Medicare Advantage Group Agreement

This NYC Medicare Advantage Plus Plan Group Agreement (hereinafter "MA Agreement") is entered into as of January 1, 2022 (hereinafter "Effective Date") by and between the City of New York ("City") acting through Mayor's Office of Labor Relations – Employee Benefits Program on behalf of the Labor Management Health Insurance Policy Committee for the New York City Health Benefits Program with an office at 22 Cortlandt Street, 12th Floor, New York, NY 10007 (hereinafter "Group") and Anthem Insurance Companies, Inc. doing business as Empire BlueCross BlueShield Retiree Solutions, on behalf of itself and the Alliance, defined below (hereinafter "Empire" or the "Alliance") sponsor of the NYC Medicare Advantage Plus Plan (hereinafter "MA Plan"). Empire and the Group each are sometimes referred to herein as a "Party" and collectively as the "Parties."

WHEREAS, the City and Municipal Labor Committee ("MLC"), an umbrella organization for municipal unions, negotiate on a variety of matters, including collective bargaining regarding health benefits pursuant to their obligations under the New York Collective Bargaining Law;

WHEREAS, to aid in the administration of the negotiated health benefits agreements, the City and the MLC established the Labor Management Health Insurance Policy Committee ("Committee") for the MLC and City representatives to meet on a regular basis to discuss City health insurance benefits; and

WHEREAS, the Employee Benefits Program ("EBP") is a division of the Mayor's Office of Labor Relations ("OLR"), and OLR is acting under the authority of the New York City Administrative Code Section 12.126(d) as the administrator of the New York City Health Benefits Program ("HBP"); and

WHEREAS, on October 30, 2020 OLR's request for authorization to enter into a Negotiated Acquisition to solicit a Medicare Advantage plan under Medicare Part C for the Medicare eligible retirees and dependents of the City of New York who are eligible for the City's Health Benefits Program was approved by the City Chief Procurement Officer; and

WHEREAS, OLR issued a public notice for a negotiated acquisition (EPIN:0021N002) in conformance with the New York City Procurement Policy Board Rules ("PPB") and had otherwise advertised in order to solicit vendors through the Notice of Intent to provide health benefits services in the form of a Medicare Advantage plan under Medicare Part C for the Medicare eligible retirees and dependents of the City of New York who are eligible for the City's Health Benefits Program; and

WHEREAS, the Retiree Health Alliance ("the Alliance"), a strategic alliance between Empire and EmblemHealth Plan, Inc. ("EmblemHealth") and their affiliates, submitted a response for such services, as provided for in the public notice for a negotiated acquisition, in the form of an expression of interest to OLR; responses were evaluated by an evaluation committee pursuant to PPB Section 3-04; and

WHEREAS, OLR determined the Alliance's proposal to be most advantageous to the City, taking into consideration technical expertise, price, contract terms, M/WBE Utilization Plan and other factors set forth in the negotiated acquisition solicitation; and

WHEREAS, the City desires to appoint the Alliance to provide a Medicare Advantage Plan Under Medicare Part C for City of New York Retirees, and their Dependents, and

NOW, THEREFORE, in consideration of the terms and conditions contained herein, the parties hereby agree as follows:

ARTICLE 1 - PURPOSE

The Alliance will provide health insurance coverage to the Group's eligible retirees and other eligible individuals as described in this MA Agreement. Empire is accountable for the operations, compliance, and performance of the MA Plan. EmblemHealth is an entity contracting with Empire to administer portions of this co-branded product to help ensure the City's retirees receive continuity of care and membership support. Specifically, EmblemHealth will co-

manage the account, provide a professional network in the downstate New York area, deliver care through Neighborhood Health Centers, and support Empire in multiple areas of plan performance.

ARTICLE 2 - DEFINITIONS

In this MA Agreement, the following terms have the meanings set forth below. Capitalized terms used in this MA Agreement that are not defined below are defined in the Evidence of Coverage.

MA Agreement Period. The 60-month base period beginning on the Effective Date, two 12-month renewal periods beginning on the expiration of the base period, if exercised, and consecutive agreed-upon periods thereafter until the MA Agreement is terminated pursuant to the termination provisions herein.

Application. Any mutually agreed upon enrollment mechanism, including, without limitation, paper applications provided by Members or the Group and spreadsheets or electronic enrollment files.

CMS. Centers for Medicare & Medicaid Services, a federal agency within the United States Department of Health and Human Services.

Covered Service. Any hospital, medical, prescription or other health care service rendered to Members for which benefits are provided pursuant to the Evidence of Coverage.

Effective Date. This MA Agreement shall be effective at 12:01 A.M. on January 1, 2022 and shall continue in full force and effect thereafter until terminated as provided herein. All periods of time under this MA Agreement will begin and end at 12:01 A.M. local time at the Group's address.

Eligible Individual(s). Individuals who meet the requirements specified by the Group's eligibility rules, CMS requirements, this MA Agreement, and the Evidence of Coverage.

Eligibility Notice. A notice provided by the Group to the Alliance setting forth information regarding individuals eligible to participate in the MA Plan. An Eligibility Notice may be an "initial" notice, including an Application, provided prior to the Effective Date or a "subsequent" notice provided from time to time thereafter. See Section 3.E below.

Evidence of Coverage. The Evidence of Coverage document provided to Members and any endorsements or riders thereto, which defines those Covered Services and benefits available to Members under this MA Agreement. The Evidence of Coverage also defines the rights and responsibilities of the Member and the MA Plan.

Grace Period. The period specified in Section 6.C hereof for payment by the Group of premiums and other charges.

MA Agreement. The following documents will constitute the MA Agreement between the Parties: this MA Agreement, and any addenda, endorsements, and schedules which are hereby incorporated by reference; the Evidence of Coverage and any riders thereto; the Group application; and the individual Applications and any reclassifications thereof submitted by Members of the Group; Appendix A – General Provisions Governing Contract for Consultants, Professional, Technical Human, and Client Services – which is attached hereto, is expressly incorporated into this MA Agreement. In the event of any express or implied conflict between the provisions of this MA Agreement and Appendix A, the following order of priority shall govern: (1) first, the body and exhibits of this Agreement shall govern; (2) thereafter, the General Provisions listed in Appendix A .

Member. A person with Medicare Parts A and B (i) who is eligible to get Covered Services, (ii) who has enrolled in the MA Plan, and (iii) and whose enrollment has been confirmed by CMS.

Provider. A duly licensed physician, health professional, hospital, pharmacy or other individual, organization and/or facility that provides health services or supplies within the scope of an applicable license and/or certification and meets any other requirements set forth in the Evidence of Coverage.

ARTICLE 3 - ELIGIBILITY AND ENROLLMENT

3.A Only Eligible Individuals may be enrolled in the MA Plan.

3.B Those individuals initially enrolled shall be Eligible Individuals for whom an Application shall have been timely filed for enrollment for themselves. Dependents who are Eligible Individuals shall be enrolled upon the timely filing of an Application on such dependent's behalf.

3.C The Group or its designee shall have the opportunity to submit Applications to add new, transferred and newly eligible individuals to the group of Members initially enrolled under this MA Agreement. However, before becoming Members, the new, transferred or newly eligible individual must be verified as Eligible Individuals.

3.D The effective date of coverage for any such additional Member whose Application is accepted by Empire shall be in accordance with the Evidence of Coverage, and CMS requirements in effect at the time the Member's Application is approved.

3.E With such frequency as the Parties shall agree, the Group or its designee shall furnish Empire with Eligibility Notices setting forth deletions and changes to information provided in a Member's initial Application or subsequent Eligibility Notices.

3.F Empire reserves the right to limit retroactive changes to enrollment in accordance with CMS guidance. Acceptance of payments from the Group or the payment of benefits to persons no longer eligible will not obligate Empire to provide or continue to provide benefits for such persons.

3.G A Member who is determined by the Group or its designee to be ineligible for enrollment in the MA Plan shall be reported by the Group or its designee on an Eligibility Notice as a deletion from the listing of Members reasonably in advance of such Member's termination. Empire shall provide notice of termination to such Member in accordance with the Evidence of Coverage and CMS requirements, and the Member's coverage shall terminate in accordance with such notice.

3.H Any retroactive disenrollments must be submitted by Empire to CMS for approval and be in accordance with CMS requirements. The Group or its designee shall be responsible for providing Empire with applicable data or information required to substantiate Empire's request to CMS for such retroactive disenrollment.

ARTICLE 4 - OBLIGATIONS OF EMPIRE AND THE ALLIANCE

4.A The Alliance shall provide health care benefits to Members who receive Covered Services under the terms of this MA Agreement and the Evidence of Coverage, and in accordance with Section 2 – Program Requirements of the Notice of Intent to Negotiate (EPIN:0021N002). However, in no event will the Alliance provide benefits for services rendered prior to the Effective Date or after the termination of this MA Agreement, or for any period for which full premium payment has not been paid to the Alliance, except as otherwise provided in the Evidence of Coverage and/or applicable CMS requirements.

4.B The Alliance shall furnish or make available an identification card, subject to review by the Group, Evidence of Coverage and all other CMS-required documents for each Member enrolled in the plan(s) covered by this MA Agreement.

4.C The Alliance shall furnish appropriate Application forms and related material necessary and appropriate for the enrollment of Members, subject to review by the Group, and shall provide such assistance to the Group or its designee as may be reasonably necessary for enrollment purposes. The Alliance shall maintain current eligibility status records in accordance with the Eligibility Notice(s) submitted by the Group or its designee for the purpose of administering this MA Agreement. All Eligibility Notice(s) shall be securely maintained by the Alliance in accordance with HIPAA laws.

4.D The Alliance is responsible for pursuing recoveries of claim payments as appropriate and as required or allowed by law. The Alliance shall determine which recoveries it will pursue in its discretion or at the reasonable direction of the Group. However, the Alliance may not pursue a recovery if the cost of collection is likely to exceed the recovery amount, or if the recovery is prohibited by law or by an agreement with a Provider or other vendor.

4.E The Alliance will review, investigate, process and pay claims according to the terms and conditions of this MA Agreement, the Evidence of Coverage, and applicable contracts with Providers or other

vendors. The Alliance may make benefit payments to either Providers or Members as described in the Evidence of Coverage, and will coordinate benefits with other payors as required by law. The Alliance will give notice in writing to the Member when a claim for benefits has been denied in accordance with CMS requirements. The notice will provide the reasons for the denial and the right to an appeal of the denial in accordance with the procedures set forth in the Evidence of Coverage and CMS requirements.

ARTICLE 5 - OBLIGATIONS OF THE GROUP

5.A The Group or its designee shall keep such records and furnish to the Alliance such notification and other information as may be reasonably required by Empire for the purpose of determining eligibility for coverage, enrolling and disenrolling Members, processing terminations, effecting changes in this MA Agreement, effecting changes due to an individual becoming eligible for Medicare, effecting changes due to a Member becoming disabled, or determining the amount payable by the Group under this MA Agreement. The Group or its designee will give notification of eligibility to each Member who is or will become eligible for enrollment in the MA Plan, and will collect and submit to the Alliance an Application for each Member desiring to enroll.

5.B The Group or its designee shall promptly forward to the Alliance all Applications, notices or other writings delivered to the Group or its designee from Members or individuals applying for coverage under this MA Agreement. If the Group receives a question or complaint regarding benefits under this MA Agreement, the Group shall advise the Member to contact the Alliance. The Alliance shall provide the Group with monthly Member Inquiry reports summarizing inquiries and resolution status, subject to HIPAA requirements.

5.C The Group or its designee will timely distribute to Members notices of premium changes and termination of this MA Agreement. Notice by the Alliance to the Group shall be deemed to constitute notice to all Members in order to effectuate any such change or termination; provided, however, that the Alliance reserves the right to provide any such notice(s) to Members if the Alliance deems it appropriate, subject to prior approval of the Group, which shall not be unreasonably withheld or delayed. The Group or its designee shall comply with all applicable laws, regulations and CMS requirements relating to the distribution of notices and information to Members.

5.D The Group hereby acknowledges, agrees and certifies its compliance with the following requirements as they relate to MA Plan.

Premium – The Group hereby agrees and certifies, as to Member premium, if any, that:

(i) Different amounts can be subsidized by the Group for different classes of Members in an MA Plan, provided such classes are reasonable and based upon objective business criteria (i.e., years of service, business location, job category, nature of compensation). Accordingly, the Group hereby certifies that such classes (if any) are reasonable and based upon objective business criteria.

(ii) The premium within a given class does not vary by Member, and

(iii) The Group must pass through any direct subsidy payments received from CMS to reduce the amount that the Member pays (or in those instances where the Member in the Group plan pays premiums on behalf of a Medicare-eligible spouse or dependent, the amount the Member pays).

ARTICLE 6 – PREMIUM, FEES AND GRACE PERIOD

6.A The premium rates for coverage under this MA Agreement are based upon the rate exhibits as of the effective date of the MA Agreement, consistent with CMS requirements, Alliance's fee policy, which may be revised from time to time, and applicable laws.

6.B The Alliance does not have an obligation to accept a partial premium payment. The Group must make payments regardless of any contributions to those payments by Members.

6.C The full amount due, including premium, taxes, fees or assessments, is due and payable on the 1st of each month during the base period and renewal terms, if exercised, of this MA Agreement. The Group is entitled to a 60-day period following the due date (the "Grace Period"), for the payment of any

premium and/or other amounts due. Once the Group exceeds its Grace Period and enters into Empire's delinquency process, the Group must pay 100% of amounts owed to avoid termination.

ARTICLE 7 - CHANGES IN THE MA AGREEMENT

7.A During the MA Agreement Period, the Alliance may change the benefit provisions and the terms and conditions thereof and/or the premium rates as a result of changes in requirements mandated by CMS or federal law, or changes in benefit provisions agreed to by the Parties in writing. The Alliance will provide written notice to the Group not less than 105 days from the effective date of any such change (other than mutually agreed changes for which notice shall be agreed upon by the Alliance and the Group) or such shorter notice as may be required to comply with CMS or federal laws changes. If the Group does not meet Rate Stipulations, as determined and agreed upon by the Alliance and the Group, the Alliance may change the premium rates, effective not less than 90 days after giving notice to the Group after the Alliance and the Group have determined that the Group does not meet such Rate Stipulations.

7.B An amendment to this MA Agreement will not be effective unless in writing and signed by an authorized representative of the Alliance and the Group. If any change to the MA Agreement, benefits, and/or premium rates is unacceptable to the Group, the Group may terminate coverage under this MA Agreement by giving written notice of termination to the Alliance in accordance with section 8.A below. The amendment will then become a part of this MA Agreement.

ARTICLE 8 - TERMINATION AND/OR SUSPENSION OF PERFORMANCE

8.A The Group may terminate this MA Agreement at any time by giving the Alliance at least sixty (60) days' advance written notice of termination. The Group must pay all amounts due for each Member covered through the effective date of termination of this MA Agreement.

8.B In addition to the terms set forth in Appendix A, if the Group fails to make in full any payment due under this MA Agreement within the Grace Period, the Alliance may request termination of this MA Agreement, by providing the Group with at least sixty (60) days' advance written notice of the proposed date of termination. If the Group fails to make full payment prior to the proposed date of termination set forth in the notice, the Alliance may in its sole discretion terminate this MA Agreement. The Alliance will accept late payment of delinquent amounts submitted by the Group to reinstate. Upon receipt of payment, the MA Agreement will be reinstated retroactively to the last date for which full premium payment was made. Any such acceptance of a delinquent payment by the Alliance shall not be deemed a waiver of the Alliance's right to request termination of this MA Agreement for any future failure of the Group to make full and timely payment of amounts due under this MA Agreement. Delivery of payment to the Alliance or the Alliance's receipt and negotiation of a tendered payment through its automatic deposit procedures shall be deemed acceptance of such reinstatement or a retraction of such request for termination. Upon termination of the MA Agreement as provided in this paragraph, the Alliance shall only have liability to make payment for Covered Services provided through the last date for which full premium payment was made by the Group.

8.C Notwithstanding any other provision of this MA Agreement, if the Group, or its designee (if any) engages in fraudulent conduct or misrepresentation, as determined by a Court of competent jurisdiction, the Alliance may, in its discretion, rescind, cancel or terminate this MA Agreement immediately, subject to CMS guidelines, and the Alliance may terminate this MA Agreement upon sixty (60) days' advance written notice to the Group. The Group shall be liable to the Alliance for any and all payments made and losses or damages sustained by the Alliance arising as a result of such the Group or designee's conduct, as determined by a Court of competent jurisdiction.

8.D Upon termination of this MA Agreement, the Alliance shall cease to have any liability for benefits or claims incurred after the effective date of termination (except as may be otherwise provided in the Evidence of Coverage and in accordance with CMS guidelines), and shall have no liability to offer continuation or conversion coverage to Members.

ARTICLE 9 - CLAIMS PAID AFTER EFFECTIVE DATE OF TERMINATION

In the event that (1) the Group terminates this MA Agreement without giving notice to the Alliance as required by this MA Agreement, (2) the MA Agreement is terminated pursuant to Sections 8.B or 8.C hereof, or (3) a Member is no longer eligible for coverage and has been terminated from the coverage without timely notice from the date the Group was made aware of the termination to the Alliance, and, in each case, and, after the effective date of termination, the Alliance makes payment of any claims which would otherwise have been payable under the terms of this MA Agreement but for the fact that the claims were incurred after the effective date of MA Agreement termination or Member ineligibility, as the case may be, the Group shall be liable to reimburse the Alliance for all claim amounts paid.

ARTICLE 10 - TERMINATION OF COVERED PERSONS

In addition to Empire's termination and cancellation rights described in the Evidence of Coverage, Empire reserves the right upon (30) thirty days' advance notice to the Group to cancel or rescind any health care benefits provided hereunder to any Member who, in Empire's and the Group's reasonable, agreed upon determination, engages in misrepresentation and/or fraudulent conduct in relation to any Application for coverage or any claims made for coverage or under this MA Agreement.

ARTICLE 11 - SERVICE MARKS

This MA Agreement constitutes a contract solely between the Group and Empire, in strategic alliance with EmblemHealth. Empire is an independent corporation operating under a license with the Blue Cross and Blue Shield Association ("Association"), an association of independent Blue Cross and Blue Shield Plans, permitting Empire to use the Blue Cross and/or Blue Shield Service Marks in the State of New York. Empire is not contracting as the agent of the Association. The Group has not entered into this MA Agreement based upon representations by any person other than Empire, in strategic alliance with EmblemHealth. No person, entity, or organization other than Empire or the Alliance will be held accountable or liable to the Group for any of Empire's or the Alliance's obligations provided under this MA Agreement. This paragraph will not create any additional obligations on the part of Empire, other than those obligations contained in this MA Agreement.

ARTICLE 12 – INTERPLAN/MEDICARE ADVANTAGE PROGRAM FOR PPO

12.A Out-of-Area Services – Medicare Advantage. Empire has relationships with other Blue Cross and/or Blue Shield Licensees ("Host Blues") referred to generally as the "Inter-Plan Medicare Advantage Program." This Program operates under rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). When Members access healthcare services outside the geographic area MA Plan serves, the claim for those services will be processed through the Inter-Plan Medicare Advantage Program. The Inter-Plan Medicare Advantage Program available to Members under this MA Agreement is described generally below.

12.B Member Liability Calculation. When a Member receives Covered Services outside of the MA Plan service area from a Medicare Advantage PPO network Provider, the cost of the service, on which Member liability (copayment/coinsurance) if any, is based will be either:

- The Medicare allowable amount for Covered Services; or
- The amount the Host Blue negotiates with its provider on behalf of MA Plan Members. The amount negotiated may be either higher than, lower than, or equal to the Medicare allowable amount.

12.C Nonparticipating Healthcare Providers. When Covered Services are provided by nonparticipating healthcare Providers, the Member's coinsurance, if any, for such services will be based on either Medicare's limiting charge (up to 115% of Medicare allowed amounts) where applicable or the Provider's billed charge. If the Provider has opted out of Medicare, the Member is responsible for the Provider's billed charge. Payments for out-of-network emergency services will be governed by applicable federal and state law and CMS requirements.

ARTICLE 13 - MA AGREEMENT ADMINISTRATION

13.A The Alliance shall determine Covered Services under the MA Agreement, in accordance with CMS requirements, and upon agreement with the Group. The Alliance also may resolve all questions arising under the Evidence of Coverage. The Alliance may establish and amend policies with regard to the

administration of benefits under the Evidence of Coverage, subject to the prior written consent of the Group, which shall not be unreasonably withheld or delayed; provided, however, that the consent of the Group shall not be required with respect to policy changes mandated by CMS. The Alliance's ability to determine eligibility for benefits shall be exercised consistently with the provisions of the MA Agreement, the Evidence of Coverage, and applicable law and CMS requirements.

13.B The Alliance may itself, or at the request of the Group and subject to CMS requirements and the terms and conditions of the MA Plan, waive or modify any referral, authorization, or certification requirements, benefit limits, or other processes contained in the Evidence of Coverage if such waiver is in the best interest of a Member or will facilitate effective and efficient administration of claims.

13.C The Alliance may, from time to time upon thirty (30) days' advance written notice to the Group, institute pilot or test programs regarding disease management, utilization management, case management and/or wellness initiatives. Such initiatives may impact some, but not all Members. The Alliance reserves the right to discontinue a pilot or test program at any time upon thirty (30) days' advance written notice to the Group.

13.D Empire will have sole responsibility for resolving appeals from claim decisions, consistent with applicable law and CMS requirements.

13.E The network arrangement for the NYC Medicare Advantage Plus plan will be as follows:

- EmblemHealth's provider network arrangement of participating professional providers including chiropractors, occupational therapists, physical therapists and speech therapists is applicable in New York, Bronx, Kings, Queens, Richmond, Nassau, Suffolk, Westchester, Orange, Rockland, Putnam, Dutchess and Sullivan counties.
- Empire's participating facilities and behavioral health providers will be applicable in New York, Bronx, Kings, Queens, Richmond, Nassau, Suffolk, Westchester, Orange, Rockland, Putnam, Dutchess and Sullivan counties.
- Blue Cross and Blue Shield Medicare Advantage PPO professional and facility providers outside of the counties listed above are considered participating.
- Members will have access to Medicare Advantage PPO providers contracted with Blue Cross Blue Shield Association plans across the nation.

ARTICLE 14 – HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

14.A All capitalized terms used but not defined in this Article have the same meaning as defined in the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA").

14.B The Alliance may disclose Summary Health Information, in accordance with HIPAA, as requested by the Group or for amending or terminating the MA Plan.

14.C In addition to the terms set forth in Appendix A, the Alliance may disclose Protected Health Information ("PHI") to the Group for it to carry out Plan administration functions, but such disclosure may occur only after receipt of written certification from the Group that: (1) the Group's Plan documents and operations comply with the privacy requirements of HIPAA; (2) the Group has provided notice to affected individuals as required by HIPAA; and (3) PHI will not be used for the purpose of employment-related actions or other actions not related to administration of benefits under the MA Plan or permitted by law.

14.D The Alliance will comply with any additional disclosure restrictions required by applicable state and federal law and CMS requirements.

ARTICLE 15 – RIGHT TO AUDIT

The following individuals and/or entities may conduct audits related to this Agreement, based on the following general guidelines, subject to the requirements and limitations of HIPAA:

15.A Not more than once each calendar year during the term of this Agreement, the Group or the Group's independent outside auditor whom the Group engages to conduct annual audits of the Group's Services, may inspect and audit, or cause to be inspected and audited, the books and records of the Alliance concerning all the Alliance Services provided under this MA Agreement, subject to confidentiality requirements in Provider agreements.

15.B In addition to the audits described in Section 15.A above, the Parties acknowledge that representatives of a regulatory or accreditation agency with jurisdiction over the MA Plan may also inspect and audit the Alliance's books and records.

15.C The Group and the Alliance shall reasonably cooperate with representatives of each other, with independent accountants and consultants retained by the Group or the Alliance, and with representatives of any regulatory or accreditation agency, to conduct any inspection or audit.

15.D All audits conducted by the Group (or any agents of the Group) shall be made during normal business hours, on the Alliance's premises, and in accordance with the Alliance's audit policy, which may be revised from time to time following thirty (30) days written notice ("Audit Notice"). The audit notice shall specify the scope of the audit, including the time period being audited (subject to the limitations set forth in Section 15.A above), and the subject matter of the audit ("Audit Scope"). All audits shall be conducted without undue interference to the audited party's business activity, and in accordance with reasonable audit practices.

15.E The Alliance shall be required to provide minimum necessary (in accordance with HIPAA) requested electronic data to the Group (or its auditor) within thirty (30) days of the Alliance's receipt of the audit notice. Such requested data shall be made available by the Alliance for on-site review. The Alliance shall not be required to provide access to its network.

15.F In the event any questions are raised, or any additional requests for information or documents or data related to the Audit Scope are reasonably requested, by the Group (or its auditor) during any audit, and the parties mutually agree that such additional requests are reasonably within the Audit Scope, the Alliance shall be obligated to respond to all such questions, and produce all additional information, documents and/or data within thirty (30) business days of receipt of such questions or requests. If the Alliance cannot fully respond in said time period, the Alliance shall provide whatever responses and materials it can within that period, and a written statement as to when the Alliance will respond fully.

15.G In the event that an Audit concludes that the Alliance has violated its obligations or the material terms of this MA Agreement, and the Alliance disputes said audit findings, the Alliance must set forth the basis for its dispute, with all supporting documentation, within thirty (30) business days of the Alliance's receipt of the disputed findings. The Alliance shall provide sufficient documentation to permit adequate review of the disputed issues and have the burden of demonstrating that the Group's (or its auditor's) conclusions are incorrect. To the extent the parties mutually agree that the Alliance fails to provide documentation substantiating any part of its position, or fails to meet its burden of proof, the Alliance shall waive its right to further dispute the matter. After receiving any documentation from the Alliance, the Group (or its auditor) shall review said documentation and advise the Alliance whether the Group has changed its audit findings or conclusions. However, to the extent the Alliance maintains a HITRUST Certification by a qualified third party auditor, and such certification covers the scope of services to be provided by the Alliance to the Group, then the determination that the Alliance has violated its obligations or the material terms of this MA Agreement shall be based on the Parties' mutual agreement.

15.H In the event that the Alliance disputes the Group's (or its auditor's) findings, and the Alliance's basis for dispute is that the Group required or authorized certain activity, procedures, mechanisms or calculations to occur that are the subject of the dispute, the Alliance shall have the burden of providing documentary evidence demonstrating its allegations. If the Alliance is unable to provide such evidence, the Alliance shall not have the right to claim that the Group required or authorized the matter.

The following terms shall control the Group's audits of the Alliance:

15.I The Group shall have the right to select its own auditor provided, however, that such auditor shall be independent and objective. However, the Group's auditor shall not be an individual or entity that is a competitor of, or has a material conflict with, the Alliance that the Parties reasonably agree, after expeditious consideration, could jeopardize the integrity of the audit. The Group also agrees not to select any auditor paid on a contingency basis, or pay any auditor on such a basis or other similar basis. The Group agrees all audit remuneration must be on a flat fee, or hourly, basis.

15.J The Alliance shall be obligated to cooperate reasonably with the Group and its auditor's efforts to audit. The Group may conduct audits of claims, benefits, eligibility, performance guarantees, and the Alliance's compliance with quote stipulations as provided in the MA Agreement for any time period during the MA Agreement Period. The Alliance's gain share formula will be made available to the auditors to confirm the Alliance's calculations are based on the terms of Addendum A – Gain Share Summary.

15.K Notwithstanding the foregoing or anything to the contrary in this Article 15, the Alliance shall not be required to furnish documents or records that it deems proprietary or sensitive, except to persons or entities who have executed a confidentiality and indemnification agreement in accordance with Section 15.L below. Any audit of claims may only relate to claims processed during the then-current and immediately preceding calendar year (the "Audit Period"). The scope of the audit shall be agreed to in writing by the Parties prior to the commencement of the audit. An audit performed pursuant to Section 15.A shall be the final audit for the Audit Period and for any prior Audit Period unless otherwise agreed to in writing by the Parties; however, claims may be re-audited pursuant to Section 15.B.

15.L Auditor(s) must execute a confidentiality and indemnification agreement with the Alliance pertaining to the Alliance's Proprietary and Confidential Information prior to conducting an audit.

15.M The Group shall provide to the Alliance copies of all final audit reports at such time as they are made available by the auditor to the Group. The Group shall notify the Alliance of any material discrepancies found during the course of the audit. The Alliance is entitled to respond to such findings prior to the issuance of the final report. The Alliance reserves the right to terminate any audit being performed by or for the Group if the Alliance reasonably determines that the confidentiality of its information is not properly being maintained or if the Alliance reasonably determines that the Group or auditor is not following the Alliance's audit policy.

15.N The Alliance reserves the right to charge a fee to the Group for expenditure of time by the Alliance's employees in completing any audit provided, however, that such fees shall (i) not exceed the reasonable costs incurred by the Alliance, and (ii) be limited to costs associated with: (1) pulling claims in excess of a mutually agreed on statistically valid sample size of claims; and (2) supporting a site visit longer than five (5) days in duration.

15.O Notwithstanding the foregoing, the Parties acknowledge and agree that the powers, duties, and obligations of the Comptroller of the City of New York pursuant to the provisions of the New York City Charter shall not be diminished, compromised or abridged in any way.

ARTICLE 16 - MISCELLANEOUS

16.A The Alliance hereby notifies the Group that the Alliance or its vendors may have reimbursement contracts with certain providers for the provision of and payment for health care services and supplies provided to, among others, Members under this MA Agreement. Under some of these contracts, there may be settlements which require the Alliance to pay the providers or vendors additional money (which may or may not be solely funded by the Alliance) or which require the providers or vendors to return a portion of volume discounts, rebates, or excess money paid. Such providers or vendors may include entities affiliated with Empire or EmblemHealth. Under many provider or vendor contracts, the negotiated reimbursement does not contemplate any type of settlement between Empire and/or EmblemHealth and the provider or vendor. The Group has no direct responsibility for additional payment to providers or vendors nor any right to discounts, rebates, or excess money received from providers or vendors.

16.B All Members enrolled under this MA Agreement shall have only the rights and benefits, and shall be subject to the terms and conditions, set forth in this MA Agreement and in the Evidence of Coverage, and as provided by CMS requirements.

16.C In addition to terms set forth in Appendix A, the Alliance agrees to treat all proprietary information about the Group's operations and its Plan in a confidential manner. The Group agrees to treat all information about the Alliance's business operations, rate and discount information, and other proprietary data or information in a confidential manner, subject to applicable state and federal laws and regulations. Neither Party will disclose any such confidential information to any other person without the prior written consent of the Party to whom the information pertains. The Alliance may disclose such confidential information to its regulators, legal advisors, lenders, business advisors, and other third Parties for purposes related to the subject matter of this MA Agreement subject to prior written approval by the Group, which shall not be unreasonably withheld or delayed. The Alliance may also make such disclosures as required or appropriate under applicable securities laws. If a Party is required by law to make a disclosure of any proprietary information, the disclosing Party will immediately provide written notice to the other Party prior to the disclosure detailing the circumstances and extent of the disclosure.

16.D The Parties acknowledge that the Alliance is not engaged in the practice of medicine; it merely makes decisions regarding the Covered Services pursuant to the Evidence of Coverage. Providers participating in MA Plan's networks are not restricted from exercising independent medical judgment regarding the treatment of their patients, regardless of the Alliance's coverage determinations.

16.E The Group agrees and understands that the MA Agreement is the controlling document for all legal purposes. The terms of the MA Agreement may not be altered or changed without the advance written agreement of both the Group and Empire.

16.F Reference is made to the provisions of 42 C.F.R. §422.402, as supplemented by Chapter 10 of the Medicare Managed Care Manual, regarding federal preemption of state laws with respect to Medicare Advantage plans, including Employer Group Waiver Plans, offered by Medicare Advantage organizations. Such plans are required to abide by all applicable federal laws, regulations and CMS or other federal agency rules, guidance or other requirements promulgated with respect to such plans (collectively, "Medicare Laws"). Any obligations of the Alliance in any Agreement to which this MA Agreement is attached or made a part of to comply with or based upon the requirements of state or local law, regulations or guidance, including, without limitation, regulations or guidance issued by state or local governmental agencies, shall not be binding on the MA Plan, which shall comply with applicable Medicare Laws in all aspects of MA Plan governance and operations.

16.G This MA Agreement supersedes any and all prior agreements between the Parties, whether written or oral, and other documents, if any, addressing the subject matter of this MA Agreement.

16.H If any provision of this MA Agreement is found to be invalid, illegal or unenforceable under applicable law, order, judgment or settlement, such provision will be excluded from the MA Agreement and the remainder of this MA Agreement will be enforceable and interpreted as if such provision is excluded.

16.I Any applicable addenda attached to this MA Agreement hereby are incorporated into this MA Agreement by reference. The Whereas Clauses of this MA agreement are hereby incorporated into his MA Agreement by reference.

16.J Neither Party shall be deemed to be in violation of this Agreement if such Party is prevented from performing any of its obligations due to a cause beyond the reasonable control of the Party such as a pandemic (an outbreak of disease that afflicts 10% or more of Members) being declared by the Centers for Disease Control or if a Force Majeure event (meaning an act of God, civil or military disruption, terrorism, fire, strike, flood, riot or war) occurs during the Measurement Period that impacts a meaningful portion of the Group's population.

IN WITNESS WHEREOF, the Parties have caused this MA Agreement to be executed in duplicate by affixing the signatures of duly authorized officers.

City of New York acting through Mayor's Office of Labor Relations – Employee Benefits Program on behalf of the Labor Management Health Insurance Policy Committee for the New York City Health Benefits Program

By_____

Title_____

Date_____

Anthem Insurance Companies, Inc. doing business as Empire BlueCross BlueShield Retiree Solutions, sponsor of the NYC Medicare Advantage Plus Plan, for itself and on behalf of the Alliance

By_____

Title_____

Date_____

Certified as to Legal Authority:
Approved as to Form:

BY:_____MB
Acting Corporation Counsel

DATE:_____

Empire BlueCross BlueShield
An Anthem Company

The City of New York

EmblemHealth®

2022 Evidence of Coverage

Register on our website to choose to receive plan communications by email or online.

NYC Medicare Advantage Plus (PPO)
City of New York

For questions, please call
Member Services: **1-833-325-1191** (TTY: **711**)
Monday through Friday, 8 a.m. to 9 p.m. ET, except holidays
www.empireblue.com/nyc-ma-plus

EVIDENCE OF COVERAGE

January 1, 2022 – December 31, 2022

Your Group-Sponsored Medicare Health Benefits and Services as a Member of NYC Medicare Advantage Plus (PPO)

This booklet gives you the details about your Medicare health care coverage from January 1, 2022 – December 31, 2022. It explains how to get coverage for health care services you need. **This is an important legal document. Please keep it in a safe place**.

Member Services:

For help or information, please call Member Services or go to your plan website: **www.empireblue.com/nyc-ma-plus**.

Call toll free **1-833-325-1191** (TTY: **711**), Monday through Friday, 8 a.m. to 9 p.m. ET, except holidays.

This plan, NYC Medicare Advantage Plus (PPO), is offered by Empire BlueCross BlueShield Retiree Solutions. When this *Evidence of Coverage* says "we," "us" or "our," it means Empire BlueCross BlueShield Retiree Solutions. When it says "the plan," "our plan" or "your plan," it means NYC Medicare Advantage Plus (PPO). When it says "you" or "your" it means you, or your covered spouse, or domestic partner, and/or covered dependent(s).

Our plan has free language interpreter services available to answer questions from non-English speaking members. Please call the Member Services number listed above to request interpreter services.

This document may be available in alternate formats. Please call the Member Services number listed above for additional information.

OMB Approval 0938-1051 (Expires: February 29, 2024)

YOUR BENEFITS CHART

In addition to your medical benefits, this chart includes information on supplemental benefits, services and discounts

 **Look for the apple!**
It shows a preventive service.

Your 2022 Medical Benefits Chart
NYC Medicare Advantage Plus Plan
City of New York

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Doctor and hospital choice You may go to doctors, specialists, and hospitals in or out of the network. You do not need a referral.		
Prior authorization* Benefit categories that include services that require prior authorization are marked with an asterisk (*). Additional information can be found on the last page of the medical benefits chart.		
Annual deductible • The deductible applies to covered services as noted within each category below, prior to the copay or coinsurance, if any, being applied.	$253 Combined in-network and out-of-network	
Inpatient 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. 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 or coronary care units) • Drugs and medications • Lab tests • X-rays and other radiology services	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 health care and combined in-network and out-of-network.	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 health care and combined in-network and out-of-network.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Inpatient hospital care (con't) • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical therapy, occupational therapy, and speech language therapy • Inpatient substance abuse services • Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care) • 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 the plan provides transplant services at a location outside the pattern of care for transplants in your community and you choose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. The reimbursement for transportation costs are while you and your companion are traveling to and from the medical providers for services related to the transplant care. The plan defines the distant location as a location that is outside of the member's service area AND a minimum of 75 miles from the member's home. Transportation and lodging costs will be reimbursed for travel mileage and lodging consistent with current IRS travel mileage and lodging guidelines. Accommodations for lodging will be reimbursed at the lesser of: 1) billed charges, or 2) $50 per day per covered person up to a maximum of $100 per day per covered person consistent with IRS guidelines.	No limit to the number of days covered by the plan. $0 copay for Medicare-covered physician services received while an inpatient during a Medicare-covered hospital stay Deductible does not apply.	No limit to the number of days covered by the plan. $0 copay for Medicare-covered physician services received while an inpatient during a Medicare-covered hospital stay Deductible does not apply. If you receive 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 an in-network hospital.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Inpatient hospital care (con't) • Blood – including storage and administration. Coverage of whole blood, packed red cells, and all other components of blood begins with the first pint. • Physician services In-network providers should notify us within one business day of any planned, and if possible, unplanned admissions or transfers, including to or from a hospital, skilled nursing facility, long term acute care hospital, or acute rehabilitation center. **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, 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-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.		

