



The Whole Health Company

MEDICARE

Group Plan

NYC Medicare Advantage Plus Enrollment Guide

City of New York
January 1, 2022 - December 31, 2022
Version: Senior Care only



Look inside!

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



What is inside

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

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Overall plan highlights

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

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

The NYC Medicare Advantage Plus Welcome Team

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

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

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



How Medicare works

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

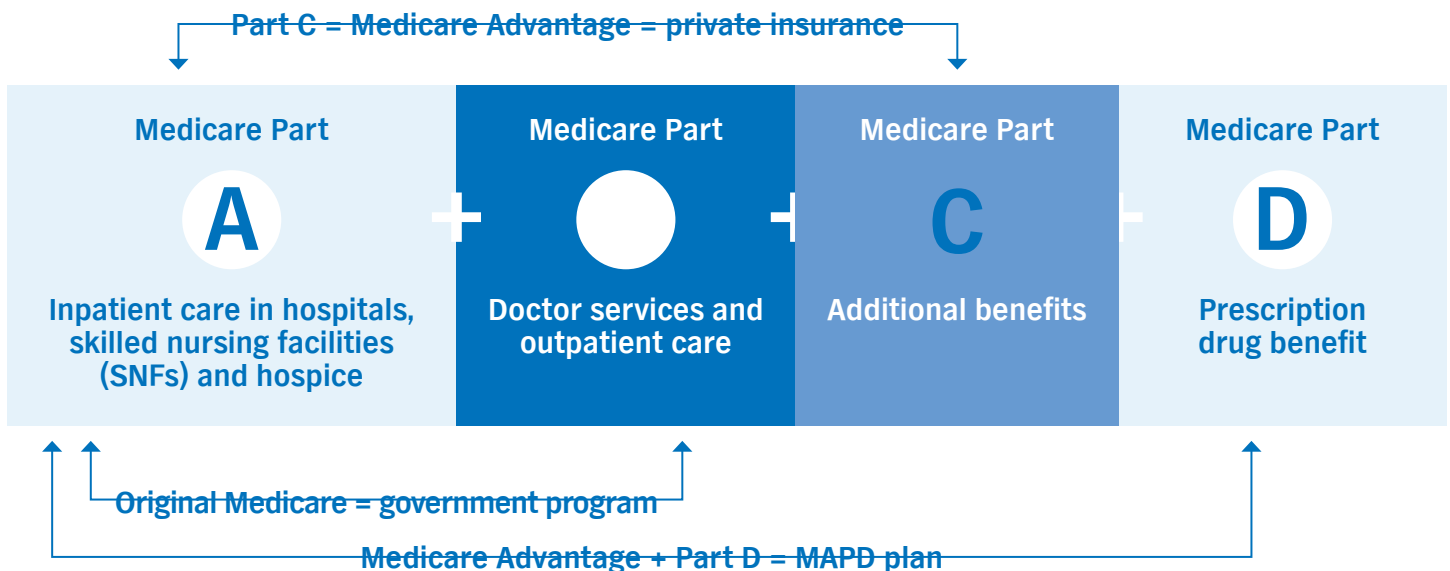
The A-B-C-Ds of Medicare

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

✓ **Medicare Parts A + B** = Original Medicare, the government program.

✓ **Medicare Part C** = Original Medicare + additional benefits. Part C is also called Medicare Advantage (MA).

✓ **Medicare Part D** = The prescription drug benefit.



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

How is Medicare Advantage different?

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

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

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

Overview	Original Medicare
Copays and coinsurance	20% coinsurance for common services such as outpatient surgery and health visits
Emergency care when traveling outside the U.S.	No coverage when traveling outside the U.S.
Annual out-of-pocket maximum (or Max OOP) is the amount members pay each year	There is no maximum amount members will pay annually
Additional benefits	Not offered

MEDICARE ADVANTAGE

Copays are used more often than coinsurance to help make cost share amounts simple and transparent.

Emergency care is provided when traveling outside the U.S.

After the Max OOP is met, **the plan pays 100% of covered costs** for the rest of the plan year.

