbers are printed on the back cover of this booklet).
- --*or*--You can contact Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

The table below explains how you should end your membership in our plan.

If you would like to switch from our plan to:	This is what you should do:
• Another Medicare health plan.	• Enroll in the new Medicare health plan. You will automatically be disenrolled from EmblemHealth VIP Rx Carveout (HMO) - Group when your new plan's coverage begins.
• Original Medicare *with* a separate Medicare prescription drug plan.	• Enroll in the new Medicare prescription drug plan. You will automatically be disenrolled from EmblemHealth VIP Rx Carveout (HMO) - Group your new plan's coverage begins.

If you would like to switch from our plan to:	This is what you should do:
• Original Medicare *without* a separate Medicare prescription drug plan.	• **Send us a written request to disenroll.** Contact Customer Service if you need more information on how to do this (phone numbers are printed on the back cover of this booklet). • You can also contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048. • You will be disenrolled from EmblemHealth VIP Rx Carveout (HMO) - Group when your coverage in Original Medicare begins.

SECTION 4 Until your membership ends, you must keep getting your medical services through our plan

Section 4.1 Until your membership ends, you are still a member of our plan

If you leave EmblemHealth VIP Rx Carveout (HMO) - Group, it may take time before your membership ends and your new Medicare coverage goes into effect. (See Section 2 for information on when your new coverage begins.) During this time, you must continue to get your medical care through our plan.

- **If you are hospitalized on the day that your membership ends, your hospital stay will usually be covered by our plan until you are discharged** (even if you are discharged after your new health coverage begins).

SECTION 5 EmblemHealth VIP Rx Carveout (HMO) - Group must end your membership in the plan in certain situations

Section 5.1 When must we end your membership in the plan?

EmblemHealth VIP Rx Carveout (HMO) - Group must end your membership in the plan if any of the following happen:

- If you no longer have Medicare Part A and Part B.
- If you move out of our service area.

- If you are away from our service area for more than six months.
    - If you move or take a long trip, you need to call Customer Service to find out if the place you are moving or traveling to is in our plan's area. (Phone numbers for Customer Service are printed on the back cover of this booklet.)
- If you become incarcerated (go to prison).
- If you are not a United States citizen or lawfully present in the United States.
- If you lie about or withhold information about other insurance you have that provides prescription drug coverage.
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get medical care. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
    - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.

Where can you get more information?

If you have questions or would like more information on when we can end your membership:

- You can call **Customer Service** for more information (phone numbers are printed on the back cover of this booklet).

Section 5.2 We cannot ask you to leave our plan for any reason related to your health

Our plan is not allowed to ask you to leave our plan for any reason related to your health.

What should you do if this happens?

If you feel that you are being asked to leave our plan because of a health-related reason, you should call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may call 24 hours a day, 7 days a week.

Section 5.3 You have the right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our

decision to end your membership. You can look in Chapter 7, Section 9 for information about how to make a complaint.

CHAPTER 9

Legal notices

Chapter 9. Legal notices

SECTION 1 Notice about governing law

Many laws apply to this *Evidence of Coverage* and some additional provisions may apply because they are required by law. This may affect your rights and responsibilities even if the laws are not included or explained in this document. The principal law that applies to this document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS. In addition, other Federal laws may apply and, under certain circumstances, the laws of the state you live in.

SECTION 2 Notice about non-discrimination

We don't discriminate based on race, ethnicity, national origin, color, religion, sex, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location. All organizations that provide Medicare Advantage plans, like our plan, must obey Federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, EmblemHealth as a Medicare Advantage Organization, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any State laws.

In some situations, other parties should pay for your medical care before your Medicare Advantage (MA) health plan. In those situations, your Medicare Advantage plan may pay, but have the right to get the payments back from these other parties. Medicare Advantage plans may not be the primary payer for medical care you receive. These situations include those in which the Federal Medicare Program is considered a secondary payer under the Medicare Secondary Payer laws. For information on the Federal Medicare Secondary Payer program, Medicare has written a booklet with general information about what happens when people with Medicare have additional insurance. It's called Medicare and Other Health Benefits: Your Guide to Who Pays First (publication number 02179). You can get a copy by calling 1-800-MEDICARE, 24 hours a day, 7 days a week, or by visiting the www.medicare.gov website.

The plan's rights to recover in these situations are based on the terms of this health plan contract, as well as the provisions of the Federal statutes governing the Medicare Program. Your MA plan coverage is always secondary to any payment made or reasonably expected to be made under:

A workers compensation law or plan of the United States or a State, any non-fault based insurance, including automobile and non-automobile no-fault and medical payments insurance, any liability insurance policy or plan (including a self-insured plan) issued under an automobile or other type of policy or coverage, and any automobile insurance policy or plan (including a self-insured plan), including, but not limited to, uninsured and underinsured motorist coverages.

Since your MA plan is always secondary to any automobile no-fault (Personal Injury Protection) or medical payments coverage, you should review your automobile insurance policies to ensure that appropriate policy provisions have been selected to make your automobile coverage primary for your medical treatment arising from an automobile accident.

As outlined herein, in these situations, your MA plan may make payments on your behalf for this medical care, subject to the conditions set forth in this provision for the plan to recover these payments from you or from other parties. Immediately upon making any conditional payment, your MA plan shall be subrogated to (stand in the place of) all rights of recovery you have against any person, entity or insurer responsible for causing your injury, illness or condition or against any person, entity or insurer listed as a primary payer above.

In addition, if you receive payment from any person, entity or insurer responsible for causing your injury, illness or condition or you receive payment from any person, entity or insurer listed as a primary payer above, your MA plan has the right to recover from, and be reimbursed by you for all conditional payments the plan has made or will make as a result of that injury, illness or condition.

Your MA plan will automatically have a lien, to the extent of benefits it paid for the treatment of the injury, illness or condition, upon any recovery whether by settlement, judgment or otherwise. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the Plan including, but not limited to, you, your representatives or agents, any person, entity or insurer responsible for causing your injury, illness or condition or any person, entity or insurer listed as a primary payer above.

By accepting benefits (whether the payment of such benefits is made to you or made on your behalf to any health care provider) from your MA plan, you acknowledge that the plan's recovery rights are a first priority claim and are to be paid to the plan before any other claim for your damages. The plan shall be entitled to full reimbursement on a first-dollar basis from any payments, even if such payment to the plan will result in a recovery to you which is insufficient to make you whole or to compensate you in part or in whole for the damages you sustained. Your MA plan is not required to participate in or pay court costs or attorney fees to any attorney hired by you to pursue your damage claims.

Your MA plan is entitled to full recovery regardless of whether any liability for payment is admitted by any person, entity or insurer responsible for causing your injury, illness or condition or by any person, entity or insurer listed as a primary payer above. The plan is entitled to full recovery regardless of whether the settlement or judgment received by you identifies the medical benefits the plan provided or purports to allocate any portion of such settlement or judgment to

payment of expenses other than medical expenses. The MA plan is entitled to recover from any and all settlements or judgments, even those designated as for pain and suffering, non-economic damages and/or general damages only.

You, and your legal representatives, shall fully cooperate with the plan's efforts to recover its benefits paid. It is your duty to notify the plan within 30 days of the date when notice is given to any party, including an insurance company or attorney, of your intention to pursue or investigate a claim to recover damages or obtain compensation due to your injury, illness or condition. You and your agents or representatives shall provide all information requested by the plan or its representatives. You shall do nothing to prejudice your MA plan's subrogation or recovery interest or to prejudice the plan's ability to enforce the terms of this provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the plan.

Failure to provide requested information or failure to assist your MA plan in pursuit of its subrogation or recovery rights may result in you being personally responsible for reimbursing the plan for benefits paid relating to the injury, illness or condition as well as for the plan's reasonable attorney fees and costs incurred in obtaining reimbursement from you.

CHAPTER 10

Definitions of important words

Chapter 10. Definitions of important words

Ambulatory Surgical Center – An Ambulatory Surgical Center is an entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization and whose expected stay in the center does not exceed 24 hours.

Annual Enrollment Period – A set time each fall when members can change their health or drug plans or switch to Original Medicare. The Annual Enrollment Period is from October 15 until December 7.

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or payment for services you already received. You may also make an appeal if you disagree with our decision to stop services that you are receiving. For example, you may ask for an appeal if we don't pay for an item, or service you think you should be able to receive. Chapter 7 explains appeals, including the process involved in making an appeal.

Balance Billing – When a provider (such as a doctor or hospital) bills a patient more than the plan's allowed cost-sharing amount. As a member of our plan, you only have to pay our plan's cost-sharing amounts when you get services covered by our plan. We do not allow providers to "balance bill" or otherwise charge you more than the amount of cost-sharing your plan says you must pay.

Benefit Period –The way that both our plan and Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. For Skilled Nursing Facility stays a benefit period begins the day you are admitted as an inpatient in a SNF. The benefit period ends when you haven't received any inpatient hospital care or skilled care in a SNF for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. For inpatient hospital stays, a benefit period begins when you are admitted to the hospital and ends when you are discharged from the hospital. If you are admitted to the hospital after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that administers Medicare. Chapter 2 explains how to contact CMS.

Coinsurance – An amount you may be required to pay as your share of the cost for services or prescription drugs ,Coinsurance is usually a percentage (for example, 20%).

Complaint - The formal name for "making a complaint" is "filing a grievance." The complaint process is used for certain types of problems *only.* This includes problems related to quality of care, waiting times, and the Customer Service you receive. See also "Grievance," in this list of definitions.

Comprehensive Outpatient Rehabilitation Facility (CORF) – A facility that mainly provides rehabilitation services after an illness or injury, and provides a variety of services including

physical therapy, social or psychological services, respiratory therapy, occupational therapy and speech-language pathology services, and home environment evaluation services.

Copayment (or "copay") – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit. A copayment is a set amount, rather than a percentage. For example, you might pay $10 or $20 for a doctor's visit.

Cost-Sharing – Cost-sharing refers to amounts that a member has to pay when services are received. (This is in addition to the plan's monthly premium.) Cost-sharing includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before services are covered; (2) any fixed "copayment" amount that a plan requires when a specific service is received; or (3) any "coinsurance" amount, a percentage of the total amount paid for a service, that a plan requires when a specific service is received.

Covered Services – The general term we use to mean all of the health care services and supplies that are covered by our plan.

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

Custodial Care – Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you do not need skilled medical care or skilled nursing care. Custodial care is personal care that can be provided by people who don't have professional skills or training, such as help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn't pay for custodial care.

Customer Service – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See Chapter 2 for information about how to contact Customer Service.

Deductible – The amount you must pay for health care or prescriptions before our plan begins to pay.

Disenroll or **Disenrollment** – The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

Durable Medical Equipment (DME) – Certain medical equipment that is ordered by your doctor for medical reasons. Examples include walkers, wheelchairs, crutches, powered mattress systems, diabetic supplies, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, or hospital beds ordered by a provider for use in the home.

Emergency – A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

Emergency Care – Covered services that are: 1) rendered by a provider qualified to furnish emergency services; and 2) needed to treat, evaluate, or stabilize an emergency medical condition.

Evidence of Coverage (EOC) and Disclosure Information – This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

Extra Help – A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

Grievance - A type of complaint you make about us, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes.

Home Health Aide – A home health aide provides services that don't need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides do not have a nursing license or provide therapy.

Hospice - A member who has 6 months or less to live has the right to elect hospice. We, your plan, must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums you are still a member of our plan. You can still obtain all medically necessary services as well as the supplemental benefits we offer. The hospice will provide special treatment for your state.

Hospital Inpatient Stay – A hospital stay when you have been formally admitted to the hospital for skilled medical services. Even if you stay in the hospital overnight, you might still be considered an "outpatient."

Initial Enrollment Period – When you are first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. For example, if you're eligible for Medicare when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

Low Income Subsidy (LIS) – See "Extra Help."

Maximum Out-of-Pocket Amount – The most that you pay out-of-pocket during the calendar year for in-network covered Part A and Part B services. Amounts you pay for your plan premiums, Medicare Part A and Part B premiums, and prescription drugs do not count toward

the maximum out-of-pocket amount. See Chapter 4, Section 1 for information about your maximum out-of-pocket amount.

Medicaid (or Medical Assistance) – A joint Federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid. See Chapter 2, Section 6 for information about how to contact Medicaid in your state.

Medically Necessary – Services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

Medicare –The Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare a Medicare Cost Plan, a PACE plan or a Medicare Advantage Plan.

Medicare Advantage Open Enrollment Period – A set time each year when members in a Medicare Advantage plan can cancel their plan enrollment and switch to another Medicare Advantage plan, or obtain coverage through Original Medicare. If you choose to switch to Original Medicare furing this period, you can also join a separate Medicare prescription drug plan at that time. The Open Enrollment Period is from January 1 until March 31, and is also available for a 3-month period after an individual is first eligible for Medicare.

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be an HMO, PPO, a Private Fee-for-Service (PFFS) plan, or a Medicare Medical Savings Account (MSA) plan. When you are enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan, and are not paid for under Original Medicare. In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**. Everyone who has Medicare Part A and Part B is eligible to join any Medicare health plan that is offered in their area, except people with End-Stage Renal Disease (unless certain exceptions apply).

Medicare Cost Plan – A Medicare Cost Plan is a plan operated by a Health Maintenance Organization (HMO) or Competitive Medical Plan (CMP) in accordance with a cost-reimbursed contract under section 1876(h) of the Act.

Medicare-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans, including our plan, must cover all of the services that are covered by Medicare Part A and B.

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

Medicare Prescription Drug Coverage (Medicare Part D) – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

"Medigap" (Medicare Supplement Insurance) Policy – Medicare supplement insurance sold by private insurance companies to fill "gaps" in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage Plan is not a Medigap policy.)

Member (Member of our Plan, or "Plan Member") – A person with Medicare who is eligible to get covered services, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Network Provider – "Provider" is the general term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services. We call them "**network providers**" when they have an agreement with our plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our plan. Our plan pays network providers based on the agreements it has with the providers or if the providers agree to provide you with plan-covered services. Network providers may also be referred to as "plan providers."

Optional Supplemental Benefits – Non-Medicare-covered benefits that can be purchased for an additional premium and are not included in your package of benefits. If you choose to have optional supplemental benefits, you may have to pay an additional premium. You must voluntarily elect Optional Supplemental Benefits in order to get them.

Organization Determination – The Medicare Advantage plan has made an organization determination when it makes a decision about whether items or services are covered or how much you have to pay for covered items or services. Organization determinations are called "coverage decisions" in this booklet. Chapter 7 explains how to ask us for a coverage decision.

Original Medicare ("Traditional Medicare" or "Fee-for-service" Medicare) – Original Medicare is offered by the government, and not a private health plan like Medicare Advantage Plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Network Provider or Out-of-Network Facility – A provider or facility with which we have not arranged to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that are not employed, owned, or operated by our plan or are not under contract to deliver covered services to you. Using out-of-network providers or facilities is explained in this booklet in Chapter 3.

Out-of-Pocket Costs – See the definition for "cost-sharing" above. A member's cost-sharing requirement to pay for a portion of services received is also referred to as the member's "out-of-pocket" cost requirement.

PACE plan – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term care (LTC) services for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible, while getting the high-quality care they need. People enrolled in PACE plans receive both their Medicare and Medicaid benefits through the plan.

Part C – see "Medicare Advantage (MA) Plan."

Part D – The voluntary Medicare Prescription Drug Benefit Program. (For ease of reference, we will refer to the prescription drug benefit program as Part D.)

Preferred Provider Organization (PPO) Plan – A Preferred Provider Organization plan is a Medicare Advantage Plan that has a network of contracted providers that have agreed to treat plan members for a specified payment amount. A PPO plan must cover all plan benefits whether they are received from network or out-of-network providers. Member cost-sharing will generally be higher when plan benefits are received from out-of-network providers. PPO plans have an annual limit on your out-of-pocket costs for services received from network (preferred) providers and a higher limit on your total combined out-of-pocket costs for services from both network (preferred) and out-of-network (non-preferred) providers.

Premium – The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Primary Care Provider (PCP) – Your primary care provider is the doctor or other provider you see first for most health problems. He or she makes sure you get the care you need to keep you healthy. He or she also may talk with other doctors and health care providers about your care and refer you to them. In many Medicare health plans, you must see your primary care provider before you see any other health care provider. See Chapter 3, Section 2.1 for information about Primary Care Providers.

Prior Authorization – Approval in advance to get. Some in-network medical services are covered only if your doctor or other network provider gets "prior authorization" from our plan. Covered services that need prior authorization are marked in the Benefits Chart in Chapter 4.

Prosthetics and Orthotics – These are medical devices ordered by your doctor or other health care provider. Covered items include, but are not limited to, arm, back and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients. See Chapter 2, Section 4 for information about how to contact the QIO for your state.

Rehabilitation Services – These services include physical therapy, speech and language therapy, and occupational therapy.

Service Area – A geographic area where a health plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (non-emergency) services. The plan may disenroll you if you permanently move out of the plan's service area.

Skilled Nursing Facility (SNF) Care – Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Special Enrollment Period – A set time when members can change their health or drug plans or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the service area, if you move into a nursing home, or if we violate our contract with you.

Special Needs Plan – A special type of Medicare Advantage Plan that provides more focused health care for specific groups of people, such as those who have both Medicare and Medicaid, who reside in a nursing home, or who have certain chronic medical conditions.

Supplemental Security Income (SSI) – A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

Urgently Needed Services – Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible.

EmblemHealth VIP Rx Carveout (HMO) – Group Customer Service

Method	Customer Service – Contact Information
CALL	**1-877-344-7364** Calls to this number are free. Hours of operation: 8:00 a.m. – 8:00 p.m., seven days a week Customer Service also has free language interpreter services available for non-English speakers.
TTY	**711** (New York State Relay Service) This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Hours of operation: 8:00 a.m. – 8:00 p.m., seven days a week
FAX	1-212-510-5373
WRITE	EmblemHealth Medicare HMO ATTN: Customer Service 55 Water Street New York, NY 10041-8190
WEBSITE	**emblemhealth.com/medicare**

Health Insurance Information Counseling and Assistance Program (HIICAP) (New York's SHIP)

HIICAP is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

Method	Contact Information
CALL	1-800-701-0501
TTY	711 (New York State Relay Service) This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	New York State Office for the Aging 2 Empire State Plaza Albany, New York 12223-1251
WEBSITE	http://www.aging.ny.gov

PRA Disclosure Statement *According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1051. If you have comments or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.*

Commercial and Medicare Benefits Charts

28. *A completed Commercial Benefits Chart (Attachment 35) and Medicare Benefits Chart (Attachment 36) for both Commercial and Medicare Advantage Plans, as applicable, citing where each of the named benefits proposed for 2021 can be found in Contract or rider language. All Contracts and/or riders relating to the 2021 benefit offering must be listed. If there is no additional cost, indicate N/C in Projected Monthly Premium column. List the cost of the standard contract and riders for each rating region once, reference the citation in all other appropriate areas.*

Please see the following pages for our Commercial Benefits Chart followed by our Medicare Benefits Chart. This identical information has also been provided on our USBs submitted, labeled as:

- *Attachment 19. Commercial Benefits Chart*
- *Attachment 20. Medicare Benefits Chart*

Offeror Name: EMBLEMHEALTH

ATTACHMENT 35

HMO BENEFITS FOR 2021 -- Commercial Plan

Covered Service	HMO Benefits	Source Document: Enter Article, Section, etc. and Page Number of Certificate of Coverage (COC), Rider Number		NYS DFS Status: Approved (include date) or Filed/ Pending	Member Cost: Enter copay/coinsurance amount, e.g., $25/visit, 20% coinsurance	Benefit Limitations: e.g., 20 visits/calendar year, 60 consecutive days Indicate "unlimited" if no limitations	Change from 2020 Enter: Yes/No and change, e.g., $5 copay increase, new benefit	Projected Monthly Premium for 2021	
		COC - Form # 155-23-LGHMOCERT	Rider Number					Individual	Family
Office Visit	Covered as required by Federal and NYS laws and/or regulation	COC, Sec. IX, Page 32		Approved 12/13/19	$5 Copay per visit	Unlimited	No	-$3.28	-$8.04
Specialty Office Visit	Covered as required by Federal and NYS laws and/or regulation	COC, Sec. IX, Page 32		Approved 12/13/19	$10 Copay per visit	Unlimited	No	-$6.86	-$16.79
Chiropractic Care	Covered as required by Federal and NYS laws and/or regulation	COC, Sec. IX, Page 28		Approved 12/13/19	$10 Copay per visit	Unlimited	No	Included in Standard package cost	Included in Standard package cost
Inpatient Hospital Care	Covered as required by Federal and NYS laws and/or regulation, not subject to deductibles, copays or coinsurance	COC, Sec. XI, Page 43		Approved 12/13/19	$0 Copay per continuous confinement	Unlimited	No	$843.58	$2,066.76
Surgery (include all settings) Physician-Inpatient Physician-Outpatient (at a hospital, facility or surgery center) Physician's Office Outpatient Surgery Facility		COC, Sec. IX, Page 28; Sec. XI, Page 43		Approved 12/13/19	 $0 Copay $0 Copay *PCP: $0 Copay *Specialist: $0 Copay *The Member is responsible for their office visit copay and not an additional copay for surgery. $0 Copay	Unlimited	No	Included in Standard package cost	Included in Standard package cost

Offeror Name: EMBLEMHEALTH

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HMO BENEFITS FOR 2021 -- Commercial Plan

Covered Service	HMO Benefits	Source Document: Enter Article, Section, etc. and Page Number of Certificate of Coverage (COC), Rider Number		NYS DFS Status: Approved (include date) or Filed/ Pending	Member Cost: Enter copay/coinsurance amount, e.g., $25/visit, 20% coinsurance	Benefit Limitations: e.g., 20 visits/calendar year, 60 consecutive days Indicate "unlimited" if no limitations	Change from 2020 Enter: Yes/No and change, e.g., $5 copay increase, new benefit	Projected Monthly Premium for 2021	
		COC - Form # 155-23-LGHMOCERT	Rider Number					Individual	Family
Skilled Nursing Facilities		COC, Sec. XI, Page 45		Approved 12/13/19	$0 Copay	Unlimited	No	$4.09	$10.01
Hospice Benefits	210 days	COC, Sec. X, Page 40		Approved 12/13/19	$0 Copay	210 days	No	Included in Standard package cost	Included in Standard package cost
Emergency Room	Covered as required by ACA	COC, Sec. VIII, Pages 26, 27		Approved 12/13/19	$75 Copay per visit	Unlimited	No	-$7.77	-$19.05
Urgent Care Facility		COC, Sec. VIII, Page 27		Approved 12/13/19	$5 Copay per visit	Unlimited	No	-$0.11	-$0.28
Ambulance: Non-airborne Airborne		COC, Sec. VII, Pages 24, 25		Approved 12/13/19	$0 Copay	Unlimited	No	Included in Standard package cost	Included in Standard package cost
Diagnostic/Therapeutic Services: Cite both Hospital and Medical/Surgical Settings									
Radiology	Covered as required by Federal and NYS laws and/or regulation	COC, Sec. IX, Page 32; Sec. XI, Page 43		Approved 12/13/19	Hospital: $0 Copay Medical/Surgical (Professional): Performed in a PCP office: $5 Copay Performed in a Specialist office: $10 Copay Performed in a Freestanding Radiology Facility: $0 Copay Performed as Outpatient Hospital Services: $0 Copay	Unlimited	Yes, increase in Copays as follows: Performed in a PCP office: $5 Copay increase Performed in a Specialist office: $10 Copay increase	Included in Standard package cost	Included in Standard package cost

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HMO BENEFITS FOR 2021 -- Commercial Plan

Covered Service	HMO Benefits	Source Document: Enter Article, Section, etc. and Page Number of Certificate of Coverage (COC), Rider Number		NYS DFS Status: Approved (include date) or Filed/ Pending	Member Cost: Enter copay/coinsurance amount, e.g., $25/visit, 20% coinsurance	Benefit Limitations: e.g., 20 visits/calendar year, 60 consecutive days Indicate "unlimited" if no limitations	Change from 2020 Enter: Yes/No and change, e.g., $5 copay increase, new benefit	Projected Monthly Premium for 2021	
		COC - Form # 155-23-LGHMOCERT	Rider Number					Individual	Family
Lab Tests	Covered as required by Federal and NYS laws and/or regulation	COC, Sec. XI, Page 43; Sec. IX, Page 32			Hospital: $0 Copay Medical/Surgical (Professional): Performed in a PCP office: $5 Copay Performed in a Specialist office: $10 Copay Performed in a Freestanding Laboratory Facility: $0 Copay Performed as Outpatient Hospital Services: $0 Copay	Unlimited	Yes, increase in Copays as follows: Performed in a PCP office: $5 Copay increase Performed in a Specialist office: $10 Copay increase	Included in Standard package cost	Included in Standard package cost
Pathology	Covered as required by Federal and NYS laws and/or regulation	COC, Sec. XI, Page 43; Sec. IX, Page 32			Hospital: $0 Copay Medical/Surgical (Professional): PCP: $0 Copay Specialist: $0 Copay	Unlimited	No	Included in Standard package cost	Included in Standard package cost

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HMO BENEFITS FOR 2021 -- Commercial Plan

Covered Service	HMO Benefits	Source Document: Enter Article, Section, etc. and Page Number of Certificate of Coverage (COC), Rider Number		NYS DFS Status: Approved (include date) or Filed/ Pending	Member Cost: Enter copay/coinsurance amount, e.g., $25/visit, 20% coinsurance	Benefit Limitations: e.g., 20 visits/calendar year, 60 consecutive days Indicate "unlimited" if no limitations	Change from 2020 Enter: Yes/No and change, e.g., $5 copay increase, new benefit	Projected Monthly Premium for 2021	
		COC - Form # 155-23-LGHMOCERT	Rider Number					Individual	Family
EKG/EEG	Covered as required by Federal and NYS laws and/or regulation	COC, Sec. IX, Page 32; Sec. XI, Page 43		Approved 12/13/19	Hospital: $0 Copay Medical/Surgical (Professional): Performed in a PCP office: $5 Copay Performed in a Specialist office: $10 Copay Performed in a Freestanding Radiology Facility: $0 Copay Performed as Outpatient Hospital Services: $0 Copay	Unlimited	Yes, increase in Copays as follows: Performed in a PCP office: $5 Copay increase Performed in a Specialist office: $10 Copay increase	Included in Standard package cost	Included in Standard package cost
Radiation	Covered as required by Federal and NYS laws and/or regulation	COC, Sec. IX, Page 32; Sec. XI, Page 43		Approved 12/13/19	Hospital: $0 Copay Medical/Surgical (Professional): Performed in a Specialist office: $10 Copay Performed in a Freestanding Radiology Facility: $0 Copay Performed as Outpatient Hospital Services: $0 Copay	Unlimited	Yes, $10 Copay increase in a Specialist office		

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HMO BENEFITS FOR 2021 -- Commercial Plan