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Inpatient mental health care* Covered services include mental health care services that require a hospital stay in a psychiatric hospital or the psychiatric unit of a general hospital. In-network providers should notify us within one business day of any planned, and if possible unplanned admissions or transfers, including to or from a hospital, skilled nursing facility, long term acute care hospital, or acute rehabilitation center.	For Medicare-covered hospital stays: $300 copay per admission Deductible does not apply. The inpatient mental health care out-of-pocket maximum is $750 per year combined with inpatient hospital care and combined in-network and out-of-network. No limit to the number of days covered by the plan. $0 copay for Medicare-covered physician services received while an inpatient during a Medicare-covered hospital stay Deductible does not apply.	For Medicare-covered hospital stays: $300 copay per admission Deductible does not apply. The inpatient mental health care out-of-pocket maximum is $750 per year combined with inpatient hospital care and combined in-network and out-of-network. No limit to the number of days covered by the plan. $0 copay for Medicare-covered physician services received while an inpatient during a Medicare-covered hospital stay Deductible does not apply.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Skilled nursing facility (SNF) care*	For Medicare-covered SNF stays:	For Medicare-covered SNF stays:
Inpatient skilled nursing facility (SNF) coverage is limited to 100 days each benefit period. A "benefit period" begins on the first day you go to a Medicare-covered inpatient hospital or a SNF. The benefit period ends when you have not been an inpatient at any hospital or SNF for 60 days in a row. Covered services include but are not limited to: • Semi-private 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. Coverage of whole blood, packed red cells, and all other components of blood begins with the first pint. • Medical and surgical supplies ordinarily provided by SNFs • 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 receive your SNF care from plan facilities. However, under certain conditions listed below, you may be able to pay in-network cost-sharing for a facility that isn't a plan 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	$0 copay for days 1-100 per benefit period Deductible does not apply. No prior hospital stay required.	$0 copay for days 1-100 per benefit period Deductible does not apply. No prior hospital stay required.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Skilled nursing facility (SNF) care (con't) In-network providers should notify us within one business day of any planned, and if possible unplanned admissions or transfers, including to or from a hospital, skilled nursing facility, long term acute care hospital, or acute rehabilitation center.		
Inpatient services covered when the hospital or SNF days are not covered or are no longer covered* 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 a 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 • Prosthetic and orthotic 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, occupational therapy, and speech language therapy	After your SNF day limits are used up, this plan will still pay for covered physician services and other medical services outlined in this benefits chart at the deductible and/or cost share amounts indicated.	

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Home health agency care*	$0 copay for Medicare-covered home health visits Deductible does not apply.	$0 copay for Medicare-covered home health visits Deductible does not apply.
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 language therapy • Medical and social services • Medical equipment and supplies	Durable Medical Equipment (DME) copay or coinsurance, if any, may apply.	Durable Medical Equipment (DME) copay or coinsurance, if any, may apply.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
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 six months or less to live if your illness runs its normal course. Your hospice doctor can be an in-network provider or an out-of-network provider. 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 this 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 Medicare for the services that Original Medicare pays for. Services covered by Original Medicare include: • Drugs for symptom control and pain relief • Short-term respite care • Home care Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit. For services that are covered by Medicare Part A or B and are not related to your terminal prognosis: If you need nonemergency, nonurgently 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 an in-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 plan cost-sharing for out-of-network services. For services that are covered by this plan but are not covered by Medicare Part A or B: This 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.	You must receive care from a Medicare-certified hospice. When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and B services are paid for by Original Medicare, not this plan. $0 copay for the one time only hospice consultation Deductible does not apply.	You must receive care from a Medicare-certified hospice. When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and B services are paid for by Original Medicare, not this plan. $0 copay for the one time only hospice consultation Deductible does not apply.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Hospice care (con't) If you have Part D prescription drug coverage, some drugs may be covered under your Part D benefit. Drugs are never covered by both hospice and your Part D plan at the same time. **Note:** If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services.		

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Outpatient services		
Physician services, including doctor's office visits*	$0 copay per visit to an in-network Primary Care Physician (PCP) for Medicare-covered services Deductible applies.	$0 copay per visit to an out-of-network Primary Care Physician (PCP) for Medicare-covered services Deductible applies.
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	$15 copay per visit to an in-network specialist for Medicare-covered services Deductible applies.	$15 copay per visit to an out-of-network specialist for Medicare-covered services Deductible applies.
• Retail health clinics		
• Basic hearing and balance exams performed by your Primary Care Physician or specialist, if your doctor orders it to see if you need medical treatment		
• Telehealth services for some physician or mental health services can be found in the section of this benefit chart titled, Video doctor visits.	$0 copay per visit to an in-network retail health clinic for Medicare-covered services Deductible applies.	$0 copay per visit to an out-of-network retail health clinic for Medicare-covered services Deductible applies.
• Some telehealth services including consultation, diagnosis, and treatment by a physician or practitioner for patients in certain rural areas or other locations approved by Medicare		
• Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home	$0 copay for Medicare-covered allergy testing Deductible applies.	$0 copay for Medicare-covered allergy testing Deductible applies.
• Telehealth services to diagnose, evaluate, or treat symptoms of a stroke, regardless of your location	$0 copay for Medicare-covered allergy injections Deductible applies.	$0 copay for Medicare-covered allergy injections Deductible applies.
• Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location		
• Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes if: o You're not a new patient **and** o The check-in isn't related to an office visit in the past 7 days **and** o The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment	See antigen cost share in Part B drug section.	See antigen cost share in Part B drug section.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network

Physician services, including doctor's office visits (con't)
• Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours if:
  ○ You're not a new patient **and**
  ○ The evaluation isn't related to an office visit in the past 7 days **and**
  ○ The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment
• Consultation your doctor has with other doctors by phone, internet, or electronic health record
• Second opinion by another in-network provider prior to surgery
• Physician services rendered in the home
• Outpatient hospital services
• 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)
• Allergy testing and allergy injections		

Chiropractic services • We cover only manual manipulation of the spine to correct subluxation.	$15 copay for each Medicare-covered visit Deductible applies.	$15 copay for each Medicare-covered visit Deductible applies.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Acupuncture for chronic low back pain*	$15 copay for each Medicare-covered visit Deductible applies.	$15 copay for each Medicare-covered visit Deductible applies.
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. Provider Requirements: Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act) may furnish acupuncture in accordance with applicable state requirements. Physician assistances (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in 1861(aa)(5) of the Act), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have: • A masters or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and, • A current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e. Puerto Rico) of the United Sates, or District of Columbia. Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations at 42 CFR §§ 410.26 and 410.27.		

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Podiatry services* Covered services include: • Diagnosis and the medical or surgical treatment of injuries and disease of the feet (such as hammer toe or heel spurs) in an office setting • Medicare-covered routine foot care for members with certain medical conditions affecting the lower limbs • A foot exam covered every six months for people with diabetic peripheral neuropathy and loss of protective sensations	$15 copay for each Medicare-covered visit Deductible applies.	$15 copay for each Medicare-covered visit Deductible applies.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Outpatient mental health care, including partial hospitalization services*	$15 copay for each Medicare-covered professional individual therapy visit Deductible applies.	$15 copay for each Medicare-covered professional individual therapy visit Deductible applies.
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	$15 copay for each Medicare-covered professional group therapy visit Deductible applies.	$15 copay for each Medicare-covered professional group therapy visit Deductible applies.
"Partial hospitalization" is a structured program of active psychiatric treatment provided as a hospital outpatient service that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.	$15 copay for each Medicare-covered professional partial hospitalization visit Deductible applies.	$15 copay for each Medicare-covered professional partial hospitalization visit Deductible applies.
	$0 copay for each Medicare-covered outpatient hospital facility individual therapy visit Deductible applies.	$0 copay for each Medicare-covered outpatient hospital facility individual therapy visit Deductible applies.
	$0 copay for each Medicare-covered outpatient hospital facility group therapy visit Deductible applies.	$0 copay for each Medicare-covered outpatient hospital facility group therapy visit Deductible applies.
	$0 copay for each Medicare-covered partial hospitalization facility visit Deductible applies.	$0 copay for each Medicare-covered partial hospitalization facility visit Deductible applies.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Outpatient substance abuse services, including partial hospitalization services* "Partial hospitalization" is a structured program of active psychiatric treatment provided as a hospital outpatient service that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.	$15 copay for each Medicare-covered professional individual therapy visit Deductible applies. $15 copay for each Medicare-covered professional group therapy visit Deductible applies. $15 copay for each Medicare-covered professional partial hospitalization visit Deductible applies. $0 copay for each Medicare-covered outpatient hospital facility individual therapy visit Deductible applies. $0 copay for each Medicare-covered outpatient hospital facility group therapy visit Deductible applies. $0 copay for each Medicare-covered partial hospitalization facility visit Deductible applies.	$15 copay for each Medicare-covered professional individual therapy visit Deductible applies. $15 copay for each Medicare-covered professional group therapy visit Deductible applies. $15 copay for each Medicare-covered professional partial hospitalization visit Deductible applies. $0 copay for each Medicare-covered outpatient hospital facility individual therapy visit Deductible applies. $0 copay for each Medicare-covered outpatient hospital facility group therapy visit Deductible applies. $0 copay for each Medicare-covered partial hospitalization facility visit Deductible applies.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers* Facilities where surgical procedures are performed and the patient is released the same day. **Note:** If you are having surgery in a hospital, 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." 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-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.	$0 copay for each Medicare-covered outpatient hospital facility or ambulatory surgical center visit for surgery Deductible applies. $0 copay for each Medicare-covered outpatient observation room visit Deductible applies.	$0 copay for each Medicare-covered outpatient hospital facility or ambulatory surgical center visit for surgery Deductible applies. $0 copay for each Medicare-covered outpatient observation room visit Deductible applies.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Outpatient hospital observation, non-surgical* 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/Pubs/pdf/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.	$0 copay for a visit to an in-network primary care physician in an outpatient hospital setting/clinic for Medicare-covered non-surgical services Deductible applies. $15 copay for a visit to an in-network specialist in an outpatient hospital setting/clinic for Medicare-covered non-surgical services Deductible applies. $0 copay for each Medicare-covered outpatient observation room visit Deductible applies.	$0 copay for a visit to an out-of-network primary care physician in an outpatient hospital setting/clinic for Medicare-covered non-surgical services Deductible applies. $15 copay for a visit to an out-of-network specialist in an outpatient hospital setting/clinic for Medicare-covered non-surgical services Deductible applies. $0 copay for each Medicare-covered outpatient observation room visit Deductible applies.
Ambulance services • Covered ambulance services include fixed wing, rotary wing, water, and ground ambulance services, to the nearest appropriate facility that can provide care only if the services are furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by the plan. • Nonemergency transportation by ambulance is appropriate if it is documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required. • Ambulance service is not covered for physician office visits.	Your provider must get an approval from the plan before you get ground, air, or water transportation that is not an emergency. $0 copay per one-way trip for Medicare-covered ambulance services Deductible does not apply.	

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
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. Emergency outpatient copay is waived if the member is admitted to the hospital within 72 hours for the same 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. This coverage is worldwide and is limited to what is allowed under the Medicare fee schedule for the services performed/received in the United States. Cost-sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network. If you receive 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 an in-network hospital.	$50 copay for each Medicare-covered emergency room visit Deductible does not apply.	

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Urgently needed services • Urgently needed services are available on a worldwide basis. The urgently needed services copay is waived if the member is admitted to the hospital within 72 hours for the same condition. If you are outside of the service area for your plan, your plan covers urgently needed services, including urgently required renal dialysis. Urgently needed services are services provided to treat a nonemergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by in-network providers or by out-of-network providers when in-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. Generally, however, if you are in the plan's service area and your health is not in serious danger, you should obtain care from an in-network provider.	$15 copay for each Medicare-covered urgently needed care visit Deductible does not apply.	
Outpatient rehabilitation services* 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).	$15 copay for Medicare-covered physical therapy, occupational therapy, and speech language therapy visits Deductible applies.	$15 copay for Medicare-covered physical therapy, occupational therapy, and speech language therapy visits Deductible applies.
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.	$15 copay for Medicare-covered cardiac rehabilitation therapy visits Deductible applies.	$15 copay for Medicare-covered cardiac rehabilitation therapy visits Deductible applies.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Pulmonary rehabilitation services* Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and a referral for pulmonary rehabilitation from the doctor treating their chronic respiratory disease.	$15 copay for Medicare-covered pulmonary rehabilitation therapy visits Deductible applies.	$15 copay for Medicare-covered pulmonary rehabilitation therapy visits Deductible applies.
Supervised exercise therapy (SET)* 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.	$15 copay for Medicare-covered supervised exercise therapy visits Deductible applies.	$15 copay for Medicare-covered supervised exercise therapy visits Deductible applies.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Durable medical equipment (DME) and related supplies* Covered items include, but are not limited to: wheelchairs, crutches, powered mattress systems, diabetic supplies, continuous blood glucose monitors, hospital bed ordered by a provider for use at home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers. Copay or coinsurance only applies when you are not currently receiving inpatient care. If you are receiving inpatient care your DME will be included in the copay or coinsurance for those services. We cover all medically necessary durable medical equipment 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. Therapeutic Continuous Glucose Monitors (CGMs) and related supplies are covered by Medicare when they meet Medicare National Coverage Determination (NCD) and Local Coverage Determinations (LCD) criteria. In addition, where there is not NCD/ LCD criteria, therapeutic CGM must meet any plan benefit limits, and the plan's evidence based clinical practice guidelines. Coverage is limited to 2 sensors per month and one receiver every 2 years. This plan covers only DUROLANE, EUFLEXXA, SUPARTZ, and Gel-SYN-3 Hyaluronic Acids (HA). For new prescriptions, we will not cover other brands unless your provider tells us it is medically necessary. The review of medical necessity for use of HA and any non-preferred brands is part of the plan's prior authorization process.	\$0 copay for Medicare-covered DME Deductible applies. \$0 copay for Medicare-covered CGMs and related supplies Deductible applies. See the Diabetes self-management training, diabetic services, and supplies benefit section for diabetic supply cost sharing.	\$0 copay for Medicare-covered DME Deductible applies. \$0 copay for Medicare-covered CGMs and related supplies Deductible applies. See the Diabetes self-management training, diabetic services, and supplies benefit section for diabetic supply cost sharing.
Prosthetic devices and related supplies* Devices (other than dental) that replace all or 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.	\$0 copay for Medicare-covered prosthetics and orthotics Deductible applies.	\$0 copay for Medicare-covered prosthetics and orthotics Deductible applies.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Home infusion therapy*	$0 copay for Medicare-covered professional services provided by a qualified home infusion supplier in the patient's home Deductible does not apply.	$0 copay for Medicare-covered professional services provided by a qualified home infusion supplier in the patient's home Deductible does not apply.
Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to an individual at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters). Covered services include but are not limited to: • Professional services, including nursing services, furnished in accordance with the plan of care • Patient training and education not otherwise covered under the durable medical equipment benefits • Remote monitoring • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier Separately from the home infusion therapy professional services, home infusion requires a durable medical equipment component: • Durable medical equipment – the external infusion pump, the related supplies and the infusion drug(s), pharmacy services, delivery, equipment set up, maintenance of rented equipment, and training and education on the use of the covered items	$0 copay for Medicare-covered durable medical equipment – includes the external infusion pump, the related supplies, and the infusion drug(s) Deductible applies.	$0 copay for Medicare-covered durable medical equipment – includes the external infusion pump, the related supplies, and the infusion drug(s) Deductible applies.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
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 • Blood glucose monitors are limited to one every year • Up to 200 blood glucose test strips and lancets for a 30-day supply • One pair per 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) for people with diabetes who have severe diabetic foot disease, including fitting of shoes or inserts • Diabetes self-management training is covered under certain conditions	$0 copay for a 30-day supply on each Medicare-covered purchase of blood glucose test strips, lancets, lancet devices, and glucose control solutions for checking the accuracy of test strips and monitors Deductible applies except for items purchased at a pharmacy. $0 copay for Medicare-covered blood glucose monitor Deductible applies except for items purchased at a pharmacy. $0 copay for Medicare-covered therapeutic shoes and inserts Deductible applies. $0 copay for Medicare-covered diabetes self-management training Deductible does not apply.	$0 copay for a 30-day supply on each Medicare-covered purchase of blood glucose test strips, lancets, lancet devices, and glucose control solutions for checking the accuracy of test strips and monitors Deductible applies except for items purchased at a pharmacy. $0 copay for Medicare-covered blood glucose monitor Deductible applies except for items purchased at a pharmacy. $0 copay for Medicare-covered therapeutic shoes and inserts Deductible applies. $0 copay for Medicare-covered diabetes self-management training Deductible does not apply.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Outpatient diagnostic tests and therapeutic services and supplies*	$15 copay for each Medicare-covered X-ray visit and/or simple diagnostic test Deductible applies.	$15 copay for each Medicare-covered X-ray visit and/or simple diagnostic test Deductible applies.
Covered services include, but are not limited to: • X-rays • Complex diagnostic tests and radiology services • Radiation (radium and isotope) therapy, including technician materials and supplies • Testing to confirm chronic obstructive pulmonary disease (COPD) • 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, packed red cells, and all other components of blood begins with the first pint • Other outpatient diagnostic tests Certain diagnostic tests and radiology services are considered complex and include heart catheterizations, sleep studies, computed tomography (CT), magnetic resonance procedures (MRIs and MRAs), and nuclear medicine studies, which includes PET scans.	$15 copay for Medicare-covered complex diagnostic test and/or radiology visit Deductible applies. $15 copay for each Medicare-covered radiation therapy treatment Deductible applies. $0 copay for Medicare-covered testing to confirm chronic obstructive pulmonary disease Deductible does not apply. $0 copay for Medicare-covered supplies Deductible applies. $15 copay for each Medicare-covered clinical/diagnostic lab test Deductible applies. $0 copay per Medicare-covered pint of blood Deductible does not apply.	$15 copay for Medicare-covered complex diagnostic test and/or radiology visit Deductible applies. $15 copay for each Medicare-covered radiation therapy treatment Deductible applies. $0 copay for Medicare-covered testing to confirm chronic obstructive pulmonary disease Deductible does not apply. $0 copay for Medicare-covered supplies Deductible applies. $15 copay for each Medicare-covered clinical/diagnostic lab test Deductible applies. $0 copay per Medicare-covered pint of blood Deductible does not apply.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Opioid treatment program services* Members of our plan with opioid use disorder (OUD) can receive coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services: • U.S. Food and Drug Administration (FDA) approved opioid agonist and antagonist medication-assisted treatment (MAT) medications • Dispensing and administration of MAT medications (if applicable) • Substance use counseling • Individual and group therapy • Toxicology testing • Intake activities • Periodic assessments	$15 copay per visit for Medicare-covered opioid treatment program services Deductible applies.	$15 copay per visit for Medicare-covered opioid treatment program services Deductible applies.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Vision care (non-routine) 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. • 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 age 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.)	$0 copay for visits to an in-network primary care physician for Medicare-covered exams to diagnose and treat diseases of the eye Deductible applies. $15 copay for visits to an in-network specialist for Medicare-covered exams to diagnose and treat diseases of the eye Deductible applies. $0 copay for Medicare-covered glaucoma screening Deductible does not apply. $0 copay for Medicare-covered diabetic retinopathy screening Deductible does not apply. $0 copay for glasses/contacts following Medicare-covered cataract surgery Deductible applies.	$0 copay for visits to an out-of-network primary care physician for Medicare-covered exams to diagnose and treat diseases of the eye Deductible applies. $15 copay for visits to an out-of-network specialist for Medicare-covered exams to diagnose and treat diseases of the eye Deductible applies. $0 copay for Medicare-covered glaucoma screening Deductible does not apply. $0 copay for Medicare-covered diabetic retinopathy screening Deductible does not apply. $0 copay for glasses/contacts following Medicare-covered cataract surgery Deductible applies.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Preventive services care and screening tests  You will see this apple next to preventive services throughout this chart. For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you in-network. However, if you are treated or monitored for an existing medical condition or an additional non-preventive service, during the visit when you receive the preventive service, a copay or coinsurance may apply for that care received. In addition, if an office visit is billed for the existing medical condition care or an additional non-preventive service received, the applicable in-network primary care physician or in-network specialist copay or coinsurance will apply.		
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.	There is no coinsurance, copayment, or deductible for members eligible for this Medicare-covered preventive screening. Deductible does not apply.	There is no coinsurance, copayment, or deductible for members eligible for this Medicare-covered preventive screening. Deductible does not apply.
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.	There is no coinsurance, copayment, or deductible for the Medicare-covered bone mass measurement. Deductible does not apply.	There is no coinsurance, copayment, or deductible for the Medicare-covered bone mass measurement. Deductible does not apply.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Colorectal cancer screening and colorectal services 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, but not within 48 months of a screening sigmoidoscopy Colorectal services: • Include the biopsy and removal of any growth during the procedure, in the event the procedure goes beyond a screening exam	There is no coinsurance, copayment, or deductible for the Medicare-covered colorectal cancer screening exam and services. Deductible does not apply.	There is no coinsurance, copayment, or deductible for the Medicare-covered colorectal cancer screening exam and services. Deductible does not apply.
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	There is no coinsurance, copayment, or deductible for members eligible for the Medicare-covered preventive HIV screening. Deductible does not apply.	There is no coinsurance, copayment, or deductible for members eligible for the Medicare-covered preventive HIV screening. Deductible does not apply.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
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.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit. Deductible does not apply.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit. Deductible does not apply.
Medicare Part B immunizations Covered services include: • Pneumonia vaccine • Flu shots, including H1N1, once each flu season in the fall and winter, with additional flu shots if medically necessary • Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B • COVID-19 vaccine • Other vaccines if you are at risk and they meet Medicare Part B coverage rules **If you have Part D prescription drug coverage, some vaccines are covered under your Part D benefit (for example, the shingles vaccine). Please refer to your Part D prescription drug benefits.**	There is no coinsurance, copayment, or deductible for the pneumonia, influenza, Hepatitis B, COVID-19, or other Medicare-covered vaccines when you are at risk and they meet Medicare Part B rules. Deductible does not apply.	There is no coinsurance, copayment, or deductible for the pneumonia, influenza, Hepatitis B, COVID-19, or other Medicare-covered vaccines when you are at risk and they meet Medicare Part B rules. Deductible does not apply.
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	There is no coinsurance, copayment, or deductible for Medicare-covered screening mammograms. Deductible does not apply.	There is no coinsurance, copayment, or deductible for Medicare-covered screening mammograms. Deductible does not apply.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
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: 1 Pap test every 12 months.	There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams. Deductible does not apply.	There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams. Deductible does not apply.
Prostate cancer screening exams For men age 50 and older, the following are covered once every 12 months: • Digital rectal exam • Prostate Specific Antigen (PSA) test	There is no coinsurance, copayment, or deductible for a Medicare-covered annual PSA test. Deductible does not apply.	There is no coinsurance, copayment, or deductible for a Medicare-covered annual PSA test. Deductible does not apply.
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.	There is no coinsurance, copayment, or deductible for the Medicare-covered intensive behavioral therapy cardiovascular disease preventive benefit. Deductible does not apply.	There is no coinsurance, copayment, or deductible for the Medicare-covered intensive behavioral therapy cardiovascular disease preventive benefit. Deductible does not apply.
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).	There is no coinsurance, copayment, or deductible for Medicare-covered cardiovascular disease testing that is covered once every five years. Deductible does not apply.	There is no coinsurance, copayment, or deductible for Medicare-covered cardiovascular disease testing that is covered once every five years. Deductible does not apply.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
"Welcome to Medicare" preventive visit The plan covers a one-time "Welcome to Medicare" preventive visit. The visit includes a review of your health, measurements of height, weight, body mass index, blood pressure, 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.	There is no coinsurance, copayment, or deductible for the Medicare-covered "Welcome to Medicare" preventive visit. Deductible does not apply.	There is no coinsurance, copayment, or deductible for the Medicare-covered "Welcome to Medicare" preventive visit. Deductible does not apply.
Annual wellness visit If you've had Medicare 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" preventive visit to be covered for annual wellness visits after you've had Part B for 12 months.	There is no coinsurance, copayment, or deductible for the Medicare-covered annual wellness visit. Deductible does not apply.	There is no coinsurance, copayment, or deductible for the Medicare-covered annual wellness visit. Deductible does not apply.
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.	There is no coinsurance, copayment, or deductible for a Medicare-covered annual depression screening visit. Deductible does not apply.	There is no coinsurance, copayment, or deductible for a Medicare-covered annual depression screening visit. Deductible does not apply.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
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 2 diabetes screenings every 12 months.	There is no coinsurance, copayment, or deductible for Medicare-covered diabetes screening tests. Deductible does not apply.	There is no coinsurance, copayment, or deductible for Medicare-covered diabetes screening tests. Deductible does not apply.
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.	There is no coinsurance, copayment, or deductible for the MDPP benefit. Deductible does not apply.	There is no coinsurance, copayment, or deductible for the MDPP benefit. Deductible does not apply.
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.	There is no coinsurance, copayment, or deductible for Medicare-covered preventive obesity screening and therapy. Deductible does not apply.	There is no coinsurance, copayment, or deductible for Medicare-covered preventive obesity screening and therapy. Deductible does not apply.
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 four 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.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit. Deductible does not apply.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit. Deductible does not apply.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Screening for lung cancer with low dose computed tomography (LDCT) For qualified individuals, a LDCT is covered every 12 months. **Eligible enrollees 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 or 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 enrollee 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.	There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision making visit or for the LDCT. Deductible does not apply.	There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision making visit or for the LDCT. Deductible does not apply.
Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when referred by your doctor. We cover three 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 two 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 referral. A physician must prescribe these services and renew their referral yearly if your treatment is needed into another plan year.	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services. Deductible does not apply.	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services. Deductible does not apply.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Smoking and tobacco use cessation (counseling to quit smoking) If you use tobacco, but do not have signs or symptoms of tobacco-related disease: We cover 2 counseling quit attempts within a 12 month period. Each counseling attempt includes up to 4 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 2 counseling quit attempts within a 12 month period. Each counseling attempt includes up to 4 face-to-face visits. These visits must be ordered by your doctor and provided by a qualified doctor or other Medicare-recognized practitioner.	There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits. Deductible does not apply.	There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits. Deductible does not apply.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Other services		
Services to treat outpatient kidney disease Covered services include: • 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) • Home dialysis or 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) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home and outpatient dialysis equipment and supplies 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 below, "Medicare Part B prescription drugs."	You do not need to get an approval from the plan before getting dialysis. But please let us know when you need to start this care, so we can help coordinate with your doctors. $0 copay for each Medicare-covered kidney disease education session Deductible does not apply. $0 copay for Medicare-covered outpatient dialysis Deductible does not apply. $0 copay for Medicare-covered home dialysis or home support services Deductible does not apply. $0 copay for Medicare-covered self-dialysis training Deductible does not apply.	You do not need to get an approval from the plan before getting dialysis. But please let us know when you need to start this care, so we can help coordinate with your doctors. $0 copay for each Medicare-covered kidney disease education session Deductible does not apply. $0 copay for Medicare-covered outpatient dialysis Deductible does not apply. $0 copay for Medicare-covered home dialysis or home support services Deductible does not apply. $0 copay for Medicare-covered self-dialysis training Deductible does not apply.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Services to treat outpatient kidney disease (con't)	$0 copay for Medicare-covered home dialysis equipment and supplies Deductible applies. $0 copay for Medicare-covered outpatient dialysis equipment and supplies Deductible applies.	$0 copay for Medicare-covered home dialysis equipment and supplies Deductible applies. $0 copay for Medicare-covered outpatient dialysis equipment and supplies Deductible applies.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Medicare Part B prescription drugs covered under your medical plan (Part B drugs)*	$0 copay for Medicare-covered Part B drugs Deductible does not apply.	$0 copay for Medicare-covered Part B drugs Deductible does not apply.
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" include substances that are naturally present in the body, such as blood clotting factors • Drugs that usually are not self-administered by the patient and are injected or infused while receiving physician, hospital outpatient, or ambulatory surgical center services • Drugs you take using durable medical equipment (such as nebulizers) that was 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 and outpatient dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics and erythropoiesis-stimulating agents such as Erythropoietin (Epogen®), Procrit® or Epoetin Alfa and Darboetin Alfa (Aranesp®) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases	$0 copay for Medicare-covered Part B drug administration Deductible does not apply. $0 copay for Medicare-covered Part B chemotherapy drugs Deductible does not apply. $0 copay for Medicare-covered Part B chemotherapy drug administration Deductible does not apply.	$0 copay for Medicare-covered Part B drug administration Deductible does not apply. $0 copay for Medicare-covered Part B chemotherapy drugs Deductible does not apply. $0 copay for Medicare-covered Part B chemotherapy drug administration Deductible does not apply.
We also cover some vaccines under our Part B prescription drug benefit.		
Some of Part B covered drugs listed above may be subject to step therapy.		

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Medicare Part B prescription drugs covered under your medical plan (Part B drugs) (con't) You may log into your secure member portal to find the list of Part B drugs that may be subject to step therapy. This list is located with your Plan Documents under your Benefits section. **If you have Part D prescription drug coverage, please refer to your *Evidence of Coverage* for information on your Part D prescription drug benefits.**		

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Additional supplemental benefits, services, and discounts		
Routine hearing services • Routine hearing exams, limited to 1 every 12 months • Hearing aid fitting evaluations, limited to 1 per covered hearing aid Routine hearing exams and fitting evaluations are limited to a $70 maximum benefit every 12 months combined in-network and out-of-network. • Hearing aids Hearing aids are limited to a $500 maximum benefit every 12 months combined in-network and out-of-network. Includes digital hearing aid technology and inner ear, outer ear, and over the ear models. Fitting adjustment after hearing aid is received, if necessary. The hearing aid benefit does not provide coverage for amplifiers, internet purchases, assistive listening devices (ALDs), earmolds or accessories. We have partnered with Hearing Care Solutions to bring you these discounts and services. For more information on your benefit, covered devices or to locate a Hearing Care Solutions provider please contact Member Services. Hearing benefit management administered by Hearing Care Solutions, an independent company.	Must use a Hearing Care Solutions participating provider. $0 copay for routine hearing exams Deductible does not apply. $0 copay for hearing aid fitting evaluations Deductible does not apply. $0 copay for hearing aids Deductible does not apply. Members receive a free battery supply during the first 3 years with a 64-cell limit per year, per hearing aid. After the plan pays benefits for routine hearing exams, hearing aids, and hearing aid fitting evaluations, you are responsible for any remaining cost.	$0 copay for routine hearing exams Deductible does not apply. $0 copay for hearing aid fitting evaluations Deductible does not apply. $0 copay for hearing aids Deductible does not apply. Members receive a free battery supply during the first 3 years with a 64-cell limit per year, per hearing aid. After the plan pays benefits for routine hearing exams, hearing aids, and hearing aid fitting evaluations, you are responsible for any remaining cost.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Routine foot care • Up to 12 covered visits per year combined in-network and out-of-network Routine foot care includes the cutting or removal of corns and calluses, the trimming, cutting, clipping or debriding of nails, and other hygienic and preventive maintenance care.	$0 copay for each visit to an in-network primary care physician for routine foot care Deductible applies. $15 copay for each visit to an in-network specialist for routine foot care Deductible applies. After the plan pays benefits for routine foot care, you are responsible for any remaining cost.	$0 copay for each visit to an out-of-network primary care physician for routine foot care Deductible applies. $15 copay for each visit to an out-of-network specialist for routine foot care Deductible applies. After the plan pays benefits for routine foot care, you are responsible for any remaining cost.
Annual routine physical exam The annual routine physical exam benefit covers a standard physical exam in addition to the Medicare-covered "Welcome to Medicare" or “Annual Wellness Visit.”	$0 copay for an annual physical exam Deductible does not apply.	$0 copay for an annual physical exam Deductible does not apply.

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Video doctor visits 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 mobile app and register. Make sure you have your 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 Membership Card ready when you sign up. **Benefits of a video doctor visit:** • The visit is just like seeing your regular doctor face-to-face, but just by web camera. • It's a great option for medical care when your doctor can't see you. Board-certified doctors can help 24/7 for most types of care and common conditions like the flu, colds, pink eye and more. • The doctor can send prescriptions to the pharmacy of your choice, if needed.[1] • If you're feeling stressed, worried or having a tough time, you can make an appointment to talk to a licensed therapist or psychologist from your home or on the road. In most cases, you can make an appointment and talk with a therapist[2] or make an appointment and talk with a psychiatrist[3] from the privacy of your home. Video doctor visits are intended to complement face-to-face visits with a board-certified physician and are available for most types of care. LiveHealth Online is the trade name of Health Management Corporation, a separate company, providing telehealth services on behalf of this Plan. 1. Prescription is prescribed based on physician recommendations and state regulations (rules). 2. Appointments are typically scheduled within 14 days, but may vary based on therapist/psychologist availability. Video psychologists or therapists cannot prescribe medications. 3. Appointments are typically scheduled within 14 days, but may vary based on psychiatrist availability. Video psychiatrists cannot prescribe controlled substances.	$0 copay for video doctor visits using LiveHealth Online Deductible does not apply.	

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Health and wellness education programs **SilverSneakers® Membership** SilverSneakers can help you live a healthier, more active life through fitness and social connection. You are covered for a fitness benefit through SilverSneakers at participating locations[1]. You have access to instructors who lead specially designed group exercise classes[2]. At participating locations nationwide[1], you can take classes[2] plus use exercise equipment and other amenities. Additionally, SilverSneakers FLEX® gives you options to get active outside of traditional gyms (like recreation centers, malls and parks). SilverSneakers also connects you to a support network and virtual resources through SilverSneakers LIVE™, SilverSneakers On-Demand™ and our mobile app, SilverSneakers GO™. All you need to get started is your personal SilverSneakers ID number. Go to SilverSneakers.com to learn more about your benefit or call 1-855-741-4985 (TTY: 711) Monday through Friday, 8 a.m. to 8 p.m. ET. Always talk with your doctor before starting an exercise program. 1. Participating locations ("PL") are not owned or operated by Tivity Health, Inc. or its affiliates. Use of PL facilities and amenities is limited to terms and conditions of PL basic membership. Facilities and amenities vary by PL. 2. Membership includes SilverSneakers instructor-led group fitness classes. Some locations offer members additional classes. Classes vary by location. SilverSneakers and SilverSneakers FLEX are registered trademarks of Tivity Health, Inc. SilverSneakers LIVE, SilverSneakers On-Demand and SilverSneakers GO are trademarks of Tivity Health, Inc. © 2021 Tivity Health, Inc. All rights reserved.	$0 copay for the SilverSneakers fitness benefit Deductible does not apply.	

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
24/7 NurseLine Also, as a member, you have access to a 24-hour nurse line, 7 days a week, 365 days a year. When you call our nurse line, you can speak directly to a registered nurse who will help answer your health-related questions. The call is toll free and the service is available anytime, including weekends and holidays. Plus, your call is always confidential. Call the nurse line at 1-833-514-1298. TTY users should call 711. Only 24/7 NurseLine is included in our plan. All other nurse access programs are excluded.	$0 copay for 24/7 NurseLine Deductible does not apply.	
Foreign travel emergency and urgently needed services Emergency or urgently needed care services while traveling outside the United States or its territories during a temporary absence of less than six months. Outpatient copay is waived if member is admitted to hospital within 72 hours for the same condition. • Emergency outpatient care • Urgently needed services • Inpatient care (60 days per lifetime) This coverage is worldwide and is limited to what is allowed under the Medicare fee schedule for the services performed/received in the United States. If you are in need of emergency care outside of the United States or its territories, you should call the Blue Cross Blue Shield Global Core Program at 800-810 BLUE or collect at 804-673-1177. Representatives are available 24 hours a day, 7 days a week, 365 days a year to assist you. When you are outside the United States or its territories, this plan provides coverage for emergency/urgent services only. This is a Supplemental Benefit and not a benefit covered under the Federal Medicare program. For more coverage, you may have the option of purchasing additional travel insurance through an authorized agency.	$50 copay for emergency care Deductible does not apply. $15 copay for urgently needed services Deductible does not apply. $300 copay per admission for emergency inpatient care Deductible does not apply.	

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Medicare Community Resource Support Need help with a specific issue? Your plan benefits are designed to cover what Medicare covers, as well as some additional supplemental benefits as described in this benefits chart, but we know that you might need additional help. As a member, your plan provides a Medicare Community Resource Support benefit to help bridge the gap between your medical benefits and your optimal health, by connecting you to resources available to you in your community. The Medicare Education and Outreach team can help you locate helpful resources within your community, such as food pantries, home maintenance programs, utility assistance programs, social activities, and much more. If you need assistance or have questions about this benefit, call Member Services at the number listed on the back of your Membership Card.	$0 copay for Medicare Community Resource Support Deductible does not apply.	
Healthy Meals* • Provides up to 14 meals per qualifying event, allows up to four (4) events each year (56 meals in total). • A qualifying event includes when you are in a hospital or a skilled nursing facility and are discharged home or when you have a Body Mass Index (BMI) of 18.5 or under, you have a BMI of 25 or higher or an A1C level more than 9.0 as determined by your provider. For fastest qualification, your provider or case manager is best suited to request this on your behalf. Alternatively, you can contact Member Services and a representative will initiate the process to validate your eligibility. In order for us to provide your meals benefit, we, or a third party acting on our behalf, may need to contact you using the phone number you provided to confirm shipping details and any nutritional requirements.	$0 copay for Healthy Meals Deductible does not apply.	

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Healthy Pantry* Special Supplemental Benefits for the Chronically Ill Maintaining a healthy diet to support a chronic medical condition can help you maintain or improve your overall health. As a Special Supplemental Benefit for the Chronically Ill, you must: • Meet the CMS mandated criteria. This criteria can be found in the Chapter "Medical benefits (what is covered and what you pay)" in your Evidence of Coverage. • Provide supporting documentation from your physician identifying you, as having a condition that can be made worse by not having or would benefit from having nutritional counseling and help with obtaining appropriate pantry items. We can help you obtain this information. We are unable to initiate your benefit without speaking to you. By requesting this benefit you are expressly authorizing us to contact you by telephone. Upon approval you are eligible for: • Monthly nutritional counseling sessions via phone. • A monthly delivery of non-perishable pantry items sent directly to your home. Your monthly box of staples will consist of a variety of non-perishable foods that can vary each month. • Your nutritional consultations will help you utilize these items and provide you with information on how to supplement them with additional food resources. You can contact Member Services on the back of your Membership Card to begin the process to validate your eligibility.	$0 copay for Healthy Pantry Deductible does not apply.	

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Health and fitness tracker for your body & mind health: Coverage includes a fitness tracking device to track your physical activity and a member engagement website designed to provide guidance, encouragement, and motivation. Limit is one device every two years provided through our contracted vendor. Additionally, this benefit provides access to a web based memory fitness program designed to help maintain or improve your focus, attention, reaction time, brain speed, and memory. Please contact Member Services for more information.	$0 copay for health and fitness tracker Deductible does not apply.	