This plan gives you access to:

- 24/7 NurseLine
- SilverSneakers
- LiveHealth Online

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

Frequently asked questions

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

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

What is a deductible?

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

What is a copay?

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

What is coinsurance?

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

What is a primary care provider (PCP)?

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

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

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

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

How is inpatient care different from outpatient care?

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

What are preventive care and services?

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

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

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

Medical benefit overview

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



Health, access and well-being

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



Nutrition

- Diabetes services and supplies
- Healthy Meals
- Healthy Pantry



Devices

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



Programs and services

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

See the full Summary of Benefits starting on page 17 for more details.

No-cost special benefits, services and access to care

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

✔ Annual health exams and preventive care

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

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

✔ MyHealth Advantage

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

These resources are available at no additional cost to you.

✔ House Call program¹

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

✔ 24/7 NurseLine²

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

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

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

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

✔ LiveHealth Online*

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

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

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

✔ Healthy Meals

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

✔ Healthy Pantry

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

✔ Wearable health and fitness tracker

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



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

✓ **SilverSneakers®¹**



SilverSneakers is a fitness and lifestyle benefit that gives you

the opportunity to connect with your community, make friends and stay active. Your membership gives you:

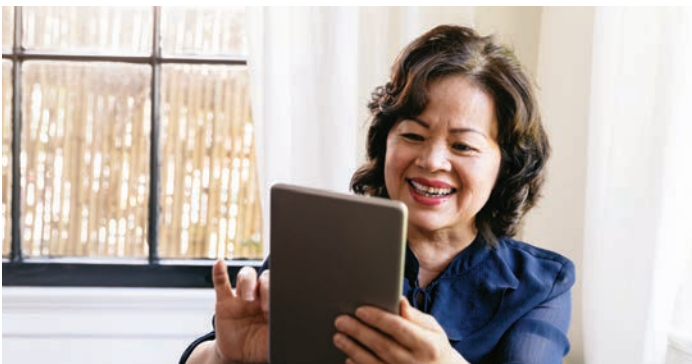
- Memberships to thousands of participating locations with use of basic amenities,² plus group exercise classes³ for all levels at select locations.
- The SilverSneakers GO™ app with adjustable workout programs tailored to individual fitness levels, schedule reminders for favorite activities, the option to find convenient locations and more.
- SilverSneakers On-Demand™ online videos for at-home workouts, plus health and nutrition tips.

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



✓ **Care and support with Aspire**

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



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

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

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

Your doctor, your choice — nationwide

How National Access Plus works

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

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

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



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

EmblemHealth Neighborhood Care

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

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

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

Every Neighborhood Care location offers:

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

NEIGHBORHOOD CARE LOCATIONS

QUEENS

Cambria Heights
Flushing
Jackson Heights

BROOKLYN

Bensonhurst
Brooklyn Heights
Crown Heights
East New York

LONG ISLAND

Bethpage

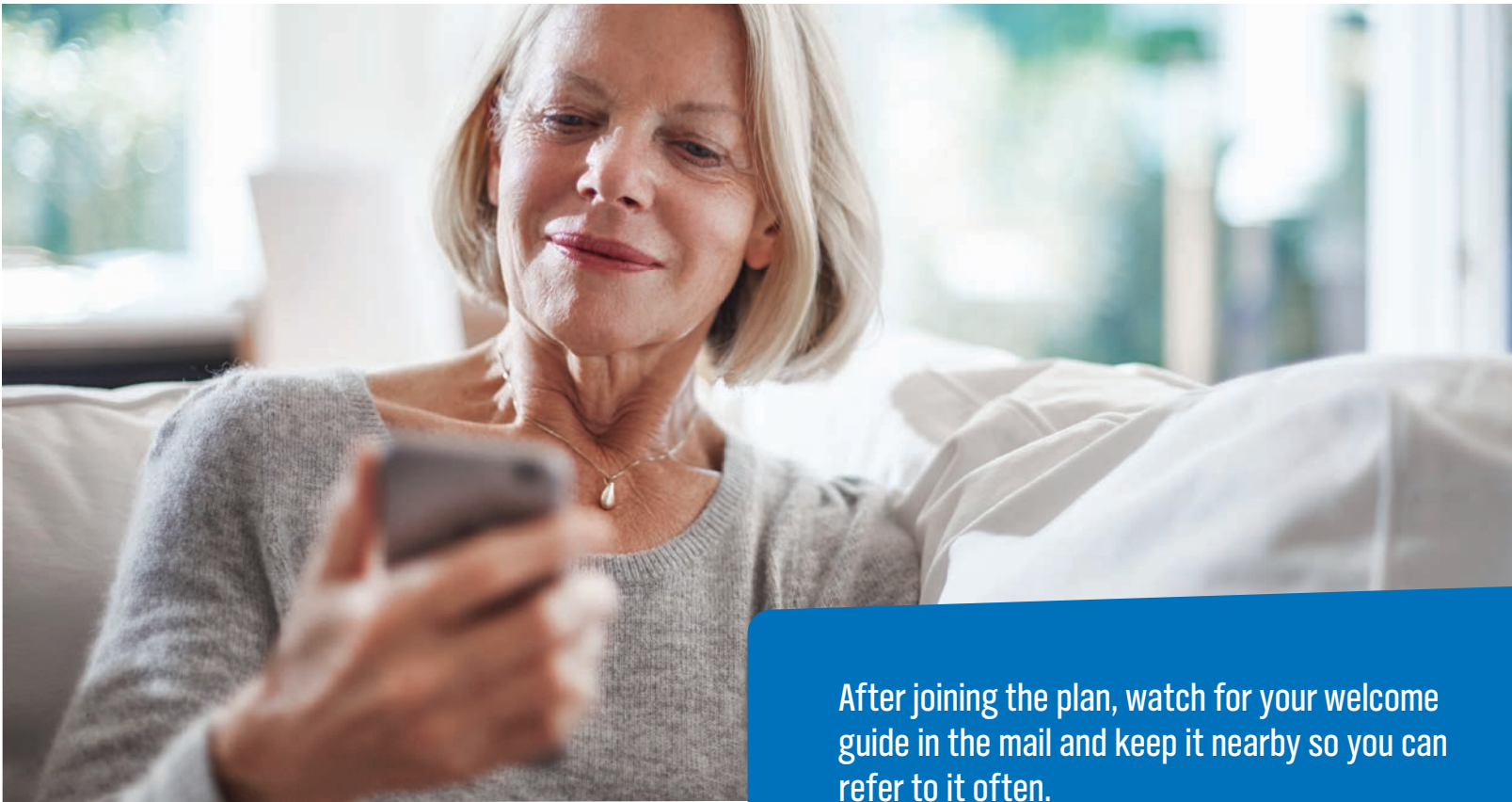
MANHATTAN

Chinatown
Duane Street
Harlem

STATEN ISLAND

Annadale
Clove Road
Richmond Avenue,
at the Mall

Easy to get started



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

- ✓ Once your enrollment in this plan is processed, we will send you:
 - Acknowledgment of your enrollment and your effective start date.
 - A letter showing proof of membership — use this until your plan membership card arrives.
 - Your plan membership card.
 - A simple health survey (within 90 days of enrollment) to help us understand and address your unique needs.

- ✓ Additionally, you will receive our plan welcome guide. It explains how to:
 - Start maximizing your benefits.
 - Find doctors, hospitals, urgent care centers and more providers.
 - Access your plan documents online and in print, if needed.
 - Contact us with questions.
 - Find help when you need it.

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

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



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

Enrollment tips:

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

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

Coordination of Benefits (COB) letter

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

You may receive a COB letter in these situations:

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



If you do not receive prescription drugs through your union welfare fund, you may purchase the prescription drug rider for the NYC Medicare Advantage Plus Plan. This Part D prescription drug plan rider will be the same as the one offered through EmblemHealth for the Senior Care program. Per CMS regulations, if you choose not to take any Part D coverage, you may be subject to higher costs in the future.

Drug plan scenarios and NYC Medicare Advantage Plus coverage

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



Online and mobile resources*

We offer two convenient ways to access your plan information.