Covered Service	HMO Benefits	Source Document: Enter Article, Section, etc. and Page Number of Certificate of Coverage (COC), Rider Number		NYS DFS Status: Approved (include date) or Filed/ Pending	Member Cost: Enter copay/coinsurance amount, e.g., $25/visit, 20% coinsurance	Benefit Limitations: e.g., 20 visits/calendar year, 60 consecutive days Indicate "unlimited" if no limitations	Change from 2020 Enter: Yes/No and change, e.g., $5 copay increase, new benefit	Projected Monthly Premium for 2021	
		COC - Form # 155-23-LGHMOCERT	Rider Number					Individual	Family
Chemotherapy	Covered as required by Federal and NYS laws and/or regulation	COC, Sec. IX, Page 28; Sec. XI, Page 43		Approved 12/13/19	Hospital: $0 Copay Medical/Surgical (Professional): Performed in a PCP office: $5 Copay Performed in a Specialist office: $10 Copay Performed as Outpatient Hospital Services: $0 Copay	Unlimited	Yes, increase in Copays as follows: Performed in a PCP office: $5 Copay increase Performed in a Specialist office: $10 Copay increase	Included in Standard package cost	Included in Standard package cost
Preventive Services									
All Members - including but not limited to: annual wellness visit/ physical, standard immunizations (recommended by ACIP), colonoscopy, screening for STDs, HIV. Alcohol/ substance abuse, tobacco use, cholesterol, diabetes and high blood	Covered as required by Federal and NYS laws and/or regulation, and ACA	COC, Sec. VI, Pages 21, 22		Approved 12/13/19	$0 Copay	1 visit per Plan Year	No	Included in Standard package cost	Included in Standard package cost
Women's Health - including but not limited to: mammograms, bone density, pap tests, anemia, iron deficiency, etc. for pregnant women	Covered as required by Federal and NYS laws and/or regulation	COC, Sec. VI, Pages 22, 23		Approved 12/13/19	$0 Copay	→ 1 baseline mammogram for Members age 35 through 39; → Upon the recommendation of the Member's Provider, an annual mammogram for Members age 35 through 39 if Medically Necessary; and → 1 mammogram annually for Members age 40 and over. → 1 annual cytology screening.	No	Included in Standard package cost	Included in Standard package cost

Offeror Name: EMBLEMHEALTH

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HMO BENEFITS FOR 2021 -- Commercial Plan

Covered Service	HMO Benefits	Source Document: Enter Article, Section, etc. and Page Number of Certificate of Coverage (COC), Rider Number		NYS DFS Status: Approved (include date) or Filed/ Pending	Member Cost: Enter copay/coinsurance amount, e.g., $25/visit, 20% coinsurance	Benefit Limitations: e.g., 20 visits/calendar year, 60 consecutive days Indicate "unlimited" if no limitations	Change from 2020 Enter: Yes/No and change, e.g., $5 copay increase, new benefit	Projected Monthly Premium for 2021	
		COC - Form # 155-23-LGHMOCERT	Rider Number					Individual	Family
Men's Health - including but not limited to: prostate cancer screening, abdominal aortic aneurysm screening	Covered as required by Federal and NYS laws and/or regulation	COC, Sec. VI, Page 23		Approved 12/13/19	$0 Copay	→ Prostate Cancer Screening at any age with a prior history of prostate cancer; and → annually for men age 50 and over who are asymptomatic and age 40 and over with a family history of prostate cancer or other prostate cancer risks.	No	Included in Standard package cost	Included in Standard package cost
Children's Health - including but not limited to: certain newborn screenings, metabolic screenings, vision, autism, lead and TB screenings, obesity counseling	Covered as required by Federal and NYS laws and/or regulation	COC, Sec. VI, Page 21		Approved 12/13/19	$0 Copay	1 visit per plan year	No	Included in Standard package cost	Included in Standard package cost
Women's Health Care/OB GYN									
Pre- and Post Natal Visits	Covered as required by Federal and NYS laws and/or regulation	COC, Sec. IX, Page 32		Approved 12/13/19	$0 Copay	Unlimited	No	Included in Standard package cost	Included in Standard package cost
Family Planning	Routine examinations; laboratory tests; birth control counseling; pregnancy testing; genetic counseling	COC, Sec. VI, Pages 22, 23		Approved 12/13/19	PCP: $5 Copay per visit Specialist: $10 Copay per visit	Unlimited The Copay is waived if it is an ACA preventive care service	No	Included in Standard package cost	Included in Standard package cost
Infertility Services	Covered as required by Federal and NYS laws and/or regulation and the infertility mandates of 2002 and 2019	COC, Sec. IX, Pages 30, 31		Approved 12/13/19	$10 Copay per visit	Limited to members between the ages of 21 through 44	No	Included in Standard package cost	Included in Standard package cost
Contraceptive Drugs and Devices	Covered as required by ACA and NYS laws and/or regulation whichever provides the higher level of benefit	COC, Sec. XIII, Page 51		Approved 12/13/19	$0 Copay	Unlimited	No	Included in Standard package cost	Included in Standard package cost

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HMO BENEFITS FOR 2021 -- Commercial Plan

Covered Service	HMO Benefits	Source Document: Enter Article, Section, etc. and Page Number of Certificate of Coverage (COC), Rider Number		NYS DFS Status: Approved (include date) or Filed/ Pending	Member Cost: Enter copay/coinsurance amount, e.g., $25/visit, 20% coinsurance	Benefit Limitations: e.g., 20 visits/calendar year, 60 consecutive days Indicate "unlimited" if no limitations	Change from 2020 Enter: Yes/No and change, e.g., $5 copay increase, new benefit	Projected Monthly Premium for 2021	
		COC - Form # 155-23-LGHMOCERT	Rider Number					Individual	Family
Rehabilitative Care, Physical, Speech & Occupational Therapy									
Inpatient Rehabilitative Care		COC, Sec. XI, Pages 44, 45		Approved 12/13/19	$0 Copay	30 days per Plan Year	No	Included in Standard package cost	Included in Standard package cost
Outpatient Rehabilitative Care		COC, Sec. IX, Page 33		Approved 12/13/19	Performed in a PCP office: $5 Copay per visit Performed in a Specialist office: $10 Copay per visit Performed in an Outpatient Facility: $0 Copay	90 visits per Plan Year (total visits include those received for Speech, Occupational, Respiratory and/or Physical Therapies)	Yes, decrease in Copays as follows: Performed in a PCP office: $5 Copay decrease Performed in an Outpatient Facility: $10 Copay decrease	$2.04	$5.00
Mental Health/Substance Abuse									
Outpatient Mental Health	Covered as required by Federal and NYS laws and/or regulation	COC, Sec. XII, Pages 47, 48		Approved 12/13/19	$0 Copay	Unlimited	No	$18.04	$44.19
Inpatient Mental Health	Covered as required by Federal and NYS laws and/or regulation	COC, Sec. XII, Page 47		Approved 12/13/19	$0 Copay	Unlimited	No	$14.43	$35.35
Coverage for Autism Spectrum Disorder	In compliance with NYS Autism legislation including Habilitative Services, Applied Behavior Analysis (ABA)	COC, Sec. X, Pages 36, 37		Approved 12/13/19	PCP: $5 Copay per visit Specialist: $10 Copay per visit	Unlimited	No	Included in Standard package cost	Included in Standard package cost
Alcohol and Substance Abuse Detoxification	Covered as required by Federal and NYS laws and/or regulation	COC, Sec. XII, Page 48		Approved 12/13/19	$0 Copay	Unlimited	No	$1.11	$2.72
Outpatient Alcoholism and Substance Abuse Rehabilitation	Covered as required by Federal and NYS laws and/or regulation	COC, Sec. XII, Page 48		Approved 12/13/19	Office Visit: $5 Copay per visit All Other Outpatient Services: $5 Copay per visit	Unlimited	Yes, $5 Copay decrease when performed at All Other Outpatient Services	$1.11	$2.72

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HMO BENEFITS FOR 2021 -- Commercial Plan

Covered Service	HMO Benefits	Source Document: Enter Article, Section, etc. and Page Number of Certificate of Coverage (COC), Rider Number		NYS DFS Status: Approved (include date) or Filed/ Pending	Member Cost: Enter copay/coinsurance amount, e.g., $25/visit, 20% coinsurance	Benefit Limitations: e.g., 20 visits/calendar year, 60 consecutive days Indicate "unlimited" if no limitations	Change from 2020 Enter: Yes/No and change, e.g., $5 copay increase, new benefit	Projected Monthly Premium for 2021	
		COC - Form # 155-23-LGHMOCERT	Rider Number					Individual	Family
Inpatient Alcoholism and Substance Abuse Rehabilitation	Covered as required by Federal and NYS laws and/or regulation.	COC, Sec. XII, Page 48		Approved 12/13/19	$0 Copay	Unlimited	No	$7.93	$19.44
Prescription Drugs: *Medically necessary federal legend and state restricted drugs, compounded medications and injectable insulin. Coverage must include contraceptive drugs and devices, fertility drugs and enteral formulas. (The copayment for injectable drugs, including fertility drugs, must be the same as the copayment for other covered drugs except drugs limited to 30 days supply at dispensing.) No annual or lifetime maximum permitted.*									
Prescription Drugs		COC, Sec. XIII, Pages 50 - 62		Approved 12/13/19	Retail 30-Day Supply: $5 Copay generic / $20 Copay brand Mail-Order 90-Day Supply: $7.50 Copay generic / $30 Copay brand	Unlimited	No	$290.69	$712.17
Other									
Diabetic Supplies	Covered as required by Federal and NYS laws and/or regulation	COC, Sec. X, Pages 38, 39		Approved 12/13/19	$5 Copay per 34 day supply	Unlimited	No	-$0.20	-$0.49
Oral Agents and Insulin	Covered as required by Federal and NYS laws and/or regulation	COC, Sec. X, Pages 38, 39		Approved 12/13/19	$5 Copay per 34 day supply	Unlimited	No	Included in Standard package cost	Included in Standard package cost
Diabetic Shoes		COC, Sec. X, Pages 38, 39, 40		Approved 12/13/19	$0 Copay	Limitations subject to prior approval requirements	No	Included in Standard package cost	Included in Standard package cost

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HMO BENEFITS FOR 2021 -- Commercial Plan

Covered Service	HMO Benefits	Source Document: Enter Article, Section, etc. and Page Number of Certificate of Coverage (COC), Rider Number		NYS DFS Status: Approved (include date) or Filed/ Pending	Member Cost: Enter copay/coinsurance amount, e.g., $25/visit, 20% coinsurance	Benefit Limitations: e.g., 20 visits/calendar year, 60 consecutive days Indicate "unlimited" if no limitations	Change from 2020 Enter: Yes/No and change, e.g., $5 copay increase, new benefit	Projected Monthly Premium for 2021	
		COC - Form # 155-23-LGHMOCERT	Rider Number					Individual	Family
Durable Medical Equipment (DME)	Medically necessary DME which can with- stand repeated use & primarily used to serve a medical purpose must be covered. Examples include but not limited to: wheelchairs, walkers, respiratory equip, oxygen supplies, replacements, repairs & maintenance, not provided for under manufacturer's warranty or purchase agreement must be covered when functionally necessary.	COC, Sec. X, Pages 39, 40		Approved 12/13/19	$0 Copay	Limitations subject to prior approval requirements	No	$7.28	$17.85
Prosthetic Devices	Medically necessary prosthetic devices that aid body functioning or replace a limb or body part in order to correct a defect of body form or function must be covered. Examples of prosthetic devices include but are not limited to: artificial limbs, pacemakers, heart valve replacements, artificial joints, external breast prostheses & Ostomy Supplies. Replacements, repairs and maintenance, not provided for under manufacturer's warranty or purchase agreement must be covered when functionally necessary	COC, Sec. X, Page 41		Approved 12/13/19	$0 Copay	Limitations subject to prior approval requirements	No	Included in Standard package cost	Included in Standard package cost

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HMO BENEFITS FOR 2021 -- Commercial Plan

Covered Service	HMO Benefits	Source Document: Enter Article, Section, etc. and Page Number of Certificate of Coverage (COC), Rider Number		NYS DFS Status: Approved (include date) or Filed/ Pending	Member Cost: Enter copay/coinsurance amount, e.g., $25/visit, 20% coinsurance	Benefit Limitations: e.g., 20 visits/calendar year, 60 consecutive days Indicate "unlimited" if no limitations	Change from 2020 Enter: Yes/No and change, e.g., $5 copay increase, new benefit	Projected Monthly Premium for 2021	
		COC - Form # 155-23-LGHMOCERT	Rider Number					Individual	Family
Orthotic Devices	Medically Necessary custom-made orthotic devices used to support, align, prevent or correct deformities or to improve the function of the foot must be covered. Orthopedic shoes and other supportive devices for treatment of weak, strained, flat, unstable or unbalanced feet should not be included for coverage. Replacements, repairs and maintenance, not provided for under a manufacturer's warranty or purchase agreement, must be covered when functionally necessary.	COC, Sec. X, Pages 39 - 42		Approved 12/13/19	$0 Copay	Limitations subject to prior approval requirements	No	$1.18	$2.89
Additional Benefits	Who is Covered - NYSHIP Eligibility Rider		155-23-NYSHIP ELIGIBILITY (07/20)	Filed and pending DFS approval			No	$0.00	$0.00
	Prescription Drug Rider for Certain Drugs		155-23-LGHMOwoRX (11/19)	Approved 12/13/19		→ Adds certain coverage for the NYSHIP plan without Prescription Drug benefits.			
	Transportation, Lodging and Meal Expenses for Transplants Rider		155-23-LGHMOTRANSPLANTS (07/16)	Approved 10/21/16		→ Coverage is $10,000 per transplant. → Maximum daily coverage for lodging and meals is $200. → Expenses are for recipient and 1 companion (2 if candidate is a minor) when travelling outside a 50 mile radius from recipient's home. → Coverage also for donor and 1 companion (2 if donor is a minor) when traveling outside a 50 mile radius from donor's home.			

ATTACHMENT 36
Offeror name: EMBLEMHEALTH

HMO BENEFITS FOR 2021 - Medicare Advantage Plan

Covered Service	HMO Medicare Advantage Benefits (coverage as required by CMS and/or NYS laws and/or regulations)	Source Document: Enter Article, Section, etc. and Page Number of Evidence of Coverage (EOC), Rider Number		NYS DFS Status: Approved (include date) or Filed/ Pending	Member Cost: Enter copay/ coinsurance amount, e.g., $25/visit, 20% coinsurance	Benefit Limitations: e.g., 20 visits/ calendar year, 60 consecutive days Indicate "unlimited" if no limitations	Change from 2020 Enter: Yes/No and change, e.g., $5 copay increase, new benefit	Projected Monthly Premium for 2021
		EOC Form # H3330_201473_C	Rider					Individual
Office Visit		Ch. 4, Sec. 2.1, Page 83			$0 Copay per visit	Unlimited	No	Covered in HIP VIP Standard Contract
Specialty Office Visit		Ch. 4, Sec. 2.1, Page 83			$5 Copay per visit	Unlimited	No	Covered in HIP VIP Standard Contract
Chiropractic Care		Ch. 4, Sec. 2.1, Page 63			$5 Copay per visit	Unlimited	No	Covered in HIP VIP Standard Contract
Inpatient Hospital Care	Not subject to deductibles, copays or coinsurance	Ch. 4, Sec. 2.1, Pages 72, 73			$0 Copay per continuous confinement	Unlimited	No	Base rate $385.15
Surgery (include all settings) Physician-Inpatient Physician-Outpatient (at a hospital, facility or surgery center) Physician's Office Outpatient Surgery Facility		 Ch. 4, Sec. 2.1, Pages 72, 73 Ch. 4, Sec. 2.1, Page 83 Ch. 4, Sec. 2.1, Page 83 Ch. 4, Sec. 2.1, Page 82			 $0 Copay $5 Copay PCP: $0 Copay Specialist: $5 Copay per visit $0 Copay	Unlimited	No	Covered in HIP VIP Standard Contract
Skilled Nursing Facilities		Ch. 4, Sec. 2.1, Pages 87, 88			$0 Copay	Up to 100 days per benefit period (non-custodial)	No	Covered in HIP VIP Standard Contract
Hospice Benefits		Ch. 4, Sec. 2.1, Pages 69, 70			Covered by Medicare	Covered by Medicare	No	Covered in HIP VIP Standard Contract

Covered Service	HMO Medicare Advantage Benefits (coverage as required by CMS and/or NYS laws and/or regulations)	Source Document: Enter Article, Section, etc. and Page Number of Evidence of Coverage (EOC), Rider Number		NYS DFS Status: Approved (include date) or Filed/ Pending	Member Cost: Enter copay/ coinsurance amount, e.g., $25/visit, 20% coinsurance	Benefit Limitations: e.g., 20 visits/ calendar year, 60 consecutive days Indicate "unlimited" if no limitations	Change from 2020 Enter: Yes/No and change, e.g., $5 copay increase, new benefit	Projected Monthly Premium for 2021
		EOC Form # H3330_201473_C	Rider					Individual
Emergency Room		Ch. 4, Sec. 2.1, Page 66; Ch. 3, Sec. 3.1, Pages 46, 47			$25 Copay per visit	Unlimited	No	Covered in HIP VIP Standard Contract

Covered Service	HMO Medicare Advantage Benefits (coverage as required by CMS and/or NYS laws and/or regulations)	Source Document: Enter Article, Section, etc. and Page Number of Evidence of Coverage (EOC), Rider Number		NYS DFS Status: Approved (include date) or Filed/ Pending	Member Cost: Enter copay/ coinsurance amount, e.g., $25/visit, 20% coinsurance	Benefit Limitations: e.g., 20 visits/ calendar year, 60 consecutive days Indicate "unlimited" if no limitations	Change from 2020 Enter: Yes/No and change, e.g., $5 copay increase, new benefit	Projected Monthly Premium for 2021
		EOC Form # H3330_201473_C	Rider					Individual
Urgent Care Facility		Ch. 4, Sec. 2.1, Page 89; Ch. 3, Sec. 3.1, Pages 47, 48			PCP: $0 Copay Specialist: $5 Copay per visit	Unlimited	No	Covered in HIP VIP Standard Contract
Ambulance: Non-airborne Airborne		Ch. 4, Sec. 2.1, Page 61; Ch. 3, Sec. 3.1, Page 46			$0 Copay	Unlimited	No	Covered in HIP VIP Standard Contract
Diagnostic/Therapeutic Services: Cite both Hospital and Medical/Surgical Settings								
Radiology		Ch. 4, Sec. 2.1, Pages 72, 74, 78, 80			Hospital: $0 Copay Medical/Surgical (Professional): PCP: $0 Copay Specialist: $0 Copay	Unlimited	No	Covered in HIP VIP Standard Contract
Lab Tests		Ch. 4, Sec. 2.1, Pages 72, 74, 78, 80			Hospital: $0 Copay Medical/Surgical (Professional): PCP: $0 Copay Specialist: $0 Copay	Unlimited	No	Covered in HIP VIP Standard Contract
Pathology		Ch. 4, Sec. 2.1, Pages 72, 74, 78, 80			Hospital: $0 Copay Medical/Surgical (Professional): PCP: $0 Copay Specialist: $0 Copay	Unlimited	No	Covered in HIP VIP Standard Contract
EKG/EEG		Ch. 4, Sec. 2.1, Pages 72, 74, 78, 80			Hospital: $0 Copay Medical/Surgical (Professional): PCP: $0 Copay Specialist: $0 Copay	Unlimited	No	Covered in HIP VIP Standard Contract

Covered Service	HMO Medicare Advantage Benefits (coverage as required by CMS and/or NYS laws and/or regulations)	Source Document: Enter Article, Section, etc. and Page Number of Evidence of Coverage (EOC), Rider Number		NYS DFS Status: Approved (include date) or Filed/ Pending	Member Cost: Enter copay/ coinsurance amount, e.g., $25/visit, 20% coinsurance	Benefit Limitations: e.g., 20 visits/ calendar year, 60 consecutive days Indicate "unlimited" if no limitations	Change from 2020 Enter: Yes/No and change, e.g., $5 copay increase, new benefit	Projected Monthly Premium for 2021
		EOC Form # H3330_201473_C	Rider					Individual
Radiation/ Chemotherapy		Ch. 4, Sec. 2.1, Pages 72, 73, 78, 80; Ch. 5, Sec. 1.1, Page 99			Hospital: $0 Copay Medical/Surgical (Professional): PCP: $0 Copay Specialist: $0 Copay	Unlimited	No	Covered in HIP VIP Standard Contract
Women's Health Care/OB GYN								
Pap Tests		Ch. 4, Sec. 2.1, Page 63			$0 Copay	→ Once every 24 months → 1 Pap test every 12 months for women at high risk of cervical cancer or have had an abnormal Pap test and are of childbearing age	No	Covered in HIP VIP Standard Contract
Mammograms		Ch. 4, Sec. 2.1, Page 62			$0 Copay	→ 1 baseline mammogram between the ages of 35 and 39 → 1 screening mammogram every 12 months for women age 40 and older → Clinical breast exams once every 24 months	No	Covered in HIP VIP Standard Contract
Bone Mineral Density Measurements & Tests		Ch. 4, Sec. 2.1, Page 61			$0 Copay	Covered every 24 months	No	Covered in HIP VIP Standard Contract
Pre- and Post Natal Visits	Covered as required by Federal and NYS laws and/or regulation	Covered			$5 Copay per visit		No	Covered in HIP VIP Standard Contract
Family Planning	Routine examinations; laboratory tests; birth control counseling; pregnancy testing; genetic counseling	Covered			PCP: $0 Copay Specialist: $5 Copay per visit		No	Covered in HIP VIP Standard Contract

Covered Service	HMO Medicare Advantage Benefits (coverage as required by CMS and/or NYS laws and/or regulations)	Source Document: Enter Article, Section, etc. and Page Number of Evidence of Coverage (EOC), Rider Number		NYS DFS Status: Approved (include date) or Filed/ Pending	Member Cost: Enter copay/ coinsurance amount, e.g., $25/visit, 20% coinsurance	Benefit Limitations: e.g., 20 visits/ calendar year, 60 consecutive days Indicate "unlimited" if no limitations	Change from 2020 Enter: Yes/No and change, e.g., $5 copay increase, new benefit	Projected Monthly Premium for 2021
		EOC Form # H3330_201473_C	Rider					Individual
Infertility Services	Covered as required by Federal and NYS laws and/or regulation	N/A		N/A	N/A		N/A	N/A

Covered Service	HMO Medicare Advantage Benefits (coverage as required by CMS and/or NYS laws and/or regulations)	Source Document: Enter Article, Section, etc. and Page Number of Evidence of Coverage (EOC), Rider Number		NYS DFS Status: Approved (include date) or Filed/ Pending	Member Cost: Enter copay/ coinsurance amount, e.g., $25/visit, 20% coinsurance	Benefit Limitations: e.g., 20 visits/ calendar year, 60 consecutive days Indicate "unlimited" if no limitations	Change from 2020 Enter: Yes/No and change, e.g., $5 copay increase, new benefit	Projected Monthly Premium for 2021
		EOC Form # H3330_201473_C	Rider					Individual
Contraceptive Drugs		Covered			**<u>Preferred Pharmacy:</u>** Retail 30-Day Supply: Tier 1 (Generic): $0 Copay Tier 2 (Preferred Brand): $0 Copay Tier 3 (Non-Preferred Drug): $45 Copay Mail Order 90-Day Supply: Tier 1 (Generic): $0 Copay Tier 2 (Preferred Brand): $0 Copay Tier 3 (Non-Preferred Drug): $67.50 Copay **<u>Standard Pharmacy:</u>** Retail 30-Day Supply: Tier 1 (Generic): $5 Copay Tier 2 (Preferred Brand): $5 Copay Tier 3 (Non-Preferred Drug): $45 Copay Mail Order 90-Day Supply: Tier 1 (Generic): $0 Copay Tier 2 (Preferred Brand): $0 Copay Tier 3 (Non-Preferred Drug): $67.50 Copay	Unlimited	No	N/A
Contraceptive Devices		N/A		N/A	N/A		N/A	N/A

Covered Service	HMO Medicare Advantage Benefits (coverage as required by CMS and/or NYS laws and/or regulations)	Source Document: Enter Article, Section, etc. and Page Number of Evidence of Coverage (EOC), Rider Number		NYS DFS Status: Approved (include date) or Filed/ Pending	Member Cost: Enter copay/ coinsurance amount, e.g., $25/visit, 20% coinsurance	Benefit Limitations: e.g., 20 visits/ calendar year, 60 consecutive days Indicate "unlimited" if no limitations	Change from 2020 Enter: Yes/No and change, e.g., $5 copay increase, new benefit	Projected Monthly Premium for 2021
		EOC Form # H3330_201473_C	Rider					Individual
Rehabilitative Care, Physical, Speech & Occupational Therapy								
Inpatient Rehabilitative Care		Ch. 4, Sec. 2.1, Pages 72, 73			$0 Copay	Unlimited	No	Covered in HIP VIP Standard Contract
Outpatient Rehabilitative Care		Ch. 4, Sec. 2.1, Page 81			$5 Copay per visit	Unlimited	No	Covered in HIP VIP Standard Contract
Mental Health/Substance Abuse								
Outpatient Mental Health	Covered as required by Federal and NYS laws and/or regulation	Ch. 4, Sec. 2.1, Page 81			$5 Copay per visit	Unlimited	No	Covered in HIP VIP Standard Contract
Inpatient Mental Health	Covered as required by Federal and NYS laws and/or regulation	Ch. 4, Sec. 2.1, Page 74			$0 Copay	190-day lifetime limit in a psychiatric facility	No	Covered in HIP VIP Standard Contract
Coverage for Autism Spectrum Disorder	In compliance with NYS Autism legislation including Habilitative Services, Applied Behavior Analysis (ABA)	N/A		N/A	N/A		N/A	N/A
Alcohol and Substance Abuse Detoxification	Covered as required by Federal and NYS laws and/or regulation	Ch. 4, Sec. 2.1, Pages 72, 73			$0 Copay	Unlimited	No	Covered in HIP VIP Standard Contract
Outpatient Alcoholism and Substance Abuse Rehabilitation	Covered as required by Federal and NYS laws and/or regulation	Ch. 4, Sec. 2.1, Page 81			$5 Copay per visit	Unlimited	No	Covered in HIP VIP Standard Contract
Inpatient Alcoholism and Substance Abuse Rehabilitation	Covered as required by Federal and NYS laws and/or regulation	Ch. 4, Sec. 2.1, Page 74			$0 Copay	Unlimited	No	Covered in HIP VIP Standard Contract