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Routine transportation • Routine transportation covers up to 24 one-way trips each year. A trip is defined as a ride from one destination to another. A trip is limited to 30 miles. • Trips are covered within your local service area for plan covered services, such as medical visits, visits to SilverSneakers locations and visits to a pharmacy to pick up prescriptions. A stop at a pharmacy after a doctor's appointment to pick up prescriptions will not count as a separate trip. When you schedule a pick-up from the visit, tell the vendor that you need to go to the pharmacy. Ask the provider/facility to call in the prescription so you have a shorter wait. • You must schedule trips 2 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 when accessing non-covered services. We have partnered with Access2Care to bring you these discounts and services. Please contact Member Services if you have questions about this benefit. Access2Care, an independent company is providing routine transportation on behalf of our plan.	$0 copay for routine transportation Deductible does not apply.	

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Private duty nursing Private duty nursing is skilled nursing care provided to a recipient by a registered nurse (R.N.) or licensed practical nurse (L.P.N.) in the home or in a hospital setting. Skilled care is defined as medically necessary services, when prescribed by a physician, that can only be rendered under State law or regulation by licensed health professionals such as a medical doctor, physician's assistant, physical therapist, occupational therapist, speech therapist, certified clinical social worker, certified nurse midwife, licensed practical nurse or registered nurse. Services are limited to the time such services are deemed medically necessary. Private duty nursing is limited to a maximum benefit of $2,500 per year combined in-network and out-of-network.	20% coinsurance for private duty nursing Deductible applies. After the plan pays benefits for private duty nursing, you are responsible for any remaining cost.	20% coinsurance for private duty nursing Deductible applies. After the plan pays benefits for private duty nursing, you are responsible for any remaining cost.
Medicare-approved clinical research studies A clinical research study 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. If you participate in a Medicare-approved study, Original Medicare pays the doctors and other providers for the covered services you receive as part of the study. Although not required, we ask that you notify us if you participate in a Medicare-approved research study.	After Original Medicare has paid its share of the Medicare-approved study, this plan will pay the difference between what Medicare has paid and this plan's cost-sharing for like services. Any remaining plan cost-sharing you are responsible for will accrue toward this plan's out-of-pocket maximum.	

Covered services	What you must pay for these covered services	
	In-Network	Out-of-Network
Wellness rewards We have created a wellness rewards incentive program to help members like you stay healthy. With this voluntary program, you can earn up to a $200 annual incentive for completion of services. These services can include, but not limited to, preventive screenings such as breast cancer screening, colorectal cancer screenings, comprehensive diabetes management (HbA1c testing/retinal screening), and bone health. Additional screenings may be added or changed each year. Participation in the annual incentive program will require the completion of a Health Risk Assessment. Please contact Member Services for more information.	$0 copay for the wellness rewards program Deductible does not apply.	
Annual out-of-pocket maximum All copays, coinsurance, and deductibles listed in this benefits chart are accrued 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.	$1,470 Combined in-network and out-of-network	

* 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 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 Chart.

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 NYC Medicare Advantage Plus (PPO), which is a group-sponsored Medicare PPO plan

You are covered by Medicare, and you have chosen to get your Medicare health care coverage through our plan, NYC Medicare Advantage Plus (PPO).

There are different types of Medicare health plans. NYC Medicare Advantage Plus (PPO) is a Medicare Advantage PPO Plan (PPO stands for Preferred Provider Organization). This plan does not include Part D prescription drug coverage. Like all Medicare health plans, this Medicare Advantage PPO is 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 explains 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 words "coverage" and "covered services" refer to the medical care and services available to you as a member of NYC Medicare Advantage Plus (PPO).

It's important for you to learn what your 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 Member Services. 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 your 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 benefits described in this *Evidence of Coverage* are in effect during the months listed on the first page, as long as you are a validly enrolled member in this plan.

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 your plan after December 31, 2022, or on your group-sponsored plan's renewal date. We can also choose to stop offering the plan, or to offer it in a different service area, after December 31, 2022.

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 explains 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 are eligible for coverage under your group-sponsored health plan retiree benefits.

If you have questions regarding your eligibility for coverage under your group-sponsored retiree benefits, please contact the group sponsor by emailing the New York City Employee Benefits Program at **healthbenefits@olr.nyc.gov**

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 physicians' services, home infusion therapy, and other outpatient services) and certain items (such as durable medical equipment (DME) and supplies).

Section 2.3 Here is the service area for our plan

Although Medicare is a federal program, our plan is available only to individuals who live in our geographic service area. To remain a member of our plan, you must continue to reside in our plan service area. The service area is described below:

Our CMS-defined geographic service area includes all 50 states, Washington, D.C., Puerto Rico, Guam, U.S. Virgin Islands, American Samoa and Northern Mariana Islands.

If you plan to move out of the service area, please contact all of the following to update your contact information:

- Member Services. Phone numbers are printed on the back cover of this booklet.
- Group sponsor of your group plan.
- Social Security. You can find their phone numbers and contact information in Chapter 2, Section 5.

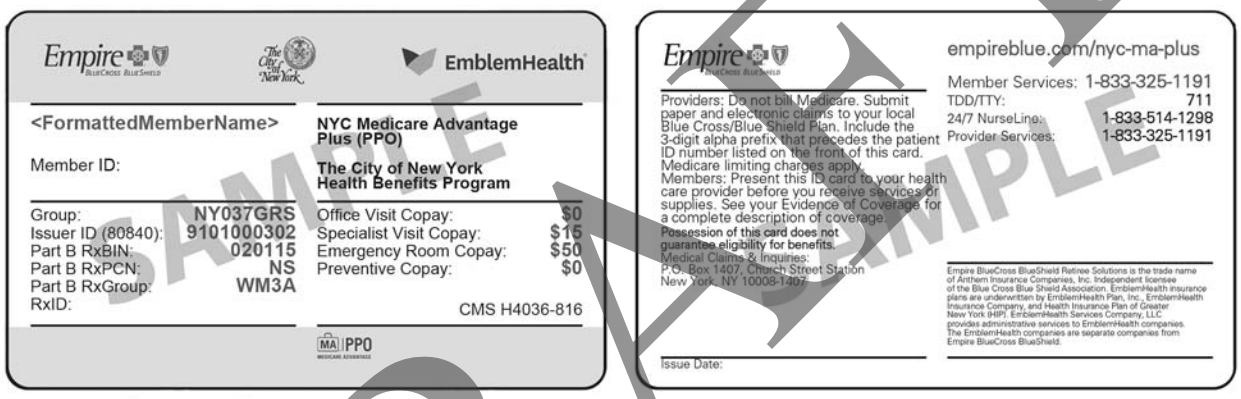
Section 2.4 U.S. citizen or lawful presence

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 NYC Medicare Advantage Plus (PPO) if you are not eligible to remain a member on this basis. NYC Medicare Advantage Plus (PPO) 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 plan membership card whenever you get any services covered by this plan. Here's a sample plan membership card to show you what yours will look like:



Do NOT use your 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 plan 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 red, white and blue Medicare card instead of using your plan 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 Member Services right away and we will send you a new card. Phone numbers for Member Services are printed on the back cover of this booklet. You can also log into **www.empireblue.com/nyc-ma-plus** to print temporary plan membership cards.

Section 3.2 The *Provider Directory*: Your guide to all providers in the plan's network

The *Provider Directory* lists our in-network providers and durable medical equipment (DME) suppliers.

This NYC Medicare Advantage Plus (PPO) plan allows you to see a provider you choose who accepts Medicare and our plan as an out-of-network provider. Your cost share is the same for in- or out-of-network providers.

What are "in-network providers?"

In-network providers are the doctors and other health care professionals, medical groups, DME 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.

Why do you need to know which providers are part of our network?

As a member of our plan, you can choose to receive care from out-of-network providers. Our plan will cover services from either in-network or out-of-network providers, as long as the services are covered benefits and medically necessary. See Chapter 3, "Using the plan's coverage for your medical services," and Chapter 4, "Medical benefits (what is covered and what you pay)," for more specific information.

Please note: While you can get your care from an out-of-network provider, the provider must be enrolled and eligible to participate in Medicare. Except for emergency care, we cannot pay a provider who is not eligible to participate in Medicare. If you go to a provider who is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive. Check with your provider before receiving services to confirm that they are enrolled and eligible to participate in Medicare. If you need any assistance with providers or have questions, please call our retiree-dedicated Member Services team. Please call at 1-833-325-1191, TTY: 711.

If you don't have your copy of the *Provider Directory*, you can request a copy from Member Services. Phone numbers are printed on the back cover of this booklet. You may ask Member Services for more information about our in-network providers, including their qualifications.

How do you locate a provider?

To locate an in-network provider, you should:

- Call your plan's Member Services phone number on the back cover of this booklet
- Visit "Find Care" on our website or
- Call **1-800-810-Blue** (**1-800-810-2583**)

1. If you are in an area without access to in-network providers, designated as a non-network county, you can use out-of-network providers who participate with Medicare.
2. If you are currently using providers who participate with Medicare, you should first inform your current providers that:
    - You are enrolled under a new plan.
    - Although the new plan is a PPO, you can continue to be seen by them if they agree.
3. If the provider elects not to provide services, you can self-refer to another provider that participates with Medicare.
4. If you are unable to find a provider, please contact Member Services, who will:
    - Respond with at least one provider of the requested provider type(s) within a reasonable travel distance.
    - Respond within 72 hours for standard requests for a provider.
    - Respond on the same day for urgent care services (medical services to be furnished within 12 hours in order to avoid the likely onset of an emergency medical condition).

Please note: Independent laboratory and specialty pharmacy claims are submitted to the plan based on the location of your referring/ordering provider. The independent lab and specialty pharmacy network status is determined based on the plan's service area for the referring provider. Durable medical equipment (DME) and supplies claims are submitted to the plan based on the location where the item is shipped to (your residence), or the location where the item was purchased from a retail store. The DME network status is determined based on the plan's service area for the location where the item was shipped to or where the item was purchased from a retail store.

SECTION 4 Your monthly premium

Section 4.1 How much is your plan premium?

Your coverage is provided through a contract with your group sponsor. Please email the New York City Employee Benefits Program at **healthbenefits@olr.nyc.gov** to get information on any plan premium amounts you may be responsible for. Or, if you are billed directly by your plan, please contact Member Services.

Many members are required to pay other Medicare premiums

As explained in Section 2 above, in order to be eligible for your 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 to pay your Medicare premiums for you to remain a member of your plan.**

Your copy of the *Medicare & You 2022* handbook gives information about the Medicare premiums in the section called "2022 Medicare Costs." This explains how the Medicare Part B premiums differ for people with different incomes. Everyone with Medicare receives a copy of the *Medicare & You* handbook 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 the *Medicare & You 2022* handbook 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, 7 days a week. TTY users should call **1-877-486-2048**.

Section 4.2 Can we change your monthly plan premium during the year?

The City of New York will pay all premiums in most cases. Generally, your plan premium won't change during the benefit year. You will be notified in advance if there will be any changes for the next benefit year in your plan premium.

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.

The doctors, hospitals and other providers need to have the correct information about you. **These 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 usknow 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 a group sponsor, 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 Member Services. Phone numbers are printed on the back cover of this booklet. Please remember to also notify your group sponsor of your group plan by emailing the New York City Employee Benefits Program at **healthbenefits@olr.nyc.gov** so they will have your most up-to-date contact information on file.

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 insurance coverage that you have in addition to this retiree coverage. 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 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 Member Services. 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, there are rules set by Medicare that decide which of your insurance plans pays first, and which pays second or even third. 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.

If you have another group-sponsored health plan in addition to this plan, the following rules will be used to determine whether this retiree coverage or your other coverage pays first:

- If you have retiree coverage, Medicare pays first.
- If your group-sponsored health plan coverage is based on your current employment or a family member's current employment, who pays first depends on your age, the number of people employed by your group-sponsored plan, 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 plan pays first if the group has 100 or more employees or at least one group in a multiple group-sponsored plan that has more than 100 employees.
    - If you're over 65 and you are still working, your plan pays first if the group has 20 or more employees or at least one group in a multiple group-sponsored plan that has more than 20 employees.
- If you have Medicare because of ESRD, your group-sponsored 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, group-sponsored 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 Member Services. 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 Your plan contacts (how to contact us, including how to reach Member Services at the plan)

How to contact our plan's Member Services

For assistance, please call or write to Member Services. We will be happy to help you.

Method	Member Services – Contact Information
CALL	**1-833-325-1191** Calls to this number are free. Monday through Friday, 8 a.m. to 9 p.m. ET, except holidays Member Services also has free language interpreter services available for non-English speakers.
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
FAX	**1-844-470-8861**
WRITE	NYC Medicare Advantage Plus (PPO) P.O. Box 61030 Virginia Beach, VA 23466
WEBSITE	**www.empireblue.com/nyc-ma-plus**

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 only need to request a coverage decision or submit an appeal or a complaint once.

You may call us if you have questions about our coverage decision process.

Method	Coverage Decisions for Medical Care – Contact Information
CALL	**1-833-325-1191** Calls to this number are free. Monday through Friday, 8 a.m. to 9 p.m. ET, except holidays

Method	Coverage Decisions for Medical Care – Contact Information
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
WRITE	Empire BlueCross BlueShield Retiree Solutions Mailstop: OH0205-A537 4361 Irwin Simpson Rd Mason, OH 45040
WEBSITE	**www.empireblue.com/nyc-ma-plus**

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)."

You only need to request a coverage decision, submit an appeal or a complaint once.

Method	Appeals – Contact Information
CALL	**1-833-325-1191** Calls to this number are free. Monday through Friday, 8 a.m. to 9 p.m. ET, except holidays
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
WRITE	Empire BlueCross BlueShield Retiree Solutions Mailstop: OH0205-A537 4361 Irwin Simpson Rd Mason, OH 45040
WEBSITE	**www.empireblue.com/nyc-ma-plus**
FAX	**1-888-458-1406**

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 in-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 – Contact Information
CALL	**1-833-325-1191** Calls to this number are free. Monday through Friday, 8 a.m. to 9 p.m. ET, except holidays
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
WRITE	Empire BlueCross BlueShield Retiree Solutions Mailstop: OH0205-A537 4361 Irwin Simpson Rd Mason, OH 45040
MEDICARE WEBSITE	You can submit a complaint about your 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 your plan 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."

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	Payment Requests – Contact Information
CALL	**1-833-325-1191** Calls to this number are free. Monday through Friday, 8 a.m. to 9 p.m. ET, except holidays Member Services also has free language interpreter services available for non-English speakers.

Method	Payment Requests – Contact Information
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
WRITE	NYC Medicare Advantage Plus (PPO) Empire BlueCross BlueShield Retiree Solutions P.O. Box 1407 Church Street Station New York, NY 10008-1407

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.
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.

Method	Medicare – Contact Information
	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 your plan: • **Tell Medicare about your complaint:** You can submit a complaint about your 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. SHIP is an independent program (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.

The SHIP 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. SHIP counselors can also help you understand your Medicare plan choices and answer questions about switching plans.

Method to Access SHIP and Other Resources:
• Visit **www.medicare.gov** • Click on "**Forms, Help, and Resources**" on far right of menu on top

Method to Access SHIP and Other Resources:

- In the drop down click on "**Phone Numbers & Websites**"
- You now have several options
  - Option #1: You can have a **live chat**
  - Option #2: You can click on any of the "**TOPICS**" in the menu on bottom
  - Option #3: You can select your **STATE** from the dropdown menu and click **GO**. This will take you to a page with phone numbers and resources specific to your state.

For contact information, please refer to the state-specific agency listing, which is located in the SHIP section of Chapter 11 in this booklet.

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 (QIO) for serving Medicare beneficiaries in each state. QIOs have different names depending on which state they are in.

The QIO 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. It is an independent organization. It is not connected with our plan.

You should contact the QIO in any of these situations:

- You have a complaint about the quality of care you have received.
- You made a complaint to your plan and you don't like our response to your complaint.
- 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 is ending too soon.

For contact information, please refer to the state-specific agency listing located in the QIO section of Chapter 11 in this booklet.

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. 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 a.m. to 7:00 p.m., 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 a.m. to 7:00 p.m., 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+).
- **Qualifying Individual (QI):** Helps pay Part B premiums.
- **Qualified Disabled & Working Individuals (QDWI):** Helps pay Part A premiums.

For contact information, please refer to the state-specific agency listing, which is located in the Medicaid section of Chapter 11 in this booklet.

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. If you press "0," you may speak with an RRB representative from 9:00 a.m. to 3:30 p.m., Monday, Tuesday, Thursday, and Friday, and from 9:00 a.m. to 12:00 p.m. on Wednesday. If you press "1," you may access the automated RRB HelpLine and recorded information, 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 another group sponsor?

If you have group insurance from another group sponsor, please contact **that group sponsor's benefits administrator** to identify how that coverage will work with these benefits. You may also call **1-800-MEDICARE** (**1-800-633-4227**). TTY users should call **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 your 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 your plan.

For the details on what medical care is covered by your plan and how much you pay when you get this care, use the benefits chart located at the front of this booklet and Chapter 4, "Medical benefits (what is covered and what you pay)."

Section 1.1 What are "in-network providers" and "covered services"?

This plan lets you pay the same copay or coinsurance percentage when seeing either in-network providers or out-of-network providers who accept Medicare and our plan as an out-of-network provider. Even if you see an out-of-network provider, you will only pay your copay amount or coinsurance.

NYC Medicare Advantage Plus Plan Provider Network:
Through the Empire and EmblemHealth alliance, NYC Medicare Advantage Plus plan members have access to a comprehensive in-network provider network that includes the following:

Together, Empire and EmblemHealth's provider network is exclusive to City of New York retirees through the NYC Medicare Advantage Plus plan.

The NYC Medicare Advantage Plus plan is a Group Medicare PPO plan. Retirees can visit any doctor or hospital that accepts Medicare nationally. About 640,000 of those Medicare providers are currently in the Empire and EmblemHealth alliance networks and are contractually bound to accept members of the NYC Medicare Advantage Plus plan.

NYC Medicare Advantage Plus Plan members have national access to the Medicare Advantage PPO providers contracted with Blue Cross Blue Shield Association plans.

EmblemHealth's provider network of participating professional providers includes chiropractors, occupational therapists, physical therapists and speech therapists. It applies only to the following areas: New York, Bronx, Kings, Queens, Richmond, Nassau, Suffolk, Westchester, Orange, Rockland, Putnam, Dutchess and Sullivan counties.

Empire's in-network facilities and behavioral health providers can be accessed in New York, Bronx, Kings, Queens, Richmond, Nassau, Suffolk, Westchester, Orange, Rockland, Putnam, Dutchess and Sullivan counties.

Rest assured the Blue Cross and Blue Shield Medicare Advantage PPO professional and facility providers *outside of the counties* listed above are considered in-network providers.

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 and health care services. The term "providers" also includes hospitals and other health care facilities.
- **"In-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. In-network providers may also be referred to as "plan providers." With your plan, you are able to see any doctor that accepts Medicare and the plan.

- **"Covered services"** include all the medical care, health care services, supplies and equipment that are covered by your plan. Your covered services for medical care are listed in the benefits chart located at the front of this booklet.

Section 1.2 Basic rules for getting your medical care covered by our plan

As a Medicare health plan, your plan must cover all services covered by Original Medicare and must follow Original Medicare's coverage rules.

Your plan will generally cover your medical care as long as:

- **The care you receive is included in your plan's medical benefits chart**. This chart is located at the front 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 receive your care from a provider who is eligible to provide services under Original Medicare.** As a member of our plan, you can receive your care from either an in-network provider or an out-of-network provider. For more about this, see Section 2 in this chapter.
    - The providers in our network are listed in the *Provider Directory*.

  Please note: While you can get your care from an out-of-network provider, the provider must be eligible to participate in Medicare. Except for emergency care, we cannot pay a provider who is not eligible to participate in Medicare. If you go to a provider who is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive. Check with your provider before receiving services to confirm that they are eligible to participate in Medicare.

SECTION 2 Using in-network and out-of-network providers to get your medical care

Section 2.1 How to get care from specialists and other in-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.

You do not need to obtain a referral before going to an in-network specialist. See your *Provider Directory* and our website for provider information about in-network specialists.

For certain services, your in-network physician will need to get prior approval from us. This is called getting "prior authorization." Prior authorization is required for in-network physicians and recommended for out-of-network physicians. Please refer to your benefits chart located at the front of this booklet for the services for which prior authorization is required or recommended.

What if a specialist or another in-network provider leaves your plan?

It is important that you know that 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 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.

You can call Member Services for assistance. Phone numbers are printed on the back cover of this booklet.

Section 2.2 How to get care from out-of-network providers

As a member of your plan, you can choose to receive care from out-of-network providers. However, please note, providers that do not contract with us are under no obligation to treat you, except in emergency situations. Your plan will cover services from either in-network or out-of-network providers, as long as the services are covered benefits and are medically necessary. Here are other important things to know about using out-of-network providers:

- You can get your care from an out-of-network provider; however, in most cases that provider must be eligible to participate in Medicare. Except for emergency care, we cannot pay a provider who is not eligible to participate in Medicare. If you receive care from a provider who is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive. Check with your provider before receiving services to confirm that they are eligible to participate in Medicare.
- You don't need to get a referral or prior authorization when you get care from out-of-network providers. However, before getting services from out-of-network providers, you may want to ask for a pre-visit coverage decision to confirm that the services you are getting are covered and are medically necessary. See Chapter 7, Section 4 for information about asking for coverage decisions. This is important because:

- Without a pre-visit coverage decision, if we later determine that the services are not covered, were not medically necessary, or we could not determine medical necessity due to lack of medical records, we may deny coverage and you will be responsible for the entire cost. If we say we will not cover your services, you have the right to appeal our decision not to cover your care. See Chapter 7, "What to do if you have a problem or complaint (coverage decisions, appeals, complaints)," to learn how to make an appeal.

- It is best to ask an out-of-network provider to bill your local Blue Plan first. But if you have already paid for the covered services, we will reimburse you for our share of the cost for covered services. Or, if an out-of-network provider sends you a bill that you think we should pay, you can send it to us for payment. See Chapter 5, "Asking us to pay our share of a bill you have received for covered medical services," for information about what to do if you receive a bill or if you need to ask for reimbursement.
- Our CMS-defined geographic service area includes all 50 states, Puerto Rico, Washington D.C., Guam, U.S. Virgin Islands, American Samoa and Northern Mariana Islands.

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 provider.
- **As soon as possible, notify us of your emergency by calling Member Services.** Phone numbers are printed on the back cover of this booklet.

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. Your 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 located at the front of this booklet.

Your plan may cover emergency care outside of the United States. Please refer to the benefits chart located at the front of this booklet for additional information.

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 your plan.

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.

Section 3.2 Getting care when you have an urgent need for services

What are "urgently needed services"?

"Urgently needed services" are a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical care. Urgently needed services may be furnished by in-network providers or by out-of-network providers. The unforeseen condition could, for example, be an unforeseen flare-up of a known condition that you have.

What if you are outside the plan's service area when you have an urgent need for care?

Your plan may cover urgently needed care outside of the United States. Please refer to the benefits chart located at the front of this booklet for additional information.

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 website, **www.empireblue.com/nyc-ma-plus**, for information on how to obtain needed care during a disaster.

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

Your plan covers all medical services that are medically necessary and are obtained consistent with plan rules. These services are listed in the plan's medical benefits chart located at the front of this booklet. You are responsible for paying the full cost of services that aren't covered by your plan, either because they are not plan-covered services, or plan rules were not followed.

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 Member Services 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. These costs will not count towards your out-of-pocket maximum. You can call Member Services 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 your 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 your plan and continue to get the rest of your care (the care that is not related to the study) through your plan.

If you want to participate in a Medicare-approved clinical research study, you do *not* need to get approval from your plan. The providers that deliver your care as part of the clinical research study do *not* need to be part of your plan's network of providers.

Although you do not need to get your 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 Member Services 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. Phone numbers are printed on the back cover of this booklet.

Section 5.2 When you participate in a clinical research study, who pays for what?

Once you join a Medicare-approved clinical research study, Original Medicare provides coverage 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, your 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 your 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 your 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 your 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 your 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 your 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 visiting the Medicare website to read or download the publication "*Medicare and Clinical Research Studies*." (The publication is available at: **www.medicare.gov/Pubs/pdf/02226-Medicare-and-Clinical-Research-Studies.pdf.**) 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 your 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.
- Your 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.

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 a period of 13 months. As a member of our plan, you will acquire ownership of the DME items following a rental period not to exceed 13 months. Your copayments will end when you obtain ownership of the item.

What happens to payments you made for DME if you switch to Original Medicare?

If you did not acquire ownership of the DME item while in your 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 your 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, our plan 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 our plan 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?

Your cost sharing for Medicare oxygen equipment coverage is located in the benefits chart at the front of this booklet.

As a member of our plan, you will acquire ownership of the oxygen equipment following a rental period not to exceed 36 months. Your cost sharing will end when you obtain ownership of the item.

Section 8.3 What happens if you leave your plan and return to Original Medicare?

If you return to Original Medicare, and did not acquire ownership prior to leaving our plan, 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 our plan, join our plan 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 our plan and then return to Original Medicare, you will pay full cost sharing for oxygen equipment coverage.

SECTION 9 Information about hospice care

Section 9.1 What is hospice care?

"Hospice" is a special way of caring for people who are terminally ill and providing counseling for their families. Hospice care is physical care and counseling that is given by a team of people who are part of a Medicare-certified public agency or private company. Depending on the situation, this care may be given in the home, a hospice facility, a hospital, or a nursing home. Care from a hospice is meant to help patients who qualify for hospice care in the last months of life by giving comfort and relief from pain. The focus is on care, not cure.

Section 9.2 How do you get hospice care if you are terminally ill?

As a member of your plan, you may receive care from any Medicare-certified Hospice program. Your doctor can help you arrange hospice care. If you are interested in using hospice services, you may call Member Services to get a list of the Medicare-certified Hospice providers in your area. Phone numbers for Member Services are printed on the back cover of this booklet. Or you may call the Regional Home Health Intermediary at **1-800-633-4227**. To get more information, visit **www.medicare.gov** on the web. Type "*Medicare Hospice Benefits*" in the search box. Or call **1-800-MEDICARE (1-800-633-4227)**. TTY users should call **1-877-486-2048**.

Section 9.3 How is your hospice care paid for?

If you enroll in a Medicare-certified Hospice program, the Original Medicare Plan, rather than this plan, will pay the hospice provider for the services you receive. Original Medicare will also pay for any services you receive that are not related to your terminal condition.

After Original Medicare has paid its share of the cost for these services, your plan may reimburse part of your costs, if the deductible or coinsurance amount applied by Original Medicare was greater than the amount that would have been applied by this plan.

SECTION 10 Information about organ transplants

Section 10.1 How to get an organ transplant if you need it

If you need an organ transplant, we will arrange to have your case reviewed by one of the transplant centers that is approved by Medicare and your plan. Some hospitals that perform transplants are approved by Medicare, and others aren't. The Medicare-approved transplant center, in conjunction with your plan, will decide whether you are a candidate for a transplant. When all requirements are met and your plan has authorized the transplant and all associated care, the following types of transplants are covered: heart, lung, combined heart/lung, liver, intestine, combined liver/intestine, kidney, pancreas, combined kidney/pancreas, multivisceral transplant, corneal, stem cell/bone marrow, and donor leukocyte infusion. The

following transplants are covered only if they are performed in a Medicare and plan-approved transplant center: heart, lung, combined heart/lung, liver, intestine, combined liver/intestine, kidney, pancreas, and combined kidney/pancreas.

When it is determined that a transplant may be needed, your doctor will need to prior authorize your transplant by calling the Member Services number on the back of your plan membership card and ask to speak with a Transplant Coordinator. All transplants are required to be prior authorized. Although certain transplants are covered, you must meet specific medical criteria for benefit coverage and the transplant must be performed in an approved facility. The Transplant Coordinator will help you in determining whether the proposed transplant is a covered benefit and that you have met all the requirements. The Transplant Coordinator will also advocate on your behalf with your transplant team to assure your best outcome.

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 the plan provides transplant services at a location outside the pattern of care for transplants in your community and you choose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion.

The reimbursement for transportation costs are while you and your companion are traveling to and from the medical providers for services related to the transplant care. Your plan defines the distant location as a location that is outside of the member's service area AND a minimum of 75 miles from the member's home. Transportation and lodging costs will be reimbursed for travel mileage and lodging consistent with current IRS travel mileage and lodging guidelines. Accommodations for lodging will be reimbursed at the lesser of: 1) billed charges, or 2) $50 per day per covered person up to a maximum of $100 per day per covered person consistent with IRS guidelines.

CHAPTER 4

Medical benefits (what is covered and what you pay)

Chapter 4 Medical benefits (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. The medical benefits chart located at the front of this booklet lists your covered services and shows how much you will pay for each covered service as a member of your plan. Later in this chapter, you can find information about medical services that are not covered and about 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. Section 1.2 explains your yearly deductible for certain categories of service.
- 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 located at the front of this booklet explains 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 located at the front of this booklet explains your coinsurance.

The cost of the service, on which your member liability coinsurance is based, will be either:

- The Medicare allowable amount for covered services.
- – *or* – the amount either we negotiate with the provider or the local Blue Medicare Advantage plan negotiates with its provider on behalf of our members, if applicable. The amount negotiated may be either higher than, lower than or equal to the Medicare allowable amount.
- Your plan provides benefits for all Original Medicare services and may provide additional benefits for services not covered by Original Medicare. For more information on how your member cost share is calculated, please see Chapter 4, Section 1.3.

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 Member Services.

Section 1.2 What is your plan deductible?

Please refer to the benefits chart located at the front of this booklet to determine if your plan has an annual deductible. If you have an annual deductible, this is the amount you have to pay out-of-pocket before we will pay our share for your covered medical services.

Until you have paid the deductible amount, you must pay the full cost for most of your covered services. Once you have paid your deductible, we will begin to pay our share of the costs for covered medical services and you will pay your share for the rest of the plan year.

The deductible does not apply to some services, including certain in-network preventive services. This means that we will pay our share of the costs for these services even if you haven't paid your deductible yet. Please refer to the benefits chart located at the front of this booklet to determine which services are not subject to your plan deductible.

Section 1.3 What is the most you will pay for Medicare Part A and Part B covered medical services?

Under our plan, there is a limit on what you have to pay out-of-pocket for covered medical services:

- Your **combined maximum out-of-pocket amount** is located on the benefits chart in the front of this booklet. This is the most you may pay during the plan year for covered Medicare Part A and Part B services received from both in-network and out-of-network providers. When applicable, the amounts you pay for deductibles, copayments and coinsurance for covered services count toward this combined maximum out-of-pocket amount. The amounts you pay for your plan premiums do not count toward your combined maximum out-of-pocket amount. If you have paid the amount located on the benefits chart at the front of this booklet for covered services, you will have 100% coverage and will not have any out-of-pocket costs for the rest of the plan year for covered Part A and Part B services.

  However, you must continue to pay the Medicare Part B premium, however, please note the City of New York reimburses for the Part B Premium. Please refer to the benefits chart located at the front of this booklet to determine your plan's maximum out-of-pocket amount, which services are included, and how your plan's maximum out-of-pocket accumulates.

Section 1.4 Our plan also limits your out-of-pocket costs for certain types of services

In addition to the combined maximum out-of-pocket amounts for covered Part A and Part B services (see Section 1.3 above), you may also have a separate maximum out-of-pocket amount that applies only to certain types of medical services. Please refer to the benefits chart located at the front of this booklet to see if you have separate maximum out-of-pocket amounts and what medical services are included.

Section 1.5 Our plan does not allow providers to "balance bill" you

As a member of our plan, an important protection for you is that after you meet any deductibles 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 an in-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 obtain covered services from an in-network provider, you pay the coinsurance percentage multiplied by our plan's reimbursement rate, as determined in the contract between the provider and our plan.
    - If you obtain 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.
    - If you obtain covered services from an out-of-network DME supplier who does not participate with Medicare, then you pay the coinsurance amount multiplied by the total charge of the non-participating provider's bill.
    - If you obtain services not covered by Medicare but covered by our plan from an out-of-network provider, then you pay the coinsurance amount multiplied by the total charge of the out-of-network provider's bill.
- If you see a provider that has opted out of Medicare, you will be responsible for the entire charge. An opt-out provider is a provider who is not enrolled with Medicare, either as a Medicare participating provider or a non-participating Medicare provider.
- If you believe a provider has "balance billed" you, call Member Services. Phone numbers are printed on the back cover of this booklet and on the back of your member ID card.

SECTION 2 Use the medical benefits chart located at the front of this booklet, along with this chapter, 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 your plan

The medical benefits chart located at the front of this booklet lists the services our plan covers and what you pay out-of-pocket for each service. 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 the accepted standards of medical practice.
- Some of the services listed in the medical benefits chart are covered as in-network services *only* if your doctor or other in-network provider gets approval in advance from us. This is sometimes called "prior authorization."
    - Covered services that need approval in advance to be covered as in-network services are identified in the medical benefits chart.
    - Prior authorization is only required for services obtained from an in-network provider. You never need prior authorization for out-of-network services from out-of-network providers, but we do request that you notify us of services and recommend you ask us to make a coverage decision in advance.

Other important things to know about our coverage:

- For benefits where your cost sharing is a coinsurance percentage, the amount you pay depends on what type of provider you receive the services from as noted below:
    - If you receive the covered services from an in-network provider, you pay the coinsurance percentage multiplied by our plan's reimbursement rate, as determined in the contract between the provider and our 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.
    - 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.
    - If you receive covered services from an out-of-network DME supplier who does not participate with Medicare, then you pay the coinsurance amount multiplied by the total charge of the non-participating provider's bill.
    - If you receive services not covered by Medicare but covered by our plan from an out-of-network provider, then you pay the coinsurance amount multiplied by the total charge of the out-of-network provider's bill.
- If you see a provider that has opted out of Medicare, you will be responsible for the entire charge. (An opt-out provider is a provider who is not enrolled with Medicare, either as a Medicare participating provider or a non-participating Medicare provider.)
- 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 2022* 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 2022, either Medicare or our plan will cover those services.

Some plans may include special supplemental benefits for the chronically ill (SSBCI benefits), as defined by the Centers for Medicare & Medicaid Services (CMS). If you are diagnosed with the following chronic condition(s)* identified below and meet certain criteria, you may be eligible for special supplemental benefits for the chronically ill.

- Chronic alcohol and other drug dependence
- Certain autoimmune disorders
- Cancer (excluding pre-cancer conditions or in-situ status)
- Certain cardiovascular disorders
- Chronic heart failure
- Dementia

- Diabetes mellitus
- End-stage liver disease
- End-stage renal disease (ESRD) requiring dialysis
- Certain hematologic disorders
- HIV/AIDS
- Certain chronic lung disorders
- Certain chronic and disabling mental health conditions
- Certain neurologic disorders
- Stroke
- Other chronic conditions such as those diseases or illnesses that are expected to be present for a majority of the plan year, impact activities of daily living, and require on-going medical treatment

*The above list of chronic conditions was provided by CMS.

For plans that offer SSBCI benefits, you are eligible based on qualifying clinical criteria of a chronic condition as determined and confirmed by your physician.

To determine if your plan offers SSBCI benefits, please refer to the benefits chart located at the front of this booklet. SSBCI benefits are located under the additional benefits section.

SECTION 3 What services are not covered by your plan?

Section 3.1 Services we do *not* cover (exclusions)

This section explains what services are "excluded" from Medicare coverage and therefore, are not covered by this plan. If a service is "excluded," it means that your 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.

Please review the benefits chart at the front of this booklet to see if any of the below are "included" as part of your plan.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Services considered not covered or reasonable and necessary, according to the standards of Original Medicare		✓ Unless specified otherwise in the benefits chart at the front of this booklet
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		✓ Unless specified otherwise in the benefits chart at the front of this booklet
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 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		✓ Unless specified otherwise in the benefits chart at the front of this booklet
Homemaker services include basic household assistance, including light housekeeping or light meal preparation		✓ Unless specified otherwise in the benefits chart at the front of this booklet

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Fees charged for care by your immediate relatives or members of your household	✓	
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		✓ Unless specified otherwise in the benefits chart at the front of this booklet
Non-routine dental care		✓ Dental care required to treat illness or injury may be covered as inpatient or outpatient care
Routine chiropractic care		✓ Only manual manipulation of the spine to correct a subluxation is covered, unless specified otherwise in the benefits chart at the front of this booklet
Routine foot care		✓ Some limited coverage provided according to Medicare guidelines, e.g., if you have diabetes, unless specified otherwise in the benefits chart at the front of this booklet
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

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Supportive devices for the feet		✓ Orthopedic or therapeutic shoes for people with diabetic foot disease, unless specified otherwise in the benefits chart at the front of this booklet
Routine hearing exams, hearing aids, or exams to fit hearing aids		✓ Unless specified otherwise in the benefits chart at the front of this booklet
Routine eye examinations, eyeglasses, radial keratotomy, LASIK surgery, vision therapy and other low vision aids		✓ Only an eye exam and one pair of eyeglasses or contact lenses are covered for people after cataract surgery, unless specified otherwise in the benefits chart at the front of this booklet
Eye refractions		✓ Unless specified otherwise in the benefits chart at the front of this booklet
Reversal of sterilization procedures and/or non-prescription contraceptive supplies	✓	
Acupuncture or acupressure		✓ Covered for chronic low back pain, unless specified otherwise in the benefits chart at the front of this booklet
Treatment of sexual dysfunction, including erectile dysfunction, impotence, and anorgasmy or hyporgasmy	✓	
Naturopath services (uses natural or alternative treatments)		✓ Unless specified otherwise in the benefits chart at the front of this booklet

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Services that you get without prior authorization, when prior authorization is required for getting that service	✓	
Private Duty Nurses		✓ Unless specified otherwise in the benefits chart at the front of this booklet
Benefits to the extent that they are available as benefits through any governmental unit (except Medicaid)		✓ Unless otherwise required by law or regulation The payment of benefits under this *Evidence of Coverage* will be coordinated with such governmental units to the extent required under existing state or federal laws
Services for illness or injury that occurs as a result of any act of war, declared or undeclared if care is received in a governmental facility	✓	
Services for court-ordered testing or care		✓ Unless medically necessary and authorized by your plan
Services for which you have no legal obligation to pay in the absence of this or like coverage	✓	
Services received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group	✓	
Charges for completion of claim forms or charges for medical records or reports unless otherwise required by law	✓	
Charges for missed or canceled appointments	✓	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Charges in excess of the maximum allowable amount		✓ Unless specified otherwise in the benefits chart at the front of this booklet
Charges for services incurred prior to your effective date	✓	
Charges for services incurred after the termination date of this coverage		✓ Except as specified elsewhere in this booklet
Services or supplies primarily for educational, vocational or training purposes		✓ Unless specified otherwise in the benefits chart at the front of this booklet
For self-help training and other forms of non-medical self-care		✓ Unless specified otherwise in the benefits chart at the front of this booklet
Bathroom assistance equipment		✓ Unless specified otherwise in the benefits chart at the front of this booklet
Ambulance service to a physician's office or a physician-directed clinic		✓ Unless specified otherwise in the benefits chart at the front of this booklet
Ambulette services		✓ Unless specified otherwise in the benefits chart at the front of this booklet
Hospice services in a Medicare-participating hospice are not paid for by this PPO, but reimbursed directly by Original Medicare when you are enrolled in a Medicare-certified Hospice		✓ Unless specified otherwise in the benefits chart at the front of this booklet

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Outpatient prescription drugs, when you have a Medicare Advantage plan that does not cover prescription drugs		✓ Medicare covers a few prescription drugs that you can obtain from a pharmacy under the medical, Part B coverage Please see the benefits chart for more information on drugs covered under your medical benefit
Surgical treatment for morbid obesity		✓ Except when it is considered medically necessary and covered under Original Medicare
Meals delivered to your home		✓ Unless specified otherwise in the benefits chart at the front of this booklet
Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance)		✓ Except when medically necessary and covered under Original Medicare
Services provided to veterans in Veterans Affairs (VA) facilities		✓ However, when emergency services are received at a 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

Your plan will not cover the excluded services listed above. Even if you receive the services at an emergency facility, the excluded services are still not covered.