1 The Empire consumer website

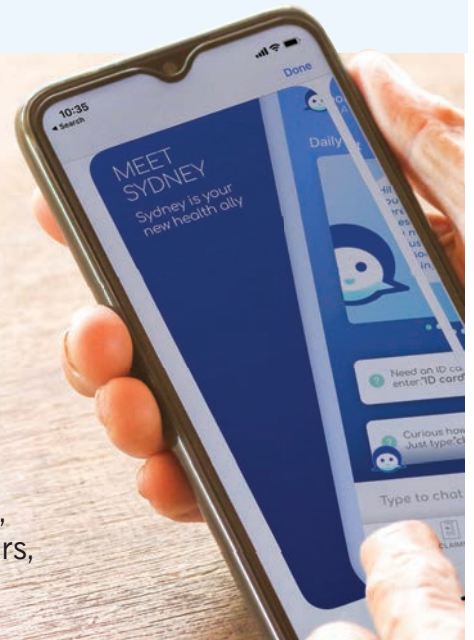
After you receive your membership card, register at www.empireblue.com/nyc-ma-plus and follow the menu options to:

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

2 The Sydney Health mobile app

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

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



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

Prior authorization

What is it?

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

How does it work?

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

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

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

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

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

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

Whose responsibility is it to receive prior authorization?

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

How do I know what services require prior authorization?

Please refer to the Summary of Benefits on the following page, each service that requires prior authorization will have an asterisk (*). Below is a brief list of most common services that require prior authorization.

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

Summary of Benefits

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

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

Need help?

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



Be in the know!

The Summary of Benefits starts on page 18.



Summary of Benefits -

PLAN NAME: NYC Medicare Advantage Plus

PLAN YEAR: January 1, 2022 - December 31, 2022

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

Covered services	What you must pay for these covered services
Monthly premium	\$0¹ 1 Consolidated Omnibus Budget Reconciliation Act (COBRA) and full pay premium: \$7.50
GHI Enhanced Medicare Part D prescription drug plan rider	\$125
Deductible	\$253 combined in network and out of network
Maximum out of pocket	\$1,470 combined in network and out of network. All copays, coinsurance, and deductibles listed in this <i>Summary of Benefits</i> accrue toward the medical plan out-of-pocket maximum, with the exception of the routine hearing services and the foreign travel emergency and urgently needed care copay or coinsurance amounts. Part D prescription drug deductibles and copays do not apply to the medical plan out-of-pocket maximum.
Inpatient hospital coverage* for Medicare-covered hospital stays	\$300 copay per admission. Deductible does not apply. The inpatient hospital out-of-pocket maximum is \$750 per year, combined with inpatient mental healthcare and combined in network and out of network. \$0 copay for Medicare-covered physician services received while an inpatient during a Medicare-covered hospital stay. Deductible does not apply.

(Continued on next page)

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

(Continued on next page)

Covered services	What you must pay for these covered services
<p>Emergency care</p> <p>Services that are both:</p> <ul style="list-style-type: none"> • Furnished by a provider qualified to furnish emergency services • Needed to evaluate or stabilize an emergency medical condition 	<p>\$50 copay for each Medicare-covered emergency room visit worldwide, in or out of network.</p> <p>Limited to what is allowed under the Medicare fee schedule for the services performed/received outside of the United States (U.S.).</p>
<p>Urgently needed services</p>	<p>\$15 copay for each Medicare-covered urgently needed care visit worldwide, in or out of network</p>
<p>Diagnostic services/labs/imaging</p> <p>X-rays; complex diagnostic tests and radiology services; radiation therapy; testing to confirm chronic obstructive pulmonary disease (COPD); surgical supplies, splints, casts, and other devices used to treat fractures and dislocations; laboratory tests; blood, including storage and administration; diagnostic tests; heart catheterizations; sleep studies; and CT, MRI/MRA, and PET scans</p>	<p>\$0 copay for Medicare-covered testing to confirm COPD, Medicare-covered supplies, and each Medicare-covered pint of blood.</p> <p>\$0 copay for supplies.</p> <p>\$15 copay for each Medicare-covered X-ray visit and/or simple diagnostic test, complex diagnostic test, and/or radiology visit, radiation therapy treatment, and clinical/diagnostic lab tests.</p>
<p>Mental health services</p> <p>Includes mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental healthcare professional, as allowed under applicable state laws</p>	<p>Outpatient: \$0 copay for each Medicare-covered individual, group, partial hospitalization, and outpatient hospital facility visit.</p> <p>Inpatient: \$300 copay per admission.</p> <p>Deductible does not apply.</p> <p>The inpatient mental healthcare out-of-pocket maximum is \$750 per year, combined with inpatient hospital care and combined in network and out of network.</p> <p>No limit to the number of days covered by the plan.</p> <p>\$0 copay for Medicare-covered physician services received while an inpatient during a Medicare-covered hospital stay.</p> <p>Deductible does not apply.</p> <p>\$15 copay for each Medicare-covered professional individual therapy visit.</p> <p>Deductible applies.</p>