Covered Service	HMO Medicare Advantage Benefits (coverage as required by CMS and/or NYS laws and/or regulations)	Source Document: Enter Article, Section, etc. and Page Number of Evidence of Coverage (EOC), Rider Number		NYS DFS Status: Approved (include date) or Filed/ Pending	Member Cost: Enter copay/ coinsurance amount, e.g., $25/visit, 20% coinsurance	Benefit Limitations: e.g., 20 visits/ calendar year, 60 consecutive days Indicate "unlimited" if no limitations	Change from 2020 Enter: Yes/No and change, e.g., $5 copay increase, new benefit	Projected Monthly Premium for 2021
		EOC Form # H3330_201473_C	Rider					Individual
Prescription Drugs: *Medically necessary federal legend and state restricted drugs, compounded medications and injectable insulin. Coverage must include contraceptive drugs and devices, fertility drugs and enteral formulas. (The copayment for injectable drugs, including fertility drugs, must be the same as the copayment for other covered drugs except drugs limited to 30 days supply at dispensing.) No annual or lifetime maximum permitted.*								
Prescription Drugs		Ch. 4, Sec. 2.1, Page 76; Chapters 5 and 6, Pages 98-137			**<u>Preferred Pharmacy:</u>** Retail 30-Day Supply: Tier 1 (Generic): $0 Copay Tier 2 (Preferred Brand): $0 Copay Tier 3 (Non-Preferred Drug): $45 Copay Mail Order 90-Day Supply: Tier 1 (Generic): $0 Copay Tier 2 (Preferred Brand): $0 Copay Tier 3 (Non-Preferred Drug): $67.50 Copay **<u>Standard Pharmacy:</u>** Retail 30-Day Supply: Tier 1 (Generic): $5 Copay Tier 2 (Preferred Brand): $5 Copay Tier 3 (Non-Preferred Drug): $45 Copay Mail Order 90-Day Supply: Tier 1 (Generic): $0 Copay Tier 2 (Preferred Brand): $0 Copay Tier 3 (Non-Preferred Drug): $67.50 Copay	Unlimited	No	$278.77
Other								
Diabetic Supplies		Ch. 4, Sec. 2.1, Page 65			$5 Copay per prescription	Unlimited	No	Covered in HIP VIP Standard Contract

Covered Service	HMO Medicare Advantage Benefits (coverage as required by CMS and/or NYS laws and/or regulations)	Source Document: Enter Article, Section, etc. and Page Number of Evidence of Coverage (EOC), Rider Number		NYS DFS Status: Approved (include date) or Filed/ Pending	Member Cost: Enter copay/ coinsurance amount, e.g., $25/visit, 20% coinsurance	Benefit Limitations: e.g., 20 visits/ calendar year, 60 consecutive days Indicate "unlimited" if no limitations	Change from 2020 Enter: Yes/No and change, e.g., $5 copay increase, new benefit	Projected Monthly Premium for 2021
		EOC Form # H3330_201473_C	Rider					Individual
Oral Agents and Insulin		Ch. 4, Sec. 2.1, Page 65			**Preferred Pharmacy:** Retail 30-Day Supply: Tier 1 (Generic): $0 Copay Tier 2 (Preferred Brand): $0 Copay Tier 3 (Non-Preferred Drug): $45 Copay Mail Order 90-Day Supply: Tier 1 (Generic): $0 Copay Tier 2 (Preferred Brand): $0 Copay Tier 3 (Non-Preferred Drug): $67.50 Copay **Standard Pharmacy:** Retail 30-Day Supply: Tier 1 (Generic): $5 Copay Tier 2 (Preferred Brand): $5 Copay Tier 3 (Non-Preferred Drug): $45 Copay Mail Order 90-Day Supply: Tier 1 (Generic): $0 Copay Tier 2 (Preferred Brand): $0 Copay Tier 3 (Non-Preferred Drug): $67.50 Copay	Unlimited	No	Covered in HIP VIP Standard Contract

Covered Service	HMO Medicare Advantage Benefits (coverage as required by CMS and/or NYS laws and/or regulations)	Source Document: Enter Article, Section, etc. and Page Number of Evidence of Coverage (EOC), Rider Number		NYS DFS Status: Approved (include date) or Filed/ Pending	Member Cost: Enter copay/ coinsurance amount, e.g., $25/visit, 20% coinsurance	Benefit Limitations: e.g., 20 visits/ calendar year, 60 consecutive days Indicate "unlimited" if no limitations	Change from 2020 Enter: Yes/No and change, e.g., $5 copay increase, new benefit	Projected Monthly Premium for 2021
		EOC Form # H3330_201473_C	Rider					Individual
Diabetic Shoes		Ch. 4, Sec. 2.1, Page 65			$0 Copay	1 pair per calendar year	No	Covered in HIP VIP Standard Contract
Durable Medical Equipment (DME)	Medically necessary DME which can withstand repeated use and primarily used to serve a medical purpose must be covered. Examples include but not limited to: wheelchairs, walkers, respiratory equip, oxygen supplies, replacements, repairs and maintenance, not provided for under a manufacturer's warranty or purchase agreement, must be covered when functionally necessary.	Ch. 4, Sec. 2.1, Page 65			$0 Copay	Limitations subject to prior approval requirements	No	$25.76

Covered Service	HMO Medicare Advantage Benefits (coverage as required by CMS and/or NYS laws and/or regulations)	Source Document: Enter Article, Section, etc. and Page Number of Evidence of Coverage (EOC), Rider Number		NYS DFS Status: Approved (include date) or Filed/ Pending	Member Cost: Enter copay/ coinsurance amount, e.g., $25/visit, 20% coinsurance	Benefit Limitations: e.g., 20 visits/ calendar year, 60 consecutive days Indicate "unlimited" if no limitations	Change from 2020 Enter: Yes/No and change, e.g., $5 copay increase, new benefit	Projected Monthly Premium for 2021
		EOC Form # H3330_201473_C	Rider					Individual
Prosthetic Devices	Medically necessary prosthetic devices that aid body functioning or replace a limb or body part in order to correct a defect of body form or function must be covered. Examples of prosthetic devices include but are not limited to: artificial limbs, pacemakers, heart valve replacements, artificial joints, external breast prostheses and Ostomy Supplies. Replacements, repairs and maintenance, not provided for under a manufacturer's warranty or purchase agreement, must be covered when functionally necessary.	Ch. 4, Sec. 2.1, Page 84			$0 Copay	Limitations subject to prior approval requirements	No	Covered in HIP VIP Standard Contract

Covered Service	HMO Medicare Advantage Benefits (coverage as required by CMS and/or NYS laws and/or regulations)	Source Document: Enter Article, Section, etc. and Page Number of Evidence of Coverage (EOC), Rider Number		NYS DFS Status: Approved (include date) or Filed/ Pending	Member Cost: Enter copay/ coinsurance amount, e.g., $25/visit, 20% coinsurance	Benefit Limitations: e.g., 20 visits/ calendar year, 60 consecutive days Indicate "unlimited" if no limitations	Change from 2020 Enter: Yes/No and change, e.g., $5 copay increase, new benefit	Projected Monthly Premium for 2021
		EOC Form # H3330_201473_C	Rider					Individual
Orthotic Devices	Medically Necessary custom-made orthotic devices used to support, align, prevent or correct deformities or to improve the function of the foot must be covered. Orthopedic shoes and other supportive devices for treatment of weak, strained, flat, unstable or unbalanced feet should not be included for coverage. Replacements, repairs and maintenance, not provided for under a manufacturer's warranty or purchase agreement, must be covered when functionally necessary.	Ch. 4, Sec. 2.1, Page 74			$0 Copay	Limitations subject to prior approval requirements	No	Covered in HIP VIP Standard Contract
Additional Benefits	Acupuncture Telehealth	Ch. 4, Sec. 2.1, Page 60 Ch. 4, Sec. 2.1, Page 83			$5 Copay PCP: $0 Copay Specialist: $5 Copay Individual Session - Mental Health: $5 Copay Individual Session - Psychiatry: $5 Copay Individual Session - Substance Abuse: $0 Copay	Up to 20 visits per year for chronic low back pain Unlimited	Yes, new benefit Yes, new benefit	Covered in HIP VIP Standard Contract

2. Member Communication Material Requirements

The Offeror must:

1. *Submit drafts of the Cover Letter for the Member communications materials mailing to HMO Members, federally mandated Summary of Benefits and Coverage (SBC) and Schedule of Benefits, in both hard copies and PDF with their Proposals. In addition, those HMOs that participated in NYSHIP in 2020 are required to submit drafts of the Side by Side Comparison of Benefits in both hard copies and PDF with their Proposals. HMOs that did not participate in NYSHIP in 2020 will not be required to furnish the Side by Side Comparison with their Proposals.*

   As required and clarified in the answers to questions released, EmblemHealth is submitting the following attachments for our response to this requirement in the following order:

   Side-by Side Comparisons
   - *Attachment 21. Side-by-Side Comparison of Benefit Changes 2020 to 2021 Actives with Rx*
   - *Attachment 22. Side-by-Side Comparison of Benefit Changes 2020 to 2021 Actives without Rx*
   - *Attachment 23. Side-by-Side Comparison of Benefit Changes 2020 to 2021 Retirees with Rx*
   - *Attachment 24. Side-by-Side Comparison of Benefit Changes 2020 to 2021 Retirees without Rx*

   Schedule of Benefits
   - *Attachment 25. Commercial HMO Schedule of Benefits with Rx*
   - *Attachment 26. Commercial HMO Schedule of Benefits without Rx*
   - *Attachment 27. Medicare Schedule of Benefits with Rx*
   - *Attachment 28. Medicare Schedule of Benefits without Rx*

   In addition, we have also provided draft communication materials to be distributed to NYSHIP members, including the Summary of Benefits, member-facing Side-by-Side comparisons, cover letters, and Summary of Benefits and Coverage (SBCs). These are drafts only at this time and will be further updated once our application is approved. These additional files include:

   Commercial Member-facing Materials
   - *Attachment 29. Commercial Member-facing Cover Letter - Actives with Rx*
   - *Attachment 30. Commercial Member-facing Summary of Benefits - Actives with Rx*

- *Attachment 31. Commercial Member-facing Plan Benefit Comparison - Actives with Rx*
- *Attachment 32. Commercial Member-facing Cover Letter - Actives without Rx*
- *Attachment 33. Commercial Member-facing Summary of Benefits - Actives without Rx*
- *Attachment 34. Commercial Member-facing Plan Benefit Comparison - Actives without Rx*
- *Attachment 35. Commercial SBC with Rx*
- *Attachment 36. Commercial SBC without Rx*

Medicare Member-facing Materials

- *Attachment 37. Medicare Member-facing Cover Letter - Retirees with Rx*
- *Attachment 38. Medicare Member-facing Cost Sharing Guide - Retirees with Rx*
- *Attachment 39. Medicare Member-facing Plan Benefit Comparison - Retirees with Rx*
- *Attachment 40. Medicare Member-facing Cover Letter - Retirees without Rx*
- *Attachment 41. Medicare Member-facing Cost Sharing Guide - Retirees without Rx*
- *Attachment 42. Medicare Member-facing Plan Benefit Comparison - Retirees without Rx*

All attachments listed have been provided in the following pages in hardcopy form and have also been provided in our USBs submitted as part of our electronic submission.

Side-by-Side Comparisons

Provided on the following pages are our Side-by-Side Comparisons in the following order:

- *Attachment 21. Side-by-Side Comparison of Benefit Changes 2020 to 2021 Actives with Rx*
- *Attachment 22. Side-by-Side Comparison of Benefit Changes 2020 to 2021 Actives without Rx*
- *Attachment 23. Side-by-Side Comparison of Benefit Changes 2020 to 2021 Retirees with Rx*
- *Attachment 24. Side-by-Side Comparison of Benefit Changes 2020 to 2021 Retirees without Rx*

HIP PRIME HMO

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ATTACHMENT 25

Health Insurance Plan of Greater New York (HIP)
Side-by-Side Comparison
For New York State Employees
2020 to 2021

MODIFIED BENEFIT	2020 Benefit Level	2021 Benefit Level
PROFESSIONAL SERVICES and OUTPATIENT CARE		
Advanced Imaging Services • Performed in a Specialist Office	$0 Copay	$10 Copay
Allergy Testing and Treatment • Performed in a PCP Office	$10 Copay	$5 Copay
Cardiac Rehabilitation • Performed as Outpatient Hospital Services	$10 Copay	$0 Copay
Chemotherapy • Performed in a PCP Office • Performed in a Specialist Office	$0 Copay $0 Copay	$5 Copay $10 Copay
Diagnostic Radiology Services • Performed in a PCP Office • Performed in a Specialist Office	$0 Copay $0 Copay	$5 Copay $10 Copay
Dialysis • Performed in a PCP Office • Performed in a Freestanding Center • Performed as Outpatient Hospital Services	$10 Copay $10 Copay $10 Copay	$5 Copay $0 Copay $0 Copay

HIP PRIME HMO

MODIFIED BENEFIT	2020 Benefit Level	2021 Benefit Level
PROFESSIONAL SERVICES and OUTPATIENT CARE – continued		
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) • Performed in a PCP Office • Performed in an Outpatient Facility	 $10 Copay $10 Copay	 $5 Copay $0 Copay
Infusion Therapy • Performed in a PCP Office • Performed in a Specialist Office • Home Infusion Therapy	 $0 Copay $0 Copay $0 Copay	 $5 Copay $10 Copay $10 Copay
Laboratory Tests • Performed in a PCP Office • Performed in a Specialist Office	 $0 Copay $0 Copay	 $5 Copay $10 Copay
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) • Performed in a PCP Office • Performed in an Outpatient Facility	 $10 Copay $10 Copay	 $5 Copay $0 Copay
Therapeutic Radiology Services • Performed in a Specialist Office	 $0 Copay	 $10 Copay
MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES		
Outpatient Alcoholism and Substance Abuse Rehabilitation • All Other Outpatient Services	 $10 Copay	 $5 Copay

HIP PRIME HMO

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ATTACHMENT 25

Health Insurance Plan of Greater New York (HIP)
Side-by-Side Comparison
For New York State Employees
2020 to 2021

MODIFIED BENEFIT	2020 Benefit Level	2021 Benefit Level
PROFESSIONAL SERVICES and OUTPATIENT CARE		
Advanced Imaging Services • Performed in a Specialist Office	$0 Copay	$10 Copay
Allergy Testing and Treatment • Performed in a PCP Office	$10 Copay	$5 Copay
Cardiac Rehabilitation • Performed as Outpatient Hospital Services	$10 Copay	$0 Copay
Chemotherapy • Performed in a PCP Office • Performed in a Specialist Office	$0 Copay $0 Copay	$5 Copay $10 Copay
Diagnostic Radiology Services • Performed in a PCP Office • Performed in a Specialist Office	$0 Copay $0 Copay	$5 Copay $10 Copay
Dialysis • Performed in a PCP Office • Performed in a Freestanding Center • Performed as Outpatient Hospital Services	$10 Copay $10 Copay $10 Copay	$5 Copay $0 Copay $0 Copay

NYSHIP Active Employees without RX
Calendar Year 2021

HIP PRIME HMO

MODIFIED BENEFIT	2020 Benefit Level	2021 Benefit Level
PROFESSIONAL SERVICES and OUTPATIENT CARE – continued		
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) • Performed in a PCP Office • Performed in an Outpatient Facility	 $10 Copay $10 Copay	 $5 Copay $0 Copay
Infusion Therapy • Performed in a PCP Office • Performed in a Specialist Office • Home Infusion Therapy	 $0 Copay $0 Copay $0 Copay	 $5 Copay $10 Copay $10 Copay
Laboratory Tests • Performed in a PCP Office • Performed in a Specialist Office	 $0 Copay $0 Copay	 $5 Copay $10 Copay
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) • Performed in a PCP Office • Performed in an Outpatient Facility	 $10 Copay $10 Copay	 $5 Copay $0 Copay
Therapeutic Radiology Services • Performed in a Specialist Office	 $0 Copay	 $10 Copay
MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES		
Outpatient Alcoholism and Substance Abuse Rehabilitation • All Other Outpatient Services	 $10 Copay	 $5 Copay

VIP Premier (HMO)

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ATTACHMENT 25

Health Insurance Plan of Greater New York (HIP)
Side-by-Side Comparison
For New York State Employees
2020 to 2021

MODIFIED BENEFIT	2020 Benefit Level	2021 Benefit Level
Acupuncture	N/A	$5 Copay per visit; Up to 20 visits per year for chronic low back pain
Telehealth	N/A	PCP: $0 Copay Specialist: $5 Copay Individual Session - Mental Health: $5 Copay Individual Session - Psychiatry: $5 Copay Individual Session - Substance Abuse: $0 Copay; Unlimited visits

NYSHIP Retirees with RX
Calendar Year 2021

VIP Premier (HMO)

ATTACHMENT 25

Health Insurance Plan of Greater New York (HIP)
Side-by-Side Comparison
For New York State Employees
2020 to 2021

MODIFIED BENEFIT	2020 Benefit Level	2021 Benefit Level
Acupuncture	N/A	$5 Copay per visit; Up to 20 visits per year for chronic low back pain
Telehealth	N/A	PCP: $0 Copay Specialist: $5 Copay Individual Session - Mental Health: $5 Copay Individual Session - Psychiatry: $5 Copay Individual Session - Substance Abuse: $0 Copay; Unlimited visits

NYSHIP Retirees without RX
Calendar Year 2021

Schedule of Benefits

Provided on the following pages are our Schedule of Benefits in the following order:

- *Attachment 25. Commercial HMO Schedule of Benefits with Rx*
- *Attachment 26. Commercial HMO Schedule of Benefits without Rx*
- *Attachment 27. Medicare Schedule of Benefits with Rx*
- *Attachment 28. Medicare Schedule of Benefits without Rx*

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ATTACHMENT 24

HIP PRIME HMO Schedule of Benefits

SERVICE CATEGORY	COVERAGE INFORMATION	
Physician Services	**Primary Care Physician Office Visits**	
	Adults	$5 Copay
	Sick Child Visits (Age 0-25)	$5 Copay
	Laboratory Services	Included in PCP office visit Copay
	Specialist Office Visits	
	Office Visits	$10 Copay
	Refractive Eye Exams	$0 Copay
	X-ray Services	$0 Copay
	Inpatient Hospital Services	
	Anesthesiology	$0 Copay
	Radiology Visits/Consultations	$0 Copay
Preventive & Wellness Care Services	Well Baby, Child Care & Immunizations	Covered in Full
	Adult Physical	Covered in Full
	Mammography & Prostate Cancer Screening	Covered in Full
	Annual Pap Test & Ob/GYN Exam	Covered in Full
	Immunizations for Adults	Covered in Full
	Colonoscopy & Sigmoidoscopy Screening for Adults	Covered in Full
	Bone Density Tests	Covered in Full
Hospital	Hospital Inpatient	$0 Copay per continuous confinement
	Hospital Outpatient Surgery	$0 Copay
	Hospital Outpatient X-ray	Covered in Full
	Hospital Outpatient Laboratory	Covered in Full
Maternity	Physician Services	$0 Copay
	Hospital Services	$0 Copay
	Nursery Care	Covered in Full
Emergency Room (ER) Visit		$75 Copay per visit
Ambulance		$0 Copay
Chiropractic Benefit		$10 Copay per visit
Durable Medical Equipment		Covered in Full
Mental Health	Inpatient	$0 Copay
	Outpatient	$0 Copay
Substance Abuse Diagnosis & Treatment	Inpatient	$0 Copay
	Outpatient	$5 Copay per visit
Physical/Occupational/Speech Therapy	Outpatient	Combined 90 visits/year; $10 Copay per visit

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HIP PRIME HMO Schedule of Benefits

SERVICE CATEGORY	COVERAGE INFORMATION	
Home Health Care		200 visits per calendar year; Covered in Full
Prescription Coverage[1]	Retail 30-Day Supply	$5 Copay generic / $20 Copay brand
	Mail Order 90-Day Supply	$7.50 Copay generic / $30 Copay brand
Lifetime Maximum Coverage		No Maximums
Additional Benefits:		
Autism Spectrum Disorder	Inpatient Outpatient: • PCP office • Specialist office Assistive Communication Devices	$0 Copay $5 Copay $10 Copay $10 Copay
Diabetic Supplies		$5 Copay per 34 day supply
Dialysis Treatment	• Performed in a PCP office • Performed in a Specialist office • Performed in a Freestanding Center • Performed as Outpatient Hospital Services	$5 Copay $10 Copay $0 Copay $0 Copay
Hospice Care		210 days; Covered in Full
Out-of-Pocket Maximum (per calendar year)		$6,850 per Individual $13,700 per Family
Skilled Nursing Facility Care		$0 Copay
Urgent Care Facility		$5 Copay per visit

FOOTNOTES

[1] *Drugs are dispensed in accordance with HIP's Drug Formulary. Please refer to your Prescription Drug Rider for details.*

Except for emergency care, the above benefits and services are covered only when provided or referred by a HIP Primary Care Physician and/or approved in advance by our HIP Care Management Program. HIP Participating Physicians and Providers have contracted with HIP to provide care to our members; they are not employees, agents, servants or representatives of HIP. This summary is provided for information only; it does not contain complete details of the Plan which are available only in the Contract or Certificate of Coverage, and it does not constitute an Agreement.

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ATTACHMENT 24

HIP PRIME HMO Schedule of Benefits

SERVICE CATEGORY	COVERAGE INFORMATION	
Physician Services	**Primary Care Physician Office Visits**	
	Adults	$5 Copay
	Sick Child Visits (Age 0-25)	$5 Copay
	Laboratory Services	Included in PCP office visit Copay
	Specialist Office Visits	
	Office Visits	$10 Copay
	Refractive Eye Exams	$0 Copay
	X-ray Services	$0 Copay
	Inpatient Hospital Services	
	Anesthesiology	$0 Copay
	Radiology Visits/Consultations	$0 Copay
Preventive & Wellness Care Services	Well Baby, Child Care & Immunizations	Covered in Full
	Adult Physical	Covered in Full
	Mammography & Prostate Cancer Screening	Covered in Full
	Annual Pap Test & Ob/GYN Exam	Covered in Full
	Immunizations for Adults	Covered in Full
	Colonoscopy & Sigmoidoscopy Screening for Adults	Covered in Full
	Bone Density Tests	Covered in Full
Hospital	Hospital Inpatient	$0 Copay per continuous confinement
	Hospital Outpatient Surgery	$0 Copay
	Hospital Outpatient X-ray	Covered in Full
	Hospital Outpatient Laboratory	Covered in Full
Maternity	Physician Services	$0 Copay
	Hospital Services	$0 Copay
	Nursery Care	Covered in Full
Emergency Room (ER) Visit		$75 Copay per visit
Ambulance		$0 Copay
Chiropractic Benefit		$10 Copay per visit
Durable Medical Equipment		Covered in Full
Mental Health	Inpatient	$0 Copay
	Outpatient	$0 Copay
Substance Abuse Diagnosis & Treatment	Inpatient	$0 Copay
	Outpatient	$5 Copay per visit
Physical/Occupational/Speech Therapy	Outpatient	Combined 90 visits/year; $10 Copay per visit

EmblemHealth

HIP PRIME HMO Schedule of Benefits

SERVICE CATEGORY	COVERAGE INFORMATION	
Home Health Care		200 visits per calendar year; Covered in Full
Lifetime Maximum Coverage		No Maximums
Additional Benefits:		
Autism Spectrum Disorder	Inpatient Outpatient: • PCP office • Specialist office Assistive Communication Devices	$0 Copay $5 Copay $10 Copay $10 Copay
Diabetic Supplies		$5 Copay per 34 day supply
Dialysis Treatment	• Performed in a PCP office • Performed in a Specialist office • Performed in a Freestanding Center • Performed as Outpatient Hospital Services	$5 Copay $10 Copay $0 Copay $0 Copay
Hospice Care		210 days; Covered in Full
Out-of-Pocket Maximum (per calendar year)		$6,850 per Individual $13,700 per Family
Skilled Nursing Facility Care		$0 Copay
Urgent Care Facility		$5 Copay per visit

FOOTNOTES

Except for emergency care, the above benefits and services are covered only when provided or referred by a HIP Primary Care Physician and/or approved in advance by our HIP Care Management Program. HIP Participating Physicians and Providers have contracted with HIP to provide care to our members; they are not employees, agents, servants or representatives of HIP. This summary is provided for information only; it does not contain complete details of the Plan which are available only in the Contract or Certificate of Coverage, and it does not constitute an Agreement.