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 your plan. In either case, you can ask your plan to pay you back. Paying you back is often called "reimbursing" you. It is your right to be paid back by your plan whenever you've paid more than your share of the cost for medical services that are covered by your 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 your plan to pay you back or to pay a bill you have received:

1. **When you've received medical care from a provider who is not in our plan's network**

   NOTICE OF CLAIM: In the event that a service is rendered for which you are billed, you have 12 months from the date of service to submit such claims to your plan.

   You can receive emergency services from any provider. You are only responsible for paying your share of the cost, not for the entire cost. You should ask the provider to bill us 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 are owed and pay you back for our share of the cost.
   - **Please note:** While you can get your care from an out-of-network provider, the provider must be eligible to participate in Medicare. Except for emergency care, we cannot pay a provider who is not eligible to participate in Medicare. If the provider is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive.

2. **When an in-network provider sends you a bill you think you should not pay**

   NOTICE OF CLAIM: In the event that a service is rendered for which you are billed, you have 12 months from the date of service to submit such claims to your plan.

   In-network providers should always bill your 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.
- Whenever you get a bill from an in-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 an in-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 Member Services for additional information about how to ask us to pay you back and deadlines for making your request. Phone numbers for Member Services are printed on the back cover of this booklet.

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 7 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

NOTICE OF CLAIM: In the event that a service is rendered for which you are billed, you have 12 months from the date of service to submit such claims to your plan.

Send us your request for payment using the Medical Claim Form found online at **www.empireblue.com/nyc-ma-plus**, along with your itemized bill, documentation of any payment you have made, and the Appointment of Representative or Power of Attorney form if someone is requesting reimbursement for you. It's a good idea to make a copy of your bill and receipts for your records.

Mail your Medical Claim Form and documents to us at this address:

NYC Medicare Advantage Plus (PPO)
Empire BlueCross BlueShield Retiree Solutions
P.O. Box 1407
Church Street Station
New York, NY 10008-1407

You must submit your claim to us within one year from the date you received the service or item.

Contact Member Services if you have any questions. Phone numbers are printed on the back cover of this booklet. If you don't know what you owe, 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. Medicare limiting charges may apply, and could be less than the billed amount. 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, please contact your provider to file the claim on your behalf. The claim must be submitted within 12 months from the date of service or according to the contract we have with your provider. We will process covered services according to your plan benefits. Any payment will be made 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 Your 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, or alternate formats)

To get information from us in a way that works for you, please call Member Services. Phone numbers are printed on the back cover of this booklet.

Your plan has people and free interpreter services available to answer questions from disabled and non-English speaking members. We can also give you information in alternate formats at no cost if you need it. We are required to give you information about your 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 Member Services. Phone numbers are printed on the back cover of this booklet.

If you have any trouble getting information from your plan in a format that is accessible and appropriate for you, please call to file a grievance with Member Services. 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. For contact information, please refer to the state-specific agency listing located in Chapter 11.

Section 1.2 We must ensure that you get timely access to your covered services

You have the right to choose a provider in your plan's network. Call Member Services 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 and still pay the in-network cost sharing amount. Prior authorization may be required on some services. Please refer to the benefits chart for more information.

As a plan member, you have the right to get appointments and covered services from your 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 explains 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 explains 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 your 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 our written notice later in this chapter, called a "Notice of Privacy Practice," that explains 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 your 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 your 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 health care 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 Member Services. Phone numbers are printed on the back cover of this booklet.

Below is the Notice of Privacy Practices as of May 2018. This Notice can change so to make sure you're viewing the most recent version, you can request the current version from Member Services. Phone numbers are printed on the back cover of this booklet, or view it on our website at **www.empireblue.com/privacy**.

Protecting your personal health information is important. Every year, we're required to send you specific information about your rights, and some of our duties to help keep your information safe. This notice combines three of these required yearly communications:

- State notice of privacy practices
- Health Insurance Portability and Accountability Act (HIPAA) notice of privacy practices
- Breast reconstruction surgery benefits

State notice of privacy practices

When it comes to handling your health information, we follow relevant state laws, which are sometimes stricter than the federal HIPAA privacy law. This notice:

- Explains your rights and our duties under state law.
- Applies to health, dental, vision and life insurance benefits you may have.

Your state may give you additional rights to limit sharing your health information. Please call the Member Services phone number on your plan membership card for more details.

Your personal information

Your non-public (private) personal information (PI) identifies you and it's often gathered in an insurance matter. You have the right to see and correct your PI. We may collect, use and share your PI as described in this notice. Our goal is to protect your PI because your information can be used to make judgments about your health, finances, character, habits, hobbies, reputation, career and credit.

We may receive your PI from others, such as doctors, hospitals or other insurance companies. We may also share your PI with others outside our company – without your approval, in some cases. But we take reasonable measures to protect your information. If an activity requires us to give you a chance to opt out, we'll let you know and we'll let you know how to tell us you don't want your PI used or shared for an activity you can opt out of.

THIS NOTICE DESCRIBES HOW HEALTH, VISION AND DENTAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION WITH REGARD TO YOUR HEALTH BENEFITS. PLEASE REVIEW IT CAREFULLY.

HIPAA notice of privacy practices

We keep the health and financial information of our current and former members private as required by law, accreditation standards and our own internal rules. We're also required by federal law to give you this notice to explain your rights and our legal duties and privacy practices.

Your Protected Health Information

There are times we may collect, use and share your Protected Health Information (PHI) as allowed or required by law, including the HIPAA Privacy rule. Here are some of those times:

Payment: We collect, use and share PHI to take care of your account and benefits, or to pay claims for health care you get through your plan.

Health care operations: We collect, use and share PHI for your health care operations.

Treatment activities: We don't provide treatment, but we collect, use and share information about your treatment to offer services that may help you, including sharing information with others providing you treatment.

Examples of ways we use your information:

- We keep information on file about your premium and deductible payments.
- We may give information to a doctor's office to confirm your benefits.
- We may share explanation of benefits (EOB) with the subscriber of your plan for payment purposes.

- We may share PHI with your doctor or hospital so that they may treat you.
- We may use PHI to review the quality of care and services you get.
- We may use PHI to help you with services for conditions like asthma, diabetes or traumatic injury.
- We may collect and use publicly and/or commercially available data about you to support you and help you get health plan benefits and services.
- We may use your PHI to create, use or share de-identified data as allowed by HIPAA.
- We may also use and share PHI directly or indirectly with health information exchanges for payment, health care operations and treatment. If you don't want your PHI to be shared in these situations visit **www.empireblue.com/privacy** for more information.

Sharing your PHI with you: We must give you access to your own PHI. We may also contact you about treatment options or other health-related benefits and services. When you or your dependents reach a certain age, we may tell you about other plans or programs for which you may be eligible, including individual coverage. We may also send you reminders about routine medical checkups and tests. You may get emails that have limited PHI, such as welcome materials. We'll ask your permission before we contact you.

Sharing your PHI with others: In most cases, if we use or share your PHI outside of treatment, payment, operations or research activities, we have to get your okay in writing first. We must also get your written permission before:

- Using your PHI for certain marketing activities.
- Selling your PHI.
- Sharing any psychotherapy notes from your doctor or therapist.

We may also need your written permission for other situations not mentioned above. You always have the right to cancel any written permission you have given at any time.

You have the right and choice to tell us to:

- Share information with your family, close friends or others involved with your current treatment or payment for your care.
- Share information in an emergency or disaster relief situation.

If you can't tell us your preference, for example in an emergency or if you're unconscious, we may share your PHI if we believe it's in your best interest. We may also share your information when needed to lessen a serious and likely threat to your health or safety.

Other reasons we may use or share your information:

We are allowed, and in some cases required, to share your information in other ways – usually for the good of the public, such as public health and research. We can share your information for these specific purposes:

- Helping with public health and safety issues, such as:
    - Preventing disease
    - Helping with product recalls
    - Reporting adverse reactions to medicines
    - Reporting suspected abuse, neglect, or domestic violence
    - Preventing or reducing a serious threat to anyone's health or safety

- Doing health research.
- Obeying the law, if it requires sharing your information.
- Responding to organ donation groups for research and certain reasons.
- Addressing workers' compensation, law enforcement and other government requests, and to alert proper authorities if we believe you may be a victim of abuse or other crimes.
- Responding to lawsuits and legal actions.

If you're enrolled with us through an employer, we may share your PHI with your group health plan. If the employer pays your premium or part of it, but doesn't pay your health insurance claims, your employer can only have your PHI for permitted reasons and is required by law to protect it.

Authorization: We'll get your written permission before we use or share your PHI for any purpose not stated in this notice. You may cancel your permission at any time, in writing. We will then stop using your PHI for that purpose. But if we've already used or shared your PHI with your permission, we cannot undo any actions we took before you told us to stop.

Genetic information: We cannot use your genetic information to decide whether we'll give you coverage or decide the price of that coverage.

Race, ethnicity and language: We may receive race, ethnicity and language information about you and protect this information as described in this notice. We may use this information to help you, including identifying your specific needs, developing programs and educational materials and offering interpretation services. We don't use race, ethnicity and language information to decide whether we'll give you coverage, what kind of coverage and the price of that coverage. We don't share this information with unauthorized persons.

Your rights

Under federal law, you have the right to:

- Send us a written request to see or get a copy of your PHI, including a request for a copy of your PHI through email. Remember, there's a risk your PHI could be read by a third party when it's sent unencrypted, meaning regular email. So we will first confirm that you want to get your PHI by unencrypted email before sending it to you. We will provide you a copy of your PHI usually within 30 days of your request. If we need more time, we will let you know.
- Ask that we correct your PHI that you believe is wrong or incomplete. If someone else, such as your doctor, gave us the PHI, we'll let you know so you can ask him or her to correct it. We may say "no" to your request, but we'll tell you why in writing within 60 days.
- Send us a written request not to use your PHI for treatment, payment or health care operations activities. We may say "no" to your request, but we'll tell you why in writing.
- Request confidential communications. You can ask us to send your PHI or contact you using other ways that are reasonable. Also, let us know if you want us to send your mail to a different address if sending it to your home could put you in danger.
- Send us a written request to ask us for a list of those with whom we've shared your PHI. We will provide you a list usually within 60 days of your request. If we need more time, we will let you know.

- Ask for a restriction for services you pay for out of your own pocket: If you pay in full for any medical services out of your own pocket, you have the right to ask for a restriction. The restriction would prevent the use or sharing of that PHI for treatment, payment or operations reasons. If you or your provider submits a claim to us, we may not agree to a restriction (see "Your rights" above). If a law requires sharing your information, we don't have to agree to your restriction.
- Call Member Services at the phone number on your plan membership card to use any of these rights. A representative can give you the address to send the request. They can also give you any forms we have that may help you with this process.

How we protect information

We're dedicated to protecting your PHI, and we've set up a number of policies and practices to help keep your PHI secure and private. If we believe your PHI has been breached, we must let you know.

We keep your oral, written and electronic PHI safe using the right procedures, and through physical and electronic ways. These safety measures follow federal and state laws. Some of the ways we keep your PHI safe include securing offices that hold PHI, password-protecting computers, and locking storage areas and filing cabinets. We require our employees to protect PHI through written policies and procedures. These policies limit access to PHI to only those employees who need the data to do their jobs. Employees are also required to wear ID badges to help keep unauthorized people out of areas where your PHI is kept. Also, where required by law, our business partners must protect the privacy of data we share with them as they work with us. They're not allowed to give your PHI to others without your written permission, unless the law allows it and it's stated in this notice.

Potential impact of other applicable laws

HIPAA, the federal privacy law, generally doesn't cancel other laws that give people greater privacy protections. As a result, if any state or federal privacy law requires us to give you more privacy protections, then we must follow that law in addition to HIPAA.

Calling or texting you

We, including our affiliates and/or vendors, may call or text you by using an automatic telephone dialing system and/or an artificial voice. But we only do this in accordance with the Telephone Consumer Protection Act (TCPA). The calls may be about treatment options or other health-related benefits and services for you. If you don't want to be contacted by phone, just let the caller know or call **1-844-203-3796** to add your phone number to our Do Not Call list. We will then no longer call or text you.

Complaints

If you think we haven't protected your privacy, you can file a complaint with us at the Member Services phone number on your plan membership card. You may also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**. We will not take action against you for filing a complaint.

Contact information

You may call us at the Member Services phone number on your plan membership card. Our representatives can help you apply your rights, file a complaint or talk with you about privacy issues.

Copies and changes

You have the right to get a new copy of this notice at any time. Even if you have agreed to get this notice by electronic means, you still have the right to ask for a paper copy. We reserve the right to change this notice. A revised notice will apply to PHI we already have about you, as well as any PHI we may get in the future. We're required by law to follow the privacy notice that's in effect at this time. We may tell you about any changes to our notice through a newsletter, our website or a letter.

Effective date of this notice

The original effective date of this Notice was April 14, 2003. This Notice was most recently revised in March 2021. This Notice can change so make sure you're viewing the most recent version. You can request the current version from Member Services at the phone number printed on your plan membership card or view it on our website at **www.empireblue.com/privacy**.

FOR MAINE RESIDENTS: Maine Notice of Additional Privacy Rights

The Maine Insurance Information and Privacy Protection Act provides consumers in Maine with the following additional rights.

The right:

- To obtain access to the consumer's recorded personal information in the possession or control of a regulated insurance entity
- To request correction if the consumer believes the information to be inaccurate
- To add a rebuttal statement to the file if there is a dispute
- To know the reasons for an adverse underwriting decision (previous adverse underwriting decisions may not be used as the basis for subsequent underwriting decisions unless the carrier makes an independent evaluation of the underlying facts)

And with very narrow exceptions, the right not to be subjected to pretext interviews.

Breast reconstruction surgery benefits

A mastectomy that's covered by your health plan includes benefits that comply with the Women's Health and Cancer Rights Act of 1998, which provides for:

- Reconstruction of the breast(s) that underwent a covered mastectomy.
- Surgery and reconstruction of the other breast to restore a symmetrical appearance.
- Prostheses and coverage for physical complications related to all stages of a covered mastectomy, including lymphedema.

You'll pay your usual deductible, copay and/or coinsurance. For details, contact your plan administrator.

For more information about the Women's Health and Cancer Rights Act, go to the United States Department of Labor website at: **www.dol.gov/agencies/ebsa/laws-and-regulations/laws/whcra**.

Section 1.4 We must give you information about the plan, its network of providers, and your covered services

As a member of your plan, 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 or alternate formats.

If you want any of the following kinds of information, please call Member Services. Phone numbers are printed on the back cover of this booklet.

- **Information about your plan.** This includes, for example, information about your plan's financial condition. It also includes information about the number of appeals made by members and your plan's Star Ratings, including how it has been rated by plan members and how it compares to other Medicare health plans.
- **Information about our in-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, you can call Member Services. Phone numbers are printed on the back cover of this booklet.
- **Information about your coverage and the rules you must follow when using your coverage.**
    - In Chapters 3 and 4 and the benefits chart located at the front 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 Member Services. 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 explains how to make a complaint about quality of care, waiting times, and other concerns.
    - If you want to ask us 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. 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 7 of this booklet explains how to ask your 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.

- **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 appropriate state-specific agency. For contact information, please refer to the state-specific agency listing located in Chapter 11.

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 explains 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 your 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 your plan in the past. To get this information, please call Member Services. 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**. TTY users should call **1-800-537-7697**. Or, call your local Office for Civil Rights. For contact information, please refer to the state-specific agency listing located in Chapter 11.

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 **Member Services**. 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, go to Chapter 2, Section 3. For contact information, please refer to the state-specific agency listing located in Chapter 11.
- 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 **Member Services**. 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, go to Chapter 2, Section 3. For contact information, please refer to the state-specific agency listing located in Chapter 11.
- You can contact **Medicare**.
    - You can visit the Medicare website to read or download the publication *Medicare Rights & Protections*. The publication is available at **www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.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 your plan

Section 2.1 What are your responsibilities?

Things you need to do as a member of your plan are listed below. If you have any questions, please call Member Services. 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.
    - The benefits chart located at the front of this booklet and 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 in addition to your plan, you are required to tell us**. Please call Member Services 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 your plan. This is called "**coordination of benefits**" because it involves coordinating the health benefits you get from your plan with any other health 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 your 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 care 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 healthcare 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:
    - Your group sponsor must pay your plan premiums, if applicable, for you to continue being a member of your plan.
    - You must pay your plan premiums, if any, to your group sponsor (or, if you are billed directly, you must send your payment to the address listed on your billing statement), to continue being a member of your 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). The benefits chart located at the front of this booklet and Chapter 4 explains what you must pay for your medical services.
  - If you get any medical services that are not covered by your 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 Member Services. Phone numbers are printed on the back cover of this booklet. Please remember to also notify your group sponsor of your group plan so they will have your most up-to-date contact information on file. Please contact your group sponsor by emailing the New York City Employee Benefits Program at **healthbenefits@olr.nyc.gov**. We need to keep your membership record up-to-date and know how to contact you.
  - **If you move *outside* of our plan service area, you cannot remain a member of our plan**. Chapter 1 explains 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 Member Services for help if you have questions or concerns**. We also welcome any suggestions you may have for improving your plan.
  - Phone numbers and calling hours for Member Services 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)

SECTION 1 Introduction

Section 1.1 What to do if you have a problem or concern

Please call us first

Your health and satisfaction are important to us. When you have a problem or concern, we hope you'll try an informal approach first. Please call Member Services. Phone numbers are printed on the back cover of this booklet. We will work with you to try to find a satisfactory solution to your problem.

You have rights as a member of your plan and as someone who is getting Medicare. We pledge to honor your rights, to take your problems and concerns seriously, and to treat you with respect.

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," 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 your plan 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. For contact information, please refer to the state-specific agency listing located in Chapter 11.

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, member 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 in-network doctor makes a (favorable) coverage decision for you whenever you receive medical care from him or her or if your in-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. In limited circumstances a request for a coverage decision will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so or if you ask for your request to be withdrawn. If we dismiss a request for a coverage decision, we will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

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. In limited circumstances a request for a coverage decision will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so or if you ask for your request to be withdrawn. If we dismiss a request for a coverage decision, we will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

If we say no to all or part of your Level 1 Appeal, you can ask for a Level 2 Appeal. The Level 2 Appeal is conducted by an Independent Review Organization that is not connected to us. 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 Member Services**. Phone numbers are printed on the back cover of this booklet.
- **You can get free help from** your State Health Insurance Assistance Program. For contact information, please refer to the state-specific agency listing located in Chapter 11.
- **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 Member Services and ask for the "Appointment of Representative" form. Phone numbers are printed on the back cover of this booklet. The form is also available on Medicare's website at **www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf**. 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 Member Services. Phone numbers are printed on the back cover of this booklet. You can also get help or information from government organizations such as your State Health Insurance Assistance Program. For contact information, please refer to the state-specific agency listing located in Chapter 11.

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 explains 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 are the benefits described in the benefits chart located at the front of this booklet and in Chapter 4 of this booklet, "Medical benefits (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 explains 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 your 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 Comprehensive Outpatient Rehabilitation Facility (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 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 your 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 topic, "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, your plan 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: Your plan considers your request for medical care coverage and gives 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 explains 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 explains 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 your plan says 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 your 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 topic, "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 by submitting a request** in writing to the fax number or address provided in Chapter 2, under "Appeals – Contact Information." You may also ask for an expedited appeal by calling us at the phone number shown in Chapter 2, under "Appeals – Contact Information" and look for the topic, "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 Member Services and ask for the "Appointment of Representative" form. Phone numbers are printed on the back cover of this booklet. The form is also available on Medicare's website at **www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf**. 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 under the topic called, "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.
    - 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: Your plan considers your appeal and we give you our answer.

- When your 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 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 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 your plan says 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 your 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.
- 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**.
- 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 your 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 your 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 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.

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 your plan 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 get after your Level 2 Appeal.
- The Level 3 Appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 8 in this chapter explains 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 explains 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 the benefits chart located at the front of this booklet and Chapter 4, "Medical benefits (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 your plan's coverage for your hospital care, including any limitations on this coverage, see the benefits chart located at the front of this booklet and Chapter 4, "Medical benefits (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 explains how to ask.

Section 6.1 During your inpatient hospital stay, you will get a written notice from Medicare that explains 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 Member Services. 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 explains 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 explains 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 6.2 below explains 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 4.2 of this chapter explains 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 Member Services. Phone numbers are printed on the back cover of this booklet. 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**. You can also see the notice online at **www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices**.

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 your plan 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 Member Services. 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. For contact information, please refer to the state-specific agency listing located in Chapter 11.

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 your 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*) explains how to reach this organization. (Or find the name, address and phone number of the Quality Improvement Organization for your state in the state-specific agency listing located in Chapter 11.)

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**. 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 your plan instead. For details about this other way to make your appeal, see Section 6.4.

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, called "the reviewers," 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 your 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 Member Services. Phone numbers are printed on the back cover of this booklet. 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**. Or you can see a sample notice online at **www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.**

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 the benefits chart, located at the front of this booklet, and 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, **your plan's 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

- **Your plan 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.
- 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 explains 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 topic, "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, **your plan is 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 your plan 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 explains 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 your 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 your plan 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 your plan 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 explains 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 the benefits chart located at the front of this booklet and Chapter 4, "Medical benefits (what is covered and what you pay)."

When your plan decides 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 explains 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 your plan is going to stop covering your care, you will receive a notice.
    - The written notice explains the date when your plan will stop covering the care for you.

- The written notice also explains what you can do if you want to ask your 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 explains 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 explains 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 your 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 your plan must follow. If you think we are not meeting our deadlines, you can file a complaint. Section 9 of this chapter explains how to file a complaint.
- **Ask for help if you need it.** If you have questions or need help at any time, please call Member Services. 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. For contact information, please refer to the state-specific agency listing located in Chapter 11.

During a Level 1 Appeal, the Quality Improvement Organization reviews your appeal and decides whether to change the decision made by your 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 your 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 explains how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in the state-specific agency listing located in Chapter 11.)

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 your plan 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 your plan 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, called "the reviewers," 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 your plan has given to them.
- By the end of the day the reviewers will inform your plan of your appeal, and you will also get a written notice from the plan 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 **your plan 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 the benefits chart, at the front of this booklet, and 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**. Your plan will stop paying its 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?

- **Your plan must reimburse you** for our share of the costs of care you have received since the date when we said your coverage would end. **Your plan 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 they 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 explains 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 your plan 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 your plan, 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 topic, "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 your 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 your plan 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 explains 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 your 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 your plan 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 your 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 explains 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, member 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 member 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 member service, or other negative behaviors	• Has someone been rude or disrespectful to you? • Are you unhappy with how our Member Services 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 Member Services or other staff at the plan? ◦ Examples include waiting too long on the phone, in the waiting room, when getting a prescription, or in the exam room.
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?

Complaint	Example
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 Member Services is the first step**. If there is anything else you need to do, Member Services will let you know. Phone numbers are printed on the back cover of this booklet.
- **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.

- You or someone you name may file a grievance. The person you name would be your "representative." You may name a relative, friend, lawyer, advocate, doctor, or anyone else to act for you. Other persons may already be authorized by the court or in accordance with state law to act for you. If you want someone to act for you who is not already authorized by the court or under state law, then you and that person must sign and date a statement that gives the person legal permission to be your representative. To learn how to name your representative, you may call Member Services. Phone numbers are printed on the back cover of this booklet.
- A grievance must be filed either verbally or in writing within 60 days of the event or incident. We must address your grievance as quickly as your case requires based on your health status, but no later than 30 days after receiving your complaint. We may extend the time frame by up to 14 days if you ask for the extension, or if we justify a need for additional information and the delay is in your best interest.
- A fast grievance can be filed concerning a plan decision not to conduct a fast response to a coverage decision or appeal, or if we take an extension on a coverage decision or appeal. We must respond to your expedited grievance within 24 hours.

- **Whether you call or write, you should contact Member Services 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 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, please refer to the state-specific agency listing located in Chapter 11. 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 your plan and also to the Quality Improvement Organization.

Section 9.5 You can also tell Medicare about your complaint

You can submit a complaint about your 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 your plan is not addressing your issue, please call **1-800-MEDICARE (1-800-633-4227)**. TTY 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 our plan 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 a plan. Section 2 explains *when* you can end your membership in our plan.
    - The process for voluntarily ending your membership varies depending on what type of new coverage you are choosing. Section 3 explains *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 explains 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 anytime during the year.

Section 2.1 You can end your membership during the Annual Enrollment Period for Individual (non-group) plans

The information in Section 2.1 and 2.2 may not apply for all City of New York retirees. Please visit the Office of Labor Relations for access to the full Summary Plan Description (SPD) for more details. You can end your membership during the **Annual Enrollment Period for Individual (non-group) plans**, 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 for Individual (non-group) plans?** This happens from October 15 through December 7.
- **What type of plan can you switch to during the Annual Enrollment Period for Individual (non-group) plans?** 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 Individual (non-group) 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 Individual (non-group) Medicare prescription drug plan.
    - – *or* – Original Medicare without a separate Individual (non-group) Medicare prescription drug plan.

- **Ending your group-sponsored Medicare Advantage plan may impact your eligibility for other coverage sponsored by your group or mean that you will not be able to re-enroll in your plan in the future. Before ending your group-sponsored Medicare Advantage coverage, please contact your group sponsor by emailing the New York City Employee Benefits Program at healthbenefits@olr.nyc.gov**.
- **When will your group-sponsored plan membership end?** Your membership will end when your new plan's coverage begins.

Section 2.2 You may be able to end your membership during the Medicare Advantage Open Enrollment Period for Individual (non-group) Plans

You have the opportunity to make *one* change to your health coverage during the **Individual (non- group) Medicare Advantage Open Enrollment Period**.

- **When is the annual Individual (non-group) 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 Individual (non-group) 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.
- **Ending your group-sponsored Medicare Advantage plan may impact your eligibility for other coverage sponsored by your group or mean that you will not be able to re-enroll in your plan in the future. Before ending your group-sponsored Medicare Advantage coverage, please contact your group sponsor by emailing the New York City Employee Benefits Program at healthbenefits@olr.nyc.gov**.
- **When will your group-sponsored plan 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

Group-sponsored plans may allow changes to their retirees' enrollment. This typically occurs during the group's open enrollment period. This may be any time of the year and does not have to coincide with the individual open enrollment period from October 15 to December 7.

Please check with your group sponsor for additional enrollment and disenrollment options, and the impact of any changes to your group-sponsored retiree benefits.

In certain situations, Medicare Advantage members 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 your plan, call **Medicare**, or visit the **Medicare website (www.medicare.gov**):
    - Usually, when you have moved outside of your plan's service area.
    - 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). PACE is not available in all states. If you would like to know if PACE is available in your state, please contact Member Services. Phone numbers are printed on the back cover of this booklet.
- **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:
    - An Individual (non-group) 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 Individual (non-group) Medicare prescription drug plan.
    - – *or* – Original Medicare *without* a separate Medicare prescription drug plan.
- **Ending your group-sponsored Medicare Advantage plan may impact your eligibility for other coverage sponsored by your group or mean that you will not be able to re-enroll in your plan in the future. Before ending your group-sponsored Medicare Advantage coverage, please contact your group sponsor by emailing the New York City Employee Benefits Program at healthbenefits@olr.nyc.gov**.
- **When will your group-sponsored plan membership end?** Your membership will end on the first of the month after we receive your request to change plans or the date you request we terminate coverage on this plan, whichever is later.

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:

- Contact your group sponsor by emailing the New York City Employee Benefits Program at **healthbenefits@olr.nyc.gov** to get information on options available to you.
- You can call **Member Services**. Phone numbers are printed on the back cover of this booklet.
- You can find the information in the ***Medicare & You 2022*** handbook.

- Everyone with Medicare receives a copy of the *Medicare & You* handbook 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 your 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 your plan to Original Medicare without a Medicare prescription drug plan, you must ask to be disenrolled from your plan. There are two ways you can ask to be disenrolled:

- You can make a request in writing to us. Contact Member Services 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**.

Ending your group-sponsored Medicare Advantage plan may impact your eligibility for other coverage sponsored by your group or mean that you will not be able to re-enroll in the plan in the future. Before ending your group-sponsored Medicare Advantage coverage, please contact your group sponsor by emailing the New York City Employee Benefits Program at healthbenefits@olr.nyc.gov.

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:
An Individual (non-group) Medicare health plan.	• Enroll in the new Medicare health plan between October 15 and December 7. • You will automatically be disenrolled from your group-sponsored plan when your new plan's coverage begins.
Original Medicare with a separate Individual (non-group) Medicare prescription drug plan.	• Enroll in the new Medicare prescription drug plan between October 15 and December 7. • You will automatically be disenrolled from your group-sponsored plan when 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 Member Services if you need more information on how to do this. Phone numbers are listed 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 your group-sponsored plan 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 our plan, 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 your plan until you are discharged**, even if you are discharged after your new health coverage begins.

SECTION 5 We must end your membership in the plan in certain situations

Section 5.1 When must we end your membership in the plan?

We 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 Member Services to find out if the place you are moving or traveling to is in your plan's area. Phone numbers for Member Services 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 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 plan 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 your group notifies us that they are canceling the group contract for this plan.
- If the premiums paid by your group sponsor for this plan are not paid in a timely manner.
- If you pay your plan premium, if applicable, directly to us, and you do not pay your plan premiums for 90 days.
    - We must notify you in writing that you have 90 days to pay your plan premium before we end your membership.
- If your group sponsor informs this plan of your loss of eligibility for their group 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 Member Services 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

We are 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 also 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

Our plan must obey laws that protect you from discrimination or unfair treatment. **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 within the service area. All organizations that provide Medicare Advantage plans, like your 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.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' **Office for Civil Rights** at **1-800-368-1019** (TTY: **1-800-537-7697**) or your local Office for Civil Rights.

If you have a disability and need help with access to care, please call us. Phone numbers are printed on the back cover of this booklet. If you have a complaint, such as a problem with wheelchair access, Member Services can help.

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, your plan, 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.

SECTION 4 Notice about subrogation and reimbursement

Subrogation and reimbursement

These provisions apply when we pay benefits as a result of injuries or illness you sustained and you have a right to a recovery or have received a recovery. We have the right to recover payments we make on your behalf from, or take any legal action against, any party responsible for compensating you for your injuries. We also have a right to be repaid from any recovery in the amount of benefits paid on your behalf. The following apply:

- The amount of our recovery will be calculated pursuant to 42 CFR 411.37, and pursuant to 42 CFR 422.108(f), no state laws shall apply to our subrogation and reimbursement rights.

- Our subrogation and reimbursement rights shall have first priority, to be paid before any of your other claims are paid. Our subrogation and reimbursement rights will not be affected, reduced, or eliminated by the "made whole" doctrine or any other equitable doctrine.
- You must notify us promptly of how, when and where an accident or incident resulting in personal injury or illness to you occurred and all information regarding the parties involved, and you must notify us promptly if you retain an attorney related to such an accident or incident. You and your legal representative must cooperate with us, do whatever is necessary to enable us to exercise our rights and do nothing to prejudice our rights.
- If you fail to repay us, we shall be entitled to deduct any of the unsatisfied portion of the amount of benefits we have paid or the amount of your recovery, whichever is less, from any future benefit under your plan.

SECTION 5 Additional legal notices

Under certain circumstances, if we pay the health care provider amounts that are your responsibility, such as deductibles, copayments or coinsurance, we may collect such amounts directly from you. You agree that we have the right to collect such amounts from you.

Assignment

The benefits provided under this *Evidence of Coverage* are for the personal benefit of the member and cannot be transferred or assigned. Any attempt to assign this contract will automatically terminate all rights under this contract.

Notice of Claim

In the event that a service is rendered for which you are billed, you have 12 months from the date of service to submit such claim(s) to your plan.

You may submit such claims to:

NYC Medicare Advantage Plus (PPO)
Empire BlueCross BlueShield Retiree Solutions
P.O. Box 1407
Church Street Station
New York, NY 10008-1407

Entire contract

This *Evidence of Coverage* and applicable riders attached hereto, and your completed enrollment form, constitute the entire contract between the parties and as of the effective date hereof, supersede all other agreements between the parties.

Waiver by agents

No agent or other person, except an executive officer of your plan, has authority to waive any conditions or restrictions of this *Evidence of Coverage* or the Medical Benefits Chart located at the front of this booklet.

No change in this *Evidence of Coverage* shall be valid unless evidenced by an endorsement signed by an authorized executive officer of the company or by an amendment to it signed by the authorized company officer.

Termination of operation

In the event of the termination of operation or dissolution of your plan in the area in which you reside, this *Evidence of Coverage* will be terminated. You will receive notice 90 days before the *Evidence of Coverage* is terminated.

Please note: If the *Evidence of Coverage* terminates, your coverage will also end. In that event, your plan will explain your options at that time. For example, there may be other health plans in the area for you to join if you wish. Or you may wish to return to Original Medicare and possibly obtain supplemental insurance. In the latter situation, your plan would arrange for you to obtain, without a health screening or a waiting period, a supplemental health insurance policy to cover Medicare coinsurance and deductibles. Whether you enroll in another prepaid health plan or not, there would be no gap in coverage.

Refusal to accept treatment

You may, for personal or religious reasons, refuse to accept procedures or treatment recommended as necessary by your primary care provider. Although such refusal is your right, in some situations it may be regarded as a barrier to the continuance of the provider/patient relationship or to the rendering of the appropriate standard of care.

When a member refuses a recommended, necessary treatment or procedure and the primary care provider believes that no professionally acceptable alternative exists, the member will be advised of this belief.

In the event you discharge yourself from a facility against medical advice, your plan will pay for covered services rendered up to the day of self-discharge. Fees pertaining to that admission will be paid on a per diem basis or appropriate Diagnostic Related Grouping (DRG), whichever is applicable.

Limitation of actions

No legal action may be taken to recover benefits within 60 days after the service is rendered. No such action may be taken later than three years after the service upon which the legal action is based was provided.

Circumstances beyond plan control

If there is an epidemic, catastrophe, general emergency or other circumstance beyond the company's control, neither your plan nor any provider shall have any liability or obligation except the following, as a result of reasonable delay in providing services:

- Because of the occurrence, you may have to obtain covered services from an out-of-network provider instead of an in-network provider. Your plan will reimburse you up to the amount that would have been covered under this *Evidence of Coverage*.
- Your plan may require written statements from you and the medical personnel who attended you confirming your illness or injury and the necessity for the treatment you received.

Plan's sole discretion

Your plan may, at its sole discretion, cover services and supplies not specifically covered by the *Evidence of Coverage*.

This applies if your plan determines such services and supplies are in lieu of more expensive services and supplies that would otherwise be required for the care and treatment of a member.

Disclosure

You are entitled to ask for the following information from your plan:

- Information on your plan's physician incentive plans
- Information on the procedures your plan uses to control utilization of services and expenditures
- Information on the financial condition of the company
- General coverage and comparative plan information

To obtain this information, call Member Services. Phone numbers are printed on the back cover of this booklet. Your plan will send this information to you within 30 days of your request.

Information about advance directives

(Information about using a legal form such as a "living will" or "power of attorney" to give directions in advance about your health care in case you become unable to make your own health care decisions).

You have the right to make your own health care decisions. **But what if you had an accident or illness so serious that you became unable to make these decisions for yourself?**

If this were to happen:

- You might want a particular person you trust to make these decisions for you.
- You might want to let health care providers know the types of medical care you would want and not want if you were not able to make decisions for yourself.
- You might want to do both — to appoint someone else to make decisions for you, and to let this person and your health care providers know the kinds of medical care you would want if you were unable to make these decisions for yourself.

If you wish, you can fill out and sign a special form that lets others know what you want done if you cannot make health care decisions for yourself. This form is a legal document. It is sometimes called an "advance directive," because it lets you give directions in advance about what you want to happen if you ever become unable to make your own health care decisions.

There are different types of advance directives and different names for them depending on your state or local area. For example, documents called a "living will" and a "power of attorney for health care" are examples of advance directives.

It's your choice whether you want to fill out an advance directive. The law forbids any discrimination against you in your medical care based on whether or not you have an advance directive.

How can you use a legal form to give your instructions in advance?

If you decide that you want to have an advance directive, there are several ways to get this type of legal form. You can get a form from your lawyer, from a social worker and from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare, such as your SHIP (which stands for State Health Insurance Assistance Program). Chapter 11 of this booklet explains how to contact your SHIP. SHIPs have different names depending on which state you are in.

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. It is important to sign this form and keep a copy at home. 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. If you know ahead of time that you are going to be hospitalized, take a copy with you.

If you are hospitalized, they will ask you about an advance directive

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.

It is your choice whether to sign or not. If you decide not to sign an advance directive form, you will not be denied care or be discriminated against in the care you are given.

What if providers don't follow the instructions you have given?