(Continued on next page)

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

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Covered services	What you must pay for these covered services
<p>Medicare Part B immunizations</p> <p>Covered services include pneumonia vaccine; flu shots, including H1N1, once each flu season in the fall and winter, with additional flu shots if medically necessary; hepatitis B vaccine if you are at high or intermediate risk of getting hepatitis B; COVID-19 vaccine; and other vaccines if you are at risk and they meet Medicare Part B coverage rules.</p> <p>If you have Part D prescription drug coverage, some vaccines are covered under your Part D benefit (for example, the shingles vaccine). Please refer to your Part D prescription drug benefits.</p>	<p>There is no coinsurance, copay, or deductible for the pneumonia, influenza, hepatitis B, COVID-19, or other Medicare-covered vaccines when you are at risk and meet Medicare Part B rules, in or out of network.</p>
<p>Chiropractic services</p> <p>for manual manipulation of the spine to correct subluxation only</p>	<p>\$15 copay for each Medicare-covered visit, in or out of network</p>
<p>Acupuncture services for chronic low back pain</p> <p>Covered services include:</p> <p>Up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstances:</p> <p>For the purpose of this benefit, chronic low back pain is defined as all of the following:</p> <ul style="list-style-type: none"> • Lasting 12 weeks or longer • Nonspecific, in that it has no identifiable systemic cause (in other words, not associated with any disease of a metastatic, inflammatory, or infectious nature) • Not associated with surgery • Not associated with pregnancy <p>An additional eight sessions will be covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually.</p>	<p>\$15 copay per visit, limited to 20 visits per year, combined in or out of network</p>
<p>Medicare Community Resource Support</p> <p>As a member, your plan provides the support of a community resource outreach team to help bridge the gap between your medical benefits and the resources available to you in your community. Our team will assist you by providing information and education about community-based services and support programs in your area. If you have questions about this benefit, call Member Services at the number listed on the back of your plan membership card.</p>	<p>\$0 copay for Medicare Community Resource Support</p>

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The NYC Medicare Advantage Plus Plan also has benefits that cover dental and vision for specific medical services and situations. Please see descriptions and coverage below.

Covered services	What you must pay for these covered services
<p>Dental services</p> <p>Nonroutine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician)</p>	<p>\$0 copay for Medicare-covered services of nonroutine dental care, in or out of network, when provided by a primary care physician.</p> <p>\$15 copay for Medicare-covered services of nonroutine dental care, in or out of network, when provided by a specialist.</p>
<p>Vision services</p> <p>Includes outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration; one glaucoma screening each year for people who are at high risk; screening for diabetic retinopathy once per year for people with diabetes; and one pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens</p>	<p>\$0 copay for nonroutine visits to a primary care physician, in or out of network, for Medicare-covered exams, glaucoma and retinopathy screening, and glasses/contacts following Medicare-covered cataract surgery.</p> <p>\$15 copay for nonroutine visits to an in-network or out-of-network specialist for Medicare-covered exams to diagnose and treat diseases of the eye.</p>
<p>Home health agency care</p> <p>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.</p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> • Part-time or intermittent skilled nursing and home health aide services (to be covered under the home healthcare benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week). • Physical therapy, occupational therapy, and speech language therapy. • Medical and social services. • Medical equipment and supplies. 	<p>\$0 copay for Medicare-covered home health visits.</p> <p>Deductible does not apply.</p> <p>Durable medical equipment (DME) copay or coinsurance, if any, may apply.</p>