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ATTACHMENT 24

EmblemHealth VIP HMO Medicare Plan Schedule of Benefits

SERVICE CATEGORY	COVERAGE INFORMATION	
Physician Services	**Primary Care Physician Office Visits**	
	Adults	$0 Copay
	Sick Child Visits (Age 0-25)	$0 Copay
	Laboratory Services	$0 Copay
	Specialist Office Visits	
	Office Visits	$5 Copay
	Vision Exams *(per calendar year)*	$5 Copay
	X-ray Services	$0 Copay
	Inpatient Hospital Services	
	Anesthesiology	$0 Copay
	Radiology Visits/Consultations	$0 Copay
Preventive & Wellness Care Services	Adult Physical	Covered in Full
	Mammography & Prostate Cancer Screening	Covered in Full
	Annual Pap Test & Ob/GYN Exam	Covered in Full
	Immunizations for Adults	Covered in Full
	Colonoscopy & Sigmoidoscopy Screening for Adults	Covered in Full
	Bone Density Tests	Covered in Full
Hospital	Hospital Inpatient	$0 Copay per continuous confinement
	Hospital Outpatient Surgery	$0 Copay
	Hospital Outpatient X-ray	$0 Copay
	Hospital Outpatient Laboratory	$0 Copay
Maternity	Physician Services	$5 Copay per visit
	Hospital Services	$0 Copay
Emergency Room (ER) Visit		$25 Copay per visit
Ambulance		$0 Copay
Chiropractic Benefit		$5 Copay per visit
Durable Medical Equipment*		Covered in Full
Mental Health	Inpatient	$0 Copay
	Outpatient	$5 Copay per visit
Substance Abuse Diagnosis & Treatment	Inpatient	$0 Copay
	Rehabilitation Outpatient	$5 Copay per visit
Physical/Occupational/Speech Therapy	Outpatient	$5 Copay per visit
Home Health Care		Covered in Full

EmblemHealth VIP HMO Medicare Plan Schedule of Benefits

SERVICE CATEGORY	COVERAGE INFORMATION	
Prescription Coverage	**Preferred Pharmacy:**	
	Retail 30-Day Supply	Tier 1 (Generic): $0 Copay Tier 2 (Preferred Brand): $0 Copay Tier 3 (Non-Preferred Drug): $45 Copay
	Mail Order 90-Day Supply	Tier 1 (Generic): $0 Copay Tier 2 (Preferred Brand): $0 Copay Tier 3 (Non-Preferred Drug): $67.50 Copay
	Standard Pharmacy:	
	Retail 30-Day Supply	Tier 1 (Generic): $5 Copay Tier 2 (Preferred Brand): $5 Copay Tier 3 (Non-Preferred Drug): $45 Copay
	Mail Order 90-Day Supply	Tier 1 (Generic): $0 Copay Tier 2 (Preferred Brand): $0 Copay Tier 3 (Non-Preferred Drug): $67.50 Copay

SERVICE CATEGORY	COVERAGE INFORMATION	
Lifetime Maximum Coverage		No Maximums
Additional Benefits:		
Acupuncture		$5 Copay
Diabetic Supplies		$5 Copay per prescription
Dialysis Treatment		$0 Copay
Hospice Care		Covered by Medicare
Skilled Nursing Facility Care		Up to 100 days per benefit period (non-custodial) $0 Copay
Telehealth	PCP office Specialist office Individual Session – Mental Health Individual Session – Psychiatry Individual Session – Substance Abuse	$0 Copay $5 Copay $5 Copay $5 Copay $0 Copay
Urgent Care Facility	PCP office Specialist office	$0 Copay $5 Copay per visit

FOOTNOTES

**Durable Medical Equipment must be Medically Necessary, in accordance with Medicare guidelines and prescribed by a HIP Participating Medical Provider, to be covered. Please note prior approval for customized Durable Medical Equipment must be obtained through our Care Management Program.*

HIP Health Plan of New York is an HMO operating with Medicare Advantage contract. Enrolled members must use HIP Participating Providers for all medical and hospital services except for emergency care or urgently needed care. If you receive medical or hospital care that is not provided or authorized by HIP (other than emergency care or urgently needed care as defined in your contract) neither HIP nor Medicare will pay for that service and you will be responsible for payment of care. This benefit package is subject to change annually at the plan's contracted renewal time with the Centers for Medicare & Medicaid Services (CMS).
(Effective 01-01-21 through 12-31-21)

EmblemHealth

ATTACHMENT 24

EmblemHealth VIP HMO Medicare Plan Schedule of Benefits

SERVICE CATEGORY	COVERAGE INFORMATION	
Physician Services	**Primary Care Physician Office Visits**	
	Adults	$0 Copay
	Sick Child Visits (Age 0-25)	$0 Copay
	Laboratory Services	$0 Copay
	Specialist Office Visits	
	Office Visits	$5 Copay
	Vision Exams *(per calendar year)*	$5 Copay
	X-ray Services	$0 Copay
	Inpatient Hospital Services	
	Anesthesiology	$0 Copay
	Radiology Visits/Consultations	$0 Copay
Preventive & Wellness Care Services	Adult Physical	Covered in Full
	Mammography & Prostate Cancer Screening	Covered in Full
	Annual Pap Test & Ob/GYN Exam	Covered in Full
	Immunizations for Adults	Covered in Full
	Colonoscopy & Sigmoidoscopy Screening for Adults	Covered in Full
	Bone Density Tests	Covered in Full
Hospital	Hospital Inpatient	$0 Copay per continuous confinement
	Hospital Outpatient Surgery	$0 Copay
	Hospital Outpatient X-ray	$0 Copay
	Hospital Outpatient Laboratory	$0 Copay
Maternity	Physician Services	$5 Copay per visit
	Hospital Services	$0 Copay
Emergency Room (ER) Visit		$25 Copay per visit
Ambulance		$0 Copay
Chiropractic Benefit		$5 Copay per visit
Durable Medical Equipment*		Covered in Full
Mental Health	Inpatient	$0 Copay
	Outpatient	$5 Copay per visit
Substance Abuse Diagnosis & Treatment	Inpatient	$0 Copay
	Rehabilitation Outpatient	$5 Copay per visit
Physical/Occupational/Speech Therapy	Outpatient	$5 Copay per visit

EmblemHealth VIP HMO Medicare Plan Schedule of Benefits

SERVICE CATEGORY	COVERAGE INFORMATION	
Home Health Care		Covered in Full
Lifetime Maximum Coverage		No Maximums
Additional Benefits:		
Acupuncture		$5 Copay
Diabetic Supplies		$5 Copay per prescription
Dialysis Treatment		$0 Copay
Hospice Care		Covered by Medicare
Skilled Nursing Facility Care		Up to 100 days per benefit period (non-custodial) $0 Copay
Telehealth	PCP office Specialist office Individual Session – Mental Health Individual Session – Psychiatry Individual Session – Substance Abuse	$0 Copay $5 Copay $5 Copay $5 Copay $0 Copay
Urgent Care Facility	PCP office Specialist office	$0 Copay $5 Copay per visit

FOOTNOTES

**Durable Medical Equipment must be Medically Necessary, in accordance with Medicare guidelines and prescribed by a HIP Participating Medical Provider, to be covered. Please note prior approval for customized Durable Medical Equipment must be obtained through our Care Management Program.*

HIP Health Plan of New York is an HMO operating with Medicare Advantage contract. Enrolled members must use HIP Participating Providers for all medical and hospital services except for emergency care or urgently needed care. If you receive medical or hospital care that is not provided or authorized by HIP (other than emergency care or urgently needed care as defined in your contract) neither HIP nor Medicare will pay for that service and you will be responsible for payment of care. This benefit package is subject to change annually at the plan's contracted renewal time with the Centers for Medicare & Medicaid Services (CMS).
(Effective 01-01-21 through 12-31-21)

Commercial Member-facing Materials

Provided on the following pages are our Commercial Member-facing Materials in the following order:

- *Attachment 29. Commercial Member-facing Cover Letter - Actives with Rx*
- *Attachment 30. Commercial Member-facing Summary of Benefits - Actives with Rx*
- *Attachment 31. Commercial Member-facing Plan Benefit Comparison - Actives with Rx*
- *Attachment 32. Commercial Member-facing Cover Letter - Actives without Rx*
- *Attachment 33. Commercial Member-facing Summary of Benefits - Actives without Rx*
- *Attachment 34. Commercial Member-facing Plan Benefit Comparison - Actives without Rx*
- *Attachment 35. Commercial SBC with Rx*
- *Attachment 36. Commercial SBC without Rx*

EmblemHealth

55 Water Street, New York, NY 10041-8190

Important plan information

MONTH DD, YYYY

25400 JP51160
<FIRSTNAME> <LASTNAME>
<ADDRESS1>
<ADDRESS2>
<CITY,> <STATE> <ZIPCODE>
<IMB BAR CODE, IF NEEDED>

Dear <FIRSTNAME> <LASTNAME>,

When you enroll in the 2021 HIP Prime plan, you can count on:

- More than 66,000 doctors and health care professionals to choose from.
- Low out-of-pocket costs and copays (the set dollar amount you pay for health services each time you use them).
- Access to leading hospitals throughout your plan's service area.
- Benefits and services that help keep you healthy, plus discounts on weight loss programs, acupuncture, massages, and more.
- Drug coverage available through network retail pharmacies and our home delivery program.

Enclosed are the following:

- **Plan Benefit Comparison:** This shows there are no benefit changes to your plan for 2021.
- **2021 Summary of Benefits:** This shows some of the products and services your health plan covers.

If you have any questions, visit **emblemhealth.com** or call us at **800-447-8255** (**TTY: 711**). Our hours are 8 a.m. to 6 p.m., Monday to Friday. A Customer Service representative will be happy to help.

We're committed to supporting you.

Sincerely,

George Babitsch
Senior Vice President, Account Management
Enclosures

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HIP Prime HMO 2020 Summary of Benefits

SERVICE CATEGORY	COVERAGE	COPAY
Physician Services	**Primary Care Physician Office Visits**	
	Adults	$5 per visit
	Sick-Child Visits (Age 0-25)	$5 per visit
	Laboratory Services	Included in primary care physician office visit copay
	Specialist Office Visits	
	Office Visits	$10 per visit
	Refractive Eye Exams	$0
	X-ray Services	$0
	Inpatient Hospital Services	
	Anesthesiology	$0
	Radiology Visits/Consultations	$0
Preventive & Wellness Care Services	Well-Baby, Child Care, and Immunizations	$0
	Adult Physical	$0
	Mammography & Prostate Cancer Screening	$0
	Annual Pap Test & OB/GYN Exam	$0
	Immunizations for Adults	$0
	Colonoscopy & Sigmoidoscopy Screening for Adults	$0
	Bone Density Tests	$0
Hospital	Hospital Inpatient	$0 per continuous stay
	Hospital Outpatient Surgery	$0
	Hospital Outpatient X-ray	$0
	Hospital Outpatient Laboratory	$0
Maternity	Physician Services	$0
	Hospital Services	$0
	Nursery Care	$0
Emergency Room (ER) Visit		$75 per visit
Ambulance		$0
Chiropractic Benefit		$10 per visit
Durable Medical Equipment		$0
Mental Health	Inpatient	$0
	Outpatient	$0
Substance Abuse Diagnosis & Treatment	Inpatient	$0
	Rehabilitation Outpatient:	
	• Primary Care Physician Office	$5 per visit
	• Specialist Office	$10 per visit
Physical/Occupational/Speech Therapy	Outpatient	$10 copay per visit Combined 90 visits per year

(Continued)

HIP Prime HMO 2020 Summary of Benefits

SERVICE CATEGORY	COVERAGE	COPAY
Home Health Care		$0 – 200 visits per calendar year
Prescription Coverage[1]	Retail 30-Day Supply Mail Order 90-Day Supply	$5 generic / $20 brand $7.50 generic / $30 brand
Lifetime Maximum Coverage		No maximums
Additional Benefits		
Autism Spectrum Disorder	Inpatient Outpatient: • Primary Care Physician Office • Specialist Office Assistive Communication Devices	$0 $5 per visit $10 per visit $10 per visit
Diabetic Supplies		$5 per 34-day supply
Dialysis Treatment		$10 per visit
Hospice Care		$0 – 210 days
Out-of-Pocket Maximum (per calendar year)		$6,850 per individual $13,700 per family
Skilled Nursing Facility Care		$0
Urgent Care		$5 per visit

[1] Drugs are dispensed in accordance with HIP's Drug Formulary. Please refer to your Prescription Drug Rider for details.

Except for emergency care, the above benefits and services are covered only when provided or referred by a HIP primary care physician and/or approved in advance by our HIP Care Management Program. HIP participating physicians and providers have contracted with HIP to provide care to our members; they are not employees, agents, servants, or representatives of HIP. This summary is provided for information only; it does not contain complete details of the Plan, which are available only in the Contract or Certificate of Coverage, and it does not constitute an Agreement.

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HIP Prime HMO Plan Benefit Comparison

For New York State Employees — 2019 to 2020

There are no benefit changes to your HIP Prime HMO plan for 2020.

EMB_MB_FLY_45360_2020_NYSHIP_SideBySideComp_Active_w_RX 9/19

EmblemHealth

55 Water Street, New York, NY 10041-8190

Important plan information

MONTH DD, YYYY

25400 JP 51160
<FIRSTNAME> <LASTNAME>
<ADDRESS1>
<ADDRESS2>
<CITY,> <STATE> <ZIPCODE>
<IMB BAR CODE, IF NEEDED>

Dear <FIRSTNAME> <LASTNAME>,

Thank you for choosing EmblemHealth.

When you enroll in the 2021 HIP Prime plan, you can count on:

- More than 66,000 doctors and health care professionals to choose from.
- Low out-of-pocket costs and copays (the set dollar amount you pay for health services each time you use them).
- Access to leading hospitals throughout your plan's service area.
- Benefits and services that help keep you healthy, plus discounts on weight loss programs, acupuncture, massages, and more.

Enclosed are the following:

- **Plan Benefit Comparison:** This shows there are no benefit changes to your plan for 2021.
- **2021 Summary of Benefits:** This shows some of the products and services your health plan covers.

If you have any questions, visit **emblemhealth.com** or call us at **800-447-8255** (**TTY: 711**). Our hours are 8 a.m. to 6 p.m., Monday to Friday. A Customer Service representative will be happy to help.

We're committed to supporting you.

Sincerely,

George Babitsch
Senior Vice President, Account Management
Enclosures

EmblemHealth®

DRAFT

HIP Prime HMO 2020 Summary of Benefits

SERVICE CATEGORY	COVERAGE	COPAY
Physician Services	**Primary Care Physician Office Visits**	
	Adults	$5 per visit
	Sick-Child Visits (Age 0-25)	$5 per visit
	Laboratory Services	Included in primary care physician office visit copay
	Specialist Office Visits	
	Office Visits	$10 per visit
	Refractive Eye Exams	$0
	X-ray Services	$0
	Inpatient Hospital Services	
	Anesthesiology	$0
	Radiology Visits/Consultations	$0
Preventive & Wellness Care Services	Well-baby, Child care, and Immunizations	$0
	Adult Physical	$0
	Mammography & Prostate Cancer Screening	$0
	Annual Pap Test & OB/GYN Exam	$0
	Immunizations for Adults	$0
	Colonoscopy & Sigmoidoscopy Screening for Adults	$0
	Bone Density Tests	$0
Hospital	Hospital Inpatient	$0 per continuous stay
	Hospital Outpatient Surgery	$0
	Hospital Outpatient X-ray	$0
	Hospital Outpatient Laboratory	$0
Maternity	Physician Services	$0
	Hospital Services	$0
	Nursery Care	$0
Emergency Room (ER) Visit		$75 per visit
Ambulance		$0
Chiropractic Benefit		$10 per visit
Durable Medical Equipment		$0
Mental Health	Inpatient	$0
	Outpatient	$0
Substance Abuse Diagnosis & Treatment	Inpatient	$0
	Rehabilitation Outpatient:	
	• Primary Care Physician Office	$5 per visit
	• Specialist Office	$10 per visit
Physical/Occupational/Speech Therapy	Outpatient	$10 per visit Combined 90 visits per year

(Continued)

EMB_MB_FLY_45360_2020_NYSHIP_Schedule_Active_no_RX 10/19

HIP Prime HMO 2020 Summary of Benefits

SERVICE CATEGORY	COVERAGE	COPAY
Home Health Care		$0 – 200 visits per calendar year
Lifetime Maximum Coverage		No maximums
Additional Benefits		
Autism Spectrum Disorder	Inpatient Outpatient: • Primary Care Physician Office • Specialist Office Assistive Communication Devices	$0 $5 per visit $10 per visit $10 per visit
Diabetic Supplies		$5 per 34-day supply
Dialysis Treatment		$10 per visit
Hospice Care		$0 – 210 days
Out-of-Pocket Maximum (per calendar year)		$6,850 per individual $13,700 per family
Skilled Nursing Facility Care		$0
Urgent Care		$5 per visit

Except for emergency care, the above benefits and services are covered only when provided or referred by a HIP primary care physician and/or approved in advance by our HIP Care Management Program. HIP participating physicians and providers have contracted with HIP to provide care to our members; they are not employees, agents, servants, or representatives of HIP. This summary is provided for information only; it does not contain complete details of the Plan, which are available only in the Contract or Certificate of Coverage, and it does not constitute an Agreement.

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HIP Prime HMO Plan Benefit Comparison

For New York State Employees — 2019 to 2020

There are no benefit changes to your HIP Prime HMO plan for 2020.

EMB_MB_FLY_45360_2020_NYSHIP_SideBySideComp_Active_no_RX 9/19

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Coverage Period:

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

EmblemHealth : HIP Prime HMO **Coverage for:** Individual/Family **Plan Type:** HMO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-624-2414. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.emblemhealth.com or call 1-800-624-2414 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	In network medical and hospital services are not subject to a deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For in network providers $6,850 Individual / $13,700 Family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, penalties, balanced-bill charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out–of–pocket limit**.
Will you pay less if you use a network provider?	Yes. See www.EmblemHealth.com or call 1-800-447-8255 for a list of participating providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). **Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.**
Do you need a referral to see a specialist?	Yes, written approval is required to see a specialist.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		*Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$5 co-pay visit	Not covered	-----None-----
	Specialist visit	$10 co-pay visit	Not covered	-----None-----
	Preventive care/screening/ immunization	No charge	Not covered	Applies to Well Child Visits; Adult Annual Physical Exams; Well Woman Exams; Bone Density Testing.
If you have a test	Diagnostic test (x-ray, blood work)	PCP office: $5 co-pay visit SCP office: $10 co-pay visit	Not covered	-----None-----
	Imaging (CT/PET scans, MRIs)	PCP office: $5 co-pay visit SCP office: $10 co-pay visit	Not covered	Preauthorization required
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.EmblemHealth.com.	Generic drugs (Tier 1)	Retail: $5 co-pay/30 day supply Mail Order: $7.50 co-pay/90 day supply	Not covered	Tier 1 and Tier 2 drugs are covered.
	Preferred brand drugs (Tier 2)	Retail: $20 co-pay/30 day supply Mail Order: $30 co-pay/90 day supply	Not covered	
	Non-preferred brand drugs (Tier 3)	Not Covered	Not covered	
	Specialty drugs	Tier 1: $5 co-pay/30 day supply Tier 2: $20 co-pay/30 day supply	Not covered	Written referral required.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	Preauthorization required
	Physician/surgeon fees	No charge	Not covered	-----None-----
If you need immediate medical attention	Emergency room care	No charge	No charge	Applies to facility charge, waived if admitted.
	Emergency medical transportation	No charge	No charge	-----None-----
	Urgent care	$5 co-pay visit	Not covered	Applies to facility charge.

Common Medical Event	Services You May Need	What You Will Pay		*Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Not covered	Preauthorization required
	Physician/surgeon fee	No charge	Not covered	-----None-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$5 co-pay visit	Not covered	Unlimited visits. For Substance Abuse care, up to 20 visits per plan year may be used for family counseling
	Inpatient services	No charge	Not covered	Preauthorization required. However, Preauthorization is not required for emergency admissions.
If you are pregnant	Office visits	No charge	Not covered	Office visit copay applies to first visit only. No charge thereafter.
	Childbirth/delivery professional services	No charge	Not covered	-----None-----
	Childbirth/delivery facility services	No charge	Not covered	Limited to 48 hours for natural delivery and 96 hours for caesarean delivery. Preauthorization required
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	40 visits per plan year. Preauthorization required.
	Rehabilitation services	Inpatient: No charge Outpatient Facility: No charge PCP office: $5 co-pay visit	Not covered	Inpatient: 30 days per plan year combined therapies. Preauthorization required. Outpatient: 30 visits per plan year combined therapies. Preauthorization required.
	Habilitation services	Inpatient: No charge Outpatient Facility: No charge PCP office: $5 co-pay visit	Not covered	
	Skilled nursing care	No charge	Not covered	30 days per plan year. Preauthorization required.
	Durable medical equipment	Not covered	Not covered	
	Hospice services	No charge	Not covered	210 days per lifetime. Preauthorization required.

Common Medical Event	Services You May Need	What You Will Pay		*Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	Refractive eye exam
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	$5 co-pay/visit	Not covered	One oral exam every six months

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care
- Hearing aids
- Long-term care
- Most coverage provided outside the United States
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery (Prior Approval required)
- Chiropractic care
- Infertility treatment (Prior Approval required)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: New York State Department of Financial Services at 1-800-342-3736 or www.dfs.ny.gov/, U.S. Department of Health and Human Services at 1-877-267-2323 x1565 or www.cciio.cms.gov, U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/contactEBSA/consumerassistance.html or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your right, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

EmblemHealth **By Phone:** Please call the number on your ID card. **In writing:** EmblemHealth Grievance and Appeals Department P.O. Box 2801 New York, NY 10116-2807 Website: www.emblemhealth.com	**For All Coverage Types** **New York State Department of Financial Services** **By Phone**: 1-800-342-3736 **In writing**: New York State Department of Financial Services Consumer Assistance Unit One Commerce Plaza Albany, NY 12257 Website: www.dfs.ny.gov

For HMO Coverage **New York State Department of Health** **By Phone:** 1-800-206-8125 **In writing:** New York State Department of Health Office of Health Insurance Programs Bureau of Consumer Services – Complaint Unit Corning Tower – OCP Room 1607 Albany, NY 12237 Email: managedcarecomplaint@health.ny.gov Website: www.health.ny.gov	**Consumer Assistance Program** **New York State Consumer Assistance Program** **By Phone:** 1-888-614-5400 **In writing:** Community Health Advocates 633 Third Avenue, 10th Floor New York, NY 10017 Email: cha@cssny.org Website: www.communityhealthadvocates.org **For Group Coverage:** **U.S. Department of Labor** **Employee Benefits Security Administration** at 1-866-444-EBSA (3272) Website: www.dol.gov/ebsa/healthreform

Does this plan provide Minimum Essential Coverage? Yes
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-624-2414
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-624-2414
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-800-624-2414
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-624-2414

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

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

Peg is having a baby

(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$0
Specialist (cost sharing)	$10
Hospital (facility) cost sharing	$0
Other cost sharing	$60

This EXAMPLE event includes services like:
Specialist office visits (prenatal care)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services Diagnostic tests (ultrasounds and blood work) Specialist visit (anesthesia)

Total Example Cost	$12,800

In the example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$125
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$185

Managing Joe's type 2 diabetes

(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$0
Specialist (cost sharing)	$10
Hospital (facility) cost sharing	$0
Other cost sharing	$55

This EXAMPLE event includes services like: Primary care physician office visits (including disease education)
Diagnostic tests (blood work)
Prescription drugs
Durable medical equipment (glucose meter)

Total Example Cost	$7,400

In the example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$725
Coinsurance	$0
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	$780

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist (cost sharing)	$10
Hospital (facility) cost sharing	$0
Other cost sharing	$37

This EXAMPLE event includes services like:
Emergency room care (including medical supplies)
Diagnostic test (x-ray)
Durable medical equipment (crutches)
Rehabilitation services (physical therapy)

Total Example Cost	$1,900

In the example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$80
Co-insurance	$0
What isn't covered	
Limits or exclusions	$37
The total Mia would pay is	$117

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

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ATTENTION: Language assistance services, free of charge, are available to you. Call **1-877-411-3625**. TTY/TDD: **711**.

Español (Spanish)
ATENCIÓN: Usted tiene a su disposición, gratis, servicios de ayuda para idiomas. Llame al **1-877-411-3625** (TTY/TDD: **711**).

中文 (Traditional Chinese)
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אידיש (Yiddish)
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বাংলা (Bengali)
মনোযোগ দিন: ভাষা সহায়তা পরিষেবাগুলি আপনার জন্য বিনামূল্যে উপলব্ধ আছে। **1-877-411-3625** (TTY/TDD: **711**) নম্বরে ফোন করুন।

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Shqip (Albanian)
VINI RE: Shërbime ndihmore për gjuhën, falas, janë në dispozicionin tuaj. Telefononi në **1-877-411-3625** (TTY/TDD: **711**).

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  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
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EmblemHealth®

Coverage Period:

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

EmblemHealth : HIP Prime HMO **Coverage for:** Individual/Family **Plan Type:** HMO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-624-2414. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.emblemhealth.com or call 1-800-624-2414 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	In network medical and hospital services are not subject to a deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For in network providers $6,850 Individual / $13,700 Family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, penalties, balanced-bill charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out–of–pocket limit**.
Will you pay less if you use a network provider?	Yes. See www.EmblemHealth.com or call 1-800-447-8255 for a list of participating providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). **Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.**
Do you need a referral to see a specialist?	Yes, written approval is required to see a specialist.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		*Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$5 co-pay visit	Not covered	-----None-----
	Specialist visit	$10 co-pay visit	Not covered	-----None-----
	Preventive care/screening/ immunization	No charge	Not covered	Applies to Well Child Visits; Adult Annual Physical Exams; Well Woman Exams; Bone Density Testing.
If you have a test	Diagnostic test (x-ray, blood work)	PCP office: $5 co-pay visit SCP office: $10 co-pay visit	Not covered	-----None-----
	Imaging (CT/PET scans, MRIs)	PCP office: $5 co-pay visit SCP office: $10 co-pay visit	Not covered	Preauthorization required
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.EmblemHealth.com.	Generic drugs (Tier 1)	Not covered	Not covered	
	Preferred brand drugs (Tier 2)	Not covered	Not covered	
	Non-preferred brand drugs (Tier 3)	Not covered	Not covered	
	Specialty drugs	Not covered	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	Preauthorization required
	Physician/surgeon fees	No charge	Not covered	-----None-----
If you need immediate medical attention	Emergency room care	No charge	No charge	Applies to facility charge, waived if admitted.
	Emergency medical transportation	No charge	No charge	-----None-----
	Urgent care	$5 co-pay visit	Not covered	Applies to facility charge.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Not covered	Preauthorization required
	Physician/surgeon fee	No charge	Not covered	-----None-----

Common Medical Event	Services You May Need	What You Will Pay		*Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$5 co-pay visit	Not covered	Unlimited visits. For Substance Abuse care, up to 20 visits per plan year may be used for family counseling
	Inpatient services	No charge	Not covered	Preauthorization required. However, Preauthorization is not required for emergency admissions.
If you are pregnant	Office visits	No charge	Not covered	Office visit copay applies to first visit only. No charge thereafter.
	Childbirth/delivery professional services	No charge	Not covered	-----None-----
	Childbirth/delivery facility services	No charge	Not covered	Limited to 48 hours for natural delivery and 96 hours for caesarean delivery. Preauthorization required
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	40 visits per plan year. Preauthorization required.
	Rehabilitation services	Inpatient: No charge Outpatient Facility: No charge PCP office: $5 co-pay visit	Not covered	Inpatient: 30 days per plan year combined therapies. Preauthorization required. Outpatient: 30 visits per plan year combined therapies. Preauthorization required.
	Habilitation services	Inpatient: No charge Outpatient Facility: No charge PCP office: $5 co-pay visit	Not covered	
	Skilled nursing care	No charge	Not covered	30 days per plan year. Preauthorization required.
	Durable medical equipment	Not covered	Not covered	
	Hospice services	No charge	Not covered	210 days per lifetime. Preauthorization required.
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	Refractive eye exam
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	$5 co-pay/visit	Not covered	One oral exam every six months

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care
- Hearing aids
- Long-term care
- Most coverage provided outside the United States
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery (Prior Approval required)
- Chiropractic care
- Infertility treatment (Prior Approval required)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: New York State Department of Financial Services at 1-800-342-3736 or www.dfs.ny.gov/, U.S. Department of Health and Human Services at 1-877-267-2323 x1565 or www.cciio.cms.gov, U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/contactEBSA/consumerassistance.html or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your right, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

EmblemHealth **By Phone:** Please call the number on your ID card. **In writing:** EmblemHealth Grievance and Appeals Department P.O. Box 2801 New York, NY 10116-2807 Website: www.emblemhealth.com	**For All Coverage Types** **New York State Department of Financial Services** **By Phone**: 1-800-342-3736 **In writing**: New York State Department of Financial Services Consumer Assistance Unit One Commerce Plaza Albany, NY 12257 Website: www.dfs.ny.gov

For HMO Coverage **New York State Department of Health** **By Phone:** 1-800-206-8125 **In writing:** New York State Department of Health Office of Health Insurance Programs Bureau of Consumer Services – Complaint Unit Corning Tower – OCP Room 1607 Albany, NY 12237 Email: managedcarecomplaint@health.ny.gov Website: www.health.ny.gov	**Consumer Assistance Program** **New York State Consumer Assistance Program** **By Phone:** 1-888-614-5400 **In writing:** Community Health Advocates 633 Third Avenue, 10th Floor New York, NY 10017 Email: cha@cssny.org Website: www.communityhealthadvocates.org **For Group Coverage:** **U.S. Department of Labor** **Employee Benefits Security Administration** at 1-866-444-EBSA (3272) Website: www.dol.gov/ebsa/healthreform

Does this plan provide Minimum Essential Coverage? Yes
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-624-2414
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-624-2414
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-800-624-2414
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-624-2414

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

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

Peg is having a baby

(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** $0
- **Specialist (cost sharing)** $10
- **Hospital (facility) cost sharing** $0
- **Other cost sharing** $96

This EXAMPLE event includes services like:
Specialist office visits (prenatal care)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services Diagnostic tests (ultrasounds and blood work) Specialist visit (anesthesia)

Total Example Cost	$12,800

In the example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$125
Coinsurance	$0
What isn't covered	
Limits or exclusions	$96
The total Peg would pay is	$221

Managing Joe's type 2 diabetes

(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** $0
- **Specialist (cost sharing)** $10
- **Hospital (facility) cost sharing** $0
- **Other cost sharing** $4,313

This EXAMPLE event includes services like: Primary care physician office visits (including disease education)
Diagnostic tests (blood work)
Prescription drugs
Durable medical equipment (glucose meter)

Total Example Cost	$7,400

In the example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$725
Coinsurance	$0
What isn't covered	
Limits or exclusions	$4,313
The total Joe would pay is	$5,038

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- **The plan's overall deductible** $0
- **Specialist (cost sharing)** $10
- **Hospital (facility) cost sharing** $0
- **Other cost sharing** $37

This EXAMPLE event includes services like:
Emergency room care (including medical supplies)
Diagnostic test (x-ray)
Durable medical equipment (crutches)
Rehabilitation services (physical therapy)

Total Example Cost	$1,900

In the example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$80
Co-insurance	$0
What isn't covered	
Limits or exclusions	$37
The total Mia would pay is	$117

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

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Complaint forms are available at **hhs.gov/ocr/office/file/index.html**.