If you believe that a doctor or hospital has not followed the instructions in your advance directive, you may file a complaint with your state's Department of Health.

Continuity and coordination of care

Your plan has policies and procedures in place to promote the coordination and continuity of medical care for our members. This includes the confidential exchange of information between primary care physicians and specialists, as well as behavioral health providers. In addition, your plan helps coordinate care with a practitioner when the practitioner's contract has been discontinued and works to enable a smooth transition to a new practitioner.

InterPlan/Medicare Advantage Program

- **Member Liability Calculation**

  When you receive covered healthcare services outside of our service area from a Medicare Advantage PPO network provider, the cost of the service, on which member liability (copayment/coinsurance) is based, will be either:

  - The Medicare allowable amount for covered services; or
  - The amount the local Blue Medicare Advantage plan negotiates with its provider on behalf of our members. The amount negotiated may be either higher than, lower than, or equal to the Medicare allowable amount.

- **Non-participating Healthcare Providers Outside Our Service Area**

  When covered healthcare services are provided outside of our service area by non-participating healthcare providers, the amount(s) you pay for such services will be based on either Medicare's limiting charge where applicable or the provider's billed charge. Payments for out-of-network emergency services will be governed by applicable federal and state law.

In these above instances the service area refers to the geographic area that we are licensed to sell the Blue brand.

CHAPTER 10

Definitions of important words

Chapter 10 Definitions of important words

Allowed Amount – The allowed amount is either:

1. The rate negotiated with in-network providers;
2. The Medicare-allowable amount for out-of-network providers who accept Medicare assignment;
3. The limiting charge for providers who do not accept assignment but who are subject to the limiting amount;
4. The provider's actual charge when the provider does not accept assignment and is not subject to the limiting amount; or
5. The provider's actual charge for non-Medicare covered benefits, your plan covers, when the provider is an out-of-network provider.

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 your plan doesn't pay for a drug, 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 our 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. A benefit period begins the day you go into a hospital or 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 new benefit period begins. There is no limit to the number of benefit periods.

Calendar Year – The period beginning January 1 of any year through December 31 of the same 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 after you pay any deductibles. Coinsurance is usually a percentage (for example, 20%).

Combined Maximum Out-of-Pocket Amount – This is the amount you will pay in a year for all Part A and Part B services from both in-network (preferred) providers and out-of-network (non-preferred) providers. In addition to the maximum out-of-pocket amount for covered Part A and Part B medical services, we may also have a maximum out-of-pocket amount for certain types of services. See Chapter 4, Section 1.3 for information about your combined maximum out-of-pocket amount. Please refer to the benefits chart at the front of this booklet for information about your combined maximum out-of-pocket amount and to see if you have separate maximum out-of-pocket amounts for specific medical services.

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 member 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, speech-language pathology services, and home environment evaluation services.

Copayment (or "copay") – If applicable, 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, or 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 or prescription drug.

Cost Sharing – If applicable, cost sharing refers to amounts that a member may have to pay when services are received. It 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 in this *EOC* to mean all of the health care services and supplies that are covered by our plan.

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.

Deductible – If applicable, the amount you must pay for health care before our plan begins to pay.

Diagnostic Testing – Testing performed to detect disease when clinical indications of active disease are present.

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 your plan.

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 Care – A special way of caring for people who are terminally ill and providing counseling for their families. Hospice care is physical care and counseling that is given by a team of people who are part of a Medicare-certified public agency or private company. Depending on the situation, this care may be given in the home, a hospice facility, a hospital, or a nursing home. Care from a hospice is meant to help patients in the last months of life by giving comfort and relief from pain. The focus is on care, not cure. For more information on hospice care, visit **www.medicare.gov** and type "*Medicare Hospice Benefits*" in the search box. Or call **1-800-MEDICARE** (**1-800-633-4227**). TTY users should call **1-877-486-2048**. Note: refer to your benefits chart for hospice benefit information.

Hospital Inpatient Stay – A hospital stay is 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" under observation. Be sure to ask the hospital if you are an inpatient status or outpatient observation status when staying overnight as the plan benefits are different for each category.

Hospital Observation Stay – Hospital outpatient services given to help the doctor decide if you need to be admitted as an inpatient or can be discharged. Observation services may be given in the Emergency Department (ED) or another area of the hospital and may include an overnight stay up to 48 hours.

In-Network Maximum Out-of-Pocket Amount – Some plans have separate in-network and out-of-network maximum out-of-pocket amounts. In this case, in-network maximum out-of-pocket is the most you will pay for covered Part A and Part B services received from in-network (preferred) providers. After you have reached this limit, you will not have to pay anything when you get covered services from in-network providers for the rest of the contract year. However, until you reach your combined out-of-pocket maximum amount, which includes services received from an out-of-network provider, you must continue to pay your share of the costs when you seek care from an out-of-network (non-preferred) provider. In addition to the maximum out-of-pocket amount for covered medical services, you may also have a maximum out-of-pocket amount for certain types of services. Please refer to the

benefits chart at the front of this booklet for information about your in-network maximum out-of-pocket amount and to see if you have separate maximum out-of-pocket amounts for specific medical services.

In-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 "in-network providers" when they have an agreement with your plan to accept our contracted rate as payment in full, and in some cases, to coordinate as well as provide covered services to members of your plan. Your plan pays in-network providers based on the agreements it has with the providers or if the providers agree to provide you with plan-covered services. In-network providers may also be referred to as "plan providers" or "network providers."

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 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 seven-month period that begins three months before the month you turn 65, includes the month you turn 65, and ends three months after the month you turn 65.

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.

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), Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), 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).

Maximum Out-of-Pocket Amount – The most that you pay out-of-pocket during the plan year for covered Part A and Part B services. Amounts you pay for your plan, Medicare Part A and Part B premiums, do not count toward the maximum out-of-pocket amount. See the benefits chart at the front of this booklet 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 (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 Advantage health plan that is offered in their area.

Medicare Advantage Open Enrollment Period (non-group plans) – 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 during this period, you can also join a separate Medicare prescription drug plan at that time. The Medicare Advantage 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 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 Part 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).

"**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).

Member Services – 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 call Member Services.

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 such as 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 your 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. If you would like to know if PACE is available in your state, please contact Member Services. Phone numbers are printed on the back cover of this booklet.

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.

Plan 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 "plan providers" when they have an agreement with this plan to accept our contracted rate as payment in full, and in some cases to coordinate as well as provide covered services to members of this plan. This plan pays plan providers based on the agreements it has with the providers or if the providers agree to provide you with plan-covered services.

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 in-network or out-of-network providers. On some PPO plans, 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 in-network (preferred) providers and some plans may have a higher limit on your total combined out-of-pocket costs for services from both in-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.

Prior Authorization – Approval in advance to get services. In the network portion of a 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, you may want to check with the plan before obtaining services from out-of-network providers to confirm that the service is covered by your plan and what your cost sharing responsibility is. Covered services that need prior authorization are marked in the benefits chart located at the front of this booklet.

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. For contact information, please refer to the state-specific agency listing located in Chapter 11.

Rehabilitation Services – These services include physical therapy, speech and language therapy, and occupational therapy.

Screening Exam – A routine exam to detect evidence of unsuspected disease.

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 plan 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 in-network providers or by out-of-network providers when in-network providers are temporarily unavailable or inaccessible.

CHAPTER 11

State organization contact information

Chapter 11 State organization contact information

SECTION 1 State Health Insurance Assistance Program (SHIP)

The following state agency information was updated on July 13, 2021. For more recent information or other questions, please contact Member Services. Phone numbers are printed on the back cover of this booklet.

Alabama

Alabama's State Health Insurance Assistance Program
201 Monroe Street, Suite 350,
Montgomery, AL 36104
1-800-243-5463, TTY: **711**
http://www.alabamaageline.gov

Alaska

Alaska State Health Insurance Assistance Program (SHIP)
550 W 7th Ave., Suite 1230
Anchorage, AK 99501
1-800-478-6065, TTY: **1-800-770-8973**
7:00 a.m. to 7:00 p.m.
http://dhss.alaska.gov/dsds/Pages/medicare/default.aspx

Arizona

Arizona State Health Insurance Assistance Program
1789 W. Jefferson Street., #950a
Phoenix, AZ 85007
1-800-432-4040, TTY: **711**
https://des.az.gov/services/older-adults/medicare-assistance

Arkansas

Senior Health Insurance Information Program (SHIIP)
1 Commerce Way 72202
Little Rock, AR 72201
1-800-224-6330, TTY: **711**
http://www.insurance.arkansas.gov/shiip.htm

California

California Health Insurance Counseling & Advocacy Program (HICAP)
1300 National Drive, Suite 200
Sacramento, CA 95834-1992
1-800-434-0222, TTY: **1-800-735-2929**
https://www.aging.ca.gov/hicap/

Colorado

Senior Health Insurance Assistance Program (SHIP)
1560 Broadway, Suite 850
Denver, CO 80202
1-888-696-7213, TTY: **1-303-894-7880**
https://cdhs.colorado.gov/contact-cdhs

Connecticut

CHOICES
55 Farmington Ave
Hartford, CT 06105-3730
1-800-203-3447, TTY: **711**
http://www.ct.gov/agingservices

Delaware

Delaware Medicare Assistance Bureau
841 Silver Lake Boulevard
Dover, DE 19904
1-800-336-9500, TTY: **711**
http://www.delawareinsurance.gov/elderinfo/

District of Columbia

Health Insurance Counseling Project (HICP)
500 K Street NE
Washington, DC 20002
1-202-724-5626, TTY: **1-202-994-6656**
http://dcoa.dc.gov/service/health-insurance-counseling

Florida

Serving Health Insurance Needs of Elders (SHINE)
4040 Esplanade Way, Suite 270
Tallahassee, FL 32399-7000
1-800-963-5337, TTY: **1-800-955-8770**
http://www.floridashine.org

Georgia

GeorgiaCares
2 Peachtree Street NW, 33rd Floor
Atlanta, GA 30303
1-866-552-4464, TTY: **711**
http://www.mygeorgiacares.org

Hawaii

HAWAII SHIP
250 S Hotel Street, Suite 406
Honolulu, HI 96813-2831
1-888-875-9229, TTY: **1-866-810-4379**
http://www.hawaiiship.org/site/1/home.aspx

Idaho

Senior Health Insurance Benefits Advisors (SHIBA)
700 West State Street., 3rd Floor
Boise, ID 83702-0043
1-800-247-4422, TTY: **711**
https://doi.idaho.gov/shiba/

Illinois

Senior Health Insurance Program (SHIP)
One Natural Resources Way, #100
Springfield, IL 62702-1271
1-800-252-8966, TTY: **1-888-206-1327**
http://www.state.il.us/aging/SHIP/default.htm

Indiana

State Health Insurance Assistance Program (SHIP)
311 W. Washington Street, Suite 300
Indianapolis, IN 46204-2787
1-800-452-4800, TTY: **1-866-846-0139**
http://www.medicare.in.gov

Iowa

Senior Health Insurance Information Program (SHIIP)
1963 Bell Avenue, Suite 100
Des Moines, IA 50315
1-800-351-4664, TTY: **1-800-735-2942**
http://www.shiip.state.ia.us/

Kansas

Senior Health Insurance Counseling for Kansas (SHICK)
503 S. Kansas Ave, New England Bldg
Topeka, KS 66603-3404
1-800-860-5260, TTY: **711**
http://www.kdads.ks.gov/commissions/commission-on-aging/medicare-programs/shick

Kentucky

State Health Insurance Assistance Program (SHIP)
275 E. Main Street.
Frankfort, KY 40621
1-877-293-7447, TTY: **711**
https://chfs.ky.gov/agencies/dail/Pages/ship.aspx

Louisiana

Senior Health Insurance Information Program (SHIIP)
1702 N. Third Street, P.O. Box 94214
Baton Rouge, LA 70802
1-800-259-5300, TTY: **711**
http://www.ldi.la.gov/SHIIP

Maine

Maine State Health Insurance Assistance Program (SHIP)
11 State House Station, 41 Anthony Ave
Augusta, ME 04333
1-877-353-3771, TTY: **711**
http://www.maine.gov/dhhs/oads/community-support/ship.html

Maryland

Senior Health Insurance Assistance Program (SHIP)
301 W. Preston Street, Suite 1007
Baltimore, MD 21201
1-800-243-3425, TTY: **711**
https://aging.maryland.gov/Pages/state-health-insurance-program.aspx

Massachusetts

Serving Health Information Needs of Elders (SHINE)
1 Ashburton Place, 5th floor
Boston, MA 02108
1-800-243-4636, TTY: **1-800-872-0166**
http://www.mass.gov/elders/healthcare/shine/serving-the-health-information-needs-of-elders.html

Michigan

MMAP, Inc.
6105 W St. Joseph, Suite 204
Lansing, MI 48917
1-800-803-7174, TTY: **711**
http://www.mmapinc.org

Minnesota

Minnesota State Health Insurance Assistance Program/Senior LinkAge Line
P.O. Box 64976
St. Paul, MN 55164-0976
1-800-333-2433, TTY: **1-800-627-3529**
http://www.mnaging.org

Mississippi

MS State Health Insurance Assistance Program (SHIP)
200 South Lamar Street
Jackson, MS 39201
1-800-948-3090, TTY: **711**
http://www.mdhs.ms.gov/adults-seniors/services-for-seniors/state-health-insurance-assistance-program/

Missouri

CLAIM
1105 Lakeview Avenue
Columbia, MO 65201
1-800-390-3330, TTY: **711**
http://www.missouriclaim.org

Montana

Montana State Health Insurance Assistance Program (SHIP)
111 N. Sanders Street
Helena, MT 59601
1-406-444-4077, TTY: **711**
http://dphhs.mt.gov/SLTC/aging/SHIP

Nebraska

Nebraska Senior Health Insurance Information Program (SHIIP)
1033 O Street, Suite 307
Lincoln, NE 68508
1-800-234-7119, TTY: **711**
http://www.doi.ne.gov/shiip

Nevada

State Health Insurance Assistance Program (SHIP)
3416 Goni Road, Suite D-132
Carson City, NV 89706
1-800-307-4444, TTY: **711**
http://nevadaadrc.com/services-and-programs/medicare/state-health-insurance-assistance-program-ship

New Hampshire

NH SHIP - ServiceLink Resource Center
129 Pleasant Street, Gallen State Office Park
Concord, NH 03301-3857
1-866-634-9412, TTY: **711**
http://www.servicelink.nh.gov/

New Jersey

State Health Insurance Assistance Program (SHIP)
P.O. Box 360
Trenton, NJ 08625-0715
1-800-792-8820, TTY: **711**
http://www.state.nj.us/humanservices/doas/services/ship/

New Mexico

Benefits Counseling Program
2550 Cerrillos Road
Santa Fe, NM 87505
1-800-432-2080, TTY: **711**
http://www.nmaging.state.nm.us/

New York

Health Insurance Information Counseling and Assistance Program (HIICAP)
2 Empire State Plaza
Albany, NY 12223-1251
1-800-701-0501, TTY: **711**
https://aging.ny.gov/

North Carolina

Seniors' Health Insurance Information Program (SHIIP)
325 N. Salisbury Street
Raleigh, NC 27603
1-855-408-1212, TTY: **711**
http://www.ncdoi.com/SHIIP/

North Dakota

Senior Health Insurance Counseling (SHIC)
600 East Boulevard Ave., 5th Floor
Bismarck, ND 58505-0320
1-888-575-6611, TTY: **1-800-366-6888**
http://www.nd.gov/ndins/shic/

Ohio

Ohio Senior Health Insurance Information Program (OSHIIP)
50 West Town Street, 3rd Floor - Suite 300
Columbus, OH 43215
1-800-686-1578, TTY: **1-614-644-3745**
https://insurance.ohio.gov/wps/portal/gov/odi/agents-and-agencies

Oklahoma

Senior Health Insurance Counseling Program (SHIP)
3625 NW 56th Street, Suite 100
Oklahoma City, OK 73112
1-800-763-2828, TTY: **711**
http://www.ok.gov/oid/Consumers/Information_for_Seniors/SHIP.html

Oregon

Senior Health Insurance Benefits Assistance Program (SHIBA)
350 Winter Street NE, Suite 330,
P.O. Box 14480
Salem, OR 97309-0405
1-800-722-4134, TTY: **711**
http://www.oregon.gov/dcbs/insurance/SHIBA/Pages/shiba.aspx

Pennsylvania

APPRISE
555 Walnut Street, 5th Floor
Harrisburg, PA 17101-1919
1-800-783-7067, TTY: **711**
http://www.portal.state.pa.us/portal/server.pt?ope

Rhode Island

Senior Health Insurance Program (SHIP)
25 Howard Ave Building 57
Cranston, RI 02920
1-888-884-8721, TTY: **1-401-462-0740**
https://oha.ri.gov/

South Carolina

(I-CARE) Insurance Counseling Assistance and Referrals for Elders
1301 Gervais Street, Suite 350
Columbia, SC 29201
1-800-868-9095, TTY: **711**
https://aging.sc.gov/

South Dakota

Senior Health Information & Insurance Education (SHIINE)
700 Governors Drive
Pierre, SD 57501
1-800-536-8197, TTY: **711**
http://www.shiine.net

Tennessee

TN SHIP
500 Deaderick Street, Suite 825
Nashville, TN 37243-0860
1-877-801-0044, TTY: **711**
http://www.tnmedicarehelp.com/

Texas

Health Information Counseling and Advocacy Program (HICAP)
701 W 51st Street
Austin, TX 78751
1-800-252-9240, TTY: **711**
http://www.dads.state.tx.us/

Utah

Senior Health Insurance Information Program (SHIP)
195 North 1950 West
Salt Lake City, UT 84116
1-800-541-7735, TTY: **711**
http://daas.utah.gov/senior-services/

Vermont

State Health Insurance Assistance Program
280 State Drive HC2 South
Waterbury, VT 05671
1-800-642-5119, TTY: **711**
https://www.nekcouncil.org/contact-the-nek-council-on-aging

Virginia

Virginia Insurance Counseling and Assistance Program (VICAP)
1610 Forest Avenue, Suite 100
Henrico, VA 23229
1-800-552-3402, TTY: **711**
http://www.vda.virginia.gov

Washington

Statewide Health Insurance Benefits Advisors (SHIBA) Helpline
P.O. Box 40256
Olympia, WA 98504-0256
1-800-562-6900, TTY: **711**
http://www.insurance.wa.gov

West Virginia

West Virginia State Health Insurance Assistance Program (WV SHIP)
1900 Kanawha Blvd. E
Charleston, WV 25305
1-877-987-4463, TTY: **711**
http://www.wvship.org

Wisconsin

Wisconsin SHIP (SHIP)
One West Wilson Street
Madison, WI 53703
1-800-242-1060, TTY: **711**
https://www.dhs.wisconsin.gov/benefit-specialists/medicare-counseling.htm

Wyoming

Wyoming State Health Insurance Information Program (WSHIIP)
106 W Adams, P.O. Box BD
Riverton, WY 82501
1-800-856-4398, TTY: **711**
http://www.wyomingseniors.com

SECTION 2 Quality Improvement Organization (QIO)

The following state agency information was updated on July 13, 2021. For more recent information or other questions, please contact Member Services. Phone numbers are printed on the back cover of this booklet.

Alabama

KEPRO - Region 4
5201 West Kennedy Boulevard, Suite 900
Tampa, FL 33609
1-888-317-0751, TTY: **711**
Monday through Friday: 9:00 a.m. - 5:00 p.m. and 11:00 a.m. to 3:00 p.m. on Saturday, Sunday and holidays in all local time zones
http://www.keproqio.com/default.aspx

Alaska

KEPRO Region 8
5700 Lombardo Center Dr., Suite 100
Seven Hills, OH 44131
1-888-317-0891, TTY: **711**
Monday through Friday: 9:00 a.m. -5:00 p.m. and 11:00 a.m. to 3:00 p.m. on Saturday, Sunday and holidays in all local time zones
http://www.keproqio.com/default.aspx

Arizona

Livanta LLC BFCC-QIO Program
10820 Guilford Rd, Suite 202
Annapolis Junction, MD 20701-1105
1-877-588-1123, TTY: **1-855-887-6668**
Monday through Friday: 9:00 a.m. - 5:00 p.m. (Local Time)
https://www.livantaqio.com/en

Arkansas

KEPRO - Region 6
5201 West Kennedy Boulevard, Suite 900
Tampa, FL 33609
1-888-315-0636, TTY: **711**
Monday through Friday: 9:00 a.m. - 5:00 p.m. and 11:00 a.m. to 3:00 p.m. on Saturday, Sunday and holidays in all local time zones
http://www.keproqio.com/default.aspx

California

Livanta LLC BFCC-QIO Program
10820 Guilford Rd, Suite 202
Annapolis Junction, MD 20701-1105
1-877-588-1123, TTY: **1-855-887-6668**
Monday through Friday: 9:00 a.m. - 5:00 p.m. (Local Time)
https://www.livantaqio.com/en

Colorado

KEPRO - Region 8
5700 Lombardo Center Dr., Suite 100
Seven Hills, OH 44131
1-888-317-0891, TTY: **711**
Monday through Friday: 9:00 a.m. - 5:00 p.m. and 11:00 a.m. to 3:00 p.m. on Saturday, Sunday and holidays in all local time zones
http://www.keproqio.com/default.aspx

Connecticut

KEPRO - Region 1
5700 Lombardo Center Dr., Suite 100
Seven Hills, OH, 44131
1-888-319-8452, TTY: **711**
Monday through Friday: 9:00 a.m. - 5:00 p.m. and 11:00 a.m. to 3:00 p.m. on Saturday, Sunday and holidays in all local time zones
http://www.keproqio.com/default.aspx

Delaware

Livanta LLC BFCC-QIO Program
10820 Guilford Rd, Suite 202
Annapolis Junction, MD 20701-1105
1-888-396-4646, TTY: **1-888-985-2660**
Monday through Friday: 9:00 a.m. - 5:00 p.m. (Local Time)
https://www.livantaqio.com/en

District of Columbia

Livanta LLC BFCC-QIO Program
10820 Guilford Rd, Suite 202
Annapolis Junction, MD 20701-1105
1-888-396-4646, TTY: **1-888-985-2660**
Monday through Friday: 9:00 a.m. - 5:00 p.m. (Local Time)
https://www.livantaqio.com/en

Florida

KEPRO - Region 4
5201 West Kennedy Boulevard, Suite 900
Tampa, FL 33609
1-888-317-0751, TTY: **711**
Monday through Friday: 9:00 a.m. - 5:00 p.m. and 11:00 a.m. to 3:00 p.m. on Saturday, Sunday and holidays in all local time zones
http://www.keproqio.com/default.aspx

Georgia

KEPRO - Region 4
5201 West Kennedy Boulevard, Suite 900
Tampa, FL 33609
1-888-317-0751, TTY: **711**
Monday through Friday: 9:00 a.m. - 5:00 p.m. and 11:00 a.m. to 3:00 p.m. on Saturday, Sunday and holidays in all local time zones
http://www.keproqio.com/default.aspx

Hawaii

Livanta LLC BFCC-QIO Program
10820 Guilford Rd, Suite 202
Annapolis Junction, MD 20701-1105
1-877-588-1123, TTY: **1-855-887-6668**
Monday through Friday: 9:00 a.m. - 5:00 p.m. (Local Time)
https://www.livantaqio.com/en

Idaho

KEPRO - Region 10
5700 Lombardo Center Dr., Suite 100
Seven Hills, OH 44131
1-888-305-6759, TTY: **711**
Monday through Friday: 9:00 a.m. - 5:00 p.m. and 11:00 a.m. to 3:00 p.m. on Saturday, Sunday and holidays in all local time zones
http://www.keproqio.com/default.aspx

Illinois

Livanta LLC BFCC-QIO Program
10820 Guilford Rd, Suite 202
Annapolis Junction, MD 20701-1105
1-888-524-9900, TTY: **1-888-985-8775**
Monday through Friday: 9:00 a.m. - 5:00 p.m. (Local Time)
https://www.livantaqio.com/en

Indiana

Livanta LLC BFCC-QIO Program
10820 Guilford Rd, Suite 202
Annapolis Junction, MD 20701-1105
1-888-524-9900, TTY: **1-888-985-8775**
Monday through Friday: 9:00 a.m. - 5:00 p.m. (Local Time)
https://www.livantaqio.com/en

Iowa

Livanta LLC BFCC-QIO Program
10820 Guilford Rd, Suite 202
Annapolis Junction, MD 20701-1105
1-888-755-5580, TTY: **1-888-985-9295**
Monday through Friday: 9:00 a.m. - 5:00 p.m. (Local Time)
https://www.livantaqio.com/en

Kansas

Livanta LLC BFCC-QIO Program
10820 Guilford Rd, Suite 202
Annapolis Junction, MD 20701-1105
1-888-755-5580, TTY: **1-888-985-9295**
Monday through Friday: 9:00 a.m. - 5:00 p.m. (Local Time)
https://www.livantaqio.com/en

Kentucky

KEPRO - Region 4
5201 West Kennedy Boulevard, Suite 900
Tampa, FL 33609
1-888-317-0751, TTY: **711**
Monday through Friday: 9:00 a.m. - 5:00 p.m. and 11:00 a.m. to 3:00 p.m. on Saturday, Sunday and holidays in all local time zones
http://www.keproqio.com/default.aspx

Louisiana

KEPRO - Region 6
5201 West Kennedy Boulevard, Suite 900
Tampa, FL 33609
1-888-315-0636, TTY: **711**
Monday through Friday: 9:00 a.m. - 5:00 p.m. and 11:00 a.m. to 3:00 p.m. on Saturday, Sunday and holidays in all local time zones
http://www.keproqio.com/default.aspx

Maine

KEPRO - Region 1
5700 Lombardo Center Dr., Suite 100
Seven Hills, OH, 44131
1-888-319-8452, TTY: **711**
Monday through Friday: 9:00 a.m. - 5:00 p.m. and 11:00 a.m. to 3:00 p.m. on Saturday, Sunday and holidays in all local time zones
http://www.keproqio.com/default.aspx

Maryland

Livanta LLC BFCC-QIO Program
10820 Guilford Rd, Suite 202
Annapolis Junction, MD 20701-1105
1-888-396-4646, TTY: **1-888-985-2660**
Monday through Friday: 9:00 a.m. - 5:00 p.m. (Local Time)
https://www.livantaqio.com/en

Massachusetts

KEPRO - Region 1
5700 Lombardo Center Dr., Suite 100
Seven Hills, OH, 44131
1-888-319-8452, TTY: **711**
Monday through Friday: 9:00 a.m. - 5:00 p.m. and 11:00 a.m. to 3:00 p.m. on Saturday, Sunday and holidays in all local time zones
http://www.keproqio.com/default.aspx

Michigan

Livanta LLC BFCC-QIO Program
10820 Guilford Rd, Suite 202
Annapolis Junction, MD 20701-1105
1-888-524-9900, TTY: **1-888-985-8775**
Monday through Friday: 9:00 a.m. - 5:00 p.m. (Local Time)
https://www.livantaqio.com/en

Minnesota

Livanta LLC BFCC-QIO Program
10820 Guilford Rd, Suite 202
Annapolis Junction, MD 20701-1105
1-888-524-9900, TTY: **1-888-985-8775**
Monday through Friday: 9:00 a.m. - 5:00 p.m. (Local Time)
https://www.livantaqio.com/en

Mississippi

KEPRO - Region 4
5201 West Kennedy Boulevard, Suite 900
Tampa, FL 33609
1-888-317-0751, TTY: **711**
Monday through Friday: 9:00 a.m. - 5:00 p.m. and 11:00 a.m. to 3:00 p.m. on Saturday, Sunday and holidays in all local time zones
http://www.keproqio.com/default.aspx

Missouri

Livanta LLC BFCC-QIO Program
10820 Guilford Rd, Suite 202
Annapolis Junction, MD 20701-1105
1-888-755-5580, TTY: **1-888-985-9295**
Monday through Friday: 9:00 a.m. - 5:00 p.m. (Local Time)
https://www.livantaqio.com/en

Montana

KEPRO - Region 8
5700 Lombardo Center Dr., Suite 100
Seven Hills, OH, 44131
1-888-317-0891, TTY: **711**
Monday through Friday: 9:00 a.m. - 5:00 p.m. and 11:00 a.m. to 3:00 p.m. on Saturday, Sunday and holidays in all local time zones
http://www.keproqio.com/default.aspx

Nebraska

Livanta LLC BFCC-QIO Program
10820 Guilford Rd, Suite 202
Annapolis Junction, MD 20701-1105
1-888-755-5580, TTY: **1-888-985-9295**
Monday through Friday: 9:00 a.m. - 5:00 p.m. (Local Time)
https://www.livantaqio.com/en

Nevada

Livanta LLC BFCC-QIO Program
10820 Guilford Rd, Suite 202
Annapolis Junction, MD 20701-1105
1-877-588-1123, TTY: **1-855-887-6668**
Monday through Friday: 9:00 a.m. - 5:00 p.m. (Local Time)
https://www.livantaqio.com/en

New Hampshire

KEPRO - Region 1
5700 Lombardo Center Dr., Suite 100
Seven Hills, OH, 44131
1-888-319-8452, TTY: **711**
Monday through Friday: 9:00 a.m. - 5:00 p.m. and 11:00 a.m. to 3:00 p.m. on Saturday, Sunday and holidays in all local time zones
http://www.keproqio.com/default.aspx

New Jersey

Livanta LLC BFCC-QIO Program
10820 Guilford Rd, Suite 202
Annapolis Junction, MD 20701-1105
1-866-815-5440, TTY: **1-866-868-2289**
Monday through Friday: 9:00 a.m. - 5:00 p.m. (Local Time)
https://www.livantaqio.com/en

New Mexico

KEPRO - Region 6
5201 West Kennedy Boulevard, Suite 900
Tampa, FL 33609
1-888-315-0636, TTY: **711**
Monday through Friday: 9:00 a.m. - 5:00 p.m. and 11:00 a.m. to 3:00 p.m. on Saturday, Sunday and holidays in all local time zones
http://www.keproqio.com/default.aspx

New York

Livanta LLC BFCC-QIO Program
10820 Guilford Rd, Suite 202
Annapolis Junction, MD 20701-1105
1-866-815-5440, TTY: **1-866-868-2289**
Monday through Friday: 9:00 a.m. - 5:00 p.m. (Local Time)
https://www.livantaqio.com/en

North Carolina

KEPRO - Region 4
5201 West Kennedy Boulevard, Suite 900
Tampa, FL 33609
1-888-317-0751, TTY: **711**
Monday through Friday: 9:00 a.m. - 5:00 p.m. and 11:00 a.m. to 3:00 p.m. on Saturday, Sunday and holidays in all local time zones
http://www.keproqio.com/default.aspx

North Dakota

KEPRO - Region 8
5700 Lombardo Center Dr., Suite 100
Seven Hills, OH, 44131
1-888-317-0891, TTY: **711**
Monday through Friday: 9:00 a.m. - 5:00 p.m. and 11:00 a.m. to 3:00 p.m. on Saturday, Sunday and holidays in all local time zones
http://www.keproqio.com/default.aspx

Ohio

Livanta LLC BFCC-QIO Program
10820 Guilford Rd, Suite 202
Annapolis Junction, MD 20701-1105
1-888-524-9900, TTY: **1-888-985-8775**
Monday through Friday: 9:00 a.m. - 5:00 p.m. (Local Time)
https://www.livantaqio.com/en

Oklahoma

KEPRO - Region 6
5201 West Kennedy Boulevard, Suite 900
Tampa, FL 33609
1-888-315-0636, TTY: **711**
Monday through Friday: 9:00 a.m. - 5:00 p.m. and 11:00 a.m. to 3:00 p.m. on Saturday, Sunday and holidays in all local time zones
http://www.keproqio.com/default.aspx

Oregon

KEPRO - Region 10
5700 Lombardo Center Dr., Suite 100
Seven Hills, OH 44131
1-888-305-6759, TTY: **711**
Monday through Friday: 9:00 a.m. - 5:00 p.m. and 11:00 a.m. to 3:00 p.m. on Saturday, Sunday and holidays in all local time zones
http://www.keproqio.com/default.aspx

Pennsylvania

Livanta LLC BFCC-QIO Program
10820 Guilford Rd, Suite 202
Annapolis Junction, MD 20701-1105
1-888-396-4646, TTY: **1-888-985-2660**
Monday through Friday: 9:00 a.m. - 5:00 p.m. (Local Time)
https://www.livantaqio.com/en

Rhode Island

KEPRO - Region 1
5700 Lombardo Center Dr., Suite 100
Seven Hills, OH, 44131
1-888-319-8452, TTY: **711**
Monday through Friday: 9:00 a.m. - 5:00 p.m. and 11:00 a.m. to 3:00 p.m. on Saturday, Sunday and holidays in all local time zones
http://www.keproqio.com/default.aspx

South Carolina

KEPRO - Region 4
5201 West Kennedy Boulevard, Suite 900
Tampa, FL 33609
1-888-317-0751, TTY: **711**
Monday through Friday: 9:00 a.m. - 5:00 p.m. and 11:00 a.m. to 3:00 p.m. on Saturday, Sunday and holidays in all local time zones
http://www.keproqio.com/default.aspx

South Dakota

KEPRO - Region 8
5700 Lombardo Center Dr., Suite 100
Seven Hills, OH, 44131
1-888-317-0891, TTY: **711**
Monday through Friday: 9:00 a.m. - 5:00 p.m. and 11:00 a.m. to 3:00 p.m. on Saturday, Sunday and holidays in all local time zones
http://www.keproqio.com/default.aspx

Tennessee

KEPRO - Region 4
5201 West Kennedy Boulevard, Suite 900
Tampa, FL 33609
1-888-317-0751, TTY: **711**
Monday through Friday: 9:00 a.m. - 5:00 p.m. and 11:00 a.m. to 3:00 p.m. on Saturday, Sunday and holidays in all local time zones
http://www.keproqio.com/default.aspx

Texas

KEPRO - Region 6
5201 West Kennedy Boulevard, Suite 900
Tampa, FL 33609
1-888-315-0636, TTY: **711**
Monday through Friday: 9:00 a.m. - 5:00 p.m. and 11:00 a.m. to 3:00 p.m. on Saturday, Sunday and holidays in all local time zones
http://www.keproqio.com/default.aspx

Utah

KEPRO - Region 8
5700 Lombardo Center Dr., Suite 100
Seven Hills, OH, 44131
1-888-317-0891, TTY: **711**
Monday through Friday: 9:00 a.m. - 5:00 p.m. and 11:00 a.m. to 3:00 p.m. on Saturday, Sunday and holidays in all local time zones
http://www.keproqio.com/default.aspx

Vermont

KEPRO - Region 1
5700 Lombardo Center Dr., Suite 100
Seven Hills, OH, 44131
1-888-319-8452, TTY: **711**
Monday through Friday: 9:00 a.m. - 5:00 p.m. and 11:00 a.m. to 3:00 p.m. on Saturday, Sunday and holidays in all local time zones
http://www.keproqio.com/default.aspx

Virginia

Livanta LLC BFCC-QIO Program
10820 Guilford Rd, Suite 202
Annapolis Junction, MD 20701-1105
1-888-396-4646, TTY: **1-888-985-2660**
Monday through Friday: 9:00 a.m. - 5:00 p.m. (Local Time)
https://www.livantaqio.com/en

Washington

KEPRO - Region 10
5700 Lombardo Center Dr., Suite 100
Seven Hills, OH 44131
1-888-305-6759, TTY: **711**
Monday through Friday: 9:00 a.m. - 5:00 p.m. and 11:00 a.m. to 3:00 p.m. on Saturday, Sunday and holidays in all local time zones
http://www.keproqio.com/default.aspx

West Virginia

Livanta LLC BFCC-QIO Program
10820 Guilford Rd, Suite 202
Annapolis Junction, MD 20701-1105
1-888-396-4646, TTY: **1-888-985-2660**
Monday through Friday: 9:00 a.m. - 5:00 p.m. (Local Time)
https://www.livantaqio.com/en

Wisconsin

Livanta LLC BFCC-QIO Program
10820 Guilford Rd, Suite 202
Annapolis Junction, MD 20701-1105
1-888-524-9900, TTY: **1-888-985-8775**
Monday through Friday: 9:00 a.m. - 5:00 p.m. (Local Time)
https://www.livantaqio.com/en

Wyoming

KEPRO - Region 8
5700 Lombardo Center Dr., Suite 100
Seven Hills, OH, 44131
1-888-317-0891, TTY: **711**
Monday through Friday: 9:00 a.m. - 5:00 p.m. and 11:00 a.m. to 3:00 p.m. on Saturday, Sunday and holidays in all local time zones
http://www.keproqio.com/default.aspx

SECTION 3 State Medicaid Offices

The following state agency information was updated on July 13, 2021. For more recent information or other questions, please contact Member Services. Phone numbers are printed on the back cover of this booklet.