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

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Additional benefits -

Covered services	What you must pay for these covered services
<p>Nonemergency transportation</p> <p>Routine nonemergency transportation covers up to 24 one-way trips each year. A trip is defined as a ride from one destination to another. A trip is limited to 30 miles.</p> <ul style="list-style-type: none"> • Trips are covered within your local service area for plan covered services, such as medical visits, visits to SilverSneakers® locations, and visits to a pharmacy to pick up prescriptions. A stop at a pharmacy after a doctor's appointment to pick up prescriptions will not count as a separate trip. When you schedule a pick-up from the doctor's visit, tell the vendor that you need to go to the pharmacy. Ask the doctor/facility to call in the prescription so you have a shorter wait. • You must schedule trips two business days in advance. When scheduling your ride, let the vendor know if you are in a wheelchair, if you need help, or if someone will be coming with you. • Trips will not be covered for non-health-related services, such as going to buy groceries, personal errands, or other reasons. <p>We have partnered with Access2Care to bring you these discounts and services. Please contact Member Services if you have questions about this benefit.</p> <p>Access2Care, an independent company, is providing routine transportation on behalf of our plan.</p>	<p>24 one-way trips each year, within 30 miles</p>
<p>Routine hearing services</p>	<p>\$0 copay for routine hearing exams.</p> <p>\$70 maximum benefit limited to one exam every 12 months, combined in network and out of network.</p> <p>\$0 copay for hearing aids.</p> <p>\$500 maximum benefit toward hearing aids every 12 months.</p>
<p>Healthy Meals</p>	<p>Provides up to 14 meals to eligible members (post-inpatient discharge or chronic condition) per qualifying event. Allows up to four events each year (56 meals in total).</p>

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

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Covered services

What you must pay for these covered services

LiveHealth® Online

LiveHealth Online lets you see board-certified doctors and licensed therapists, psychologists, and psychiatrists through live, two-way video on your smartphone, tablet, or computer. It's easy to get started. You can sign up at livehealthonline.com or download the free LiveHealth Online app and register. Make sure you have your plan membership card ready — you'll need it to answer some questions.

Sign up for free

You must enter your health insurance information during enrollment, so have your plan membership card ready when you sign up.

Benefits of a video doctor visit

- The visit is just like seeing your regular doctor face to face, but just by web camera.
- It's a great option for medical care when your doctor can't see you. Board-certified doctors can help 24/7 for most types of care and common conditions like the flu, colds, pink eye, and more.
- The doctor can send prescriptions to the pharmacy of your choice, if needed.¹
- If you're feeling stressed, worried, or having a tough time, you can make an appointment to talk to a licensed therapist or psychologist from your home or on the road.
- In most cases, you can make an appointment and talk with a therapist² or make an appointment and talk with a psychiatrist³ from the privacy of your home.

Video doctor visits are intended to complement face-to-face visits with a board-certified physician and are available for most types of care.

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

1 Prescription is prescribed based on physician recommendations and state regulations (rules).

2 Appointments are typically scheduled within 14 days, but may vary based on therapist/psychologist availability. Video psychologists or therapists cannot prescribe medications.

3 Appointments are typically scheduled within 14 days, but may vary based on psychiatrist availability. Video psychiatrists cannot prescribe controlled substances.

\$0 copay for video doctor visits using LiveHealth Online.

Deductible does not apply.

Learn more about Medicare

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

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

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

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

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

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

EmblemHealth Medicare Part D Pharmacy Coverage

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

If you currently purchase an individual, direct pay prescription drug plan (PDP), once you are enrolled in the NYC Medicare Advantage Plus Plan, you will be automatically disenrolled in that direct pay prescription drug plan. You will need to enroll in a new group prescription drug plan by January 1, 2022 — through your union or in the GHI Enhanced Medicare Part D Prescription Drug Plan (High Option Rider) — if you want to keep prescription drug coverage.