Medicare Member-facing Materials

Provided on the following pages are our Medicare Member-facing Materials in the following order:

- *Attachment 37. Medicare Member-facing Cover Letter - Retirees with Rx*
- *Attachment 38. Medicare Member-facing Cost Sharing Guide - Retirees with Rx*
- *Attachment 39. Medicare Member-facing Plan Benefit Comparison - Retirees with Rx*
- *Attachment 40. Medicare Member-facing Cover Letter - Retirees without Rx*
- *Attachment 41. Medicare Member-facing Cost Sharing Guide - Retirees without Rx*
- *Attachment 42. Medicare Member-facing Plan Benefit Comparison - Retirees without Rx*

EmblemHealth

55 Water Street, New York, NY 10041-8190

Important plan information

MONTH DD, YYYY

25400 JP51160
<FIRSTNAME> <LASTNAME>
<ADDRESS1>
<ADDRESS2>
<CITY,> <STATE> <ZIPCODE>
<IMB BAR CODE, IF NEEDED>

Dear <FIRSTNAME> <LASTNAME>,

Thank you for choosing EmblemHealth.

We want to let you know about your 2021 benefits. There are many advantages to being a member in the 2021 VIP Premier (HMO) Medicare plan:

- More than 60,000 doctors and health care professionals to choose from.
- Low out-of-pocket costs and copays (the set dollar amount you pay for health services each time you use them).
- Access to leading hospitals throughout your plan's service area.
- Benefits and services that help keep you healthy, plus discounts on weight loss programs, acupuncture, massages, and more.
- Drug coverage through retail pharmacies and our home delivery program.

Enclosed are the following:

- **Plan Benefit Comparison:** This shows there are no benefit changes to your plan for 2021.
- **2021 Cost Sharing Guide:** This shows what your share of the cost is for some of the plan's products and services.

Prescription drug coverage benefit for 2021
The HIP VIP Premier Medicare plan offers drug coverage.

When you get your prescription drugs at a pharmacy that offers "preferred" cost-sharing, you will pay less for medicines and refills. Cost-sharing means that you and EmblemHealth share the costs of some services that are covered in your plan. These costs include premiums, deductibles, copayments, and coinsurance.

(Continued)

To find a “preferred” pharmacy, visit our website at **emblemhealth.com/medicare**, and look in “Find a Pharmacy.” Or, call us at **877-344-7364**. Our hours are 8 a.m. to 8 p.m., seven days a week. A Customer Service representative will be happy to help.

Since your eligibility may be different than the guidelines listed in your contract, please refer to your New York State Health Insurance Program (NYSHIP) general information booklet for complete guidelines.

If you have any questions, visit **emblemhealth.com** or call us at **877-344-7364** (**TTY: 711**). Our hours are 8 a.m. to 8 p.m., seven days a week. A Customer Service representative will be happy to help.

We’re committed to supporting you.

Sincerely,

George Babitsch
Senior Vice President, Account Management

Enclosures

EmblemHealth

VIP PREMIER (HMO) GROUP (NYSHIP) 2021 Cost-Sharing Guide For Medicare Members Residing in Bronx, Kings, New York, Queens, Richmond, Nassau, Suffolk, and Westchester Counties

Benefits	Your Cost-Sharing
Deductible – The amount you pay before your plan starts to pay.	$0
Maximum out-of-pocket – The most you will have to pay for services. This does not include prescription drugs.	$3,400 per year. This includes copays (the set dollar amount you pay for health services each time you use them) and deductibles.

Inpatient Hospital Coverage	
Inpatient hospital coverage* – You pay this amount if you are admitted to a hospital.	$0

Outpatient Hospital Coverage	
Ambulatory surgery*	$0
Outpatient surgery*	$0
Renal (Kidney) dialysis	$0

Doctor Visits	
Primary care provider	$0 per visit
Specialist	$5 per visit
Routine foot care	$5 per visit
Chiropractic care*	$5 per visit

Preventive Care (e.g., annual physical exam, flu, and pneumonia vaccines)	Covered in full

Emergency Care	$25 per visit $0 if admitted within 1 day Worldwide coverage

Urgently Needed Services	$5 per visit

Diagnostic Services/Labs/Imaging*	
Diagnostic services including MRIs, MRAs, PET, and CAT scans	$0
Lab tests	$0
X-ray	$0
Radiation therapy	$0

Hearing Services	
Medicare-covered hearing exam	$5
Routine hearing exam	$5 per yearly visit
Hearing aid	Plan pays up to $500 toward the purchase of a hearing aid every 36 months

Dental Services	
Preventive dental care	Not covered
Comprehensive dental care	Not covered
Dental discount	$5 for one examination (comprehensive or periodic) every 6 months $10 per visit for one prophylaxis (cleaning) every 6 months Additional services, including but not limited to x-rays, fillings, crowns or dentures, will be provided at a discounted rate subject to a fee schedule.

Vision Services	
Routine eye exam	$5 per yearly visit
Medicare-covered eyewear	$0 if you get a new prescription as a result of cataract surgery
Routine eyewear	$0 for one pair of eyeglasses or contact lenses

Mental Health Services*	
Inpatient: no limit in a general hospital; 190-day lifetime limit in a psychiatric facility	$0
Outpatient mental health therapy	$0 per visit

Skilled Nursing Facility*	
Nursing home following hospital stay Up to 100 days per benefit period	$0 Prior hospital stay not required

Substance Abuse Services*	
Outpatient alcohol and substance abuse therapy	$0 per visit

EmblemHealth

VIP PREMIER (HMO) GROUP (NYSHIP) 2021 Cost-Sharing Guide For Medicare Members Residing in Bronx, Kings, New York, Queens, Richmond, Nassau, Suffolk, and Westchester Counties

Rehabilitation Therapies*	
Physical therapy	$5 per visit
Speech therapy	$5 per visit
Occupational therapy	$5 per visit
Cardiac/pulmonary rehabilitation	$0 per visit
Supervised exercise therapy (SET)	$0 per visit

Transportation	
Ground ambulance	$0 per trip
Routine transportation	Not covered

Part B Drugs*	$0

Prescription Drug Coverage				
Tier Level	**Initial Coverage and Coverage Gap $0 – $6,350**			**Catastrophic Over $6,350**
	At Preferred Pharmacies 30-day supply	**At Standard Pharmacies 30-day supply**	**Mail Order 90-day supply**	**You Pay**
Tier 1: Generic	$0	$5	$0	$3.46 or 5% of the cost
Tier 2: Preferred Brand	$0	$5	$0	$8.95 or 5% of the cost
Tier 3: Non-Preferred Drug	$45	$45	$67.50	$3.46, $8.95 or 5% of the cost

Other Benefits	
Durable medical equipment (DME)*	$0
Diabetic supplies and services (non-Part D)	$5
Home health care (non-custodial) *	$0
Acupuncture	Not covered
Fitness benefit - SilverSneakers®	Not covered
Hospice care	Not covered
Private duty nursing	Not covered
Over-the-counter medication (OTC)	Not covered

** Prior authorization rules may apply.*

IMPORTANT INFORMATION

*You can find a full list of the preventive services in your Evidence of Coverage (EOC) at **emblemhealth.com/Medicare**.*

All services covered in this cost-sharing guide are subject to medical necessity review.

For an actual description of your benefits, including exclusions, limitations or specific conditions, see your 2021 Medicare Plan EOC. In the event of a discrepancy between the information contained in the guide and the provisions of your 2021 Medicare EOC, the specific provisions of the EOC shall prevail over the cost-sharing guide.

*This information is not a complete description of benefits. Call **877-344-7364** (**TTY: 711**) for more information.*

*If you have questions, or want to request a copy of the EOC, call Customer Service at **877-344-7364** (**TTY: 711**). Our hours are 8 a.m. to 8 p.m., seven days a week. Or, visit us at **emblemhealth.com/medicare**.*

EmblemHealth®

DRAFT

VIP Premier (HMO) Medicare Plan Benefit Comparison

For New York State Employees — 2019 to 2020

There are no benefit changes to your VIP Premier (HMO) plan for 2020.

EMB_MB_FLY_45360_2020_NYSHIP_SideBySideComp_Retiree_w_RX 9/19

H3330_200025_C Group

EmblemHealth

55 Water Street, New York, NY 10041-8190

Important plan information

MONTH DD, YYYY

25400 JP51160
<FIRSTNAME> <LASTNAME>
<ADDRESS1>
<ADDRESS2>
<CITY,> <STATE> <ZIPCODE>
<IMB BAR CODE, IF NEEDED>

Dear <FIRSTNAME> <LASTNAME>,

Thank you for choosing EmblemHealth.

We want to let you know about your 2021 benefits. There are many advantages to being a member in the 2021 VIP Premier (HMO) Medicare plan:

- More than 60,000 doctors and health care professionals to choose from.
- Low out-of-pocket costs and copays (the set dollar amount you pay for health services each time you use them).
- Access to leading hospitals throughout your plan's service area.
- Benefits and services that help keep you healthy, plus discounts on weight loss programs, acupuncture, massages, and more.

Enclosed are the following:

- **Plan Benefit Comparison:** This shows there are no benefit changes to your plan for 2021.
- **2021 Cost Sharing Guide:** This shows what your share of the cost is for some of the plan's products and services.

Since your eligibility may be different than the guidelines listed in your contract, please refer to your New York State Health Insurance Program (NYSHIP) general information booklet for complete guidelines.

If you have any questions, visit **emblemhealth.com** or call us at **877-344-7364** (**TTY: 711**). Our hours are 8 a.m. to 8 p.m., seven days a week. A Customer Service representative will be happy to help.

(Continued)

We’re committed to supporting you.

Sincerely,

George Babitsch
Senior Vice President, Account Management

Enclosures

EmblemHealth

VIP Rx Carveout (HMO) Group (NYSHIP)
2021 Cost-Sharing Guide
For Medicare Members Residing in Richmond, Nassau, Bronx, Kings, New York, Queens, Suffolk, and Westchester Counties

Benefits	Your Cost-Sharing
Deductible – The amount you pay before your plan starts to pay.	$0
Maximum out-of-pocket – The most you will have to pay for services. This does not include prescription drugs.	$3,400 per year. This includes copays (the set dollar amount you pay for health services each time you use them) and deductibles.

Inpatient Hospital Coverage	
Inpatient hospital coverage* – You pay this amount if you are admitted to a hospital.	$0

Outpatient Hospital Coverage	
Ambulatory surgery*	$0
Outpatient surgery*	$0
Renal (Kidney) dialysis	$0

Doctor Visits	
Primary care provider	$0 per visit
Specialist	$5 per visit
Routine foot care	$5 per visit
Chiropractic care*	$5 per visit

Preventive Care (e.g., annual physical exam, flu, and pneumonia vaccines)	Covered in full

Emergency Care	$25 per visit $0 if admitted within 1 day Worldwide coverage

Urgently Needed Services	$5 per visit

Diagnostic Services/Labs/Imaging*	
Diagnostic services including MRIs, MRAs, PET, and CAT scans	$0
Lab tests	$0
X-ray	$0
Radiation therapy	$0

Hearing Services	
Medicare-covered hearing exam	$5
Routine hearing exam	$5 per yearly visit
Hearing aid	Plan pays up to $500 toward the purchase of a hearing aid every 36 months

Dental Services	
Preventive dental care	Not covered
Comprehensive dental care	Not covered
Dental discount	$5 for one examination (comprehensive or periodic) every 6 months $10 per visit for one prophylaxis (cleaning) every 6 months Additional services, including but not limited to x-rays, fillings, crowns or dentures, will be provided at a discounted rate subject to a fee schedule.

Vision Services	
Routine eye exam	$5 per yearly visit
Medicare-covered eyewear	$0 if you get a new prescription as a result of cataract surgery
Routine eyewear	$0 for one pair of eyeglasses or contact lenses

Mental Health Services*	
Inpatient: no limit in a general hospital; 190-day lifetime limit in a psychiatric facility	$0
Outpatient mental health therapy	$0 per visit

Skilled Nursing Facility*	
Nursing home following hospital stay Up to 100 days per benefit period	$0 Prior hospital stay not required

Substance Abuse Services*	
Outpatient alcohol and substance abuse therapy	$0 per visit

Rehabilitation Therapies*	
Physical therapy	$5 per visit
Speech therapy	$5 per visit
Occupational therapy	$5 per visit
Cardiac/pulmonary rehabilitation	$0 per visit
Supervised exercise therapy (SET)	$0 per visit

Transportation	
Ground ambulance	$0 per trip
Routine transportation	Not covered

Part B Drugs*	$0

Other Benefits	
Durable medical equipment (DME)*	$0
Diabetic supplies and services (non-Part D)	$5
Home health care (non-custodial)*	$0
Acupuncture	Not covered
Fitness benefit - SilverSneakers®	Not covered
Hospice care	Not covered
Private duty nursing	Not covered
Over-the-counter medication (OTC)	Not covered

** Prior authorization rules may apply.*

IMPORTANT INFORMATION

*You can find a full list of the preventive services in your Evidence of Coverage (EOC) at **emblemhealth.com/Medicare**.*

All services covered in this cost-sharing guide are subject to medical necessity review.

For an actual description of your benefits, including exclusions, limitations or specific conditions, see your 2021 Medicare Plan EOC. In the event of a discrepancy between the information contained in the guide and the provisions of your 2021 Medicare EOC, the specific provisions of the EOC shall prevail over the cost-sharing guide.

*This information is not a complete description of benefits. Call **877-344-7364 (TTY: 711)** for more information. If you have questions, or want to request a copy of the EOC, call Customer Service at **877-344-7364 (TTY: 711)**. Our hours are 8 a.m. to 8 p.m., seven days a week. Or, visit us at **emblemhealth.com/medicare**.*

EmblemHealth®

DRAFT

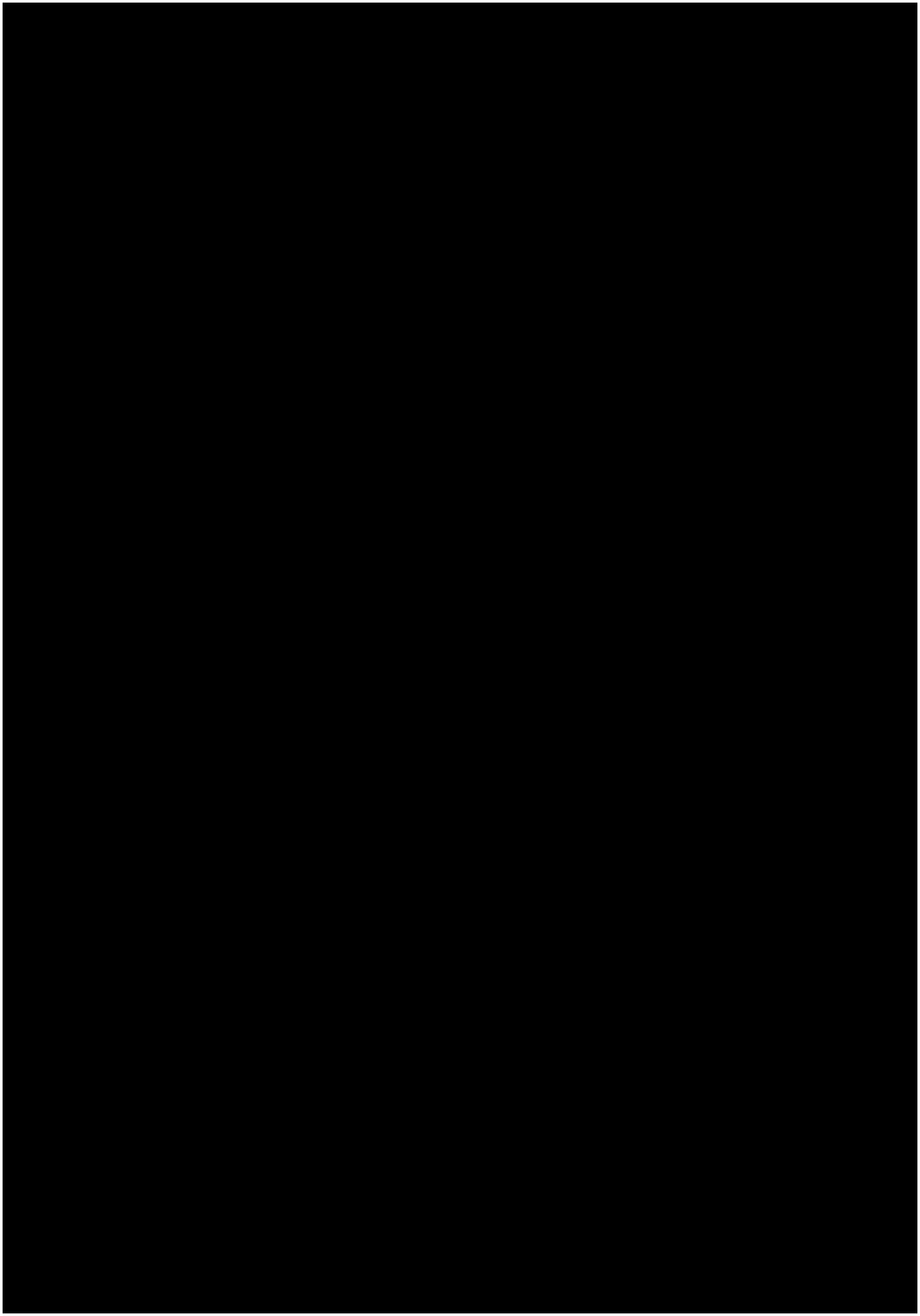
VIP Premier (HMO) Medicare Plan Benefit Comparison

For New York State Employees — 2019 to 2020

There are no benefit changes to your VIP Premier (HMO) plan for 2020.

EMB_MB_FLY_45360_2020_NYSHIP_SideBySideComp_Retiree_no_RX 9/19

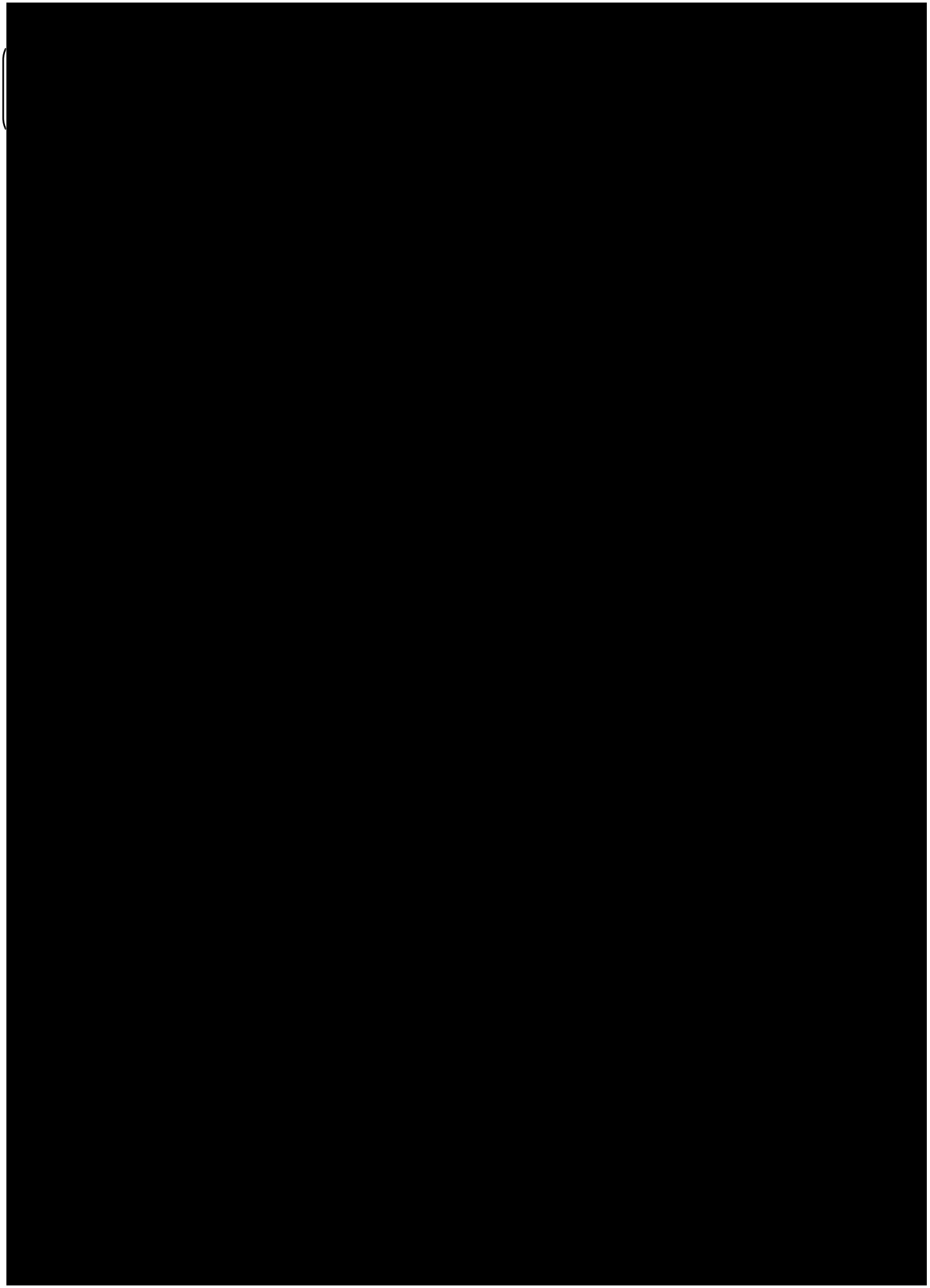
H3330_200026_C



Five Largest Employer Groups

3. *The Offeror must provide a list of its current five largest employer groups in descending order by number of contracts using the Current Five Largest Employer Groups chart (Attachment 16).*

As required, please see our completed form provided on the following page. This identical information has also been provided on our USBs submitted, labeled as *Attachment 44. Five Largest Employer Groups Chart*.



Additional Responses to Questions #4 through #9

4. *Federally required Summary of Benefits and Coverage (SBC) for the proposed benefit package offered through NYSHIP. If the final 2021 SBC is not available for inclusion with this submission, please submit a draft version and advise when it is expected to be finalized. A finalized SBC must be submitted as soon as it is available, but no later than October 1, 2020.*

Please see our draft Summary of Benefits and Coverage (SBCs) for both with and without prescription coverage provided previously in our response herein. In addition, this same, identical information has also been provided within our electronic submission on USBs, labeled as:

- *Attachment 35. Commercial SBC with Rx*
- *Attachment 36. Commercial SBC without Rx*

Note that although no specific date is currently available, EmblemHealth will ensure all SBCs are finalized and submitted ahead of the October 1, 2020 deadline.

5. *Additional Member Communication Materials to Members for 2021 – Cover Letters, Marketing Materials. Refer to Section 3.6 of these Specifications for specific details. To ensure all Members have plan information prior to the NYSHIP Option Transfer Period, HMOs must submit confirmation to the Department that all Required Communications Materials have been mailed to Members by October 21, 2020.*

Please see all of our draft Commercial and Medicare member-facing materials provided previously in our response herein. This includes our draft cover letters, summary of benefits, plan benefit comparisons, SBCs, and Medicare Cost Sharing Guides.

As required, EmblemHealth will ensure all final materials are sent for review and approval before being distributed. Once distributed, confirmation will be sent to the Department that all mailings have been completed by the deadline.

6. *Choices Page, for both Commercial and Medicare Advantage Plans, as applicable. HMOs will have ten business days to complete their HMO e-page(s), after which time, access will be denied. All HMOs submitting Proposals will be required to access a Department online data interface (HMO ePage) through which plan benefit details will be electronically submitted to the Department. Additionally, HMOs are required to print a hard copy of their Choices page information from the database and submit it with their Proposal. This process will enable the Department to implement their online health benefit plan comparison tool. [Note: HMOs will ONLY be granted access to the Department's online data interface with their ePage if they have completed and submitted an affirmative Notice of Intent (Attachment 28) to participate in the 2021 NYSHIP plan year. The Notice of Intent will only be considered valid if it is sent to both the Department and the JLMC Contact Members (Attachment 13).]*

HMOs that participate in NYSHIP during 2020 will be able to edit selected fields of their 2021 Choices page content in the electronic templates to accurately describe plan benefits for the 2021 Plan Year. HMOs that did not participate in NYSHIP during 2020 will access blank electronic templates to electronically submit their Choices page information.

The Department's Communications Unit will use the electronic information submitted by each HMO to format a version of their pages for the Choices guide. HMOs will receive copies of their final Choices pages for sign off for accuracy via e-mail from the Communications Unit. Benefits described on an HMO's Choices pages will be binding upon such HMO, even in the event of erroneous oversight during such review.