Alabama

Alabama Medicaid Agency
P.O. Box 5624
501 Dexter Avenue
Montgomery, AL 36130-5624
1-334-242-5000, TTY: **711**
8:00 a.m. - 4:30 p.m. Monday through Friday
http://www.medicaid.alabama.gov

Alaska

Alaska Medicaid
3601 C Street
Anchorage, AK 99503
1-907-465-3347, TTY: **711**
8:00 a.m. - 4:30 p.m. Monday through Friday
http://dhss.alaska.gov/Commissioner/Pages/Contacts/default.aspx

Arizona

Arizona Health Care Cost Containment System
801 E. Jefferson
Phoenix, AZ 85034
1-800-523-0231, TTY: **711**
8:00 a.m. - 1:00 p.m. and 2:00 p.m. to 5:00 p.m. Monday through Friday
http://www.azahcccs.gov

Arkansas

Arkansas Medicaid
Donaghey Plaza South
P.O. Box 1437, Slot S401
Little Rock, AR 72203-1437
1-800-482-5431, TTY: **711**
8:00 a.m. - 4:30 p.m. Monday through Friday
https://humanservices.arkansas.gov/divisions-shared-services/medical-services/contact-dms-2/

California

Medi-Cal
P.O. Box 997417 MS 4607
Sacramento, CA 95899-7417
1-800-541-5555, TTY: **711**
8:00 a.m. - 5:00 p.m. Monday through Friday
http://www.medi-cal.ca.gov

Colorado

Colorado Medicaid
1570 Grant Street
Denver, CO 80203
1-800-221-3943, TTY: **711**
8:00 a.m. - 4:30 p.m. Mon - Fri;
8:00 a.m. - 12:00 p.m. Sat
https://www.healthfirstcolorado.com/

Connecticut

HUSKY Health Program
P.O. Box 5005
Wallingford, CT 06492
1-800-859-9889, TTY: **1-866-492-5276**
8:00 a.m. - 6:00 p.m. Monday through Friday
http://www.ct.gov/hh/site/default.asp

Delaware

Delaware Medicaid
Lewis Building
1901 N. DuPont Highway
New Castle, DE 19720
1-800-372-2022, TTY: **711**
8:00 a.m. - 4:30 p.m. Monday through Friday
http://www.dhss.delaware.gov/dhss/dmma/medicaid.html

District of Columbia

DC Medicaid
441 4th Street, NW, 900S
Washington, DC 20001
1-202-442-5988, TTY: **711**
8:15 a.m. - 4:45 p.m. Monday through Friday
http://dhcf.dc.gov/service/what-medicaid

Florida

Florida Medicaid
2727 Mahan Drive MS#6
Tallahassee, FL 32308
1-888-419-3456, TTY: **1-800-955-8771**
8:00 a.m. - 5:00 p.m. Monday through Friday
http://www.ahca.myflorida.com/Medicaid/index.shtml/about

Georgia

Georgia Medicaid
Georgia Department of Community Health
2 Peachtree Street, NW
Atlanta, GA 30303
1-877-423-4746, TTY: **711**
8:00 a.m. - 5:00 p.m. Monday through Friday
https://medicaid.georgia.gov/

Hawaii

Department of Human Services Med-QUEST Division
820 Mililani Street, Suite 606
Honolulu, HI 96813
1-800-316-8005, TTY: **1-855-585-8604**
9:00 a.m. - 3:00 p.m. Monday through Friday
https://medquest.hawaii.gov/

Idaho

Idaho Medicaid
P.O. Box 83720
Boise, ID 83720
1-877-456-1233, TTY: **711**
8:00 a.m. - 5:00 p.m. Monday through Friday
https://healthandwelfare.idaho.gov/ContactUs/tabid/127/Default.aspx

Illinois

Illinois Medicaid
100 South Grand Avenue East
Springfield, IL 62762
1-800-843-6154, TTY: **711**
8:30 a.m. - 5:00 p.m. Monday through Friday
http://www.hfs.illinois.gov/medical/apply.html

Indiana

Indiana Medicaid
P.O. Box 7083
402 W Washington Street
Indianapolis, IN 46204
1-800-457-4584, TTY: **711**
8:00 a.m. - 6:00 p.m. Mon - Fri
http://member.indianamedicaid.com/

Iowa

Iowa Medicaid
P.O. Box 36510
Des Moines, IA 50315
1-800-338-8366, TTY: **1-800-735-2942**
8:00 a.m. - 5:00 p.m. Monday through Friday
http://www.dhs.iowa.gov

Kansas

KanCare
503 S. Kansas Ave.
Topeka, KS 66603
1-800-432-3535, TTY: **711**
8:00 a.m. - 5:00 p.m. Monday through Friday
http://www.kancare.ks.gov/

Kentucky

Kentucky Medicaid
275 East Main Street
Frankfort, KY 40621
1-855-306-8959, TTY: **711**
8:00 a.m. - 5:00 p.m. Monday through Friday
http://www.chfs.ky.gov

Louisiana

Louisiana Medicaid
P.O. Box 629
Baton Rouge, LA 70821-9278
1-888-342-6207, TTY: **711**
8:00 a.m. - 4:30 p.m. Monday through Friday
http://ldh.la.gov/

Maine

MaineCare
11 State House Station
Augusta, ME 04333-0011
1-800-977-6740, TTY: **711**
7:00 a.m. - 6:00 p.m. Monday through Friday
http://www.maine.gov/dhhs/oms/index.shtml

Maryland

Maryland Medicaid
201 West Preston Street
Baltimore, MD 21201
1-877-463-3464, TTY: **711**
8:30 a.m. - 5:00 p.m. Monday through Friday
https://health.maryland.gov/pages/index.aspx

Massachusetts

MassHealth
One Ashburton Place, 11th Floor
Boston, MA 02108
1-800-841-2900, TTY: **1-800-497-4648**
8:00 a.m. - 5:00 p.m. Monday through Friday
http://www.mass.gov/eohhs/gov/departments/masshealth/

Michigan

Michigan Medicaid
P.O. Box 30195,
333 S. Grand Ave
Lansing, MI 48909
1-866-275-6424, TTY: **711**
8:00 a.m. - 5:00 p.m. Monday through Friday
http://www.michigan.gov/mdch/0,4612,7-132-2943_4860—,00.html

Minnesota

Minnesota's Medical Assistance Program
PO Box 64838
St. Paul, MN 55164
1-800-657-3739, TTY: **711**
8:00 a.m. - 5:00 p.m. Monday through Friday
https://mn.gov/dhs/general-public/about-dhs/contact-us/division-addresses.jsp

Mississippi

Mississippi Medicaid
550 High Street, Suite 1000
Jackson, MS 39201
1-800-421-2408, TTY: **711**
7:30 a.m. - 5:00 p.m. Monday through Friday
http://www.medicaid.ms.gov

Missouri

MO HealthNet
615 Howerton Court
P.O. Box 6500
Jefferson City, MO 65102-6500
1-855-373-4636, TTY: **711**
6:00 a.m. - 6:30 p.m. Monday through Friday
https://dss.mo.gov/

Montana

Montana Medicaid and Healthy Montana Kids (HMK) Plus
P.O. Box 202925
Helena, MT 59457
1-800-362-8312, TTY: **711**
8:00 a.m. - 5:00 p.m. Monday through Friday
http://www.dphhs.mt.gov

Nebraska

Nebraska Medicaid
301 Centennial Mall South
Lincoln, NE 68509-5026
1-855-632-7633, TTY: **711**
8:00 a.m. - 5:00 p.m. Monday through Friday
https://dhhs.ne.gov/Pages/Medicaid-Services.aspx

Nevada

Nevada Medicaid
1100 East William Street Suite 101
Carson City, NV 89701
1-877-638-3472, TTY: **711**
8:00 a.m. - 5:00 p.m. Monday through Friday
http://dhcfp.nv.gov/

New Hampshire

NH Medicaid
129 Pleasant Street
Concord, NH 03301
1-800-852-3345, TTY: **1-800-735-2964**
8:00 a.m. – 4:30 p.m. Monday through Friday
http://www.dhhs.state.nh.us/ombp/medicaid/index.htm

New Jersey

Division of Medical Assistance and Health Services
P.O. Box 712
Trenton, NJ 08625-0712
1-800-701-0710, TTY: **711**
Monday and Thursday 8:00 a.m. - 8:00 p.m.
Tuesday, Wednesday, Friday 8:00 a.m. - 5:00 p.m.
http://www.state.nj.us/humanservices/dmahs

New Mexico

NM Human Services Dept.
P.O. Box 2348
Santa Fe, NM 87504-2348
1-800-283-4465, TTY: **1-855-227-5485**
8:00 a.m. - 5:00 p.m. Monday through Friday
http://www.hsd.state.nm.us/

New York

New York Medicaid
Corning Tower, Empire State Plaza
Albany, NY 12237
1-800-541-2831, TTY: **711**
8:00 a.m. - 8:00 p.m. Monday through Friday
9:00 a.m. - 1:00 p.m. Saturday
http://www.health.ny.gov/health_care/medicaid/

North Carolina

North Carolina Medicaid
2501 Mail Service Center
Raleigh, NC 27699-2501
1-888-245-0179, TTY: **711**
8:00 a.m. - 5:00 p.m. Monday through Friday
https://dma.ncdhhs.gov/

North Dakota

North Dakota Medicaid
600 E. Boulevard Avenue, Dept 325
Bismarck, ND 58505-0250
1-800-755-2604, TTY: **711**
8:00 a.m. - 5:00 p.m. Monday through Friday
http://www.nd.gov/dhs/services/medicalserv/medicaid/

Ohio

Ohio Department of Medicaid
50 West Town Street, Suite 400
Columbus, OH 43215
1-800-324-8680, TTY: **1-800-292-3572**
7:00 a.m. - 8:00 p.m. Monday through Friday
http://medicaid.ohio.gov/

Oklahoma

Oklahoma Health Care Authority
4345 N. Lincoln Blvd
Oklahoma City, OK 73105
1-888-365-3742, TTY: **711**
8:00 a.m. - 5:00 p.m. Monday through Friday
http://www.insureoklahoma.org

Oregon

Oregon Department of Human Services
500 Summer Street, NE, E-20
Salem, OR 97301-1097
1-800-375-2863, TTY: **711**
8:00 a.m. - 5:00 p.m. Monday through Friday
http://www.oregon.gov/oha/healthplan/pages/index.aspx

Pennsylvania

Pennsylvania Medical Assistance
Health and Welfare Building, Rm 515
P.O. Box 2675
Harrisburg, PA 17105
1-800-692-7462, TTY: **1-800-451-5886**
8:30 a.m. - 4:45 p.m. Monday through Friday
http://www.dhs.pa.gov/

Rhode Island

Rhode Island Medicaid
3 West Road
Cranston, RI 02920
1-855-697-4347, TTY: **1-800-745-5555**
8:30 a.m. - 3:30 p.m. Monday through Friday
http://www.dhs.ri.gov/

South Carolina

Healthy Connections
P.O. Box 8206
Columbia, SC 29202
1-888-549-0820, TTY: **711**
8:00 a.m. - 5:00 p.m. Monday through Friday
https://www.scdhhs.gov/

South Dakota

South Dakota Medicaid
700 Governors Drive, Richard F Kneip Bldg
Pierre, SD 57501
1-800-597-1603, TTY: **711**
8:00 a.m. - 6:00 p.m. Monday through Friday
http://dss.sd.gov/medicaid/

Tennessee

TennCare
310 Great Circle Road
Nashville, TN 37243
1-800-342-3145, TTY: **711**
8:00 a.m. - 5:00 p.m. Monday through Friday
https://www.tn.gov/tenncare

Texas

Texas Health and Human Services
P. O. Box 13247
Austin, TX 78711-3247
1-800-252-8263, TTY: **711**
7:00 a.m. - 7:00 p.m. Mon - Fri
http://www.hhsc.state.tx.us/medicaid/index.shtml

Utah

Utah Department of Health Medicaid
Division of Medicaid and Health Financing
P.O. Box 143106
Salt Lake City, UT 84114
1-801-538-6155, TTY: **711**
8:00 a.m. - 5:00 p.m. Monday through Friday
(Thursday 11:00 a.m. - 5:00 p.m.)
https://medicaid.utah.gov/

Vermont

Green Mountain Care
280 State Drive
Waterbury, VT 05671-1010
1-802-879-5900, TTY: **711**
7:45 a.m. - 4:30 p.m. Monday through Friday
https://dvha.vermont.gov/

Virginia

Virginia Medicaid
600 East Broad Street
Richmond, VA 23219
1-804-786-7933, TTY: **711**
8:00 a.m. - 5:00 p.m. Monday through Friday
https://www.dmas.virginia.gov/#/index

Washington

Washington Apple Health
P.O. Box 45531
Olympia, WA 98504
1-800-562-3022, TTY: **711**
7:00 a.m. - 5:00 p.m. Monday through Friday
http://www.hca.wa.gov/medicaid/Pages/index.aspx

West Virginia

West Virginia Medicaid
WV Bureau for Medical Services
350 Capital Street, Room 251
Charleston, WV 25301-3709
1-304-558-1700, TTY: **711**
8:00 a.m. - 4:30 p.m. Monday through Friday
http://www.dhhr.wv.gov/bms/Pages/default.aspx

Wisconsin

Wisconsin Medicaid
1 West Wilson Street
Madison, WI 53703
1-800-362-3002, TTY: **711**
8:00 a.m. - 6:00 p.m. Monday through Friday
https://www.dhs.wisconsin.gov/

Wyoming

Wyoming Medicaid
P.O. Box 667
Cheyenne, WY 82003
1-800-251-1269, TTY: **711**
9:00 a.m. - 5:00 p.m. Monday through Friday
http://health.wyo.gov

SECTION 4 State Medicare Offices

The following state agency information was updated on July 13, 2021. For more recent information or other questions, please contact Member Services. Phone numbers are printed on the back cover of this booklet.

All 50 U.S. States and Washington, D.C.

Medicare Contact Center Operations
P.O. Box 1270
Lawrence, KS 66044
1-800-633-4227, TTY: 1**-877-486-2048**
24 hours, 7 days a week
www.medicare.gov

SECTION 5 Civil Rights Commission

The following state agency information was updated on July 13, 2021. For more recent information or other questions, please contact Member Services. Phone numbers are printed on the back cover of this booklet.

Alabama

Office for Civil Rights of the Southeast Region – Atlanta
Sam Nunn Atlanta Federal Center, Suite 16T70
61 Forsyth Street, SW
Atlanta, GA 30303-8909
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:00 a.m. -4:30 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Alaska

Office for Civil Rights of the Pacific Region
90 7th Street, Suite 4-100
San Francisco, CA 94103
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:00 a.m. –8:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Arizona

Office for Civil Rights of the Pacific Region
90 7th Street, Suite 4-100
San Francisco, CA 94103
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:00 a.m. – 8:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Arkansas

Office for Civil Rights of the Southwest Region
1301 Young Street, Suite 106
Dallas, TX 75202
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
7:30 a.m. - 8:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

California

Office for Civil Rights of the Pacific Region
90 7th Street, Suite 4-100
San Francisco, CA 94103
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:00 a.m. – 8:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Colorado

Office for Civil Rights of Rocky Mountain Region
1961 Stout Street, Room 08-148
Denver, CO 80294
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:00 a.m. - 8:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Connecticut

Office for Civil Rights of New England Region
J.F. Kennedy Federal Building, Room 1875
Boston, MA 02203
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:00 a.m. - 8:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Delaware

Office for Civil Rights of the Mid-Atlantic Region
801 Market Street Suite 9300
Philadelphia, PA 19107-3134
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
9:30 a.m. - 3:30 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

District of Columbia

Office for Civil Rights of the Mid-Atlantic Region
801 Market Street Suite 9300
Philadelphia, PA 19107-3134
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
9:30 a.m. - 3:30 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Florida

Office for Civil Rights of the Southeast Region - Atlanta
Sam Nunn Atlanta Federal Center, Suite 16T70
61 Forsyth Street, SW
Atlanta, GA 30303-8909
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:00 a.m. - 4:30 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Georgia

Office for Civil Rights of the Southeast Region - Atlanta
Sam Nunn Atlanta Federal Center, Suite 16T70
61 Forsyth Street, SW
Atlanta, GA 30303-8909
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:00 a.m. - 4:30 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Hawaii

Office for Civil Rights of the Pacific Region
90 7th Street, Suite 4-100
San Francisco, CA 94103
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:00 a.m. – 8:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Idaho

Office for Civil Rights of the Pacific Region
90 7th Street, Suite 4-100
San Francisco, CA 94103
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:00 a.m. – 8:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Illinois

Office for Civil Rights of the Midwest Region
233 N Michigan Ave, Suite 240
Chicago, IL 60601
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:30 a.m. - 5:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Indiana

Office for Civil Rights of the Midwest Region
233 N Michigan Ave, Suite 240
Chicago, IL 60601
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:30 a.m. - 5:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Iowa

Office for Civil Rights of the Midwest Region
233 N. Michigan Ave, Suite 240
Chicago, IL 60601
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:30 a.m. - 5:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Kansas

Office for Civil Rights of the Midwest Region
233 N Michigan Ave, Suite 240
Chicago, IL 60601
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:30 a.m. - 5:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Kentucky

Office for Civil Rights of the Southeast Region - Atlanta
Sam Nunn Atlanta Federal Center, Suite 16T70
61 Forsyth Street, SW
Atlanta, GA 30303-8909
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:00 a.m. - 4:30 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Louisiana

Office for Civil Rights of the Southwest Region
1301 Young Street, Suite 106
Dallas, TX 75202
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
7:30 a.m. - 8:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Maine

Office for Civil Rights of New England Region
J.F. Kennedy Federal Building, Room 1875
Boston, MA 02203
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:00 a.m. - 8:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Maryland

Office for Civil Rights of the Mid-Atlantic Region
801 Market Street, Suite 9300
Philadelphia, PA 19107-3134
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
9:30 a.m. - 3:30 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Massachusetts

Office for Civil Rights of New England Region
J.F. Kennedy Federal Building, Room 1875
Boston, MA 02203
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:00 a.m. - 8:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Michigan

Office for Civil Rights of the Midwest Region
233 N Michigan Ave, Suite 240
Chicago, IL 60601
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:30 a.m. - 5:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Minnesota

Office for Civil Rights of the Midwest Region
233 N Michigan Ave, Suite 240
Chicago, IL 60601
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:30 a.m. - 5:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Mississippi

Office for Civil Rights of the Southeast Region - Atlanta
Sam Nunn Atlanta Federal Center, Suite 16T70
61 Forsyth Street, SW
Atlanta, GA 30303-8909
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:00 a.m. - 4:30 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Missouri

Office for Civil Rights of the Midwest Region
233 N Michigan Ave, Suite 240
Chicago, IL 60601
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:30 a.m. - 5:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Montana

Office for Civil Rights of Rocky Mountain Region
1961 Stout Street, Room 08-148
Denver, CO 80294
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:00 a.m. - 8:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Nebraska

Office for Civil Rights of the Midwest Region
233 N Michigan Ave, Suite 240
Chicago, IL 60601
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:30 a.m. - 5:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Nevada

Office for Civil Rights of the Pacific Region
90 7th Street, Suite 4-100
San Francisco, CA 94103
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:00 a.m. – 8:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

New Hampshire

Office for Civil Rights of New England Region
J.F. Kennedy Federal Building, Room 1875
Boston, MA 02203
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:00 a.m. - 8:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

New Jersey

Office for Civil Rights of Eastern and Caribbean Region
26 Federal Plaza, Suite 3312
New York, NY 10278
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:30 a.m. - 5:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

New Mexico

Office for Civil Rights of the Southwest Region
1301 Young Street, Suite 106
Dallas, TX 75202
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
7:30 a.m. - 8:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

New York

Office for Civil Rights of Eastern and Caribbean Region
26 Federal Plaza, Suite 3312
New York, NY 10278
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:30 a.m. - 5:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

North Carolina

Office for Civil Rights of the Southeast Region - Atlanta
Sam Nunn Atlanta Federal Center, Suite 16T70
61 Forsyth Street, SW
Atlanta, GA 30303-8909
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:00 a.m. - 4:30 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

North Dakota

Office for Civil Rights of Rocky Mountain Region
1961 Stout Street, Room 08-148
Denver, CO 80294
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:00 a.m. - 8:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Ohio

Office for Civil Rights of the Midwest Region
233 N Michigan Ave, Suite 240
Chicago, IL 60601
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:30 a.m. - 5:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Oklahoma

Office for Civil Rights of the Southwest Region
1301 Young Street, Suite 106
Dallas, TX 75202
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
7:30 a.m. - 8:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Oregon

Office for Civil Rights of the Pacific Region
90 7th Street, Suite 4-100
San Francisco, CA 94103
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:00 a.m. – 8:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Pennsylvania

Office for Civil Rights of the Mid-Atlantic Region
801 Market Street, Suite 9300
Philadelphia, PA 19107-3134
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
9:30 a.m. - 3:30 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Rhode Island

Office for Civil Rights of New England Region
J.F. Kennedy Federal Building, Room 1875
Boston, MA 02203
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:00 a.m. - 8:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

South Carolina

Office for Civil Rights of the Southeast Region - Atlanta
Sam Nunn Atlanta Federal Center, Suite 16T70
61 Forsyth Street, SW
Atlanta, GA 30303-8909
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:00 a.m. - 4:30 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

South Dakota

Office for Civil Rights of Rocky Mountain Region
1961 Stout Street, Room 08-148
Denver, CO 80294
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:00 a.m. - 8:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Tennessee

Office for Civil Rights of the Southeast Region - Atlanta
Sam Nunn Atlanta Federal Center, Suite 16T70
61 Forsyth Street, SW
Atlanta, GA 30303-8909
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:00 a.m. - 4:30 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Texas

Office for Civil Rights of the Southwest Region
1301 Young Street, Suite 106
Dallas, TX 75202
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
7:30 a.m. - 8:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Utah

Office for Civil Rights of Rocky Mountain Region
1961 Stout Street, Room 08-148
Denver, CO 80294
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:00 a.m. - 8:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Vermont

Office for Civil Rights of New England Region
J.F. Kennedy Federal Building, Room 1875
Boston, MA 02203
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:00 a.m. - 8:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Virginia

Office for Civil Rights of the Mid-Atlantic Region
801 Market Street, Suite 9300
Philadelphia, PA 19107-3134
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
9:30 a.m. - 3:30 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Washington

Office for Civil Rights of the Pacific Region
90 7th Street, Suite 4-100
San Francisco, CA 94103
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:00 a.m. – 8:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

West Virginia

Office for Civil Rights of the Mid-Atlantic Region
801 Market Street, Suite 9300
Philadelphia, PA 19107-3134
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
9:30 a.m. - 3:30 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Wisconsin

Office for Civil Rights of the Midwest Region
233 N Michigan Ave, Suite 240
Chicago, IL 60601
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:30 a.m. - 5:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Wyoming

Office for Civil Rights of Rocky Mountain Region
1961 Stout Street, Room 08-148
Denver, CO 80294
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:00 a.m. - 8:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

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.*

The NYC Medicare Advantage Plus plan is offered through an alliance between Empire BlueCross BlueShield Retiree Solutions and EmblemHealth. Empire and EmblemHealth have come together to create a new, customized, fully insured Group Medicare Advantage program for the City of New York. Empire BlueCross BlueShield Retiree Solutions is an LPPO plan with a Medicare contract. Enrollment in Empire BlueCross BlueShield Retiree Solutions depends on contract renewal. Empire BlueCross BlueShield Retiree Solutions is the trade name of Anthem Insurance Companies, Inc. Independent licensee of the Blue Cross Blue Shield Association. EmblemHealth insurance plans are underwritten by EmblemHealth Plan, Inc., EmblemHealth Insurance Company, and Health Insurance Plan of Greater New York (HIP). EmblemHealth Services Company, LLC provides administrative services to EmblemHealth companies. The EmblemHealth companies are separate companies from Empire BlueCross BlueShield.

Empire BlueCross BlueShield
An Anthem Company

The City of New York

Embler

For questions, please call

Member Services: **1-833-325-1191** (TTY: **711**)

Monday through Friday, 8 a.m. to 9 p.m. ET, except holidays

www.empireblue.com/nyc-ma-plus

Addendum A

Featured Plans and Rates - MA

City of New York

January 1, 2022 - December 31, 2028

	1/1/2022 to 12/31/2022	1/1/2023 to 12/31/2026	1/1/2027 to 12/31/2027	1/1/2028 to 12/31/2028
Medical Plan	**NYC Medicare Advantage Plus Plan**	**NYC Medicare Advantage Plus Plan**	**NYC Medicare Advantage Plus Plan**	**NYC Medicare Advantage Plus Plan**
Medical	**Monthly billed PMPM rates** $7.50	**Monthly billed PMPM rates** $0.00	**Monthly billed PMPM rates** $0.00 Premium contingent upon Group Performance	**Monthly billed PMPM rates** $0.00 Premium contingent upon Group Performance

Please refer to Quote Stipulations.

Addendum A - Quote Stipulations

Quote Stipulations

- Rates and benefits of MA Plan may need to be revised based on material legislative and regulatory changes including, but not limited to, CMS guidance, which becomes effective during the MA Agreement Period.
- This quote assumes co-branding (Group name and/ or logo is allowed on MA Plan Member materials including Medicare Advantage plan quality and health programs).
- Benefit to incorporate MA Plan deductible of $253 and Inpatient copays of $300 per admission must be implemented on 1/1/2022.
- Participants have Medicare Parts A and B.
- Eligibility for enrollment into the MA Plan for Medicare-eligible individuals is based on meeting the Group's requirements for coverage of retiree medical benefits.
- Contracted premium rates are on a Per-Member-Per-Month (PMPM) basis. The City will pay the exhibited rate for a one-member individual coverage class. The City will pay twice the exhibited rate for each family in the Medicare Family coverage class.
- Broker Commissions are excluded.
- Eligibility Provisions
  1. All Medicare eligible retirees and their eligible dependent spouses/dependents (except as provided in Section 3 below) will be auto enrolled into the NYC MA Plus plan with an option to opt out. The following members will not be auto enrolled:
     - Foreign members
     - Members without Part A and Part B
  2. The following Medicare eligible individuals will be provided the opportunity to enroll into the NYC MA Plus plan:
     - COBRA members
  3. Other provisions
     - Current Retirees

       All current Medicare retirees and their eligible dependents, age 65 and older, will automatically be enrolled in the NYC Medicare Advantage Plus Plan. Retirees who do not wish to be enrolled in the new Plan, effective January 1, 2022, will have the ability to opt-out and remain in their current retiree health plan only. Retirees will NOT have the option to transfer to another health plan during the annual Fall Retiree Transfer Period, effective for January 1, 2022.

On-going, retirees may remain in their current health plan. For the annual Fall Transfer Period, effective for January 1, 2023, retirees who enrolled into the NYC Medicare Advantage Plus Plan may transfer back to their previous retiree health plan. Other retirees may transfer into the NYC Medicare Advantage Plus Plan or the GHI/EBCBS Senior Care plan.

At future annual Fall Transfer Periods, retirees only have the option of transferring to the NYC Medicare Advantage Plus Plan or the GHI/EBCBS Senior Care plan.

- Retirees Turning 65 in 2021
  Medicare eligible Retirees and their eligible dependents turning 65 in 2021 will be enrolled into the Medicare component of their current health plan, if applicable, in the month of their 65th birthday.

  Retirees will be notified that effective January 1, 2022, that they will be enrolled into the NYC Medicare Advantage Plus Plan. Retirees who do not wish to be enrolled in the new Plan, effective January 1, 2022, will have the ability to opt-out and remain in the Medicare component of their current retiree health plan only. Retirees will not have the option to transfer to another health plan during the annual Retiree Transfer Period, effective for January 1, 2022. If their current health plan does not have a Medicare component, the retiree may select another health plan.

  For the annual Fall Transfer Period, effective for January 1, 2023, retirees who enrolled into the NYC Medicare Advantage Plus Plan may transfer back to their previous retiree health plan. Other retirees may transfer to the NYC Medicare Advantage Plus Plan or the GHI/EBCBS Senior Care plan.

  At future annual Fall Transfer Periods, retirees only have the option of transferring to the NYC Medicare Advantage Plus Plan or the GHI/EBCBS Senior Care plan.

- On-Going Retirees Turning 65
  For retirees turning 65 on or after January 1, 2022 and on-going, retirees and their eligible dependents will automatically be enrolled in the NYC Medicare Advantage Plus Plan. Retirees who do not wish to be enrolled in the new Plan, will have the ability to opt-out into the GHI/EBCBS Senior Care plan.
  At future annual Fall Transfer Periods, retirees only have the option of transferring to the NYC Medicare Advantage Plus Plan or the GHI/EBCBS Senior Care plan.

- Spouses/dependents who are currently enrolled in a current City Medicare health plan other than the Senior Care plan, and the non-Medicare retiree is not MA eligible: the spouse/dependent will remain in their current City Medicare plan until retiree turns 65. At that point, both will be auto enrolled into the NYC MA Plus plan with an option to opt out. If the non-Medicare retiree is enrolled in GHI/EBCBS CBP, the Medicare eligible dependent will be auto enrolled into the MA Plan with the option to opt-out.

- CMS guidance does not allow a network-based Medicare Advantage plan (LPPO, HMO) to be offered with an individual Part D waiver plan. If the Medicare Advantage plan is being offered with another carrier's Part D group waiver plan, the Part D carrier must coordinate care with Empire.

- CMS requires 800-series MA and stand-alone PDP plans to coordinate care (Per Chapter 12, 20.1.8 & Chapter 9, 30.8 in CMS Medicare Manual) and our pricing assumes any group Part D plan carriers offered to City of New York members will abide by this CMS requirement. The statement does not preclude EmblemHealth from offering a group stand-alone PDP plan to the City of New York.
- This quote is contingent upon the majority of the enrolled membership residing in an adequate network service area, as defined by CMS. The service area and plan design are subject to CMS approval.

Multi-Year Stipulations

Multi-Year pricing may be adjusted if any of the following stipulations are not met:

- All quoted rates are based on an initial effective date of 1/1/2022.
- The MA Plan premium shown in our offer is guaranteed for the time periods quoted and applicable scenarios, subject to stipulations as outlined.
- No less than 0.5% reduction in applicable CMS EGWP benchmark between rate guarantee year and the preceding year for 2023, 2024, 2025 and 2026. The measurement will be made in aggregate for City of New York population and will not include Star rating changes.
- Overall CMS risk score actions - including normalization, model changes and coding difference adjustments - not to be worse than a 2% reduction each and any year for 2023, 2024, 2025 and 2026 in terms of overall impact to group.
- Group contract runs from 1/1/2022 through 12/31/2026, with two one-year renewals for 2027 and 2028 based on group loss ratio.
- Assumes group/fund membership will not vary more than 10% from the original enrolled membership (enrollment as of January 1, 2022, exclusive of members who successfully opt out prior to December 31, 2021) and county mix does not change by more than 10% from quote assumptions.
- In the event the City learns of non-CMS mandated changes to other carriers' plans being offered to City's retirees, the City shall promptly advise Empire of such changes.
- Annual premium guarantees do not include additional products, plan changes, or services being added to the MA Plan after January 1, 2022.
- Annual premium guarantees do not include additional state or government-imposed taxes or government-imposed fees. Any additional government-imposed taxes or government-imposed fees, if applicable, will be an addition to the quoted premium.
- Annual premium guarantees do not apply if regulatory or legislative changes materially modify the product offering after January 1, 2022.
- The Empire offer is extended to include beyond the guarantees already provided through 2026 as follows:
  - If the MA Plan plan performance from 7/1/2025 through 6/30/2026 runs at or below a 92% MLR, Empire agrees to continuing the $0 premium rate for MA Plan for 2027.
  - If the City's Medicare Advantage plan performance from 7/1/2025 through 6/30/2026 runs above a 92% MLR, the renewal premium will be developed using an experience rating formula consistent with Empire's Group Medicare Advantage formulas in place at that time.

- If the MA Plan performance from 7/1/2026 through 6/30/2027 runs at or below a 92% MLR, Empire agrees to continuing the $0 premium rate for MA Plan for 2028.
- If the City's Medicare Advantage plan performance from 7/1/2026 through 6/30/2027 runs above a 92% MLR, the renewal premium will be developed using an experience rating formula consistent with Empire's Group Medicare Advantage formulas in place at that time.

All multi-year stipulations would apply and be extended through the 2028 quote. This includes, but is not limited to, CMS EGWP benchmark no less than 0.5% reduction between renewal and preceding year, and CMS risk score actions not to be worse than a 2% reduction from the prior period. The MLR definition would be consistent with our gain share loss ratio calculation.

Additional Stipulations

- Retirees who opt out of the NYC Medicare Advantage Plus Plan must pay the premium difference between the NYC Medicare Advantage Plus Plan and their selected retiree Medicare health plan, if applicable.
- Allowance stipulations: Empire will assist City with any bona fide costs incurred as a result of the transition to the MA Plan. Empire is extending $7 million to the City in implementation funding subject to the following:
  - Will require any expenses to be submitted in writing and approved by Empire
  - Amounts are for a bona fide expense incurred by the City related to the implementation of the MA Plan that benefits the member/and or the Medicare Program.
  - The expense is limited to the actual cost of the services incurred as a result of the transition.
  - The expense is based on the projected cost of the services incurred between the contract award date and twelve months after the initial effective date, not to exceed amount listed above.

Addendum A

City of New York
GAIN SHARE SUMMARY
January 1, 2022 THROUGH DECEMBER 31, 2026

Income Received:	
Group Premium Less Any Government Taxes/Fees	**$0.00**
CMS Revenue (adjusted for sequestration)	**$0.00**
Total Income Received	**$0.00**
Claim Expense:	
Incurred Claims with IBNR	**$0.00**
Capitation and Other Non-Benefit Expense	**$0.00**
Total Claim Expense	**$0.00**
Loss Ratio	**0.00%**

Refund Award:

94.26% to 95% MLR	**75% share of revenue difference from 95% MLR and actual group MLR**
93.51% to 94.25% MLR	**85% share of revenue difference from 94.25% and actual group loss ratio.**
93.50% and under MLR	**100% share of revenue difference from 93.50% MLR and actual group MLR**

Definitions:
Claim Expense: Claims incurred and paid by Empire for retirees in the Group includes capitation and non-benefit expense allocations. An adjustment for incurred, but not reported (IBNR) applies. Non-benefit expense examples include Quality Improvement Initiatives and provider settlements.

CMS Revenue: Risk Adjusted payments collected to date from Center for Medicare and Medicaid Services for retirees of the Group, and reduced for sequestration adjustments for the refund period.

Total Income Received: The sum of CMS payments plus Group Premium during Refund Period. Income excludes any government taxes and fees as well as any commission and TPA administration fees.

Loss Ratio: The ratio of claims to the quantity of CMS Revenue and Group premium payments received and applicable for the policy period.

Refund Award: Payment from Empire due to the Group limited by the total amount the Group has paid in premium.

Refunding Period: The policy period for which the refund calculation is determined (loss ratio).

Refund Periods and Timing:
Refunds will be calculated on the 24 Month period 1/1/2022 through 12/31/2023; followed by 12 month periods for 2024, 2025, and 2026. Calculation will be performed in September following the end of the refunding period. If a refund is awarded it shall be due within 90 days following the calculation.

The following stipulations apply:

- Gain share arrangement will be offered provided rate sheet stipulations are met.
- The Gain Share arrangement will be provided to the City of New York for quoting, provided there is a minimum average enrollment of 25,000 for a refunding period.
- County mix does not change by more than 10% from the 1/1/2022 quoted membership.
- City of New York is only eligible for the Experience Refund if City of New York maintains continuous coverage during the Policy Period.
- Results will be based on City of New York experience.
- Agreement may be amended if regulatory or legislative changes materially modify the product offering.

Addendum B – Performance Guarantee Agreement

This Addendum to the Medicare Advantage Group Agreement between the City of New York ("City") acting through Mayor's Office of Labor Relations – Employee Benefits Program on behalf of the Labor Management Health Insurance Policy Committee for the New York City Health Benefits Program with an office at 22 Cortlandt Street, 12th Floor, New York, NY 10007 ("Group") and Anthem Insurance Companies, Inc. doing business as Empire BlueCross BlueShield Retiree Solutions ("Empire" or "the Alliance") on behalf of itself and the Alliance dated as of January 1, 2022 (the "MA Agreement") provides certain guarantees pertaining to the Alliance's performance under the MA Agreement ("Performance Guarantees") and shall be effective for the period from January 1, 2022 through December 31, 2028 (the "Performance Period"). Descriptions of the terms of each Performance Guarantee applicable to the Parties are set forth in the Attachment to this Addendum and incorporated by reference into this Addendum. This Addendum shall supplement the MA Agreement. If there are any inconsistencies between the terms of the MA Agreement, including any prior Addendums or Exhibits, and this Addendum, the terms of this Addendum shall control. Capitalized terms used but not defined herein shall have the meaning(s) set forth in the Agreement.

Section 1. General Conditions

A. The Performance Guarantees described in the Attachment to this Addendum shall be in effect only for the Performance Period indicated above, unless specifically indicated otherwise in the Attachment.

B. The Alliance shall conduct an analysis of the data necessary to calculate any one of the Performance Guarantees within the timeframes provided in the Attachment to this Addendum. In addition, any calculation of Performance Guarantees, reports provided, or analysis performed by the Alliance shall be based on the Alliance's then current measurement and calculation methodology, which shall be available to the Group upon request.

C. Any audits performed by the Alliance to test compliance with any of the Performance Guarantees shall be based on a statistically valid sample size with a 95% confidence level.

D. If the Parties do not have a fully executed MA Agreement in effect at the end of the Measurement Period, the Alliance shall have no obligation to make payment under these Performance Guarantees.

E. Unless otherwise specified in the Attachment to this Addendum, the measurement of the Performance Guarantee shall be based on: (1) the performance of any service team, business unit, or measurement group assigned by the Alliance to the activity to which the specific Performance Guarantee being measured relates; and (2) data that is maintained and stored by the Alliance or its Vendors.

F. If Group terminates the MA Agreement prior to the end of the Performance Period, or if the Agreement is terminated by the Alliance for non-payment of amounts owed by Group to the Alliance, then Group shall forfeit any right to collect any further payments under any outstanding Performance Guarantees, whether such Performance Guarantees are for a prior or current Measurement Period or Performance Period.

G. The Alliance reserves the right to make changes to or eliminate any of the Performance Guarantees provided in the Attachment to this Addendum upon the occurrence of the following:

   (1) A change to the plan benefits or the administration of the plan initiated by Group that, as mutually agreed by the Parties, significantly impacts the Alliance's ability to meet a Performance Guarantee

H. Some Performance Guarantees may measure and compare year to year performance. The term "Baseline Period" refers to the equivalent time period designated in the Attachment to this Addendum preceding the Measurement Period.

I. As determined by the Alliance, Performance Guarantees may be measured using either aggregated data or Group-specific Data. The term Group-specific Data means the data associated with Group's Plan that has not been aggregated with other data from other groups. Performance Guarantees will specify if Group-specific Data shall be used for purposes of measuring performance under the Performance Guarantee.

J. If any Performance Guarantees are tied to a particular program and its components, such Performance Guarantees are only valid if the Group participates in the program and such components for the entirety of the Measurement Period associated with the Performance Guarantee.

Section 2. Payment:

A. If the Alliance fails to meet any of the obligations specifically described in a Performance Guarantee, the Alliance shall pay Group the applicable amount set forth in the Attachment describing the Performance Guarantee. Payment shall be in the form of a check to the Group which will occur annually unless otherwise stated in the Performance Guarantee.

B. Notwithstanding the above, the Alliance has the right to offset any amounts owed to Group under any of the Performance Guarantees contained in the Attachment to this Addendum against any amounts owed by Group to the Alliance, including, without limitation, under the MA Agreement.

C. Notwithstanding the foregoing, the Alliance's obligation to make payment under the Performance Guarantees is conditioned upon Group's timely performance of its obligations provided in the MA Agreement, in this Addendum and the Attachment, including providing the Alliance with the information or data required by the Alliance in the Attachment. The Alliance shall not be obligated to make payment under a Performance Guarantee if Group's or Group's vendor's action or inaction adversely impacts the Alliance's ability to meet any of its obligations provided in the Attachment related to such Performance Guarantee, which expressly includes, but is not limited to, Group's or its vendor's failure to timely provide the Alliance with accurate and complete data or information in the form and format expressly required by the Alliance.