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

Enrolling in a plan

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

If you are currently enrolled in the **GHI Enhanced Medicare Part D Prescription Drug Plan (High Option Rider)**, you do not need to take any action. You will automatically continue to receive your benefits through this plan. If you have a group prescription drug plan through your union, you may remain in that group plan.

Prescription coverage overview

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

(Prescription coverage rates appear on the following page.)



EmblemHealth Medicare Part D Pharmacy Coverage

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

<p>Initial Coverage period</p>	<p>Until you reach your Initial Coverage Limit of \$4,430 for drug purchases, you will pay:</p> <p>\$0 deductible</p> <ul style="list-style-type: none">• Tier 1: preferred generics: 25% of the drug cost• Tier 2: preferred brand: 25% of the drug cost• Tier 3: nonpreferred drug: 25% of the drug cost• Tier 4: specialty: 25% of the drug cost
<p>Coverage Gap period</p>	<p>Once the value of your drug purchases exceeds your Initial Coverage Limit of \$4,430, you will pay:</p> <p>\$0 deductible</p> <ul style="list-style-type: none">• Tier 1: preferred generics: 25% of the drug cost• Tier 2: preferred brand: 25% of the drug cost• Tier 3: nonpreferred drug: 25% of the drug cost• Tier 4: specialty: 25% of the drug cost
<p>Catastrophic Coverage period</p>	<p>After you meet your true out-of-pocket (TrOOP) amount spending limit of \$7,050, you will pay:</p> <ul style="list-style-type: none">• Tier 1: preferred generics: \$3.95 or 5% of the drug cost, whichever is greater• Tier 2: preferred brand: \$9.85 or 5% of the drug cost, whichever is greater• Tier 3: nonpreferred drug: \$3.95 & \$9.85, or 5% of the drug cost, whichever is greater• Tier 4: specialty: \$3.95 & \$9.85, or 5% of the drug cost, whichever is greater

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

✓ How you qualify for this plan

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

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

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

✓ How to enroll

Effective January 1, 2022, the City of New York is replacing the Senior Care Plan, as the base-line premium free plan, with the New York City Medicare Advantage Plus (PPO) Plan. You will be automatically enrolled in the New York City Medicare Advantage Plus (PPO) Plan at no cost to you. You have other plan options available to you through the City of New York. If you want to opt out of this coverage, please follow the instructions below based on which plan you want to select:

- Retirees can only opt out of the NYC Medicare Advantage Plus Plan in order to remain in their current retiree health plan. The opt-out period for the NYC Medicare Advantage Plus Plan is extended until further notice. By opting out of the NYC Medicare Advantage Plus Plan, you will be responsible for the full premium difference between the NYC Medicare Advantage Plus Plan and your plan's cost. To opt to remain enrolled in Senior Care, complete the electronic opt-out form at www.empireblue.com/nyc-ma-plus and select the option to remain on Senior Care or complete the opt-out form on the following page and follow the instructions on the form.
- If you wish to cease your City of New York retiree coverage altogether and no longer receive Medicare Part B premium reimbursement, complete the NYC Health Benefits Application/Change Form available on the Office of Labor Relations (OLR) website at www1.nyc.gov/site/olr/health/retiree/health-retiree-forms-and-downloads.page. If you drop your medical coverage, you may be able to reenroll during the next open enrollment period.

NYC Medicare Advantage Plus Plan Opt-Out Form for current Senior Care members

Effective January 1, 2022, City of New York is automatically enrolling Medicare-eligible retirees, along with their eligible dependents, into a premium-free plan: The NYC Medicare Advantage Plus Plan.