As required, EmblemHealth has completed the 2021 HMO ePages for both our Commercial and Medicare Advantage plans online. In addition to our online updates, we have also included the print out of this information, which has been provided on the following pages. This identical information has also been provided on our USBs submitted, labeled as follows:

- *Attachment 45. Commercial HMO ePage - Benefit Information*
- *Attachment 46. Medicare Advantage HMO ePage - Benefit Information*

HIP - Commercial

Character count: 4228 out of 4250

Commercial

Office Visits	$5 per visit
Annual Adult Routine Physicals	No copayment
Well Child Care	No copayment
Specialty Office Visits	$10 per visit
Diagnostic/Therapeutic Services	
Radiology	$5 PCP Visit; $10 Specialist Visit
Lab Tests	$5 PCP Visit; $10 Specialist Visit
Pathology	No copayment
EKG/EEG	$5 PCP Visit; $10 Specialist Visit
Radiation	$10 Specialist Visit
Chemotherapy	$5 PCP Visit; $10 Specialist Visit
Dialysis	$5 PCP Visit; $10 Specialist Visit; $0 Freestanding Center/Outpatient Hospital
Women's Health Care/Reproductive Health	
Pap Tests	No copayment
Mammograms	No copayment
Prenatal Visits	No copayment
Postnatal Visits	No copayment
Bone Density Tests	No copayment
Breastfeeding Services and Equipment	No copayment

External Mastectomy Prosthesis	No copayment
Family Planning Services	$5 PCP, $10 specialist per visit
Infertility Services	$10 per visit
Contraceptive Drugs [1]	No copayment
Contraceptive Devices [1]	No copayment
Inpatient Hospital Surgery	No copayment
Physician	
Facility	
Outpatient Surgery	
Hospital	No copayment
Physician's Office	No copayment
Outpatient Surgery Facility	No copayment
Emergency Department	$75 per visit (waived if admitted)
Urgent Care Facility	$5 copayment
Ambulance	No copayment
Telemedicine	$5 PCP; $10 Specialist [2]
Outpatient Mental Health	No copayment, unlimited
Individual	
Group	
Inpatient Mental Health	No copayment, unlimited
Outpatient Drug/Alcohol Rehab	$5 per visit, unlimited

Inpatient Drug/Alcohol Rehab	No copayment, unlimited
Durable Medical Equipment	No copayment
Prosthetics	No copayment
Orthotics	No copayment
Rehabilitative Care, Physical, Speech and Occupational Therapy	
Inpatient	No copayment, 30 days max
Outpatient Physical or Occupational Therapy	$5 PCP Visit; $10 Specialist Visit; $0 Outpatient Facility , 90 visits max all outpatient rehabilitative care
Outpatient Speech Therapy	$5 PCP Visit; $10 Specialist Visit; $0 Outpatient Facility , 90 visits max all outpatient rehabilitative care
Diabetic Supplies	$5 per 34-day supply
Retail	
Mail Order	
Insulin and Oral Agents	$5 per 34-day supply
Retail	
Mail Order	
Diabetic Shoes [3]	No copayment, when medically necessary
Weight Loss/Bariatric Surgery	Bariatric surgery is covered with prior approval. Applicable cost-sharing applies.
Hospice	No copayment, 210 days max
Skilled Nursing Facility	No copayment, unlimited
Prescription Drugs	
Retail	$5 Tier 1; $20 Tier 2, 30-day supply
Mail Order	$7.50 Tier 1,$30 Tier 2, 90-day supply

Additional Prescription Drug Related Information	Subject to drug formulary, includes fertility drugs, injectable and self-injectable medications and enteral formulas. Copayments reduced by 50 percent when utilizing EmblemHealth mail-order service. Up to a 90-day supply of generic or brand-name drugs may be obtained.
Specialty Drugs	Coverage provided through the EmblemHealth Specialty Pharmacy Program. Specialty drugs include injectables and oral agents that are more complex to administer, monitor and store in comparison with traditional drugs. Specialty drugs require prior approval, which can be obtained by the HIP prescribing physician. Specialty drugs are subject to the applicable Rx copayment, Rx formulary and distribution from our preferred specialty pharmacy.
Additional Benefits	
Annual Out-of-Pocket Maximum (In-Network Benefits)	$6,850 Individual, $13,700 Family per year
Dental	Not covered
Vision	No copayment for routine and refractive eye exams
Hearing Aids	Cochlear implants only
Out of Area	Covered for emergency care only
Additional Benefits HMOs (as applicable)	
Eyeglasses	$35 per pair; one pair every 24 months for selected frames
Laser Vision Correction (LASIK)	Discount program
Fitness Program	Discount program
Alternative Medicine Program	Discount program
Artificial Insemination	$10 per visit
Prostate Cancer Screening	No copayment

Plan Highlights for 2021	EmblemHealth's HIP Prime HMO Plan features low out-of-pocket costs at the point of service. Telehealth visits are covered as available from your PCP/Specialist.
Participating Physicians	The HIP Prime network offers the choice of a traditional network of independent physicians who see patients in their own offices, as well as providers in physician group practices that meet most, if not all, of a member's medical needs under one roof. Group practices offer services in most major specialties such as cardiology and ophthalmology, plus ancillary services like lab tests, X-rays and pharmacy services.
Affiliated Hospitals	HIP Prime members have access to more than 100 of the area's leading hospitals, including major teaching institutions.
Pharmacies and Prescriptions	Filling a prescription is easy with more than 40,000 participating pharmacies nationwide, including more than 4,700 participating pharmacies throughout New York State. HIP Prime members have access to a mail-order program through Express Scripts. The HIP Prime Plan offers a closed formulary. Tier 1 includes generic drugs; Tier 2 includes brand-name drugs. We offer a closed formulary.
Medicare Coverage	Retirees who are not Medicare-eligible are offered the same coverage as active employees. Medicare-primary retirees who reside in NYSHIP-approved service counties are required to enroll in the VIP Premier (HMO) Medicare Plan, a Medicare Advantage Plan that provides Medicare benefits and more.

Plan Mailing Address

Name: EmblemHealth

Address: 55 Water Street

Address:

City: New York

State: NY

Zip: 10041

Additional Addresses

Information Numbers

Customer Service: 1-800-447-8255

TTY: 1-888-447-4833

Website

www.emblemhealth.com

Important Note: Only participating providers in the counties listed below are part of this HMO's network within NYSHIP.Please be sure to check before receiving care that your provider participates with this HMO's NYSHIP network.

NYSHIP Code number 050

A Network and IPA HMO serving individuals living or working in the following select counties:

Bronx, Kings, Nassau, New York, Queens, Richmond, Suffolk and Westchester

NYSHIP Code number 220

A IPA HMO serving individuals living or working in the following select counties:

Albany, Columbia, Greene, Rensselaer, Saratoga, Schenectady, Warren and Washington

NYSHIP Code number 350

A IPA HMO serving individuals living or working in the following select counties:

Delaware, Dutchess, Orange, Putnam, Sullivan and Ulster

Comments for DCS

Footnotes:

1. Covered for FDA-approved contraceptive drugs/devices only.
2. Telemedicine should read as Telehealth
3. Precertification must be obtained from participating vendor prior to purchase.

HIP - Medicare Advantage

Character count: 4187 out of 4250

Medicare Advantage	
Office Visits	No copayment
Annual Adult Routine Physicals	No copayment
Specialty Office Visits	$5 per visit
Diagnostic/Therapeutic Services	
Radiology	No copayment
Lab Tests	No copayment
Pathology	No copayment
EKG/EEG	No copayment
Radiation	No copayment
Chemotherapy	No copayment
Dialysis	No copayment
Women's Health Care/Reproductive Health	
Pap Tests	No copayment
Mammograms	No copayment
Prenatal Visits	$5 per visit
Postnatal Visits	$5 per visit
Bone Density Tests	No copayment
Breastfeeding Services and Equipment	Not covered
External Mastectomy Prosthesis	No copayment
Family Planning Services	$0 PCP, $5 specialist per visit

Infertility Services	Not covered
Contraceptive Drugs	Applicable Rx copayment
Contraceptive Devices	Not covered
Inpatient Hospital Surgery	No copayment
Physician	
Facility	
Outpatient Surgery	
Hospital	No copayment
Physician's Office	$0 PCP, $5 specialist per visit
Outpatient Surgery Facility	No copayment
Emergency Department	$25 per visit (waived if admitted)
Urgent Care Facility	$5 per visit
Ambulance	No copayment
Telemedicine	No Copay for PCP or Individual Substance Abuse; $5 per Specialist, Individual Mental Health, & Individual Psychiatry; Unlimited Visits [1]
Outpatient Mental Health	$5 per visit, unlimited
Individual	
Group	
Inpatient Mental Health	No copayment , no limit in a general hospital; 190-day lifetime limit in a psychiatric facility
Outpatient Drug/Alcohol Rehab	$5 per visit, unlimited
Inpatient Drug/Alcohol Rehab	No copayment, unlimited

Durable Medical Equipment	No copayment
Prosthetics	No copayment
Orthotics	No copayment
Rehabilitative Care, Physical, Speech and Occupational Therapy	
Inpatient	No copayment, unlimited
Outpatient Physical or Occupational Therapy	$5 per visit, unlimited
Outpatient Speech Therapy	$5 per visit, unlimited
Diabetic Supplies	$5 per prescription
Retail	
Mail Order	
Insulin and Oral Agents	
Retail	$0 Tier 1 & Tier 2 (Preferred Pharmacy), $5 Tier 1 & Tier 2 (Standard Pharmacy), $45 Tier 3 , Specialty Drugs limited to 30-day supply
Mail Order	$0 Tier 1 & Tier 2, $67.50 Tier 3 , 90-day supply; Specialty Drugs limited to 30-day supply
Diabetic Shoes [2]	No copayment, when medically necessary
Weight Loss/Bariatric Surgery	Medicare-covered bariatric surgery is covered. The service category applicable cost-sharing will apply and prior authorization may be required.
Hospice	Covered by Medicare for 180 days in a Medicare-certified hospice facility, plus unlimited 60-day extensions if Medicare guidelines are met.
Skilled Nursing Facility	No copayment , 100 days max per benefit period (non-custodial)
Prescription Drugs	

Retail	$0 Tier 1 & Tier 2 (Preferred Pharmacy), $5 Tier 1 & Tier 2 (Standard Pharmacy), $45 Tier 3 , Specialty Drugs limited to 30-day supply
Mail Order	$0 Tier 1 & Tier 2, $67.50 Tier 3 , 90-day supply; Specialty Drugs limited to 30-day supply
Additional Prescription Drug Related Information	
Specialty Drugs	Specialty drugs include injectables & oral agents. Specialty drugs require prior approval and are subject to a copayment and formulary.
Additional Benefits	
Dental	$5 exam and $10 cleaning every 6 months. Dental discounts available.
Vision	$5 per visit (routine only)
Hearing Aids	$500 max per 36 months
Out of Area	Covered for emergency care only
Additional Benefits HMOs (as applicable)	
Eyeglasses	No copayment for one pair per 12 months; applies to select frames
Podiatry	$5 per visit, 4 visits max, for routine procedures
Prostate Cancer Screening	No copayment
Acupuncture	$5 per visit , 20 visits max; prior authorization may be required
Plan Highlights for 2021	EmblemHealth's Medicare Advantage HMO Plan features low out-of-pocket costs at the point of service. New benefits for 2021 include Telehealth visits which are covered, as available from your PCP or Specialist, and Acupuncture visits with up to 20 visits covered each year for chronic low back pain.

Participating Physicians	The HIP Prime network offers a traditional network of independent physicians who see patients in their own offices, as well as providers in physician group practices. Group practices offer services in most major specialties plus ancillary services like lab tests, X-rays and pharmacy services.
Affiliated Hospitals	HIP VIP members have access to more than 100 of the area's leading hospitals, including major teaching institutions.
Pharmacies and Prescriptions	More than 40,000 pharmacies nationwide, with more than 4,700 pharmacies in NYS. Mail-order program through Express Scripts. You pay less for your medicines when using a retail Preferred Pharmacy or mail order. Preferred Pharmacies include Walgreens, Rite Aid and Walmart, to name a few. The VIP Premier Medicare Plan offers a closed formulary. We offer a closed formulary.
Medicare Coverage	Medicare-primary NYSHIP retirees who reside in NYSHIP-approved service counties are required to enroll in the VIP Premier (HMO) Medicare Plan, a Medicare Advantage Plan that provides Medicare benefits and more. To qualify, you must be enrolled in Medicare Parts A and B and live in the service area.

Plan Mailing Address

Name: EmblemHealth

Address: 55 Water Street

Address:

City: New York

State: NY

Zip: 10041

Additional Addresses

Information Numbers

Customer Service: 1-877-344-7364

TTY: 1-888-447-4833

Website

www.emblemhealth.com

Important Note: Only participating providers in the counties listed below are part of this HMO's network within NYSHIP.Please be sure to check before receiving care that your provider participates with this HMO's NYSHIP network.

NYSHIP Code number 050

A Network and IPA HMO serving individuals living or working in the following select counties:

Bronx, Kings, Nassau, New York, Queens, Richmond, Suffolk and Westchester

NYSHIP Code number 220

A IPA HMO serving individuals living or working in the following select counties:

Albany, Columbia, Greene, Rensselaer, Saratoga, Schenectady, Warren and Washington

NYSHIP Code number 350

A IPA HMO serving individuals living or working in the following select counties:

Delaware, Dutchess, Orange, Putnam, Sullivan and Ulster

Comments for DCS

Enter Comments

Footnotes:

1. Telemedicine should read as Telehealth.
2. Precertification must be obtained from the participating vendor prior to purchase. One pair of diabetic shoes (including insert) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts are allowed per calendar year.

7. *Schedule of Benefits required for Commercial Plan and Medicare Advantage Plan enrollees, if applicable. [Note: If this is part of the Offeror's Certificate of Coverage and/or Evidence of Coverage, indicate page numbers where this information can be found].*

Please see our Schedule of Benefits provided previously in our response herein. In addition, this same, identical information has also been provided within our electronic submission on USBs, labeled as:

- *Attachment 25. Commercial HMO Schedule of Benefits with Rx*
- *Attachment 26. Commercial HMO Schedule of Benefits without Rx*
- *Attachment 27. Medicare Schedule of Benefits with Rx*
- *Attachment 28. Medicare Schedule of Benefits without Rx*

8. *Side by Side Comparison of Benefit Changes 2020 to 2021 (document must be titled as such) identifying changes from 2020 (current year) to 2021 (upcoming year) for Commercial Plan and Medicare Advantage Plan Enrollees, if applicable. In the event there are no changes in the benefits offered, the HMO is required to mail an affirmative statement to Members confirming that there are no changes from the previous year; a copy of the statement of "no change" should be included in this submission, if applicable. This requirement is only for HMOs that participated in NYSHIP in 2020. See SAMPLE Side-by-Side Comparison (Attachment 25).*

Please see our Side-by-Side Comparisons provided previously in our response herein. In addition, this same, identical information has also been provided within our electronic submission on USBs, labeled as:

- *Attachment 21. Side-by-Side Comparison of Benefit Changes 2020 to 2021 Actives with Rx*
- *Attachment 22. Side-by-Side Comparison of Benefit Changes 2020 to 2021 Actives without Rx*
- *Attachment 23. Side-by-Side Comparison of Benefit Changes 2020 to 2021 Retirees with Rx*
- *Attachment 24. Side-by-Side Comparison of Benefit Changes 2020 to 2021 Retirees without Rx*

9. *Listing of Certificate/Group Contract, Riders and/or Amendments (see SAMPLE Contract and Rider Summary (Attachment 30)). Include both Commercial HMO and Medicare Advantage Plan documents.*

Please see the following pages and our USBs submitted for this information, labeled as *Attachment 47. Certificate-Group Contract-Rider Summary*.

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ATTACHMENT 30

Certificate/Group Contract/Rider and/or Amendment Summary

Form/Rider Name	Form/Rider Number	Status Approved-Final/Pending/Draft	Applicable Plan Commercial HMO/Medicare Advantage	Brief Summary of Purpose
HMO Group Contract	155-23-LGHMOCONTRACT (07/16)	Approved-Final	Commercial HMO	Base Contract
HMO Certificate of Coverage	155-23-LGHMOCERT (08/19)	Approved-Final	Commercial HMO	Base Contract
HMO Prime Schedule of Benefits	155-23-LGHMOPRIMESCHEDULE (01/20)	Approved-Final	Commercial HMO	Provides cost-sharing for benefits; day and/or visit limits; and services that require prior approval
Prescription Drug Rider for Certain Drugs	155-23-LGHMOwoRX (11/19)	Approved-Final	Commercial HMO	Adds Prescription Drug coverage for the plan without Prescription Drug benefits.
Transportation, Lodging and Meal Expenses for Transplants Rider	155-23-LGHMOTRANSPLANTS (07/16)	Approved-Final	Commercial HMO	Adds coverage for transportation, lodging and meal expenses for transplant recipients to the base contract

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ATTACHMENT 30

Certificate/Group Contract/Rider and/or Amendment Summary

Rider Name	Rider/Form Number	Status Approved-Final/Pending/Draft	Applicable Plan Commercial HMO/Medicare Advantage	Brief Summary of Purpose
Who is Covered (NYSHIP Eligibility Rider)	155-23-NYSHIP ELIGIBILITY (07/20)	Pending DFS Approval	Commercial HMO	NYSHIP Eligibility
Medicare Evidence of Coverage	H3330_201473_C	Draft	Medicare Advantage	CMS required description of benefits and services with prescription drug coverage
Medicare Evidence of Coverage	H3330_127362_C	Draft	Medicare Advantage	CMS required description of benefits and services without prescription drug coverage

3. Website Access

1. *In accordance with Section 3.9 of these Specifications, the Offeror must provide the following:*

a. *The website address to the online prescription drug formulary that the Offeror proposes for the NYSHIP plan;*

The URL to our online prescription drug formulary is https://www.emblemhealth.com/resources/pharmacy/drugs-covered. Once at the site, click on the 2020 Large Group Formulary to view the formulary applicable to NYSHIP members.

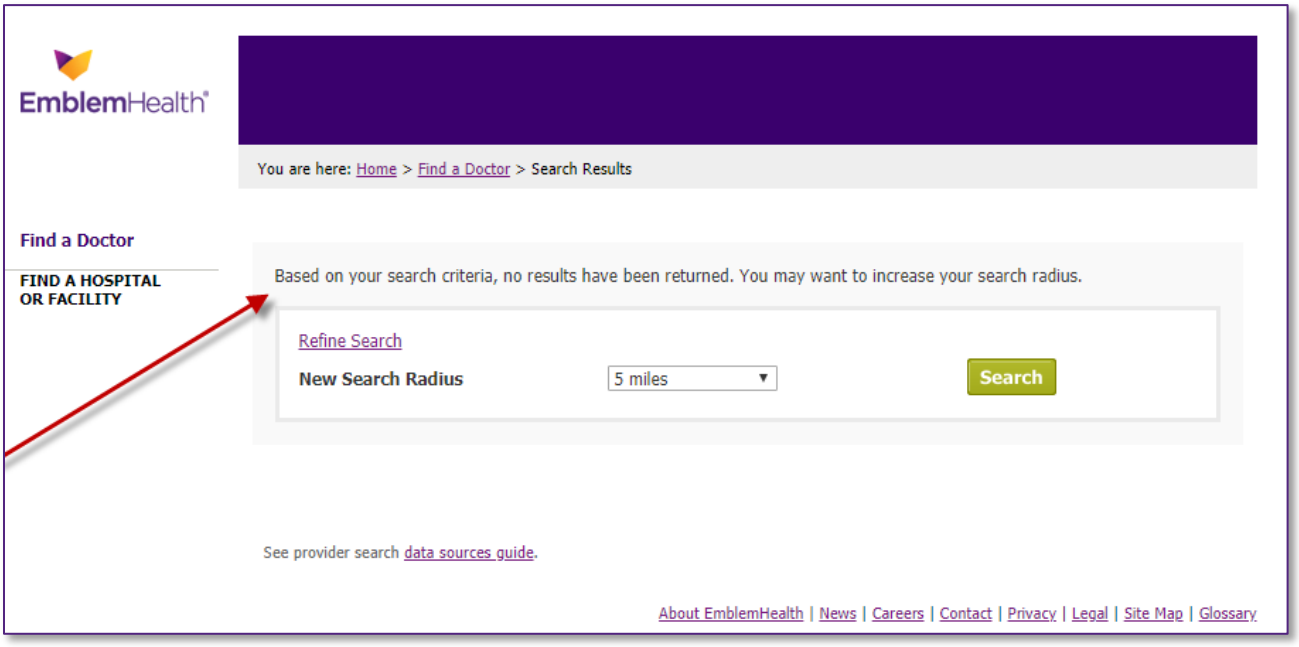
b. *The process by which JLMC Members obtain the user IDs and passwords necessary to access the HMO website to view applications available to Members other than protected health information.*

The EmblemHealth website, www.emblemhealth.com, provides a single online resource from which all of our online tools for enrollees can be accessed. This includes our EmblemHealth Member Portal at https://www.emblemhealth.com/sign-in which provides an area to login, as well as a link to register if the member has not already registered. NYSHIP members can seamlessly register online using their Member ID located on their ID card. Through our public website and portal, provider search, benefits information, wellness information, and much more is available to enrollees.

c. *For the Provider search, provide a copy of the message that would be returned if a Member entered a zip code outside of the HMOs approved NYSHIP service area.*

NYSHIP enrollees can search for a provider through our website at https://portals.emblemhealth.com/ProviderSearchEHHIP/Search.aspx. If an enrollee attempts to search for a provider in a zip code that is out of the specified coverage area, our Provider Search tool will return the following message, *"Based on your search criteria, no results have been returned. You may want to increase your search radius."* The following screenshot further illustrates the message that will be displayed.

Exhibit 9. EmblemHealth Provider Search Tool: Out of Service Area Message



Appendix 1. New York Subcontractors and Suppliers (Attachment 12)

An Offeror is required to complete New York State Subcontractors and Suppliers (Attachment 12). New York State businesses have a substantial presence in State contracts and strongly contribute to the economies of the State and the nation. In recognition of their economic activity and leadership in doing business in NYS, An Offeror for this Contract is strongly encouraged and expected to consider NYS businesses in the fulfillment of the requirements of the Contract. Such partnering may be as subcontractors, suppliers, protégés, or other supporting roles.

As a local, regional health plan, EmblemHealth predominately does business with local New York State subcontractors and suppliers. We have a large number of vendors, suppliers, delegates, subcontractors, union groups, and other strategic alliances we work with in our local area. With regard to our subcontractors identified in our Administrative Proposal response, we have completed the attachment required to indicate those particular subcontractors who have locations in the State of New York. This identical information has also been submitted on our USBs, labeled as *Attachment 48. NYS Subcontractors and Suppliers*.

ATTACHMENT 12

New York State Subcontractors and Suppliers - "Health Maintenance Organizations Specifications for the New York State Health Insurance Program"

Offeror Name: Health Insurance Plan of Greater New York d/b/a EmblemHealth

As stated in Section 2 of these Specifications, an Offeror is encouraged to use New York State businesses in the performance of Program Services. Please complete the following exhibit to reflect the Offeror's proposed utilization of New York State businesses.

Name(s) of New York Subcontractors and/or Suppliers	Address, City, State, and Zip Code	Description of Services or Supplies Provided	Estimated Value Over 5-Year Contract Period	Identify if Subcontractor and/or Supplier
Beacon Health Options, Inc.	10 British American Blvd. Latham, NY 12110	Behavioral Health	TBD	Subcontractor
Beacon Health Options, Inc.	14 Wall Street, 21st Floor New York, NY 10005	Behavioral Health	TBD	Subcontractor
Quest Diagnostics, Inc.	See attached listing	Diagnostics/Lab Tests	TBD	Subcontractor
The Care Management Co.	200 Corp. Blvd. South Yonkers, NY 10701	Utilization Review	TBD	Subcontractor
Heritage NE Medical Mgmt. d/b/a HealthCare Partners	501 Franklin Ave, Suite 300 Garden City, NY 11530	Utilization Review	TBD	Subcontractor
OrthoNet LLC	1311 Mamaroneck Ave, Suite 240 White Plains, NY 10605	Utilization Review	TBD	Subcontractor

Site Code	Site Name	Address	City	State	Zip	County	Site Type	Phone	Fax	Operation Hours
ABO	Quest Diagnostics	2 Executive Park Dr 2nd Fl	Albany	NY	12203-3700	Albany	PSC	518-438-3388	518-438-6731	M-F 7:30 am-1:00 pm & 2:00 pm-3:30 pm|Sa 7:30 am-12:00 pm; Drug Screen: M-F 10:00 am-1:00 pm & 2:00 pm-3:00 pm|Sa 10:00 am-11:30 am
LTH	Quest Diagnostics	579 Troy Schenectady Rd Ste 222 Latham Farms Shopping Center	Latham	NY	12110-4029	Albany	PSC	518-785-7765	518-786-9799	M-F 7:00 am-12:00 pm & 1:00 pm-3:00 pm; Drug Screen: M-F 10:00 am-12:00 pm & 1:00 pm-2:30 pm
AD5	Quest Diagnostics	Bronx - 4238 Bronx Blvd	Bronx	NY	10466-2671	Bronx	PSC	718-655-3545	718-655-3654	M-F 7:30 am-12:00 pm & 1:00 pm-3:30 pm|Sa 9:00 am-1:00 pm
BRX	Quest Diagnostics	3250 Westchester Ave Ste 105	Bronx	NY	10461-4500	Bronx	PSC	718-518-8282	718-518-1979	M-F 8:00 am-12:00 pm & 1:00 pm-4:00 pm|Sa 8:00 am-12:00 pm; Drug Screen: M-F 10:00 am-12:00 pm & 1:00 pm-3:30 pm|Sa 10:00 am-11:30 am
C77	Quest Diagnostics	1 Halleck St	Bronx	NY	10474-7085	Bronx	PSC	866-697-8378		T-Sa 7:00 am-6:00 pm
C78	Quest Diagnostics	1400 Pelham Parkway South	Bronx	NY	10461-0000	Bronx	PSC	866-697-8378		M-Su Vary
FE6	Quest Diagnostics	3765 Riverdale Ave Ste 6	Bronx	NY	10463-1845	Bronx	PSC	718-884-2425	718-884-2486	M-Th 8:00 am-11:30 am & 12:30 pm-4:00 pm|F 8:00 am-11:30 am & 12:30 pm-3:00 pm; Drug Screen: M-Th 10:00 am-11:30 am & 12:30 pm-3:30 pm|F 10:00 am-11:30 am & 12:30 pm-2:30 pm
J2Z	Quest Diagnostics	2415A Arthur Ave	Bronx	NY	10458-6076	Bronx	PSC	718-220-2221	718-220-2229	M-F 8:00 am-11:30 am & 12:30 pm-4:00 pm|Sa 8:00 am-12:00 pm; Drug Screen: M-F 10:00 am-11:30 am & 12:30 pm-3:30 pm
WBG	Quest Diagnostics	2015 Williamsbridge Rd	Bronx	NY	10461-1606	Bronx	PSC	718-430-0546	718-430-0588	M-F 7:00 am-3:30 pm|Sa 8:00 am-12:00 pm; Drug Screen: M-F 7:00 am-3:00 pm|Sa 8:00 am-12:00 pm
YWT	Quest Diagnostics	345 Harry L Dr	Johnson City	NY	13790-1404	Broome	PSC	607-798-1041	607-798-1097	M-F 7:00 am-11:00 am & 12:00 pm-2:00 pm; Drug Screen: M-F 7:00 am-11:00 am & 12:00 pm-1:30 pm; TSPOT: M-F 8:00 am-11:00 am & 12:00 pm-1:00 pm
ETP	Associated Clinical Laboratories	193 East Main Street	Westfield	NY	14787-1104	Chatauqua	PSC	716-326-7300	716-326-7308	M-F 6:30 am-2:30 pm|Sa 7:00 am-12:00 pm; Drug Screen: M-F 6:45 am-11:45 am; TSPOT: M-F 8:00 am-1:00 pm
HXM	Associated Clinical Laboratories	312 Central Avenue	Dunkirk	NY	14048-2125	Chautauqua	PSC	716-363-7417	716-363-7419	M-F 7:00 am-11:30 am & 12:00 pm-3:30 pm|Sa 7:00 am-12:00 pm; Drug Screen: M-F 7:30 am-11:30 am & 12:00 pm-2:00 pm; TSPOT: M-F 8:00 am-1:00 pm
JAT	Quest Diagnostics	320 Prather Ave Ste 200B-c	Jamestown	NY	14701-6820	Chautauqua	PSC	716-484-7147	716-484-1232	M-F 6:30 am-4:00 pm|Sa 7:00 am-12:00 pm; Drug Screen: M-F 7:00 am-1:00 pm; TSPOT: M-F 8:00 am-1:00 pm
IDW	Quest Diagnostics	6 Euclid Ave	Cortland	NY	13045-1257	Cortland	PSC	607-756-8203	607-756-1843	M-F 7:00 am-12:00 pm & 12:30 pm-2:30 pm; Drug Screen: M-F 9:30 am-12:00 pm & 12:30 pm-2:00 pm; TSPOT: M-F 8:00 am-12:00 pm & 12:30 pm-1:00 pm
FIS	Quest Diagnostics	982 Main St Ste 9	Fishkill	NY	12524-3506	Dutchess	PSC	845-896-4067	845-897-4750	M-F 7:00 am-4:00 pm|Sa 7:00 am-11:00 am; Drug Screen: M-F 10:00 am-3:30 pm|Sa 9:00 am-10:30 am
GVG	Quest Diagnostics	3999 Albany Post Road Unit F1	Hyde Park	NY	12538-1947	Dutchess	PSC	845-229-0650	845-229-0715	M-F 7:00 am-11:30 am & 12:30 pm-2:30 pm|Sa 8:00 am-12:00 pm; Drug Screen: M-F 9:00 am-11:30 am & 12:30 pm-2:30 pm