D. Where the Amount at Risk for a Performance Guarantee is on a Per Member Per Month (PMPM) fee basis, the Guarantee will be calculated by multiplying the PMPM amount by the actual annual enrollment during the Measurement Period.

Addendum B – Performance Guarantee Attachment

Medicare Advantage Performance Guarantees
January 1, 2022 Effective Date

More About the Guarantees

Guarantees will be effective from 1/1/2022 to 12/31/2028, as noted. The guarantees are measured and settled annually, with exceptions specified.

These guarantees cover aspects of performance related to the Alliance's control. Listed below are potential reasons that may alter the terms of the guarantees:

- The number of Medicare Advantage enrolled members varies 10% or more from original membership, as of January 1, 2022, exclusive of opt-outs prior to December 31, 2021.
- Changes in law.
- the Alliance does not receive information or other support from the City that would allows the Alliance to meet the Guarantee.
- There is no executed Group Agreement on file.
- The City terminates the Agreement before the end of a Measurement Period, or the Alliance terminates it because of non-payment.
- The City terminates participation in particular programs tied to Performance Guarantees, prior to completion of the Measurement.

General Terms

- **Performance Category**: Describes the general type of Performance Guarantee
- **Reporting Period:** Refers to how often the Alliance will report on our performance under a Performance Guarantee
- **Measurement Period:** The period of time under which performance is measured, which may be the same as, or differ from, the period of time equal to the Performance Period
- **Penalty Calculation:** Generally refers to how the Alliance's payment will be calculated in the event the Alliance does not meet the targets specified under the Performance Guarantee
- **Amount at Risk:** The amount the Alliance may pay if we fail to meet the targets specified under the Performance Guarantee

Additional Terms and Conditions

- Performance will be based on the results of a designated service team/business unit assigned to the City, unless the guarantee is noted differently.
- The credit for any penalties will be calculated on a Per Member Per Month basis.
- City-specific Member Services and Quality Performance Guarantees apply when there are 10,000 or more Medicare Advantage enrolled members.
- Coding Accuracy Performance Guarantees apply when there are 10,000 or more Medicare Advantage enrolled members.
- Case Management Member Engagement Performance Guarantees exclude Identified Members whom the Alliance cannot reach due to incorrect or invalid telephone numbers, including numbers where permission is required by law but not provided, or those Identified Members who have requested that the Alliance not contact them.

Amount at Risk

The total amount at risk for the below performance guarantees between Empire and the City shall not exceed $3.85 PMPM in 2022, $3.75 PMPM in 2023* and $4.05 PMPM in 2024 – 2028.

* Beginning in 2024, we will offer mutually agreed upon Gaps in Care/Health Outcomes performance guarantees based on our analysis of health management opportunities for the City's members.

Performance Guarantees

Performance Category	Year One 1/1/2022 - 12/31/2022	Years Two - Seven 1/1/2023 - 12/31/2028
Implementation		
Open Enrollment Meetings	$0.35 PMPM	N/A
Welcome Kit Delivery	$0.35 PMPM	N/A
Open Enrollment ID Card Issuance	$0.35 PMPM	N/A
First Impressions Call Line	$0.35 PMPM	N/A
Initial Eligibility File Processing	$0.35 PMPM	N/A
Implementation Satisfaction Survey	$0.35 PMPM	N/A
Ongoing		
Member Services		
Member Services - Call Abandonment Rate	$0.25 PMPM	$0.25 PMPM
Member Services – Average Speed to Answer	$0.25 PMPM	$0.25 PMPM
Member Services – Member Satisfaction	$0.25 PMPM	$0.25 PMPM
New Member ID Cards	$0.25 PMPM	$0.25 PMPM
New Member Welcome Kit	$0.25 PMPM	$0.25 PMPM
Annual Notice of Change	$0.25 PMPM	$0.25 PMPM
Quality		
Case Management Member Outreach	N/A	$0.30 PMPM
Case Management Member Enrollment	N/A	$0.30 PMPM
Case Management Member Engagement	N/A	$0.30 PMPM
Case Management High Dollar Claimant Assessments	N/A	$0.30 PMPM
Case Management Member Outreach for Post-Discharge Counseling	N/A	$0.30 PMPM
Gaps in Care/Health Outcomes (Years 3 - 7)	N/A	$0.30 PMPM
Financial		
Coding Accuracy	N/A	$0.25 PMPM
Data Management		
Data Transfer	$0.25 PMPM	$0.25 PMPM
Account Management		
Account Management Satisfaction Survey	N/A	$0.25 PMPM

IMPLEMENTATION (2022)

Performance Category	Amount at Risk	Guarantee	Penalty Calculation		Measurement and Reporting Period
Open Enrollment Meetings	Year 1 $0.35 PMPM	Beginning on a mutually agreed upon date, the Alliance agrees to hold retiree meetings at up to 30 retiree locations/meetings within New York City and the immediate area, and up to ten other locations with retiree concentrations with personnel, presentations and materials approved by the City. These meetings will be attended by the City's Account Management team, and may be held virtually, depending upon CDC guidelines.	Results 100% at Risk	Penalty	Measurement Period City's Effective Date Reporting Period 60 calendar days following Effective Date
Welcome Kit Delivery	Year 1 $0.35 PMPM	100% of Welcome Kits will be mailed to Open Enrollment participants no later than ten days prior to the City's effective date provided that Empire receives an accurate electronic eligibility file and receipt of CMS confirmation of enrollment no later than 45 days prior to the City's effective date. An Accurate Eligibility File is defined as (1) an electronic eligibility file formatted in a mutually agreed upon manner and (2) contains an error rate of less than 1%. This Guarantee will apply to clean enrollment records in the electronic eligibility file.	Results 100% 98.5% - 99.9% 97.0% - 98.4% Less than 97.0%	Penalty None 25% 50% 100%	Measurement Period City's Effective Date Reporting Period 60 calendar days following Effective Date
Open Enrollment ID Card Issuance	Year 1 $0.35 PMPM	100% of ID cards will be mailed to Open Enrollment participants no later than ten days prior to the City's effective date provided that Empire receives an accurate electronic eligibility file and receipt of CMS confirmation of enrollment no later than 45 days prior to the City's effective date. An Accurate Eligibility File is defined as (1) an electronic eligibility file formatted in a mutually agreed upon manner and (2) contains an error rate of less than 1%. This Guarantee will apply to clean enrollment records in the electronic eligibility file. This will be measured with Group-specific data.	Results 100% 98.5% - 99.9% 97.0% - 98.4% Less than 97%	Penalty None 25% 50% 100%	Measurement Period City's Effective Date Reporting Period 60 calendar days following Effective Date
First Impressions Welcome Line	Year 1 $0.35 PMPM	The First Impressions welcome line will be operational within 45 days of award notification. Staff will be available 8 a.m. to 9 p.m., ET, Monday through Friday, excluding company holidays.	Results 100% at Risk	Penalty	Measurement Period City's Effective Date Reporting Period 60 calendar days following Effective Date
Initial Eligibility File Processing	Year 1 $0.35 PMPM	Initial enrollment records from accurate eligibility files will be processed within 3 business days of receipt provided that Empire receives an accurate electronic eligibility file no later than 45 calendar days prior to the City's effective date. An accurate eligibility file is defined as an electronic eligibility file formatted in a mutually agreed upon manner; and contains an error rate of less than 1%. The guarantee will apply to records that process systematically and accepted by CMS, identified as clean records received. Any record not processed systematically or not accepted by CMS will follow CMS guidelines for processing based on error reason.	Results 100% 98.5% - 99.9% 97.0% - 98.4% Less than 97.0%	Penalty None 25% 50% 100%	Measurement Period City's Effective Date Reporting Period 60 calendar days following Effective Date

Performance Category	Amount at Risk	Guarantee	Penalty Calculation		Measurement and Reporting Period
Implementation Satisfaction Survey	Year 1 $0.35 PMPM	A minimum average score of 3.0 will be attained on the Implementation Survey. The Alliance will prepare and send an Implementation Survey to the City.	Results 3.0 or Greater 2.5 to 2.9 2.0 to 2.4 Less than 2.0	Penalty None 25% 50% 100%	Measurement Period City's Effective Date Reporting Period 60 calendar days following Effective Date

ONGOING: 2022/2023 FORWARD

Performance Category	Amount at Risk	Guarantee	Penalty Calculation	Measurement and Reporting Period
Member Services Call Abandonment Rate	Year 1-7 $0.25 PMPM	A maximum of 5% of member calls will be abandoned. Abandoned Calls are defined as member calls that are waiting for a Customer Service Representative (CSR) but are abandoned before connecting with a CSR. This Guarantee will be calculated based on the number of calls abandoned divided by the total number of calls received in the customer service telephone system. Calls abandoned in less than five seconds will not be included in this calculation. This guarantee will be measured using City-specific results. In Year 1, measurement will begin at the start of the fourth month.	Results / Penalty 5% or less: None 5.01 – 5.50%: 25% 5.51 - 6.0%: 50% Greater than 6%: 100%	Measurement Period Annual Reporting Period Quarterly
Member Services Call Average Speed to Answer	Year 1-7 $0.25 PMPM	The average speed to answer (ASA) will be 30 seconds or less. ASA is defined as the average number of whole seconds members wait and/or are in the telephone system before receiving a response from a CSR or an interactive voice response (IVR) unit. This guarantee will be measured using City-specific results. In Year 1, measurement will begin at the start of the fourth month.	Results / Penalty 30 secs or less: None 31 – 34 secs: 25% 35 – 39 secs: 50% 40 seconds or Greater: 100%	Measurement Period Annual Reporting Period Quarterly
Member Services Member Satisfaction Service Skills	Year 1-7 $0.25 PMPM	A minimum average score of 85% will be attained on the service skills component of the member satisfaction survey. The e-mail survey is conducted after a member calls a CSR. Each member caller is asked to rate the CSR. The response is scored based on the total number of attributes that a member caller rates as positive, defined as top-2-box scores, divided by the number of attributes for which the member caller provides an answer (Member Score). This guarantee will be measured using City-specific results. In Year 1, measurement will begin at the start of the fourth month.	Results / Penalty 85% or Greater: None 82.5 – 84.9%: 25% 80.0 – 82.4%: 50% Less than 80%: 100%	Measurement Period Annual Reporting Period Quarterly
New Member ID Cards	Year 1-7 $0.25 PMPM	A minimum of 99% of ongoing ID cards will be mailed to Members within 10 business days of Empire's processing of an accurate eligibility file provided Empire receives CMS confirmation of enrollment. An Accurate Eligibility File is defined as: (1) an eligibility file formatted in a mutually agreed upon manner; (2) received by Empire outside of an open enrollment period; and, (3) contains an error rate of less than 1%. This Guarantee will apply to clean enrollment records in the electronic eligibility file. This guarantee will be measured using City-specific results.	Results / Penalty 99.0% or greater: None 97.5 – 98.9%: 25% 96.0 – 97.4%: 50% Less than 96%: 100%	Measurement Period Annual Reporting Period Quarterly

Performance Category	Amount at Risk	Guarantee	Penalty Calculation	Measurement and Reporting Period
Welcome Kit Delivery	Year 1-7 $0.25 PMPM	A minimum of 99% of Welcome Kits will be mailed to Members within 10 business days of Empire's processing of an accurate eligibility file, or by the Member's effective date, provided Empire receives CMS confirmation of enrollment. An Accurate Eligibility File is defined as: (1) an eligibility file formatted in a mutually agreed upon manner; (2) received by Empire outside of an open enrollment period; and, (3) contains an error rate of less than 1%. This Guarantee will apply to clean enrollment records in the electronic eligibility file. This will be measured using City-specific results.	Results / Penalty 99.0% or greater: None 97.5 – 98.9%: 25% 96.0 – 97.4%: 50% Less than 96%: 100%	Measurement Period Annual Reporting Period Quarterly
Annual Notice of Change	Year 1-7 $0.25 PMPM	The Alliance will meet CMS requirements regarding delivery of the Annual Notice of Change (ANOC) to 100% of the City's members. This will be measured using City-specific results.	Results / Penalty 100%: None 98.5 – 99.9%: 25% 97.0 – 98.4%: 50% Less than 97%: 100%	Measurement Period Annual Reporting Period Annual
Case Management Member Outreach	Year 2-7 $0.30 PMPM	A minimum of 75% of members identified as appropriate for Case Management programs will receive outreach from case management. This Guarantee will be calculated based on the number of contacted Members divided by all Identified Members. This will be measured with City-specific Data.	Results / Penalty 75% or greater: None 73.5 – 74.9%: 25% 72.0 – 73.4%: 50% Less than 72%: 100%	Measurement Period Annual Reporting Period Annual
Case Management Member Enrollment	Year 2-7 $0.30 PMPM	A minimum of 50% of eligible members contacted to enroll in Case Management programs will enroll in a Case Management program. This Guarantee will be calculated based on the number of contacted Members who enroll in a Case Management program divided by all contacted Members. This will be measured with City-specific Data	Results / Penalty 50% or greater: None 48.5 – 49.9%: 25% 47.0 – 48.4%: 50% Less than 47%: 100%	Measurement Period Annual Reporting Period Annual
Case Management Member Engagement	Year 2-7 $0.30 PMPM	A minimum of 75% of members who accept case management will receive at least two completed calls from Empire within the first six months of enrollment. Members on the National Do Not Call Registry are excluded and will receive an introduction letter encouraging the member to contact Empire. This Guarantee will be calculated based on the number of Identified Members who receive successful contact from Empire or at least two attempted outreach telephone calls from Empire or an introduction letter for those members on the National Do Not Call Registry within six months of enrollment divided by the total number of Members who accept case management. This will be measured with City-specific Data.	Results / Penalty 75% or greater: None 73.5 – 74.9%: 25% 72.0 – 73.4%: 50% Less than 72%: 100%	Measurement Period Annual Reporting Period Annual

Performance Category	Amount at Risk	Guarantee	Penalty Calculation	Measurement and Reporting Period
Case Management High Dollar Claimant Assessments	Year 2-7 $0.30 PMPM	A minimum of 90% of Identified Members who accumulate $75,000 or more of paid claims in a rolling 12-month period will receive successful contact or at least 2 attempted outreach telephone calls from the Alliance within 30 calendar days of identification by the Alliance. Members on the National Do Not Call Registry are excluded and will receive an introduction letter encouraging the member to contact the Alliance. If Prescription Drug benefits are administered by third party payers other than Empire, this Guarantee will include Prescription Drugs claims, if Prescription Drug claims data is received from the City in a format that is acceptable to Empire. This Guarantee will be calculated based on the number of Identified Members who receive successful contact or at least 2 attempted outreach telephone calls from the Alliance or an introduction letter for those members on the National Do Not Call Registry within 30 calendar days of identification by the Alliance divided by the number of Identified Members who accumulate $75,000 or more of paid claims in a rolling 12-month period. This will be measured with City-specific data.	Results — Penalty 90% or greater — None 88.5 – 89.9% — 25% 87.0 – 88.4% — 50% Less than 87% — 100%	Measurement Period Annual Reporting Period Annual
Case Management Member Outreach for Post-Discharge Counseling	Year 2-7 $0.30 PMPM	A minimum of 90% of Identified Members will receive successful contact from the Alliance or receive at least 2 attempted outreach telephone calls within 3 business days of notification of discharge where the Identified Member had a length of stay of 3 days or greater. This Guarantee does not include admissions related to behavioral health services. This Guarantee will be calculated based on the number of Identified Members who receive successful contact from the Alliance or at least 2 attempted outreach telephone calls following notification of discharge divided by all Identified Members with a length of stay of 3 days or greater. This will be measured with City-specific data.	Results — Penalty 90% or greater — None 88.5 – 89.9% — 25% 87.0 – 88.4% — 50% Less than 87% — 100%	Measurement Period Annual Reporting Period Annual
Gaps in Care/Health Outcomes	Year 3-7 $0.30 PMPM	Empire will present to the City a description of a comprehensive wellness, disease management and health management program, including clinical metrics and outcome trends, identifying health management opportunities for the City's members. We will collaborate with the City to develop meaningful, mutually agreed upon quality performance guarantees based on this analysis, with a total maximum amount at risk of $0.30 PMPM. Programs may include inpatient care management, transition of care, emerging risk intervention, and diabetes prevention, pending discussions with the City. Empire will implement this performance category effective January 1, 2024.	Performance results and penalties to be determined based on programs developed through analysis of the City's clinical metrics and outcome trends. The total maximum amount at risk collectively for all Gaps in Care/Health Outcomes programs shall be $0.30 PMPM.	Measurement Period Annual Reporting Period Annual

Performance Category	Amount at Risk	Guarantee	Penalty Calculation	Measurement and Reporting Period
Coding Accuracy	Year 2-7 $0.25 PMPM	The Alliance's risk adjustment program is designed to collect accurate and complete diagnosis code information to reflect the true health status of the member. As part of this commitment, the Alliance identifies coding gaps (i.e. conditions previously reported in prior years but not yet reported in the current calendar year) and communicates these to our providers for evaluation, treatment, documentation and coding, based on the provider's assessment and independent clinical judgment. Empire will maintain coding accuracy for Medicare risk adjustment (MRA) activities at not less than 90%. This will be measured using Medicare Advantage book of business data.	Results / Penalty 90% or greater: None 80.0 – 89.9%: 25% 70.0 – 79.9%: 50% Less than 70%: 100%	Measurement Period Annual Reporting Period Annual
Data Transfer	Year 1-7 $0.25 PMPM	Empire will provide accurate and timely data feeds, based on mutually agreed vendors, file layouts, parameters, secure file transition protocols and timeframes. The guarantee will use City-specific data; measured and reported annually using per file transfer/data exchange.	Results / Penalty 100%: None 90.0 – 99.9%: 25% 80.0 – 89.9%: 50% Less than 80%: 100%	Measurement Period Annual Reporting Period Annual
Account Management Satisfaction	Year 2-7 $0.25 PMPM	A minimum average score of 3 will be attained on the Account Management Satisfaction Survey (AMSS). A minimum of three responses by the City to the AMSS is required to base the score on Employer-specific responses only. If three responses are received from the City, an average score is calculated by adding the scoresfrom each respondent divided by the total number of Employer respondents. If fewer than three responses are received, the score will be calculated as follows: Two Employer responses: 2/3 of the score will be based on Employer-specific AMSS results and 1/3 of the score will be based on the aggregate score of all AMSS results received by the Account Management Team. One Employer response: 1/3 of the score will be based on Employer- specific AMSS results and 2/3 of the score will be based on the aggregate score of all AMSS results received by the Account Management Team. 0 Employer responses: The score will be based on the aggregate score of all AMSS results received by the Account Management Team.	Results / Penalty 3.0 or Greater: None 2.5 to 2.9: 25% 2.0 to 2.4: 50% Less than 2.0: 100%	Measurement Period Annual Reporting Period Annual

APPENDIX A

GENERAL PROVISIONS GOVERNING CONTRACTS FOR CONSULTANTS, PROFESSIONAL, TECHNICAL, HUMAN, AND CLIENT SERVICES

ARTICLE 1 - DEFINITIONS

Section 1.01 Definitions

The following words and expressions, or pronouns used in their stead, shall, wherever they appear in this Agreement, be construed as follows, unless a different meaning is clear from the context:

A. "Agency Chief Contracting Officer" or "ACCO" means the position delegated authority by the Agency Head to organize and supervise the procurement activity of subordinate Agency staff in conjunction with the City Chief Procurement Officer.

B. "Agreement" means the various documents, including this Appendix A and the Medicare Advantage Group Agreement, incorporated herein by reference, that constitute the contract between the Contractor and the City.

C. "City" means the City of New York.

D. "City Chief Procurement Officer" or "CCPO" means the position delegated authority by the Mayor to coordinate and oversee the procurement activity of Mayoral agency staff, including the ACCOs.

E. "Commissioner" or "Agency Head" means the head of the Department or his or her duly authorized representative. The term "duly authorized representative" shall include any person or persons acting within the limits of his or her authority.

F. "Comptroller" means the Comptroller of the City of New York.

G. "Contractor" means the entity entering into this Agreement with the City.

H. "Days" means calendar days unless otherwise specifically noted to mean business days.

I. "Department" or "Agency" means the City agency or office through which the City has entered into this Agreement.

J. "Law" or "Laws" means the New York City Charter ("Charter"), the New York City Administrative Code ("Admin. Code"), a local rule of the City of New York, the Constitutions of the United States and the State of New York, a statute of the United States or of the State of New York and any ordinance, rule or regulation having the force of law and adopted pursuant thereto, as amended, and common law.

K. "Procurement Policy Board" or "PPB" means the board established pursuant to Charter § 311 whose function is to establish comprehensive and consistent procurement policies and rules that have broad application throughout the City.

L. "PPB Rules" means the rules of the Procurement Policy Board as set forth in Title 9 of the Rules of the City of New York ("RCNY"), § 1-01 *et seq*.

M. "SBS" means the New York City Department of Small Business Services.

N. "State" means the State of New York.

ARTICLE 2 – REPRESENTATIONS, WARRANTIES, CERTIFICATIONS, AND DISCLOSURES

Section 2.01 Procurement of Agreement

A. The Contractor represents and warrants that, with respect to securing or soliciting this Agreement, the Contractor is in compliance with the requirements of the New York State Lobbying Law (Legislative Law §§ 1-a *et seq*.). The Contractor makes such representation and warranty to induce the City to enter into this Agreement and the City relies upon such representation and warranty in the execution of this Agreement.

B. For any breach or violation of the representation and warranty set forth in Paragraph A above, the Commissioner shall have the right to annul this Agreement without liability, entitling the City to recover all monies paid to the Contractor; and the Contractor shall not make claim for, or be entitled to recover, any sum or sums due under this Agreement. The rights and remedies of the City provided in this Section 2.01(B) are not exclusive and are in addition to all other rights and remedies allowed by Law or under this Agreement.

Section 2.02 Conflicts of Interest

A. The Contractor represents and warrants that neither it nor any of its directors, officers, members, partners or employees, has any interest nor shall they acquire any interest, directly or indirectly, which conflicts in any manner or degree with the performance of this Agreement. The Contractor further represents and warrants that no person having such interest or possible interest shall be employed by or connected with the Contractor in the performance of this Agreement.

B. Consistent with Charter § 2604 and other related provisions of the Charter, the Admin. Code and the New York State Penal Law, no elected official or other officer or employee of the City, nor any person whose salary is payable, in whole or in part, from the City Treasury, shall participate in any decision relating to this Agreement which affects his or her personal interest or the interest of any corporation, partnership or other entity in which he or she is, directly or indirectly, interested; nor shall any such official, officer, employee, or person have any interest in, or in the proceeds of, this Agreement. This Section 2.02(B) shall not prevent directors, officers, members, partners, or employees of the Contractor from participating in decisions relating to this Agreement where their sole personal interest is in the Contractor.

C. The Contractor shall not employ a person or permit a person to serve as a member of the Board of Directors or as an officer of the Contractor if such employment or service would violate Chapter 68 of the Charter.

Section 2.03 Certification Relating to Fair Practices

A. The Contractor and each person signing on its behalf certifies, under penalties of perjury, that to the best of its, his or her knowledge and belief:

1. The prices and other material terms set forth in this Agreement have been arrived at independently, without collusion, consultation, communication, or agreement with any other bidder or proposer or with any competitor as to any matter relating to such prices or terms for the purpose of restricting competition;

2. Unless otherwise required by Law or where a schedule of rates or prices is uniformly established by a government agency through regulation, policy, or directive, the prices and other material terms set forth in this Agreement that have been quoted in this Agreement and on the bid or proposal submitted by the Contractor have not been knowingly disclosed by the Contractor, directly or indirectly, to any other bidder or proposer or to any competitor prior to the bid or proposal opening; and

3. No attempt has been made or will be made by the Contractor to induce any other person or entity to submit or not to submit a bid or proposal for the purpose of restricting competition.

B. The fact that the Contractor (i) has published price lists, rates, or tariffs covering items being procured, (ii) has informed prospective customers of proposed or pending publication of new or revised price lists for such items, or (iii) has sold the same items to other customers at the same prices and/or terms being bid or proposed, does not constitute, without more, a disclosure within the meaning of this Section 2.03.

Section 2.04 Disclosures Relating to Vendor Responsibility

The Contractor represents and warrants that it has duly executed and filed all disclosures as applicable, in accordance with Admin. Code § 6-116.2, PPB Rule § 2-08, and the policies and procedures of the Mayor's Office of Contract Services. The Contractor acknowledges that the Department's reliance on the completeness and veracity of the information stated therein is a material condition to the execution of this Agreement, and the Contractor represents and warrants that the information it and its principals have provided is accurate and complete.

Section 2.05 Disclosure Relating to Bankruptcy and Reorganization

If the Contractor files for bankruptcy or reorganization under Chapter Seven or Chapter Eleven of the United States Bankruptcy Code, the Contractor shall disclose such action to the Department within seven days of filing.

Section 2.06 Authority to Execute Agreement

The Contractor represents and warrants that: (i) its execution, delivery and performance of this Agreement have been duly authorized by all necessary corporate action on its part; (ii) it has

all necessary power and authority to execute, deliver and perform its obligations under this Agreement; and (iii) once executed and delivered, this Agreement will constitute its legal, valid and binding obligation, enforceable in accordance with its terms.

ARTICLE 3 - ASSIGNMENT AND SUBCONTRACTING

Section 3.01 Assignment

A. The Contractor shall not assign, transfer, convey, or otherwise dispose of this Agreement, or the right to execute it, or the right, title, or interest in or to it or any part of it, or assign, by power of attorney or otherwise, any of the monies due or to become due under this Agreement, without the prior written consent of the Commissioner. The giving of any such consent to a particular assignment shall not dispense with the necessity of such consent to any further or other assignments. Any such assignment, transfer, conveyance, or other disposition without such written consent shall be void.

B. Before entering into any such assignment, transfer, conveyance, or other disposal of this Agreement, the Contractor shall submit a written request for approval to the Department giving the name and address of the proposed assignee. The proposed assignee's disclosure that is required by PPB Rule § 2-08(e) must be submitted within 30 Days after the ACCO has granted preliminary written approval of the proposed assignee, if required. Upon the request of the Department, the Contractor shall provide any other information demonstrating that the proposed assignee has the necessary facilities, skill, integrity, past experience, and financial resources to perform the specified services in accordance with the terms and conditions of this Agreement. The Department shall make a final determination in writing approving or disapproving the assignee after receiving all requested information.

C. Failure to obtain the prior written consent to such an assignment, transfer, conveyance, or other disposition may result in the revocation and annulment of this Agreement, at the option of the Commissioner. The City shall thereupon be relieved and discharged from any further liability and obligation to the Contractor, its assignees, or transferees, who shall forfeit all monies earned under this Agreement, except so much as may be necessary to pay the Contractor's employees.

D. The provisions of this Section 3.01 shall not hinder, prevent, or affect an assignment by the Contractor for the benefit of its creditors made pursuant to the Laws of the State.

E. This Agreement may be assigned, in whole or in part, by the City to any corporation, agency, or instrumentality having authority to accept such assignment. The City shall provide the Contractor with written notice of any such assignment.

Section 3.02 Subcontracting

A. In accordance with PPB Rule § 4-13, all subcontractors must be approved by the Department prior to commencing work under a subcontract, which approval shall not be unreasonably withheld or delayed. Contractor's Key Subcontractors as of the Effective Date are

set forth in Schedule B hereto below.

1. *Approval when subcontract is $20,000 or less.* The Department hereby grants approval for all subcontractors providing services covered by this Agreement pursuant to a subcontract in an amount that does not exceed $20,000.00. The Contractor must submit monthly reports to the Department listing all such subcontractors and shall list the subcontractor in the City's Payee Information Portal (www.nyc.gov/pip).

2. Approval when subcontract is greater than $20,000.

a. The Contractor shall not enter into any subcontract for an amount greater than $20,000.00 without the prior approval by the Department.

b. Prior to entering into any subcontract for an amount greater than $20,000.00, the Contractor shall submit a written request for the approval of the proposed subcontractor to the Department giving the name and address of the proposed subcontractor, the portion of the work and materials that it is to perform and furnish, and the estimated cost of the subcontract. If the subcontractor is providing professional services under this Agreement for which professional liability insurance or errors and omissions insurance is reasonably commercially available, the Contractor shall submit proof of professional liability insurance in the amount required by Article 7. In addition, the Contractor shall list the proposed subcontractor in the City's Payee Information Portal (www.nyc.gov/pip) and provide the following information: maximum subcontract value, description of subcontractor work, start and end date of the subcontract, and the subcontractor's industry.[1]

c. Upon receipt of the information required above, the Department in its discretion may grant or deny preliminary approval for the Contractor to contract with the subcontractor.

[1] Assistance establishing a Payee Information Portal account and using the system may be obtained by emailing the Financial Information Services Agency Help Desk at pip@fisa.nyc.gov.

d. The Department shall notify the Contractor within 30 Days whether preliminary approval has been granted. If preliminary approval is granted, the Contractor shall provide such documentation as may be requested by the Department to show that the proposed subcontractor has the necessary facilities, skill, integrity, past experience and financial resources to perform the required work, including, the proposed subcontract and/or any of the items listed in PPB Rule 4-13(d)(3).

e. Upon receipt of all relevant documentation, the Department shall notify the Contractor in writing within 15 days whether the proposed subcontractor is approved. If the proposed subcontractor is not approved, the Contractor may submit another proposed subcontractor unless the Contractor decides to do the work. No subcontractor shall be permitted to perform work unless approved by the Department.

f. For proposed subcontracts that do not exceed $25,000.00, the Department's approval shall be deemed granted if the Department does not issue a written approval or disapproval within 45 Days of the Department's receipt of the written request for approval or, if PPB Rule 2-08(e) is applicable, within 45 Days of the Department's acknowledged receipt of fully completed disclosures for the subcontractor.

B. All subcontracts must be in writing. All subcontracts shall contain provisions that effectively accomplish the following:

1. The work performed by the subcontractor must be in accordance with the terms of the Agreement between the City and the Contractor;

2. Nothing contained in the agreement between the Contractor and the subcontractor shall impair the rights of the City;

3. Nothing contained in the agreement between the Contractor and the subcontractor, or under the Agreement between the City and the Contractor, shall create any contractual relation between the subcontractor and the City; and

4. The subcontractor specifically agrees to be bound by Section 4.05(D) and Article 5 of this Appendix A and specifically agrees that the City may enforce such provisions directly against the subcontractor as if the City were a party to the subcontract.

C. The Contractor agrees that it is as fully responsible to the Department for the acts and omissions of its subcontractors and of persons either directly or indirectly employed by such subcontractors as it is for the acts and omissions of any person directly employed by it.

D. For determining the value of a subcontract, all subcontracts with the same subcontractor shall be aggregated.

The Department may revoke the approval of a subcontractor granted or deemed granted pursuant to Section 3.02(A) if revocation is deemed to be in the interest of the City in writing on no less than 10 Days' notice unless a shorter period is warranted by considerations of health, safety, integrity issues, or other similar factors. Upon the effective date of such revocation, the Contractor shall cause the subcontractor to cease all work under the Agreement. The City shall not incur any further obligation for services performed by such subcontractor pursuant to this Agreement beyond the effective date of the revocation. The City shall pay for services provided by the subcontractor in accordance with this Agreement prior to the effective date of revocation. In the event the Department revokes approval of a subcontractor, Contractor will have a reasonable period of time, not to exceed 90 days (unless the parties agree a shorter period is warranted by considerations of health, safety, integrity issues, or other similar factors), to get approval for and engage a replacement for such subcontractor. ,

E. The Department's approval of a subcontractor shall not relieve the Contractor of any of its responsibilities, duties, and liabilities under this Agreement. At the request of the Department, the Contractor shall provide the Department a copy of any subcontract.

F. Individual employer-employee contracts are not subcontracts subject to the requirements of this Section 3.02.

G. The Contractor shall report in the City's Payee Information Portal payments made to each subcontractor within 30 days of making the payment. If any of the information provided in accordance with Section 3.02(A)(2)(b) changes during the term of this Agreement, the Contractor shall update the information in such Portal accordingly. Failure of the Contractor to list a subcontractor and/or to report subcontractor payments in a timely fashion may result in the Department declaring the Contractor in default of the Agreement and will subject Contractor to liquidated damages in the amount of $100 per day for each day that the Contractor fails to identify a subcontractor along with the required information about the subcontractor and/or fails to report payments to a subcontractor, beyond the time frames set forth herein or in the notice from the City.

ARTICLE 4 - LABOR PROVISIONS

Section 4.01 Independent Contractor Status

The Contractor and the City agree that the Contractor is an independent contractor and not an employee, subsidiary, affiliate, division, department, agency, office, or unit of the City. Accordingly, the Contractor and its employees, officers, and agents shall not, by reason of this Agreement or any performance pursuant to or in connection with this Agreement, assert the existence of any relationship or status on the part of the Contractor, with respect to the City, that differs from or is inconsistent with that of an independent contractor.

Section 4.02 Employees and Subcontractors

All persons who are employed by the Contractor and all the Contractor's subcontractors (including without limitation, consultants and independent contractors) that are retained to perform services under or in connection with this Agreement are neither employees of the City nor under contract with the City. The Contractor, and not the City, is responsible for their work, direction, compensation, and personal conduct while the Contractor is engaged under this Agreement. Nothing in this Agreement, and no entity or person's performance pursuant to or in connection with this Agreement, shall create any relationship between the City and the Contractor's employees, agents, subcontractors, or subcontractor's employees or agents (including without limitation, a contractual relationship, employer-employee relationship, or quasi-employer/quasi-employee relationship) or impose any liability or duty on the City (i) for or on account of the acts, omissions, liabilities, rights or obligations of the Contractor, its employees or agents, its subcontractors, or its subcontractor's employees or agents (including without limitation, obligations set forth in any collective bargaining agreement); or (ii) for taxes of any nature; or (iii) for any right or benefit applicable to an official or employee of the City or to any officer, agent, or employee of the Contractor or any other entity (including without limitation, Workers' Compensation coverage, Employers' Liability coverage, Disability Benefits coverage, Unemployment Insurance benefits, Social Security coverage, employee health and welfare benefits or employee retirement benefits, membership or credit). The Contractor and its employees, officers, and agents shall not, by reason of this Agreement or any performance pursuant to or in connection with this Agreement, (i) hold themselves out as, or claim to be, officials or employees of the City, including any department, agency, office, or unit of the City, or (ii) make or support in any way on behalf of or for the benefit of the Contractor, its employees, officers, or agents any demand, application, or claim upon or against the City for any right or benefit applicable to an official or employee of the City or to any officer, agent, or employee of the Contractor or any other entity. Except as specifically stated in this Agreement, nothing in the Agreement and no performance pursuant to or in connection with the Agreement shall impose any liability or duty on the City to any person or entity whatsoever.

Section 4.03 Removal of Individuals Performing Work

The Contractor shall not have anyone perform work under this Agreement who is not competent, faithful, and skilled in the work for which he or she shall be employed. Whenever the Commissioner shall inform the Contractor, in writing, that any individual is, in his or her opinion, incompetent, unfaithful, or unskilled, such individual shall no longer perform work under this Agreement. Prior to making a determination to direct a Contractor that an individual shall no longer perform work under this Agreement, the Commissioner shall provide the Contractor an opportunity to be heard on no less than five Days' written notice. The Commissioner may direct the Contractor to prohibit the individual from performing work under the Agreement pending the opportunity to be heard and the Commissioner's determination.

Section 4.04 Minimum Wage; Living Wage

A. Except for those employees whose minimum wage is required to be fixed in accordance with N.Y. Labor Law §§ 220 or 230 or by Admin. Code § 6-109, all persons employed by the Contractor in the performance of this Agreement shall be paid, without subsequent deduction or rebate, unless expressly authorized by Law, not less than the minimum wage as prescribed by Law. Any breach of this Section 4.04 shall be deemed a material breach of this Agreement.

B. If this Agreement involves the provision of homecare services, day care services, head start services, services to persons with cerebral palsy, building services, food services, or temporary services, as those services are defined in Admin. Code § 6-109 ("Section 6-109"), in accordance with Section 6-109, the Contractor agrees as follows:

1. The Contractor shall comply with the requirements of Section 6-109, including, where applicable, the payment of either a prevailing wage or a living wage, as those terms are defined in Section 6-109.

2. The Contractor shall not retaliate, discharge, demote, suspend, take adverse employment action in the terms and conditions of employment or otherwise discriminate against any employee for reporting or asserting a violation of Section 6-109, for seeking or communicating information regarding rights conferred by Section 6-109, for exercising any other rights protected under Section 6-109, or for participating in any investigatory or court proceeding relating to Section 6-109. This protection shall also apply to any employee or his or her representative who in good faith alleges a violation of Section 6-109, or who seeks or communicates information regarding rights conferred by Section 6-109 in circumstances where he or she in good faith believes it applies.

3. The Contractor shall maintain original payroll records for each of its covered employees reflecting the days and hours worked on contracts, projects, or assignments that are subject to the requirements of Section 6-109, and the wages paid and benefits provided for such hours worked. The Contractor shall maintain these records for the duration of the term of this Agreement and shall retain them for a period of four years after completion of this Agreement. For contracts involving building services, food services, or temporary services, the Contractor shall submit copies of payroll records, certified by the Contractor under penalty of perjury to be true and accurate, to the Department with every requisition for payment. For contracts involving homecare, day care, head start or services to persons with cerebral palsy, the Contractor shall submit either certified payroll records or categorical information about the wages, benefits, and job classifications of covered employees of the Contractor, and of any subcontractors, which shall be the substantial equivalent of the information required in Section 6- 109(2)(a)(iii).

4. The Contractor and all subcontractors shall pay all covered employees by check and shall provide employees check stubs or other documentation at least once each month containing information sufficient to document compliance with the requirements of the Living Wage Law concerning living wages, prevailing wages, supplements, and health benefits. In addition, if this Agreement is for an amount greater than $1,000,000.00, checks issued by the Contractor to covered employees shall be generated by a payroll service or automated payroll system (an in-house system may be used if approved by the Department). For any subcontract for an amount greater than $750,000.00, checks issued by a subcontractor to covered employees shall be generated by a payroll service or automated payroll system (an in-house system may be used if approved by the Department).