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

If you choose to opt out of the NYC Medicare Advantage Plus Plan, you are acknowledging that **you agree to pay an additional plan premium of \$191.57 to remain in your current retiree health plan for 2022**, and if you have selected the 365 Hospital Rider, an additional \$2.83 to buy up to the 365 Hospital Rider, the specifics of which will be determined in August, and available on the Health Benefits Program website at <https://www1.nyc.gov/site/olr/health/summaryofplans/health-ratechart.page>

You also acknowledge that:

- You can only opt out of the NYC Medicare Advantage Plus Plan in order to remain in your current retiree health plan for 2022, the GHI/Empire BlueCross BlueShield Senior Care plan.

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

To opt out of the NYC Medicare Advantage Plus Plan and remain in the GHI/Empire BlueCross BlueShield Senior Care plan for 2022, please complete and sign the form on the next page and return it via mail, fax or email. Each Medicare-eligible participant (i.e., retiree, spouse or dependent) must complete a separate opt-out form.

DO NOT complete this opt-out form if you would like to be enrolled in the NYC Medicare Advantage Plus Plan. No action is required by you. You will automatically be enrolled in the NYC Medicare Advantage Plus Plan effective January 1, 2022.

By your signature on the next page, you acknowledge that you **do not** wish to participate in the NYC Medicare Advantage Plus Plan and hereby elect to continue participation in your current plan option for 2022.

CMS-mandated language

If you wish to cease your City of New York retiree health coverage altogether, complete the NYC Health Benefits Application/Change Form available on the Health Benefits Program website at:

<https://www1.nyc.gov/site/olr/health/retiree/health-retiree-forms-and-downloads.page>. Please be advised, you will NOT be eligible for the reimbursement by the City of the Medicare Part B premium if you cease City of New York retiree health coverage. You may, however, reenroll in City retiree health benefits during the next Transfer Period.



NYC Medicare Advantage Plus Plan Opt-Out Form

Complete this form if you wish to Opt Out of the NYC Medicare Advantage Plus Plan.

This section should be completed the by the Medicare-eligible participant:

First Name: _____ Last Name: _____

Address: _____

City, State and ZIP: _____

Home phone: _____ Cell phone: _____

Email Address: _____

Medicare Number: _____

Social Security Number: _____

Date of Birth: _____

Complete this section with the City Retiree's information:

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

Retiree's Medicare Number: _____

Retiree's Social Security Number: _____

Date of Birth: _____

City Agency from which the City employee retired: _____

By signing below, I elect to continue participation in GHI/Empire BlueCross BlueShield Senior Care basic plan for 2022, and acknowledge that **I will pay an additional plan premium of \$191.57 per month and if you have selected the 365 Hospital Rider, an additional \$2.83 to buy up to the 365 Hospital Rider, to remain in the GHI/Empire BlueCross BlueShield Senior Care basic plan**, the specifics for which will be determined in August and available on the Health Benefits Program website at <https://www1.nyc.gov/site/olr/health/summaryofplans/health-ratechart.page>

Signature of Participant Opting Out

Date

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

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

Mail to: **NYC Medicare Advantage Plus Plan, PO Box 173605, Denver, CO 80217**

Required information for 2022

Your rights, protections and Medicare options

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

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

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

You may have other options, too

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

Geographic service areas covered by this plan

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

Your Medicare protections

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

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

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

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

Required information for 2022

Information about Medicare

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

Pay your Medicare Part B premiums

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

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

Enrolling in other plans

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

Notifying your group sponsor

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

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

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

About IRMAA and your income level

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

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

High-income surcharges

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

Required information for 2022

Information about Medicare

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

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

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

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

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

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

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

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

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

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

The EmblemHealth companies are separate companies from Empire BlueCross BlueShield.

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

Required information for 2022

It is important we treat you fairly

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

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

Find help in your language

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

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

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

Arabic:

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

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

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

Farsi:

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

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

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

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

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

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

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

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

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

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

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

Empire BlueCross BlueShield Retiree Solutions – H4036

2021 Medicare Star Ratings

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

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

Some of the areas Medicare reviews for these ratings include:

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

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

★★★★
4 Stars

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

Health Plan Services: ★★★★★
4 Stars

Drug Plan Services: ★★★★★
3.5 Stars

The number of stars shows how well our plan performs.

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

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

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

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

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

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

Important information regarding your plan

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

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

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

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

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

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

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

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



The Whole Health Company