Site Code	Site Name	Address	City	State	Zip	County	Site Type	Phone	Fax	Operation Hours
FNK	Quest Diagnostics	695 Dutchess Tpke Ste 102	Poughkeepsie	NY	12603-6442	Dutchess	PSC	845-452-8405	845-452-8491	M-F 8:00 am-4:00 pm; Drug Screen: M-F 10:00 am-3:30 pm
U4B	Quest Diagnostics	2566A South Rd	Poughkeepsie	NY	12601-5397	Dutchess	PSC	845-471-4441	845-471-4567	M-F 7:00 am-12:00 pm & 1:00 pm-4:00 pm|Sa 8:00 am-12:00 pm; Drug Screen: M-F 8:00 am-12:00 pm & 1:00 pm-3:00 pm
QH2	Quest Diagnostics	12845 Broadway St	Alden	NY	14004-1223	Erie	PSC	716-937-6677	716-937-6779	M-F 6:15 am-2:00 pm; Drug Screen: M-F 6:15 am-1:00 pm; TSPOT: M-F 8:00 am-1:00 pm
AHS	Quest Diagnostics	3950 E Robinson Rd Ste 105	Amherst	NY	14228-2044	Erie	PSC	716-691-1744	716-691-0028	M-F 6:30 am-3:00 pm; Drug Screen: M-F 7:00 am-2:00 pm; TSPOT: M-F 8:00 am-1:00 pm
ESE	Quest Diagnostics	3980 Sheridan Dr Dent Tower Ste 314	Amherst	NY	14226-1727	Erie	PSC	716-839-0351	716-839-0353	M-F 9:00 am-3:00 pm
GF1	Quest Diagnostics	3620 Sheridan Dr Ste 100	Amherst	NY	14226-1631	Erie	PSC	716-833-1363	716-833-1369	M-F 6:00 am-5:00 pm|Sa 6:00 am-11:00 am; Drug Screen: M-F 6:00 am-4:00 pm|Sa 6:00 am-10:00 am
QUZ	Quest Diagnostics	3500 Main St University Plaza	Amherst	NY	14226-3120	Erie	PSC	716-835-3826	716-838-6674	M-F 6:30 am-2:30 pm; Drug Screen: M-F 6:30 am-1:30 pm
ZCG	Quest Diagnostics	4181 Transit Rd Transit Town Plaza	Amherst	NY	14221-7206	Erie	PSC	716-633-8354	716-633-8792	M-F 6:30 am-4:00 pm|Sa 6:00 am-11:00 am; Drug Screen: M-F 6:30 am-3:00 pm|Sa 6:00 am-10:00 am
L4Y	Quest Diagnostics	4233 Lake Ave Ste 2	Blasdell	NY	14219-0000	Erie	PSC	716-822-1122	716-822-1133	M-F 8:30 am-4:00 pm; Drug Screen: M-F 8:45 am-3:00 pm
LE2	Quest Diagnostics	155 Lawn Ave	Buffalo	NY	14207-1816	Erie	PSC	716-877-1113	716-877-1333	M-F 8:45 am-12:00 pm & 12:45 pm-4:30 pm; Drug Screen: M-F 9:00 am-11:00 am & 12:45 pm-3:30 pm; TSPOT: M-F 8:00 am-12:00 pm & 12:45 pm-1:00 pm
WE7	Quest Diagnostics	455 Delaware Ave	Buffalo	NY	14202-1514	Erie	PSC	716-855-2131	716-855-2151	M-F 6:30 am-3:00 pm|Sa 6:00 am-11:00 am; Drug Screen: M-F 6:30 am-2:00 pm|Sa 6:00 am-10:00 am; TSPOT: M-F 8:00 am-1:00 pm
YKQ	Quest Diagnostics	1317 Jefferson Ave	Buffalo	NY	14208-2102	Erie	PSC	716-882-3020	716-882-3139	M-F 9:00 am-4:30 pm; Drug Screen: M-F 9:00 am-3:30 pm
ZRS	Quest Diagnostics	2629 Delaware Ave Delaware Place Plaza	Buffalo	NY	14216-1722	Erie	PSC	716-874-1703	716-876-6081	M-F 5:00 am-1:00 pm|Sa 6:00 am-11:00 am; Drug Screen: M-F 5:00 am-12:00 pm|Sa 6:00 am-10:00 am
HRM	Quest Diagnostics	3842 Harlem Rd	Cheektowaga	NY	14215-1935	Erie	PSC	716-835-9522	716-835-8988	M-F 6:30 am-4:00 pm; Drug Screen: M-F 6:30 am-3:00 pm; TSPOT: M-F 8:00 am-1:00 pm
ZQH	Quest Diagnostics	1779 Walden Ave Ste 300	Cheektowaga	NY	14225-4930	Erie	PSC	716-894-1575	716-894-1673	M-F 5:30 am-1:30 pm; Drug Screen: M-F 5:30 am-12:30 pm
TRA	Quest Diagnostics	5340 Transit Rd	Depew	NY	14043-4334	Erie	PSC	716-681-5517	716-681-7491	M-F 6:00 am-4:00 pm|Sa 6:00 am-11:00 am; Drug Screen: M-F 7:00 am-3:00 pm|Sa 6:00 am-10:00 am
YWI	Quest Diagnostics	6970 Erie Rd Lower Level	Derby	NY	14047-9591	Erie	PSC	716-947-5201	716-947-5276	M-F 6:00 am-1:30 pm; Drug Screen: M-F 6:00 am-12:30 pm
AUO	Quest Diagnostics	268 Main St	East Aurora	NY	14052-1637	Erie	PSC	716-652-5327	716-652-1276	M-F 5:30 am-1:30 pm|Sa 6:00 am-11:00 am; Drug Screen: M-F 5:30 am-12:30 pm|Sa 6:00 am-10:00 am

Site Code	Site Name	Address	City	State	Zip	County	Site Type	Phone	Fax	Operation Hours
JI1	Quest Diagnostics	1738 Grand Island Blvd	Grand Island	NY	14072-2122	Erie	PSC	716-773-3040	716-773-3090	M-F 6:00 am-2:00 pm; Drug Screen: M-F 6:00 am-1:00 pm; TSPOT: M-F 8:00 am-1:00 pm
D15	Quest Diagnostics	5360 Southwestern Blvd	Hamburg	NY	14075-3596	Erie	PSC	866-697-8378		M-Su Vary
HBR	Quest Diagnostics	3674 Commerce Place Bldg 3, Ste A	Hamburg	NY	14075-3664	Erie	PSC	716-649-9171	716-649-7109	M-F 5:15 am-2:00 pm|Sa 6:00 am-11:00 am; Drug Screen: M-F 5:30 am-1:00 pm|Sa 6:00 am-10:00 am
ERZ	Quest Diagnostics	4845 Transit Rd	Lancaster	NY	14043-4783	Erie	PSC	716-656-0385	716-656-0158	M-F 5:00 am-1:30 pm; Drug Screen: M-F 5:00 am-12:30 pm
N1S	Quest Diagnostics	3041 Orchard Park Rd	Orchard Park	NY	14127-1208	Erie	PSC	716-677-9996	716-677-9998	M-F 5:00 am-3:00 pm|Sa 6:00 am-11:00 am; Drug Screen: M-F 5:00 am-2:00 pm|Sa 6:00 am-10:00 am
E5Y	Quest Diagnostics	231 S. Cascade Dr	Springville	NY	14141-0000	Erie	PSC	716-592-7755	716-592-7779	M-F 6:30 am-2:00 pm; Drug Screen: M-F 6:30 am-1:00 pm; TSPOT: M-F 8:00 am-1:00 pm
KNM	Quest Diagnostics	4041 Delaware Ave Ste 110	Tonawanda	NY	14150-6850	Erie	PSC	716-877-5040	716-877-0128	M-F 6:30 am-4:30 pm|Sa 6:00 am-11:00 am; Drug Screen: M-F 6:30 am-3:30 pm|Sa 6:00 am-10:00 am; TSPOT: M-F 8:00 am-1:00 pm
ESD	Quest Diagnostics	264 Center Rd	West Seneca	NY	14224-1947	Erie	PSC	716-677-6255	716-677-4845	M-F 5:30 am-2:00 pm; Drug Screen: M-F 5:30 am-1:00 pm
SNE	Quest Diagnostics	1106 Union Rd Southgate Plaza	West Seneca	NY	14224-3450	Erie	PSC	716-675-1505	716-675-1605	M-F 8:00 am-6:00 pm|Sa 6:00 am-11:00 am; Drug Screen: M-F 8:00 am-5:00 pm|Sa 6:00 am-10:00 am
WIE	Quest Diagnostics	1150 Youngs Rd	Williamsville	NY	14221-8053	Erie	PSC	716-688-7149	716-688-0454	M-F 7:00 am-4:00 pm; Drug Screen: M-F 7:00 am-3:00 pm; TSPOT: M-F 8:00 am-1:00 pm
BY8	Quest Diagnostics	1930 Saranac Ave The Outpost Professional Building Suite 205	Lake Placid	NY	12946-1171	Essex	PSC	518-523-2222	518-523-2277	M-F 7:00 am-11:00 am & 12:00 pm-3:00 pm
JTN	Quest Diagnostics	86 Briggs St Ste 2A	Johnstown	NY	12095-1566	Fulton	PSC	518-736-4665	518-736-4676	M-F 7:00 am-11:00 am & 12:00 pm-3:00 pm; Drug Screen: M-F 9:00 am-11:00 am & 12:00 pm-2:30 pm
D13	Quest Diagnostics	30 Catskill Cmns	Catskill	NY	12414-1755	Greene	PSC	866-697-8378		M-Su Vary
A5B	Quest Diagnostics	126 Wyckoff Avenue	Brooklyn	NY	11237-8072	Kings	PSC	718-576-6617	718-576-6619	M-F 8:00 am-11:30 am & 12:30 pm-3:00 pm|Sa 8:00 am-12:00 pm
BB9	Quest Diagnostics	408 Rockaway Ave	Brooklyn	NY	11212-5634	Kings	PSC	718-566-2320	718-566-2620	M-F 7:30 am-2:30 pm|Sa 9:00 am-1:00 pm; Drug Screen: M-F 10:00 am-12:00 pm & 1:00 pm-2:30 pm|Sa 10:00 am-12:30 pm
BGP	Quest Diagnostics	147 Greenpoint Ave 1st Fl	Brooklyn	NY	11222-2301	Kings	PSC	718-383-6785	718-383-7061	M-F 7:00 am-3:00 pm|Sa 7:00 am-12:00 pm; Drug Screen: M-F 9:00 am-3:00 pm|Sa 10:00 am-12:30 pm; TSPOT: M-F 8:00 am-1:00 pm
BKK	Quest Diagnostics	7601 4th Ave	Brooklyn	NY	11209-3207	Kings	PSC	718-833-2354	718-833-2521	M-F 8:00 am-5:00 pm|Sa 7:00 am-2:00 pm; Drug Screen: M-F 10:00 am-4:30 pm
BKN	Quest Diagnostics	1660 E 14th St Ste LL2	Brooklyn	NY	11229-1171	Kings	PSC	718-787-1025	718-787-1027	M-Th 7:00 am-3:30 pm|F,Sa 7:00 am-1:00 pm|Su 9:00 am-1:00 pm; Drug Screen: M-Th 10:00 am-3:00 pm|F 10:00 am-12:30 pm|Sa,Su 9:30 am-12:30 pm

Site Code	Site Name	Address	City	State	Zip	County	Site Type	Phone	Fax	Operation Hours
BKR	Quest Diagnostics	2035 Ralph Ave Ste B1	Brooklyn	NY	11234-5300	Kings	PSC	718-209-1678	718-209-1958	M-F 8:00 am-4:00 pm|Sa 7:00 am-12:00 pm; Drug Screen: M-F 10:00 am-3:30 pm|Sa 10:00 am-11:30 am
BRK	Quest Diagnostics	1272 51st St	Brooklyn	NY	11219-3517	Kings	PSC	718-853-3322	718-853-3838	M-F 8:00 am-3:30 pm; Drug Screen: M-F 10:00 am-2:30 pm
C82	Quest Diagnostics	275 Atlantic Ave	Brooklyn	NY	11201-5714	Kings	PSC	866-697-8378		T-Sa 7:00 am-6:00 pm
D27	Quest Diagnostics	450 Clarkson Ave	Brooklyn	NY	11203-2012	Kings	PSC	866-697-8378		M-Su Vary
EJM	Quest Diagnostics	15 Bay 29th St 2nd Fl	Brooklyn	NY	11214-4013	Kings	PSC	718-946-1934	347-482-1931	M-F 7:00 am-11:30 am & 12:30 pm-2:30 pm|Sa 7:00 am-1:00 pm; Drug Screen: M-F 10:00 am-2:00 pm|Sa 10:00 am-12:30 pm
F87	Quest Diagnostics	599 Winthrop St	Brooklyn	NY	11203-2651	Kings	PSC	866-697-8378		M-Su Vary
HQX	Quest Diagnostics	348 13th St Ste 102	Brooklyn	NY	11215-6177	Kings	PSC	718-965-1319	718-965-1847	M-F 7:00 am-3:00 pm|Sa 7:00 am-1:00 pm; Drug Screen: M-F 9:00 am-2:30 pm|Sa 9:00 am-12:30 pm
JFL	Quest Diagnostics	949 48th St	Brooklyn	NY	11219-2919	Kings	PSC	718-633-1834	718-854-1067	M-F 7:30 am-11:00 am & 12:00 pm-3:30 pm
JKL	Quest Diagnostics	1416 Newkirk Ave	Brooklyn	NY	11226-6522	Kings	PSC	718-859-3051	718-859-5081	M-F 8:00 am-4:00 pm|Sa 8:00 am-12:00 pm
NZG	Quest Diagnostics	101 Broadway Ste 302	Brooklyn	NY	11211-8663	Kings	PSC	718-384-0521	718-387-0250	M-F 8:30 am-11:30 am & 12:30 pm-3:30 pm|Su 9:00 am-1:00 pm; Drug Screen: M-F 10:00 am-11:30 am & 12:30 pm-3:30 pm|Su 10:00 am-12:30 pm
P5W	Quest Diagnostics	726 58Th Street Lower Level	Brooklyn	NY	11220-3917	Kings	PSC	347-668-0891	718-439-0996	M-F 8:00 am-12:00 pm & 1:00 pm-3:30 pm|Sa 8:00 am-2:00 pm
Q5D	Quest Diagnostics	1000 Church Ave	Brooklyn	NY	11218-2710	Kings	PSC	718-282-2828	718-282-2822	M-F 8:00 am-5:00 pm
Q5E	Quest Diagnostics	101 Pennsylvania Ave	Brooklyn	NY	11207-2428	Kings	PSC	917-909-6609	718-342-3228	M-F 8:00 am-5:00 pm
Q5F	Quest Diagnostics	195 Montague St Fl 2	Brooklyn	NY	11201-3631	Kings	PSC	718-797-2727	718-797-2929	M-F 8:00 am-5:00 pm; TSPOT: M-F 8:00 am-1:00 pm
Q5G	Quest Diagnostics	740 64Th St	Brooklyn	NY	11220-4714	Kings	PSC	718-833-2223	718-833-2233	M-F 8:00 am-4:00 pm|Sa 8:00 am-1:00 pm
R2G	Quest Diagnostics	224-226 Atlantic Ave	Brooklyn	NY	11201-5727	Kings	PSC	718-797-1122	718-797-1234	M-F 7:00 am-5:00 pm|Sa 7:00 am-1:00 pm; Drug Screen: M-F 10:00 am-5:00 pm
R5B	Quest Diagnostics	3245 Nostrand Ave	Brooklyn	NY	11229-3716	Kings	PSC	718-339-2727	718-339-2799	M-F 8:00 am-12:00 pm & 1:00 pm-5:00 pm
R5C	Quest Diagnostics	546 Eastern Pkwy	Brooklyn	NY	11225-1604	Kings	PSC	718-221-1818	718-221-1811	M-F 8:00 am-12:00 pm & 1:00 pm-5:00 pm

Site Code	Site Name	Address	City	State	Zip	County	Site Type	Phone	Fax	Operation Hours
R5H	Quest Diagnostics	447 Atlantic Ave	Brooklyn	NY	11217-1702	Kings	PSC	718-522-5567	718-522-5255	M-F 8:00 am-5:00 pm
S5B	Quest Diagnostics	233 Nostrand Ave	Brooklyn	NY	11205-4924	Kings	PSC	718-622-2626	718-622-2929	M-F 8:00 am-12:00 pm & 1:00 pm-5:00 pm
TYS	Quest Diagnostics	82 Church Ave	Brooklyn	NY	11218-5152	Kings	PSC	718-438-1111	718-438-1141	M-F 8:00 am-3:00 pm; Drug Screen: M-F 10:00 am-2:30 pm
D16	Quest Diagnostics	2024 Genesee St	Oneida	NY	13421-2680	Madison	PSC	866-697-8378		M-Su Vary
J1O	Quest Diagnostics	1340 Riverfront Center	Amsterdam	NY	12010-4610	Montgomery	PSC	518-842-2244	518-842-2254	M-F 7:00 am-11:00 am & 12:00 pm-3:00 pm; Drug Screen: M-F 10:00 am-11:00 am & 12:00 pm-2:30 pm
BBN	Quest Diagnostics	4276 Hempstead Tpke	Bethpage	NY	11714-5721	Nassau	PSC	516-677-7701	516-579-8716	M-F 6:00 am-3:30 pm|Sa 6:00 am-12:00 pm; Drug Screen: M-F 10:00 am-3:00 pm
CDU	Quest Diagnostics	222 Rockaway Tpke Ste 6	Cedarhurst	NY	11516-1833	Nassau	PSC	516-677-7703	516-239-0597	M-F 7:00 am-3:00 pm|Sa 7:00 am-12:00 pm|Su 8:00 am-12:00 pm; Drug Screen: M-F 10:00 am-2:30 pm|Sa,Su 10:00 am-11:30 am
FPK	Quest Diagnostics	265 Jericho Tpke	Floral Park	NY	11001-2146	Nassau	PSC	516-677-7704	516-327-8949	M-F 6:30 am-3:00 pm|Sa 6:00 am-12:00 pm; Drug Screen: M-F 10:00 am-2:30 pm|Sa 10:00 am-11:30 am
FRR	Quest Diagnostics	101 South Bergen Pl 2nd Fl	Freeport	NY	11520-3357	Nassau	PSC	516-677-7705	516-379-6744	M,T,Th,F 7:00 am-3:00 pm|W 7:00 am-1:00 pm|Sa 7:00 am-12:00 pm; Drug Screen: M,T,Th,F 10:00 am-3:00 pm|W 10:00 am-11:45 am
GDC	Quest Diagnostics	520 Franklin Ave Ste 104	Garden City	NY	11530-5801	Nassau	PSC	516-677-7706	516-294-1841	M-F 6:30 am-3:00 pm|Sa 7:00 am-12:00 pm; Drug Screen: M-F 10:00 am-2:30 pm|Sa 10:00 am-11:30 am
HNY	Quest Diagnostics	391B Fulton Ave	Hempstead	NY	11550-4127	Nassau	PSC	516-677-7709	516-559-8608	M-F 7:00 am-12:30 pm & 1:30 pm-3:00 pm; Drug Screen: M-F 10:00 am-12:30 pm & 1:30 pm-2:30 pm
LS	Quest Diagnostics	2001 Marcus Ave Ste 98W Lobby Level	Lake Success	NY	11042-1011	Nassau	PSC	516-677-7710	516-326-8503	M,T 7:00 am-2:00 pm|W-F 7:00 am-3:30 pm|Sa 7:00 am-12:00 pm; Drug Screen: M,T 10:00 am-1:30 pm|W-F 10:00 am-3:00 pm|Sa 10:00 am-11:30 am
GNH	Quest Diagnostics	4900 Merrick Road 2nd Fl	Massapequa Park	NY	11762-3807	Nassau	PSC	516-677-7736	516-798-2137	M-F 6:00 am-3:30 pm|Sa 6:00 am-12:00 pm; Drug Screen: M-F 10:00 am-3:00 pm
WWZ	Quest Diagnostics	2209 Merrick Rd 2nd Fl	Merrick	NY	11566-4786	Nassau	PSC	516-771-0214	516-771-0232	M,W,F 7:00 am-3:30 pm|T,Th 7:00 am-5:00 pm|Sa 8:00 am-12:00 pm; Drug Screen: M-F 10:00 am-3:00 pm
W2G	Quest Diagnostics	212 Station Plz N	Mineola	NY	11501-3802	Nassau	PSC	516-677-7712	516-747-7577	M,T,Th,F 7:00 am-3:00 pm|W 7:00 am-7:00 pm|Sa 7:00 am-12:00 pm; Drug Screen: M,T,Th,F 10:00 am-2:30 pm|W 10:00 am-6:30 pm|Sa 10:00 am-11:30 am
AUL	Quest Diagnostics	146A Manetto Hill Rd Ste101	Plainview	NY	11803-1323	Nassau	PSC	516-677-7713	516-681-8482	M-F 6:00 am-3:00 pm|Sa 6:00 am-12:00 pm; Drug Screen: M-F 6:00 am-2:30 pm|Sa 6:00 am-11:30 am
RKE	Quest Diagnostics	165 North Village Ave Ste 103	Rockville Centre	NY	11570-3701	Nassau	PSC	516-677-7715	516-678-0890	M-F 6:30 am-3:00 pm|Sa 6:30 am-12:00 pm; Drug Screen: M-F 10:00 am-2:30 pm
V6S	Quest Diagnostics	1502 Old Northern Blvd	Roslyn	NY	11576-1126	Nassau	PSC	516-626-6036	516-626-2577	M-F 7:00 am-11:30 am & 12:30 pm-2:00 pm|Sa 8:00 am-12:00 pm; Drug Screen: M-F 8:00 am-11:30 am & 12:30 pm-1:00 pm|Sa 9:00 am-11:00 am; TSPOT: M-F 8:00 am-1:00 pm

Site Code	Site Name	Address	City	State	Zip	County	Site Type	Phone	Fax	Operation Hours
EHQ	Quest Diagnostics	850 Hicksville Rd Ste 114	Seaford	NY	11783-1300	Nassau	PSC	516-677-7716	516-735-0820	M-F 6:00 am-3:30 pm|Sa 6:00 am-12:00 pm; Drug Screen: M-F 10:00 am-3:00 pm|Sa 8:00 am-11:30 am
J3D	Quest Diagnostics	269 Jericho Tpke	Syosset	NY	11791-4502	Nassau	PSC	516-677-5355	516-677-5499	M-F 6:00 am-4:00 pm|Sa 6:00 am-12:00 pm; Drug Screen: M-F 6:30 am-3:30 pm|Sa 6:00 am-11:30 am
A5E	Quest Diagnostics	385 Ft. Washington Avenue	New York	NY	10033-6740	New York	PSC	212-928-9200	212-928-3921	M-F 8:00 am-12:00 pm & 1:00 pm-3:30 pm|Sa 9:00 am-12:00 pm
C88	Quest Diagnostics	125 White St	New York	NY	10013-4497	New York	PSC	866-697-8378		T-Sa 7:00 am-6:00 pm
CE9	Quest Diagnostics	21 E 22nd St 1st Fl	New York	NY	10010-5332	New York	PSC	212-228-7788	212-228-7881	M-F 8:30 am-4:30 pm
D46	Quest Diagnostics	1 Police Plz	New York	NY	10038-1403	New York	PSC	866-697-8378		M-Su Vary
D49	Quest Diagnostics	1 Police Plz Serology Only	New York	NY	10038-1403	New York	PSC	866-697-8378		M-Su Vary
DE1	Quest Diagnostics	224 East 96th St	New York	NY	10128-3802	New York	PSC	212-348-7700	212-876-9103	M-F 8:00 am-4:00 pm|Sa 8:00 am-12:00 pm; Drug Screen: M-F 10:00 am-3:30 pm|Sa 10:00 am-11:30 am
DE2	Quest Diagnostics	215 W 125th St	New York	NY	10027-4426	New York	PSC	212-222-3211	212-222-3611	M-F 8:30 am-12:00 pm & 1:00 pm-5:00 pm; Drug Screen: M-F 9:00 am-4:00 pm
F20	Quest Diagnostics	52 Chambers St	New York	NY	10007-1222	New York	PSC	866-697-8378		M-Su Vary
HAT	Quest Diagnostics	137 East 36th St Ste 7	New York	NY	10016-3528	New York	PSC	212-251-0018	212-683-6503	M-F 8:00 am-4:00 pm; Drug Screen: M-F 10:00 am-4:00 pm
JTK	Quest Diagnostics	4071 Broadway	New York	NY	10032-1511	New York	PSC	917-521-0370	917-521-0548	M-F 8:00 am-12:00 pm & 1:00 pm-4:00 pm; Drug Screen: M-F 10:00 am-12:00 pm & 1:00 pm-3:30 pm
KWV	Quest Diagnostics	331 W 57Th Street	New York	NY	10019-3101	New York	PSC	212-757-4242	212-757-4844	M-F 8:00 am-4:00 pm; Drug Screen: M-F 10:00 am-3:30 pm
NEY	Quest Diagnostics	2 W 86th St Apt 1A	New York	NY	10024-3625	New York	PSC	212-873-8757	212-873-1993	M-F 8:00 am-4:00 pm; Drug Screen: M-F 8:00 am-3:30 pm
NNY	Quest Diagnostics	65 E 76th St	New York	NY	10021-1844	New York	PSC	212-794-6400	212-879-2379	M-F 8:00 am-4:00 pm|Sa 8:00 am-12:00 pm; Drug Screen: M-F 10:00 am-3:30 pm
Q5I	Quest Diagnostics	590 5Th Avenue	New York	NY	10036-4702	New York	PSC	212-221-1131	212-221-1311	M-F 8:00 am-12:00 pm & 1:00 pm-4:00 pm|Sa Vary
QWE	Quest Diagnostics	314 W 14th St. 3rd Fl	New York	NY	10014-5002	New York	PSC	646-336-0962	646-638-0517	M-F 8:00 am-4:00 pm
SIX	Quest Diagnostics	115 E 57th St Ste 1530	New York	NY	10022-2100	New York	PSC	212-909-8009	212-759-5236	M-F 8:00 am-4:00 pm|Sa 8:00 am-12:00 pm; Drug Screen: M-F 10:00 am-4:00 pm|Sa 10:00 am-11:30 am

Site Code	Site Name	Address	City	State	Zip	County	Site Type	Phone	Fax	Operation Hours
T2O	Quest Diagnostics	160 W 26Th St Ste 201	New York	NY	10001-6975	New York	PSC	646-336-8031	646-336-8049	M-F 8:00 am-12:00 pm & 1:00 pm-4:00 pm
VFB	Quest Diagnostics	41 Elizabeth St Ste 702	New York	NY	10013-4637	New York	PSC	212-374-2255	212-374-2257	M-F 7:30 am-3:30 pm|Sa 9:00 am-4:00 pm; Drug Screen: M-F 10:00 am-3:00 pm|Sa 10:00 am-3:30 pm
Y6M	Quest Diagnostics	268 3Rd Ave	New York	NY	10010-6313	New York	PSC	646-933-8014	212-777-7699	M-F 8:00 am-4:00 pm; Drug Screen: M-F 9:00 am-3:00 pm; TSPOT: M-F 8:00 am-1:00 pm
YGO	Quest Diagnostics	139 Centre St Ste 207	New York	NY	10013-4552	New York	PSC	212-343-0242	212-343-0297	M-F 8:00 am-4:00 pm|Sa 8:00 am-12:00 pm; Drug Screen: M-F 10:00 am-4:00 pm|Sa 10:00 am-11:30 am; TSPOT: M-F 8:00 am-1:00 pm
R7J	Quest Diagnostics	790 Center St	Lewiston	NY	14092-1706	Niagara	PSC	716-754-1670	716-754-2162	M-F 5:30 am-1:00 pm|Sa 6:00 am-10:00 am; Drug Screen: M-F 6:00 am-12:00 pm|Sa 6:00 am-9:00 am
GC3	Quest Diagnostics	5891 S Transit Rd	Lockport	NY	14094-6305	Niagara	PSC	716-433-8944	716-433-3284	M-F 5:30 am-4:30 pm|Sa 6:00 am-11:00 am; Drug Screen: M-F 5:30 am-3:30 pm|Sa 6:00 am-10:00 am; TSPOT: M-F 8:00 am-1:00 pm
QKR	Quest Diagnostics	2735 Main St	Newfane	NY	14108-1203	Niagara	PSC	716-778-7353	716-778-7478	M-F 7:00 am-3:00 pm; Drug Screen: M-F 7:00 am-2:00 pm; TSPOT: M-F 8:00 am-1:00 pm
WPV	Quest Diagnostics	1370 Military Rd	Niagara Falls	NY	14304-1730	Niagara	PSC	716-297-7105	716-297-7185	M-F 6:00 am-4:30 pm|Sa 6:00 am-11:00 am; Drug Screen: M-F 6:00 am-3:00 pm|Sa 6:00 am-10:00 am; TSPOT: M-F 8:00 am-1:00 pm
ZQL	Quest Diagnostics	742 Portage Rd Haeberle Plaza	Niagara Falls	NY	14301-1924	Niagara	PSC	716-285-4619	716-285-9548	M-F 6:00 am-1:45 pm; Drug Screen: M-F 6:00 am-12:45 pm
XJY	Quest Diagnostics	301 Meadow Dr Unit 76	North Tonawanda	NY	14120-2819	Niagara	PSC	716-694-9558	716-692-8365	M-F 5:00 am-1:00 pm|Sa 6:00 am-11:00 am; Drug Screen: M-F 5:00 am-12:00 pm|Sa 6:00 am-10:00 am
XC8	Quest Diagnostics	1790 Black River Blvd Ste 19	Rome	NY	13440-2454	Oneida	PSC	315-339-0520	315-339-0545	M-F 6:30 am-11:30 am & 12:30 pm-2:00 pm; Drug Screen: M-F 6:30 am-11:00 am & 12:30 pm-1:30 pm; TSPOT: M-F 8:00 am-1:00 pm
YC1	Quest Diagnostics	2002 Genesee St	Utica	NY	13502-5628	Oneida	PSC	315-735-5636	315-735-5686	M-F 6:00 am-3:00 pm|Sa 7:00 am-11:00 am; Drug Screen: M-F 10:00 am-2:00 pm|Sa 8:00 am-10:00 am; TSPOT: M-F 8:00 am-1:00 pm
A3W	Quest Diagnostics	138 E Genesee St	Baldwinsville	NY	13027-2720	Onondaga	PSC	315-635-3353	315-635-3363	M-F 7:30 am-1:00 pm & 2:00 pm-4:00 pm|Sa 9:00 am-12:00 pm; Drug Screen: M-F 8:00 am-12:30 pm & 2:00 pm-3:00 pm|Sa 9:00 am-11:30 am; TSPOT: M-F 8:00 am-1:00 pm
XC7	Quest Diagnostics	5366 W Genesee St	Camillus	NY	13031-2252	Onondaga	PSC	315-468-0597	315-468-0598	M-W 7:30 am-12:30 pm & 1:00 pm-3:00 pm|Th,F 7:30 am-12:30 pm; Drug Screen: M-W 7:30 am-12:30 pm & 1:00 pm-2:30 pm|Th,F 7:30 am-12:00 pm; TSPOT: M-W 7:30 am-1:00 pm|Th,F 7:30 am-10:30 am
JXC	Quest Diagnostics	5586 Legionnaire Dr Ste 7	Cicero	NY	13039-3504	Onondaga	PSC	315-699-7161	315-699-7561	M-F 7:00 am-12:30 pm; Drug Screen: M-F 8:00 am-12:00 pm; TSPOT: M-F 8:00 am-1:00 pm
L4E	Quest Diagnostics	4820 W Taft Rd Ste 204	Liverpool	NY	13088-2806	Onondaga	PSC	315-451-5554	315-451-5558	M-F 7:30 am-12:00 pm & 12:30 pm-3:45 pm|Sa 7:00 am-12:00 pm; Drug Screen: M-F 10:00 am-12:00 pm & 12:30 pm-2:30 pm|Sa 8:00 am-11:00 am; TSPOT: M-F 8:00 am-1:00 pm
HLL	Quest Diagnostics	1000 East Genesee St Hill Medical Building Ste 200	Syracuse	NY	13210-1885	Onondaga	PSC	315-471-3627	315-475-6941	M-F 7:30 am-3:30 pm; Drug Screen: M-F 10:00 am-2:30 pm; TSPOT: M-F 8:00 am-1:00 pm
XC9	Quest Diagnostics	396 Grant Blvd.	Syracuse	NY	13206-2601	Onondaga	PSC	315-433-2321	315-433-2363	M-F 7:00 am-2:30 pm; Drug Screen: M-F 7:30 am-2:00 pm; TSPOT: M-F 8:00 am-1:00 pm

Site Code	Site Name	Address	City	State	Zip	County	Site Type	Phone	Fax	Operation Hours
GHN	Quest Diagnostics	30 Hatfield Ln	Goshen	NY	10924-6766	Orange	PSC	845-615-1453	845-615-1409	M-F 7:30 am-4:00 pm|Sa 8:00 am-12:00 pm; Drug Screen: M-F 10:00 am-3:00 pm|Sa 10:00 am-11:00 am
NKD	Quest Diagnostics	791 Route 17M Monroe Shopping Center	Monroe	NY	10950-2620	Orange	PSC	845-783-3889	845-783-3903	M-F 7:00 am-3:00 pm; Drug Screen: M-F 7:00 am-3:00 pm
NGK	Quest Diagnostics	347 Fullerton Ave	Newburgh	NY	12550-3726	Orange	PSC	845-562-2107	845-562-1626	M-F 6:30 am-3:00 pm|Sa 8:00 am-12:00 pm; Drug Screen: M-F 10:00 am-3:00 pm|Sa 10:00 am-11:30 am
GYP	Quest Diagnostics	667 Stoneleigh Ave Ste 115	Carmel	NY	10512-2454	Putnam	PSC	845-278-6953	845-278-6955	M-W,F 7:30 am-12:00 pm & 1:00 pm-3:00 pm|Th 7:30 am-12:00 pm & 1:00 pm-3:15 pm|Sa 8:00 am-12:00 pm; Drug Screen: M-F 8:00 am-12:00 pm & 1:00 pm-2:00 pm|Sa 8:00 am-11:30 am
ASA	Quest Diagnostics	27-47 Crescent St Lower Level Ste 102-103	Astoria	NY	11102-3142	Queens	PSC	718-545-2488	718-545-3097	M-F 7:00 am-3:30 pm|Sa 8:00 am-12:00 pm; Drug Screen: M-F 10:00 am-2:30 pm|Sa 10:00 am-12:00 pm
YBC	Quest Diagnostics	3014 37th St	Astoria	NY	11103-3809	Queens	PSC	718-777-2125	718-777-2176	M-F 9:00 am-1:00 pm & 2:00 pm-4:00 pm|Sa 8:00 am-12:00 pm; Drug Screen: M-F 10:00 am-1:00 pm & 2:00 pm-3:30 pm
BSD	Quest Diagnostics	44 - 02 Francis Lewis Blvd Ste 1A	Bayside	NY	11361-3041	Queens	PSC	718-279-0008	718-428-5674	M-F 7:00 am-3:30 pm|Sa 7:00 am-1:00 pm
C85	Quest Diagnostics	1515 Hazen St	East Elmhurst	NY	11370-1381	Queens	PSC	866-697-8378		T-Sa 6:00 am-9:00 pm
F88	Quest Diagnostics	7520 Astoria Blvd Fdny- All-cdc Serology Only	East Elmhurst	NY	11370-1138	Queens	PSC	866-697-8378		M-Su Vary
F90	Quest Diagnostics	7520 Astoria Blvd	East Elmhurst	NY	11370-1138	Queens	PSC	866-697-8378		M-Su Vary
F91	Quest Diagnostics	7520 Astoria Blvd Nyc H&h- All-cdc Serology Only	East Elmhurst	NY	11370-1138	Queens	PSC	866-697-8378		M-Su Vary
YRD	Quest Diagnostics	40 08 Forley St	Elmhurst	NY	11373-1427	Queens	PSC	718-476-7926	718-476-7946	M-F 8:00 am-3:30 pm|Sa 8:00 am-12:00 pm; Drug Screen: M,T,Th,F 10:00 am-3:30 pm|W 10:00 am-2:00 pm|Sa 10:00 am-11:30 am
LDX	Quest Diagnostics	136-20 38th Ave 4th Fl Ste CFA	Flushing	NY	11354-4277	Queens	PSC	718-886-5984	718-886-5986	M-F 7:00 am-3:30 pm|Sa,Su 8:00 am-12:00 pm; Drug Screen: M-F 10:00 am-3:30 pm|Sa,Su 10:00 am-12:00 pm
FHL	Quest Diagnostics	7010 Austin St 2nd Fl Ste 201	Forest Hills	NY	11375-1021	Queens	PSC	718-544-0376	718-520-6534	M-F 7:00 am-5:00 pm|Sa 7:00 am-1:00 pm; Drug Screen: M-F 10:00 am-4:30 pm|Sa 10:00 am-12:30 pm
HBN	Quest Diagnostics	82-29 153rd Ave Lindenwood Village Shopping Center	Howard Beach	NY	11414-1751	Queens	PSC	718-323-3687	718-323-3788	M-F 7:00 am-3:00 pm|Sa 8:00 am-1:00 pm; Drug Screen: M-F 9:00 am-2:30 pm|Sa 10:00 am-12:30 pm
CU3	Quest Diagnostics	16624 Jamaica Ave	Jamaica	NY	11432-5241	Queens	PSC	718-291-4022	718-291-4055	M-F 8:00 am-3:00 pm|Sa 8:00 am-12:00 pm; Drug Screen: M-F 9:00 am-2:30 pm|Sa 9:00 am-11:30 am
MIV	Quest Diagnostics	6122 Fresh Pond Rd	Middle Village	NY	11379-1233	Queens	PSC	718-366-8636	718-366-8696	M-F 6:30 am-3:30 pm|Sa 7:00 am-1:00 pm; Drug Screen: M-F 10:00 am-3:30 pm|Sa 10:00 am-12:30 pm
AAD	Quest Diagnostics	3733 Richmond Ave	Staten Island	NY	10312-3856	Richmond	PSC	718-967-6433	718-967-7154	M-F 7:00 am-5:00 pm|Sa 7:00 am-1:00 pm; Drug Screen: M-F 10:00 am-4:30 pm|Sa 10:00 am-12:30 pm

Site Code	Site Name	Address	City	State	Zip	County	Site Type	Phone	Fax	Operation Hours
HYL	Quest Diagnostics	2627 Hylan Blvd Bldg A	Staten Island	NY	10306-4320	Richmond	PSC	718-351-3574	718-980-3426	M-F 7:00 am-3:30 pm|Sa 7:00 am-1:00 pm; Drug Screen: M-F 10:00 am-3:00 pm|Sa 10:00 am-12:30 pm
KKL	Quest Diagnostics	4855 Hylan Blvd	Staten Island	NY	10312-6319	Richmond	PSC	718-948-2892	718-967-3052	M-F 7:00 am-3:30 pm|Sa 7:00 am-1:00 pm; Drug Screen: M-F 10:00 am-3:00 pm|Sa 10:00 am-12:30 pm
SIB	Quest Diagnostics	1361 Hylan Blvd	Staten Island	NY	10305-1978	Richmond	PSC	718-979-5481	718-980-9179	M-F 6:30 am-4:00 pm|Sa 7:00 am-1:00 pm; Drug Screen: M-F 10:00 am-3:30 pm|Sa 10:00 am-12:30 pm
SIE	Quest Diagnostics	653 Forest Ave	Staten Island	NY	10310-2517	Richmond	PSC	718-442-2822	718-442-2866	M-F 7:00 am-3:30 pm
SNU	Quest Diagnostics	78 Todt Hill Rd Ste 109	Staten Island	NY	10314-4528	Richmond	PSC	718-816-7782	718-816-1498	M-F 7:00 am-5:00 pm|Sa 7:00 am-1:00 pm; Drug Screen: M-F 10:00 am-4:30 pm|Sa 10:00 am-12:30 pm
TNV	Quest Diagnostics	7001 Amboy Rd Tottenville Square Shopping Center	Staten Island	NY	10307-1444	Richmond	PSC	718-227-9961	718-227-4469	M-F 7:00 am-3:30 pm|Sa 7:00 am-1:00 pm; Drug Screen: M-F 10:00 am-3:00 pm|Sa 10:00 am-12:30 pm
VIC	Quest Diagnostics	651 Willowbrook Rd	Staten Island	NY	10314-6809	Richmond	PSC	718-494-4660	718-698-9378	M-F 7:00 am-3:30 pm|Sa 7:00 am-1:00 pm; Drug Screen: M-F 10:00 am-3:00 pm|Sa 10:00 am-12:30 pm
XLM	Quest Diagnostics	1460 Victory Blvd	Staten Island	NY	10310-3914	Richmond	PSC	718-447-6317	718-447-6374	M-F 7:00 am-3:30 pm|Sa 7:00 am-12:00 pm; Drug Screen: M-F 10:00 am-3:00 pm|Sa 10:00 am-11:30 am
NU	Quest Diagnostics	420 Market St	Nanuet	NY	10954-2744	Rockland	PSC	845-623-8220	845-623-7686	M-F 7:30 am-4:00 pm|Sa 8:00 am-12:00 pm; Drug Screen: M-F 10:00 am-3:30 pm|Sa 8:00 am-11:30 am
NCI	Quest Diagnostics	151 N Main St Unit 307	New City	NY	10956-3851	Rockland	PSC	845-634-2712	845-634-2715	M-F 6:30 am-2:30 pm|Sa 7:30 am-11:30 am; Drug Screen: M-F 10:00 am-3:00 pm|Sa 10:00 am-11:00 am
PNA	Quest Diagnostics	978 Route 45 Ste 202	Pomona	NY	10970-3528	Rockland	PSC	845-354-2412	845-354-2759	M-F 8:00 am-4:00 pm|Sa 8:00 am-12:00 pm; Drug Screen: M-F 10:00 am-3:00 pm|Sa 8:00 am-11:00 am
SUF	Quest Diagnostics	Indian Rock Shopping Center Route 59 & Hemion Road	Suffern	NY	10901-4822	Rockland	PSC	845-369-1487	845-369-1464	M-F 7:30 am-3:00 pm; Drug Screen: M-F 10:00 am-2:00 pm
MW1	Quest Diagnostics	2106 Ellsworth Blvd	Malta	NY	12020-3349	Saratoga	PSC	518-289-5219	518-400-1777	M-F 7:00 am-11:00 am & 12:00 pm-3:00 pm; Drug Screen: M-F 10:00 am-11:00 am & 12:00 pm-2:30 pm
AY8	Quest Diagnostics	1478 State St	Schenectady	NY	12304-2917	Schenectady	PSC	518-410-9570	518-388-8559	M-F 7:00 am-12:00 pm & 1:00 pm-3:00 pm; Drug Screen: M-F 10:00 am-12:00 pm & 1:00 pm-2:30 pm
BY9	Quest Diagnostics	571 Main St	Cobleskill	NY	12043-4102	Schoharie	PSC	518-461-7235	518-234-2244	M-F 7:00 am-11:00 am & 12:00 pm-3:00 pm
ZAA	Quest Diagnostics	500 West Main St Suite 202-203	Babylon	NY	11702-3009	Suffolk	PSC	516-677-7718	631-321-0214	M-F 6:30 am-3:30 pm|Sa 6:30 am-12:00 pm; Drug Screen: M-Th 10:00 am-4:00 pm|F 10:00 am-3:00 pm|Sa 10:00 am-11:30 am
BHR	Quest Diagnostics	8 Saxon Ave Ste D	Bay Shore	NY	11706-7036	Suffolk	PSC	516-677-7719	631-969-7843	M-F 6:00 am-3:30 pm|Sa 6:00 am-12:00 pm; Drug Screen: M-F 10:00 am-3:00 pm
SYS	Quest Diagnostics	534 Montauk Hwy	Center Moriches	NY	11934-2207	Suffolk	PSC	516-677-7720	631-878-5938	M-F 6:00 am-3:30 pm|Sa 6:00 am-12:00 pm

Site Code	Site Name	Address	City	State	Zip	County	Site Type	Phone	Fax	Operation Hours
LMC	Quest Diagnostics	2171 Jericho Tpke Ste 102	Commack	NY	11725-3412	Suffolk	PSC	516-677-7721	631-499-4956	M-F 6:00 am-3:30 pm|Sa 7:00 am-12:00 pm; Drug Screen: M-F 6:00 am-2:30 pm
EB	Quest Diagnostics	285 Sills Rd Bldg 8 Ste A	East Patchogue	NY	11772-4869	Suffolk	PSC	516-677-7728	631-475-6956	M,W-F 6:00 am-3:30 pm|T 6:00 am-6:00 pm|Sa 6:00 am-12:00 pm; Drug Screen: M,W-F 10:00 am-3:00 pm|T 10:00 am-5:30 pm
DTW	Quest Diagnostics	23 Technology Dr Ste 2	East Setauket	NY	11733-4069	Suffolk	PSC	516-677-7723	631-751-7882	M-F 6:30 am-3:30 pm|Sa 6:30 am-12:00 pm; Drug Screen: M-F 10:00 am-3:00 pm
DTX	Quest Diagnostics	490 Wheeler Rd Ste 190	Hauppauge	NY	11788-4372	Suffolk	PSC	516-677-7724	631-273-6348	M-F 6:00 am-2:30 pm|Sa 6:00 am-12:00 pm; Drug Screen: M-F 10:00 am-2:00 pm
HUG	Quest Diagnostics	175 E Main St Ste 105	Huntington	NY	11743-2912	Suffolk	PSC	631-421-2682	631-421-2687	M-F 7:00 am-3:30 pm|Sa 7:00 am-12:00 pm; Drug Screen: M-F 10:00 am-3:00 pm
DTY	Quest Diagnostics	570 Expressway Dr South Ste 1J	Medford	NY	11763-2049	Suffolk	PSC	516-677-7727	631-447-0953	M-F 6:00 am-2:30 pm|Sa 6:00 am-12:00 pm; Drug Screen: M-F 10:00 am-2:00 pm
PJF	Quest Diagnostics	1010 Route 112 2nd Fl	Port Jefferson Station	NY	11776-2054	Suffolk	PSC	516-677-7729	631-476-3634	M-F 6:30 am-3:30 pm|Sa 6:30 am-12:00 pm; Drug Screen: M-F 10:00 am-3:00 pm|Sa 10:00 am-11:30 am
J5D	Quest Diagnostics	889 Harrison Avenue	Riverhead	NY	11901-2090	Suffolk	PSC	631-727-7727	631-727-7771	M-F 6:00 am-3:00 pm|Sa 6:00 am-12:00 pm; Drug Screen: M-F 7:00 am-2:30 pm
L7B	Quest Diagnostics	160 Middle Rd	Sayville	NY	11782-3126	Suffolk	PSC	516-677-7734	631-567-1665	M-F 7:00 am-3:00 pm|Sa 7:00 am-12:00 pm; Drug Screen: M-F 10:00 am-2:30 pm|Sa 9:00 am-11:00 am; TSPOT: M-F 8:00 am-1:00 pm
V6T	Quest Diagnostics	91 College Plaza Unit A	Selden	NY	11784-4034	Suffolk	PSC	516-677-7731	631-698-0251	M-F 7:00 am-3:30 pm|Sa 7:00 am-12:00 pm; Drug Screen: M-F 10:00 am-2:00 pm; TSPOT: M-F 8:00 am-1:00 pm
SME	Quest Diagnostics	222 Middle Country Rd Ste 107	Smithtown	NY	11787-2814	Suffolk	PSC	516-677-7732	631-360-2738	M-F 6:00 am-3:30 pm|Sa 6:00 am-12:00 pm; Drug Screen: M-F 10:00 am-3:00 pm; TSPOT: M-Sa 8:00 am-1:00 pm
WDV	Quest Diagnostics	6144 Route 25A Bldg B Ste 8	Wading River	NY	11792-2018	Suffolk	PSC	516-677-7733	631-929-7382	M 6:30 am-4:30 pm|T-F 6:30 am-3:00 pm; Drug Screen: M 10:00 am-3:30 pm|T-F 10:00 am-2:30 pm
GRX	Quest Diagnostics	380 Washington Ave Ste A	Kingston	NY	12401-3702	Ulster	PSC	845-340-0673	845-340-0675	M-F 7:00 am-4:30 pm|Sa 8:00 am-12:00 pm; Drug Screen: M-F 10:00 am-4:00 pm|Sa 10:00 am-11:30 am
GFQ	Quest Diagnostics	246 Main St Ste 202	New Paltz	NY	12561-1608	Ulster	PSC	845-255-6309	845-255-8057	M-F 7:00 am-12:00 pm; Drug Screen: M-F 10:00 am-11:00 am
FQW	Quest Diagnostics	330 Route 212 Old Grand Union Plaza	Saugerties	NY	12477-5122	Ulster	PSC	845-246-5760	845-246-6863	M-F 7:00 am-12:00 pm & 1:00 pm-2:30 pm; Drug Screen: M-F 10:00 am-12:00 pm & 1:00 pm-2:00 pm
CM2	Quest Diagnostics	295 Main St Suite 22	North Creek	NY	12853-2207	Warren	PSC	518-251-0101	518-251-0102	M-F 7:00 am-11:00 am & 12:00 pm-3:00 pm
MUV	Quest Diagnostics	105 Stevens Ave Ste 205	Mount Vernon	NY	10550-2680	Westchester	PSC	914-664-3400	914-699-4136	M-F 7:00 am-11:00 am & 12:00 pm-3:00 pm|Sa 8:00 am-12:00 pm; Drug Screen: M-F 10:00 am-11:00 am & 12:00 pm-2:30 pm|Sa 10:00 am-11:30 am
LXA	Quest Diagnostics	83 South Bedford Rd 3rd Fl	Mt. Kisco	NY	10549-3457	Westchester	PSC	914-666-7654	914-666-8112	M-F 7:30 am-12:00 pm & 1:00 pm-3:00 pm; Drug Screen: M-F 7:30 am-12:00 pm

Site Code	Site Name	Address	City	State	Zip	County	Site Type	Phone	Fax	Operation Hours
NRE	Quest Diagnostics	150 Lockwood Ave Ste 38	New Rochelle	NY	10801-4916	Westchester	PSC	914-235-2400	914-632-4398	M-F 8:00 am-4:00 pm; Drug Screen: M-F 10:00 am-3:30 pm
G2C	Quest Diagnostics	1869A E Main St Beach Shopping Center	Peekskill	NY	10566-2505	Westchester	PSC	914-737-3223	914-737-3233	M-F 8:00 am-12:00 pm & 1:00 pm-3:30 pm|Sa 8:00 am-12:00 pm; Drug Screen: M-F 10:00 am-12:00 pm & 1:00 pm-3:00 pm
WHS	Quest Diagnostics	280 Dobbs Ferry Rd Sprain Brook Medical Center	White Plains	NY	10607-1900	Westchester	PSC	914-946-6271	914-946-6318	M,T,Th,F 8:00 am-4:00 pm|W,Sa 8:00 am-12:00 pm; Drug Screen: M,T,Th,F 10:00 am-3:30 pm|W 10:00 am-11:30 am
YON	Quest Diagnostics	970 N Broadway Ste 205	Yonkers	NY	10701-1310	Westchester	PSC	914-964-9700	914-376-7308	M-F 7:30 am-5:00 pm|Sa 8:00 am-12:00 pm; Drug Screen: M-F 10:00 am-4:30 pm|Sa 10:00 am-11:30 am
QTE	Quest Diagnostics Incorporated	One Malcolm Avenue	Teterboro	NJ	07608	Bergen	Main Lab	866 697-8378		Open 24 hrs/7days wk
M3B	Quest Diagnostics Clinical Laboratories, Inc.	50 Republic Road	Melville	NY	11747-4215	Suffolk	Main Lab	866 697-8378		Open 24 hrs/7days wk

Appendix 2. 2019 Health Fairs and Events (Attachment 20)

Please see the following page for EmblemHealth's completed 2019 Health Fairs and Events form as it pertains to health fairs conducted in our approved regions. This identical information has also been submitted on our USBs, labeled as *Attachment 49. 2019 Health Fairs and Events*.

[redacted]

2019 Health Fairs and Events - "Health Maintenance Organizations Specifications for the New York State Health Insurance Program"

Offeror Name: Health Insurance Plan of Greater New York d/b/a EmblemHealth

NOTE: Add additional rows as necessary.

Employer Name	Date of Event	Event Description
PEF Annual Member Mtg.	September 16-17, 2019	Invited Vendor to attend Annual PEF Members' Mtg.

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Email: bbenson@emblemhealth.com