5. The Department will provide written notices to the Contractor, prepared by the Comptroller, detailing the wages, benefits, and other protections to which covered employees are entitled under Section 6-109. Such notices will be provided in English, Spanish and other languages spoken by ten percent or more of a covered employer's covered employees. Throughout the term of this Agreement, the Contractor shall post in a prominent and accessible place at every work site and provide each covered employee a copy of the written notices provided by the Department. The Contractor shall provide the notices to its subcontractors and require them to be posted and provided to each covered employee.

6. The Contractor shall ensure that its subcontractors comply with the requirements of Section 6-109, and shall provide written notification to its subcontractors of those requirements. All subcontracts made by the Contractor shall be in writing and shall include provisions relating to the wages, supplements, and health benefits required by Section 6-109. No work may be performed by a subcontractor employing covered employees prior to the Contractor entering into a written subcontract with the subcontractor.

7. Each year throughout the term of the Agreement and whenever requesting the Department's approval of a subcontractor, the Contractor shall submit to the Department an updated certification, as required by Section 6-109 and in the form of the certification attached to this Agreement, identifying any changes to the current certification.

8. Failure to comply with the requirements of Section 6-109 may, in the discretion of the Department, constitute a material breach by the Contractor of the terms of this Agreement. If the Contractor and/or subcontractor receives written notice of such a breach and fails to cure such breach within 30 Days, the City shall have the right to pursue any rights or remedies available under this Agreement or under applicable law, including termination of the Agreement. If the Contractor fails to perform in accordance with any of the requirements of Section 6-109 and fails to cure such failure in accordance with the preceding sentence, and there is a continued need for the service, the City may obtain from another source the required service as specified in the original Agreement, or

any part thereof, and may charge the Contractor for any difference in price resulting from the alternative arrangements, and may, as appropriate, invoke such other sanctions as are available under the Agreement and applicable law. In addition, the Contractor agrees to pay for all costs incurred by the City in enforcing the requirements of Section 6-109, including the cost of any investigation conducted by or on behalf of the Department or the Comptroller, where the City discovers that the Contractor or its subcontractor(s) failed to comply with the requirements of this Section 4.04(B) or of Section 6-109. The Contractor also agrees, that should it fail or refuse to pay for any such investigation, the Department is hereby authorized to deduct from a Contractor's account an amount equal to the cost of such investigation.

Section 4.05 Non-Discrimination in Employment

A. General Prohibition. To the extent required by law, the Contractor shall not unlawfully discriminate against any employee or applicant for employment because of actual or perceived age, religion, religious practice, creed, sex, gender, gender identity or gender expression, sexual orientation, status as a victim of domestic violence, stalking, and sex offenses, familial status, partnership status, marital status, caregiver status, pregnancy, childbirth or related medical condition, disability, presence of a service animal, predisposing genetic characteristics, race, color, national origin (including ancestry), alienage, citizenship status, political activities or recreational activities as defined in N.Y. Labor Law 201-d, arrest or conviction record, credit history, military status, uniformed service, unemployment status, salary history, or any other protected class of individuals as defined by City, State or Federal laws, rules or regulations. The Contractor shall comply with all statutory and regulatory obligations to provide reasonable accommodations to individuals with disabilities, due to pregnancy, childbirth, or a related medical condition, due to status as a victim of domestic violence, stalking, or sex offenses, or due to religion.

B. N.Y. Labor Law § 220-e. If this Agreement is for the construction, alteration or repair of any public building or public work or for the manufacture, sale, or distribution of materials, equipment, or supplies, the Contractor agrees, as required by N.Y. Labor Law § 220-e, that:

1. In the hiring of employees for the performance of work under this Agreement or any subcontract hereunder, neither the Contractor, subcontractor, nor any person acting on behalf of such Contractor or subcontractor, shall by reason of race, creed, color, disability, sex or national origin discriminate against any citizen of the State of New York who is qualified and available to perform the work to which the employment relates;

2. Neither the Contractor, subcontractor, nor any person on his or her behalf shall, in any manner, discriminate against or intimidate any employee hired for the performance of work under this Agreement on account of race, creed, color, disability, sex or national origin;

3. There may be deducted from the amount payable to the Contractor by the City under this Agreement a penalty of $50.00 for each person for each calendar day during which such person was discriminated against or intimidated in violation of the provisions of this Agreement; and

4. This Agreement may be terminated by the City, and all monies due or to become due hereunder may be forfeited, for a second or any subsequent violation of the terms or conditions of this Section 4.05.

The provisions of this Section 4.05(B) shall be limited to operations performed within the territorial limits of the State of New York.

C. Admin. Code § 6-108. If this Agreement is for the construction, alteration or repair of buildings or the construction or repair of streets or highways, or for the manufacture, sale, or distribution of materials, equipment or supplies, the Contractor agrees, as required by Admin. Code § 6-108, that:

1. It shall be unlawful for any person engaged in the construction, alteration or repair of buildings or engaged in the construction or repair of streets or highways pursuant to a contract with the City or engaged in the manufacture, sale or distribution of materials, equipment or supplies pursuant to a contract with the City to refuse to employ or to refuse to continue in any employment any person on account of the race, color or creed of such person.

2. It shall be unlawful for any person or any servant, agent or employee of any person, described in Section 4.05(C)(1) above, to ask, indicate or transmit, orally or in writing, directly or indirectly, the race, color, creed or religious affiliation of any person employed or seeking employment from such person, firm or corporation.

Breach of the foregoing provisions shall be deemed a breach of a material provision of this Agreement.

Any person, or the employee, manager or owner of or officer of such firm or corporation who shall violate any of the provisions of this Section 4.05(C) shall, upon conviction thereof, be punished by a fine of not more than $100.00 or by imprisonment for not more than 30 Days, or both.

D. E.O. 50 -- Equal Employment Opportunity

1. This Agreement is subject to the requirements of City Executive Order No. 50 (1980) ("E.O. 50"), as revised, and the rules set forth at 66 RCNY §§ 10-01 *et seq*. No agreement will be awarded unless and until these requirements have been complied with in their entirety. The Contractor agrees that it:

a. Will not discriminate unlawfully against any employee or applicant for employment because of race, creed, color, national origin, sex, age, disability,

marital status, sexual orientation or citizenship status with respect to all employment decisions including, but not limited to, recruitment, hiring, upgrading, demotion, downgrading, transfer, training, rates of pay or other forms of compensation, layoff, termination, and all other terms and conditions of employment;

b. Will not discriminate unlawfully in the selection of subcontractors on the basis of the owners', partners' or shareholders' race, color, creed, national origin, sex, age, disability, marital status, sexual orientation, or citizenship status;

c. Will state in all solicitations or advertisements for employees placed by or on behalf of the Contractor that all qualified applicants will receive consideration for employment without unlawful discrimination based on race, color, creed, national origin, sex, age, disability, marital status, sexual orientation or citizenship status, and that it is an equal employment opportunity employer;

d. Will send to each labor organization or representative of workers with which it has a collective bargaining agreement or other contract or memorandum of understanding, written notification of its equal employment opportunity commitments under E.O. 50 and the rules and regulations promulgated thereunder;

e. Will furnish before this Agreement is awarded all information and reports including an Employment Report which are required by E.O. 50, the rules and regulations promulgated thereunder, and orders of the SBS, Division of Labor Services ("DLS"); and

f. Will permit DLS to have access to all relevant books, records, and accounts for the purposes of investigation to ascertain compliance with such rules, regulations, and orders.

2. The Contractor understands that in the event of its noncompliance with the nondiscrimination clauses of this Agreement or with any of such rules, regulations, or orders, such noncompliance shall constitute a material breach of this Agreement and noncompliance with E.O. 50 and the rules and regulations promulgated thereunder. After a hearing held pursuant to the rules of DLS, the Director of DLS may direct the Commissioner to impose any or all of the following sanctions:

a. Disapproval of the Contractor; and/or

b. Suspension or termination of the Agreement; and/or

c. Declaring the Contractor in default; and/or

d. In lieu of any of the foregoing sanctions, imposition of an employment program.

3. Failure to comply with E.O. 50 and the rules and regulations promulgated thereunder in one or more instances may result in the Department declaring the Contractor to be non-responsible.

4. The Contractor agrees to include provisions that effectively accomplish the purpose of the foregoing Sections 4.05(D)(1)-(3) in every subcontract or purchase order in excess of $100,000.00 to which it becomes a party unless exempted by E.O. 50 and the rules and regulations promulgated thereunder, so that such provisions will be binding upon each subcontractor or vendor. The Contractor will take such action with respect to any subcontract or purchase order as may be directed by the Director of DLS as a means of enforcing such provisions including sanctions for noncompliance. A supplier of unfinished products to the Contractor needed to produce the item contracted for shall not be considered a subcontractor or vendor for purposes of this Section 4.05(D)(4).

5. The Contractor further agrees that it will refrain from entering into any subcontract or modification thereof subject to E.O. 50 and the rules and regulations promulgated thereunder with a subcontractor who is not in compliance with the requirements of E.O. 50 and the rules and regulations promulgated thereunder. A supplier of unfinished products to the Contractor needed to produce the item contracted for shall not be considered a subcontractor for purposes of this Section 4.05(D)(5).

6. Nothing contained in this Section 4.05(D) shall be construed to bar any religious or denominational institution or organization, or any organization operated for charitable or educational purposes, that is operated, supervised or controlled by or in connection with a religious organization, from lawfully limiting employment or lawfully giving preference to persons of the same religion or denomination or from lawfully making such selection as is calculated by such organization to promote the religious principles for which it is established or maintained.

Section 4.06 Paid Sick Leave Law

A. Introduction and General Provisions.

1. The Earned Sick Time Act, also known as the Paid Sick Leave Law ("PSLL"), requires covered employees who annually perform more than 80 hours of work in New York City to be provided with paid sick time.[2] Contractors of the City or of other governmental entities may be required to provide sick time pursuant to the PSLL.

[2] Pursuant to the PSLL, if fewer than five employees work for the same employer, as determined pursuant Admin. Code § 20-912(g), such employer has the option of providing such employees uncompensated sick time.

2. The PSLL became effective on April 1, 2014, and is codified at Title 20, Chapter 8, of the Admin. Code. It is administered by the City's Department of Consumer Affairs ("DCA"). DCA's rules promulgated under the PSLL are codified at Chapter 7 of Title 6 of the Rules of the City of New York ("Rules").

3. The Contractor agrees to comply in all respects with the PSLL and the Rules, and as amended, if applicable, in the performance of this Agreement. The Contractor further acknowledges that such compliance is a material term of this Agreement and that failure to comply with the PSLL in performance of this Agreement may result in its termination.

4. The Contractor must notify the ACCO in writing within 10 Days of receipt of a complaint (whether oral or written) regarding the PSLL involving the performance of this Agreement. Additionally, the Contractor must cooperate with DCA's education efforts and must comply with DCA's subpoenas and other document demands as set forth in the PSLL and Rules.

5. The PSLL is summarized below for the convenience of the Contractor. The Contractor is advised to review the PSLL and Rules in their entirety. On the website www.nyc.gov/PaidSickLeave there are links to the PSLL and the associated Rules as well as additional resources for employers, such as Frequently Asked Questions, timekeeping tools and model forms, and an event calendar of upcoming presentations and webinars at which the Contractor can get more information about how to comply with the PSLL. The Contractor acknowledges that it is responsible for compliance with the PSLL notwithstanding any inconsistent language contained herein.

B. Pursuant to the PSLL and the Rules: Applicability, Accrual, and Use.

1. An employee who works within the City of New York for more than eighty hours in any consecutive 12-month period designated by the employer as its "calendar year" pursuant to the PSLL ("Year") must be provided sick time. Employers must provide a minimum of one hour of sick time for every 30 hours worked by an employee and compensation for such sick time must be provided at the greater of the employee's regular hourly rate or the minimum wage. Employers are not required to provide more than 40 hours of sick time to an employee in any Year.

2. An employee has the right to determine how much sick time he or she will use, provided that employers may set a reasonable minimum increment for the use of sick time not to exceed four hours per Day. In addition, an employee may carry over up to 40 hours of unused sick time to the following Year, provided that no employer is required to allow the use of more than 40 hours of sick time in a Year or carry over unused paid sick time if the employee is paid for such unused sick time and the employer provides the employee with at least the legally required amount of paid sick time for such employee for the immediately subsequent Year on the first Day of such Year.

3. An employee entitled to sick time pursuant to the PSLL may use sick time for any of the following:

a. such employee's mental illness, physical illness, injury, or health condition or the care of such illness, injury, or condition or such employee's need for medical diagnosis or preventive medical care;

b. such employee's care of a family member (an employee's child, spouse, domestic partner, parent, sibling, grandchild, or grandparent, or the child or parent of an employee's spouse or domestic partner) who has a mental illness, physical illness, injury or health condition or who has a need for medical diagnosis or preventive medical care;

c. closure of such employee's place of business by order of a public official due to a public health emergency; or

d. such employee's need to care for a child whose school or childcare provider has been closed due to a public health emergency.

4. An employer must not require an employee, as a condition of taking sick time, to search for a replacement. However, an employer may require an employee to provide: reasonable notice of the need to use sick time; reasonable documentation that the use of sick time was needed for a reason above if for an absence of more than three consecutive work days; and/or written confirmation that an employee used sick time pursuant to the PSLL. However, an employer may not require documentation specifying the nature of a medical condition or otherwise require disclosure of the details of a medical condition as a condition of providing sick time and health information obtained solely due to an employee's use of sick time pursuant to the PSLL must be treated by the employer as confidential.

5. If an employer chooses to impose any permissible discretionary requirement as a condition of using sick time, it must provide to all employees a written policy containing those requirements, using a delivery method that reasonably ensures that employees receive the policy. If such employer has not provided its written policy, it may not deny sick time to an employee because of non-compliance with such a policy.

6. Sick time to which an employee is entitled must be paid no later than the payday for the next regular payroll period beginning after the sick time was used.

C. *Exemptions and Exceptions*. Notwithstanding the above, the PSLL does not apply to any of the following:

1. an independent contractor who does not meet the definition of employee under N.Y. Labor Law § 190(2);

2. an employee covered by a valid collective bargaining agreement in effect on April 1, 2014, until the termination of such agreement;

3. an employee in the construction or grocery industry covered by a valid collective bargaining agreement if the provisions of the PSLL are expressly waived in such collective bargaining agreement;

4. an employee covered by another valid collective bargaining agreement if such provisions are expressly waived in such agreement and such agreement provides a benefit comparable to that provided by the PSLL for such employee;

5. an audiologist, occupational therapist, physical therapist, or speech language pathologist who is licensed by the New York State Department of Education and who calls in for work assignments at will, determines his or her own schedule, has the ability to reject or accept any assignment referred to him or her, and is paid an average hourly wage that is at least four times the federal minimum wage;

6. an employee in a work study program under Section 2753 of Chapter 42 of the United States Code;

7. an employee whose work is compensated by a qualified scholarship program as that term is defined in the Internal Revenue Code, Section 117 of Chapter 20 of the United States Code; or

8. a participant in a Work Experience Program (WEP) under N.Y. Social Services Law § 336-c.

D. *Retaliation Prohibited.* An employer may not threaten or engage in retaliation against an employee for exercising or attempting in good faith to exercise any right provided by the PSLL. In addition, an employer may not interfere with any investigation, proceeding, or hearing pursuant to the PSLL.

E. Notice of Rights.

1. An employer must provide its employees with written notice of their rights pursuant to the PSLL. Such notice must be in English and the primary language spoken by an employee, provided that DCA has made available a translation into such language. Downloadable notices are available on DCA's website at http://www.nyc.gov/html/dca/html/law/PaidSickLeave.shtml.

2. Any person or entity that willfully violates these notice requirements is subject to a civil penalty in an amount not to exceed $50.00 for each employee who was not given appropriate notice.

F. *Records*. An employer must retain records documenting its compliance with the PSLL for a period of at least three years, and must allow DCA to access such records in furtherance of an investigation related to an alleged violation of the PSLL.

G. Enforcement and Penalties.

1. Upon receiving a complaint alleging a violation of the PSLL, DCA has the right to investigate such complaint and attempt to resolve it through mediation. Within 30 Days of written notification of a complaint by DCA, or sooner in certain circumstances, the employer must provide DCA with a written response and such other information as DCA may request. If DCA believes that a violation of the PSLL has occurred, it has the right to issue a notice of violation to the employer.

2. DCA has the power to grant an employee or former employee all appropriate relief as set forth in Admin. Code § 20-924(d). Such relief may include, among other remedies, treble damages for the wages that should have been paid, damages for unlawful retaliation, and damages and reinstatement for unlawful discharge. In addition, DCA may impose on an employer found to have violated the PSLL civil penalties not to exceed $500.00 for a first violation, $750.00 for a second violation within two years of the first violation, and $1,000.00 for each succeeding violation within two years of the previous violation.

H. *More Generous Polices and Other Legal Requirements.* Nothing in the PSLL is intended to discourage, prohibit, diminish, or impair the adoption or retention of a more generous sick time policy, or the obligation of an employer to comply with any contract, collective bargaining agreement, employment benefit plan or other agreement providing more generous sick time. The PSLL provides minimum requirements pertaining to sick time and does not preempt, limit, or otherwise affect the applicability of any other law, regulation, rule, requirement, policy or standard that provides for greater accrual or use by employees of sick leave or time, whether paid or unpaid, or that extends other protections to employees. The PSLL may not be construed as creating or imposing any requirement in conflict with any federal or state law, rule, or regulation.

Section 4.07 Whistleblower Protection Expansion Act

A. In accordance with Local Laws 30 and 33 of 2012, codified at Admin. Code §§ 6-132 and 12-113, respectively,

1. Contractor shall not take an adverse personnel action with respect to an officer or employee in retaliation for such officer or employee making a report of information concerning conduct which such officer or employee knows or reasonably believes to involve corruption, criminal activity, conflict of interest, gross mismanagement or abuse of authority by any officer or employee relating to this Agreement to (i) the Commissioner of the Department of Investigation, (ii) a member of

the New York City Council, the Public Advocate, or the Comptroller, or (iii) the City Chief Procurement Officer, ACCO, Agency head, or Commissioner.

2. If any of Contractor's officers or employees believes that he or she has been the subject of an adverse personnel action in violation of this Section 4.07, he or she shall be entitled to bring a cause of action against Contractor to recover all relief necessary to make him or her whole. Such relief may include but is not limited to: (i) an injunction to restrain continued retaliation, (ii) reinstatement to the position such employee would have had but for the retaliation or to an equivalent position, (iii) reinstatement of full fringe benefits and seniority rights, (iv) payment of two times back pay, plus interest, and (v) compensation for any special damages sustained as a result of the retaliation, including litigation costs and reasonable attorney's fees.

3. Contractor shall post a notice provided by the City (attached hereto) in a prominent and accessible place on any site where work pursuant to the Agreement is performed that contains information about:

a. how its employees can report to the New York City Department of Investigation allegations of fraud, false claims, criminality or corruption arising out of or in connection with the Agreement; and

b. the rights and remedies afforded to its employees under Admin. Code §§ 7-805 (the New York City False Claims Act) and 12-113 (the Whistleblower Protection Expansion Act) for lawful acts taken in connection with the reporting of allegations of fraud, false claims, criminality or corruption in connection with the Agreement.

4. For the purposes of this Section 4.07, "adverse personnel action" includes dismissal, demotion, suspension, disciplinary action, negative performance evaluation, any action resulting in loss of staff, office space, equipment or other benefit, failure to appoint, failure to promote, or any transfer or assignment or failure to transfer or assign against the wishes of the affected officer or employee.

5. This Section 4.07 is applicable to all of Contractor's subcontractors having subcontracts with a value in excess of $100,000.00; accordingly, Contractor shall include this Section 4.07 in all subcontracts with a value in excess of $100,000.00.

B. Section 4.07 is not applicable to this Agreement if it is valued at $100,000.00 or less. Sections 4.07(A)(1), (2), (4), and (5) are not applicable to this Agreement if it was solicited pursuant to a finding of an emergency. Section 4.07(A)(3) is neither applicable to this Agreement if it was solicited prior to October 18, 2012 nor if it is a renewal of a contract executed prior to October 18, 2012.

ARTICLE 5 - RECORDS, AUDITS, REPORTS, AND INVESTIGATIONS

Section 5.01 Books and Records

The Contractor agrees to maintain accurate books, records, documents, and other evidence, and to utilize appropriate accounting procedures and practices that sufficiently and properly reflect all direct and indirect costs of any nature expended in the performance of this Agreement. To the extent practicable, records pertaining to this Agreement shall be clearly demarcated and distinct from all other records.

Section 5.02 Retention of Records

The Contractor agrees to retain all books, records, documents, other evidence relevant to this Agreement, including those required pursuant to Section 5.01, for six years after the final payment or expiration or termination of this Agreement, or for a period otherwise prescribed by Law, whichever is later. In addition, if any litigation, claim, or audit concerning this Agreement has commenced before the expiration of the six-year period, the books, records, documents, and other evidence must be retained until the completion of such litigation, claim, or audit. Any books, records, documents, and other evidence that are created in an electronic format in the regular course of business may be retained in an electronic format. Any books, records, documents, or other evidence that are created in the regular course of business as a paper copy may be retained in an electronic format provided that they satisfy the requirements of N.Y. Civil Practice Law and Rules ("CPLR") 4539(b), including the requirement that the reproduction is created in a manner "which does not permit additions, deletions, or changes without leaving a record of such additions, deletions, or changes." Furthermore, the Contractor agrees to waive any objection to the admissibility of any such books, records, documents, or other evidence on the grounds that such documents do not satisfy CPLR 4539(b).

Section 5.03 Inspection

A. At any time during the Agreement or during the record retention period set forth in Section 5.02, the City, including the Department and the Department's Office of the Inspector General, as well as City, State, and federal auditors and any other persons duly authorized by the City shall, upon reasonable notice, have full access to and the right to examine and copy all books, records, documents, and other evidence maintained or retained by or on behalf of the Contractor pursuant to this Article 5. Notwithstanding any provision herein regarding notice of inspection, all books, records, documents, and other evidence of the Contractor kept pursuant to this Agreement shall be subject to immediate inspection, review, and copying by the Department's Office of the Inspector General, the Comptroller, and/or federal auditors without prior notice and at no additional cost to the City. The Contractor shall make such books, records documents, and other evidence available for inspection in the City of New York or shall reimburse the City for expenses associated with the out-of-City inspection.

B. The Department shall have the right to have representatives of the Department or

of the City, State or federal government present to observe the services being performed. If

observation of particular services or activity would constitute a waiver of a legal privilege or violate the Law or an ethical obligation under the New York Rules of Professional Conduct for attorneys, National Association of Social Workers Code of Ethics or other similar code governing the provision of a profession's services in New York State, the Contractor shall promptly inform the Department or other entity seeking to observe such work or activity. Such restriction shall not act to prevent government representatives from inspecting the provision of services in a manner that allows the representatives to ensure that services are being performed in accordance with this Agreement.

C. The Contractor shall not be entitled to final payment until the Contractor has complied with any request for inspection or access given under this Section 5.03, subject to Paragraph D. below.

D. Notwithstanding the foregoing, all rights of inspection, examination, access and copying set forth above shall be subject to the requirements and limitations of HIPAA.

Section 5.04 Audit

A. This Agreement and all books, records, documents, and other evidence required to be maintained or retained pursuant to this Agreement, including all vouchers or invoices presented for payment and the books, records, and other documents upon which such vouchers or invoices are based (e.g., reports, cancelled checks, accounts, and all other similar material), are subject to audit by (i) the City, including the Comptroller, the Department, and the Department's Office of the Inspector General, (ii) the State, (iii) the federal government, and (iv) other persons duly authorized by the City. Such audits may include examination and review of the source and application of all funds whether from the City, the State, the federal government, private sources, or otherwise.

B. Audits by the City, including the Comptroller, the Department, and the Department's Office of the Inspector General, are performed pursuant to the powers and responsibilities conferred by the Charter and the Admin. Code, as well as all orders, rules, and regulations promulgated pursuant to the Charter and Admin. Code.

C. The Contractor shall submit any and all documentation and justification in support of expenditures or fees under this Agreement as may be required by the Department and by the Comptroller in the exercise of his/her powers under Law.

D. The Contractor shall not be entitled to final payment until the Contractor has complied with the requirements of this Section 5.04, subject to Paragraph E. below.

E. Notwithstanding the foregoing, all rights of audit set forth above shall be subject to the requirements and limitations of HIPAA.

Section 5.05 No Removal of Records from Premises

Where performance of this Agreement involves use by the Contractor of any City books, records, documents, or data (in hard copy, or electronic or other format now known or developed in the future) at City facilities or offices, the Contractor shall not remove any such items or material (in the format in which it originally existed, or in any other converted or derived format) from such facility or office without the prior written approval of the Department's designated official. Upon the request by the Department at any time during the Agreement or after the Agreement has expired or terminated, the Contractor shall return to the Department any City books, records, documents, or data that has been removed from City premises.

Section 5.06 Electronic Records

As used in this Appendix A, the terms "books," "records," "documents," and "other evidence" refer to electronic versions as well as hard copy versions.

Section 5.07 Investigations Clause

A. The Contractor agrees to cooperate fully and faithfully with any investigation, audit or inquiry conducted by a State or City agency or authority that is empowered directly or by designation to compel the attendance of witnesses and to examine witnesses under oath, or conducted by the Inspector General of a governmental agency that is a party in interest to the transaction, submitted bid, submitted proposal, contract, lease, permit, or license that is the subject of the investigation, audit or inquiry.

B.

1. If any person who has been advised that his or her statement, and any information from such statement, will not be used against him or her in any subsequent criminal proceeding refuses to testify before a grand jury or other governmental agency or authority empowered directly or by designation to compel the attendance of witnesses and to examine witnesses under oath concerning the award of or performance under any transaction, agreement, lease, permit, contract, or license entered into with the City, or State, or any political subdivision or public authority thereof, or the Port Authority of New York and New Jersey, or any local development corporation within the City, or any public benefit corporation organized under the Laws of the State, or;

2. If any person refuses to testify for a reason other than the assertion of his or her privilege against self-incrimination in an investigation, audit or inquiry conducted by a City or State governmental agency or authority empowered directly or by designation to compel the attendance of witnesses and to take testimony under oath, or by the Inspector General of the governmental agency that is a party in interest in, and is seeking testimony concerning the award of, or performance under, any transaction, agreement, lease, permit, contract, or license entered into with the City, the State, or any political subdivision thereof or any local development corporation within the City, then;

C.

6. The Commissioner or Agency Head whose agency is a party in interest to the transaction, submitted bid, submitted proposal, contract, lease, permit, or license shall convene a hearing, upon not less than five (5) Days written notice to the parties involved to determine if any penalties should attach for the failure of a person to testify.

7. If any non-governmental party to the hearing requests an adjournment, the Commissioner or Agency Head who convened the hearing may, upon granting the adjournment, suspend any contract, lease, permit, or license pending the final determination pursuant to Paragraph E below without the City incurring any penalty or damages for delay or otherwise.

D. The penalties that may attach after a final determination by the Commissioner or Agency Head may include but shall not exceed:

1. The disqualification for a period not to exceed five years from the date of an adverse determination for any person, or any entity of which such person was a member at the time the testimony was sought, from submitting bids for, or transacting business with, or entering into or obtaining any contract, lease, permit or license with or from the City; and/or

2. The cancellation or termination of any and all such existing City contracts, leases, permits or licenses that the refusal to testify concerns and that have not been assigned as permitted under this Agreement, nor the proceeds of which pledged, to an unaffiliated and unrelated institutional lender for fair value prior to the issuance of the notice scheduling the hearing, without the City incurring any penalty or damages on account of such cancellation or termination; monies lawfully due for goods delivered, work done, rentals, or fees accrued prior to the cancellation or termination shall be paid by the City.

E. The Commissioner or Agency Head shall consider and address in reaching his or her determination and in assessing an appropriate penalty the factors in Paragraphs (1) and (2) below. He or she may also consider, if relevant and appropriate, the criteria established in Paragraphs (3) and (4) below, in addition to any other information that may be relevant and appropriate:

1. The party's good faith endeavors or lack thereof to cooperate fully and faithfully with any governmental investigation or audit, including but not limited to the discipline, discharge, or disassociation of any person failing to testify, the production of accurate and complete books and records, and the forthcoming testimony of all other members, agents, assignees or fiduciaries whose testimony is sought.

2. The relationship of the person who refused to testify to any entity that is a party to the hearing, including, but not limited to, whether the person whose testimony is sought has an ownership interest in the entity and/or the degree of authority and responsibility the person has within the entity.

3. The nexus of the testimony sought to the subject entity and its contracts, leases, permits or licenses with the City.

4. The effect a penalty may have on an unaffiliated and unrelated party or entity that has a significant interest in an entity subject to penalties under Paragraph D above, provided that the party or entity has given actual notice to the Commissioner or Agency Head upon the acquisition of the interest, or at the hearing called for in Paragraph (C)(1) above gives notice and proves that such interest was previously acquired. Under either circumstance, the party or entity must present evidence at the hearing demonstrating the potential adverse impact a penalty will have on such person or entity.

F. Definitions

1. The term "license" or "permit" as used in this Section shall be defined as a license, permit, franchise, or concession not granted as a matter of right.

2. The term "person" as used in this Section shall be defined as any natural person doing business alone or associated with another person or entity as a partner, director, officer, principal or employee.

3. The term "entity" as used in this Section shall be defined as any firm, partnership, corporation, association, or person that receives monies, benefits, licenses, leases, or permits from or through the City, or otherwise transacts business with the City.

4. The term "member" as used in this Section shall be defined as any person associated with another person or entity as a partner, director, officer, principal, or employee.

G. In addition to and notwithstanding any other provision of this Agreement, the Commissioner or Agency Head may in his or her sole discretion terminate this Agreement upon not less than three (3) Days written notice in the event the Contractor fails to promptly report in writing to the City Commissioner of Investigation any solicitation of money, goods, requests for future employment or other benefits or thing of value, by or on behalf of any employee of the City or other person or entity for any purpose that may be related to the procurement or obtaining of this Agreement by the Contractor, or affecting the performance of this Agreement.

Section 5.08 Confidentiality

A. The Contractor agrees to hold confidential, both during and after the completion or termination of this Agreement, all of the reports, information, or data, furnished to, or prepared, assembled or used by, the Contractor under this Agreement. The Contractor agrees to maintain the confidentiality of such reports, information, or data by using a reasonable degree of care, and using at least the same degree of care that the Contractor uses to preserve the confidentiality of its own confidential information. The Contractor agrees that such reports, information, or data shall not be made available to any person or entity without the prior written approval of the Department. The obligation under this Section 5.08 to hold reports, information or data confidential shall not apply where the Contractor is legally required to disclose such reports, information or data, by virtue

of a subpoena, court order, CMS or other governmental agency requirements, or otherwise ("disclosure demand"), provided that the Contractor complies with the following: (1) the Contractor shall provide advance notice to the Commissioner, in writing or by e-mail, that it received a disclosure demand for to disclose such reports, information or data and (2) if requested by the Department, the Contractor shall not disclose such reports, information, or data until the City has exhausted its legal rights, if any, to prevent disclosure of all or a portion of such reports, information or data. The previous sentence shall not apply if the Contractor is prohibited by law from disclosing to the Department the disclosure demand for such reports, information or data.

B. The Contractor shall provide notice to the Department within five business days of the discovery by the Contractor of any breach of security, as defined in Admin. Code § 10-501(b), of any unencrypted or encrypted data, where the encryption key has also been accessed or acquired, in use by the Contractor that contains social security numbers or other personal identifying information as defined in Admin. Code § 10-501 ("Personal Identifying Information"), where such breach of security arises out of the acts or omissions of the Contractor or its employees, subcontractors, or agents. Upon the discovery of such security breach, the Contractor shall take reasonable steps to remediate the cause or causes of such breach, and shall provide notice to the Department of such steps. Contractor shall be responsible for providing notification to affected individuals (including, where necessary, creditor monitoring services) and regulators as required by law. In the event of such breach of security, without limiting any other right of the City, the City shall have the right to withhold further payments under this Agreement for the purpose of set-off in sufficient sums to cover the costs of notifications and/or other actions mandated by any Law, or administrative or judicial order, to address the breach. The City shall also have the right to withhold further payments hereunder for the purpose of set-off in sufficient sums to cover the costs of credit monitoring services for the victims of such a breach of security by a national credit reporting agency, and/or any other commercially reasonable preventive measure. The Department shall provide the Contractor with written notice and a reasonable opportunity to comment on such measures prior to implementation. Alternatively, at the City's discretion, or if monies remaining to be earned or paid under this Agreement are insufficient to cover the costs detailed above, the Contractor shall pay directly for the costs, detailed above, if any.

C. The Contractor shall restrict access to confidential information to persons who have a legitimate work related purpose to access such information. The Contractor agrees that it will instruct its officers, employees, and agents to maintain the confidentiality of any and all information required to be kept confidential by this Agreement.

D. The Contractor, and its officers, employees, and agents shall notify the Department, at any time either during or after completion or termination of this Agreement, of any intended statement to the press or any intended issuing of any material for publication in any media of communication (print, news, television, radio, Internet, etc.) regarding the services provided or the data collected pursuant to this Agreement at least 24 hours prior to any statement to the press or at least five business days prior to the submission of the material for publication, or such shorter periods as are reasonable under the circumstances. The Contractor may not issue any statement or submit any material for publication that includes confidential information as prohibited by this Section 5.08.

E. At the request of the Department, the Contractor shall return to the Department any and all confidential information in the possession of the Contractor or its subcontractors. If the Contractor or its subcontractors are legally required to retain any confidential information, the Contractor shall notify the Department in writing and set forth the confidential information that it intends to retain and the reasons why it is legally required to retain such information. The Contractor shall confer with the Department, in good faith, regarding any issues that arise from the Contractor retaining such confidential information. If the Department does not request such information or the Law does not require otherwise, such information shall be maintained in accordance with the requirements set forth in Section 5.02.

F. A breach of this Section 5.08 shall constitute a material breach of this Agreement for which the Department may terminate this Agreement pursuant to Article 10. The Department reserves any and all other rights and remedies in the event of unauthorized disclosure.

ARTICLE 6 - COPYRIGHTS, PATENTS, INVENTIONS, AND ANTITRUST

Section 6.01 Copyrights and Ownership of Work Product

A. Any reports, documents, data, photographs, deliverables, and/or other materials produced pursuant to this Agreement, and any and all drafts and/or other preliminary materials in any format related to such items produced pursuant to this Agreement, shall upon their creation become the exclusive property of the City, subject to the requirements and limitations of HIPAA.

B. Any reports, documents, data, photographs, deliverables, and/or other materials provided pursuant to this Agreement ("Copyrightable Materials") shall be considered "work-made-for-hire" within the meaning and purview of Section 101 of the United States Copyright Act, 17 U.S.C. § 101, and the City shall be the copyright owner thereof and of all aspects, elements, and components thereof in which copyright protection might exist. To the extent that the Copyrightable Materials do not qualify as "work-made-for-hire," the Contractor hereby irrevocably transfers, assigns and conveys exclusive copyright ownership in and to the Copyrightable Materials to the City, free and clear of any liens, claims, or other encumbrances. The Contractor shall retain no copyright or intellectual property interest in the Copyrightable Materials. The Copyrightable Materials shall be used by the Contractor for no purpose other than in the performance of this Agreement without the prior written permission of the City. The Department may grant the Contractor a license to use the Copyrightable Materials on such terms as determined by the Department and set forth in the license.

C. The Contractor acknowledges that the City may, in its sole discretion, register copyright in the Copyrightable Materials with the United States Copyright Office or any other government agency authorized to grant copyright registrations. The Contractor shall fully cooperate in this effort, and agrees to provide any and all documentation necessary to accomplish this.

D. The Contractor represents and warrants that the Copyrightable Materials: (i) are wholly original material not published elsewhere (except for material that is in the public domain); (ii) do not violate any copyright Law; (iii) do not constitute defamation or invasion of the right of privacy or publicity; and (iv) are not an infringement, of any kind, of the rights of any third party. To the extent that the Copyrightable Materials incorporate any non-original material, the Contractor has obtained all necessary permissions and clearances, in writing, for the use of such non-original material under this Agreement, copies of which shall be provided to the City upon execution of this Agreement.

E. If the services under this Agreement are supported by a federal grant of funds, the federal and State government reserves a royalty-free, non-exclusive irrevocable license to reproduce, publish, or otherwise use and to authorize others to use, for federal or State government purposes, the copyright in any Copyrightable Materials developed under this Agreement.

F. If the Contractor publishes a work dealing with any aspect of performance under this Agreement, or with the results of such performance, the City shall have a royalty-free, non-exclusive irrevocable license to reproduce, publish, or otherwise use such work for City governmental purposes.

Section 6.02 Patents and Inventions

The Contractor shall promptly and fully report to the Department any discovery or invention arising out of or developed in the course of performance of this Agreement. If the services under this Agreement are supported by a federal grant of funds, the Contractor shall promptly and fully report to the federal government for the federal government to make a determination as to whether patent protection on such invention shall be sought and how the rights in the invention or discovery, including rights under any patent issued thereon, shall be disposed of and administered in order to protect the public interest.

Section 6.03 Pre-existing Rights

In no case shall Sections 6.01 and 6.02 apply to, or prevent the Contractor from asserting or protecting its rights in any discovery, invention, report, document, data, photograph, deliverable, or other material in connection with or produced pursuant to this Agreement that existed prior to or was developed or discovered independently from the activities directly related to this Agreement.

Section 6.04 Antitrust

The Contractor hereby assigns, sells, and transfers to the City all right, title, and interest in and to any claims and causes of action arising under the antitrust laws of the State or of the United States relating to the particular goods or services procured by the City under this Agreement.

ARTICLE 7 - INSURANCE

Section 7.01 Agreement to Insure

The Contractor shall maintain the following types of insurance if and as indicated in Schedule A (with the minimum limits and special conditions specified in Schedule A) throughout the term of this Agreement, including any applicable guaranty period. All insurance shall meet the requirements set forth in this Article 7. Wherever this Article 7 requires that insurance coverage be "at least as broad" as a specified form (including all ISO forms), there is no obligation that the form itself be used, provided that the Contractor can demonstrate that the alternative form or endorsement contained in its policy provides coverage at least as broad as the specified form.

Section 7.02 Workers' Compensation, Disability Benefits, and Employers' Liability Insurance

A. The Contractor shall maintain workers' compensation insurance, employers' liability insurance, and disability benefits insurance, in accordance with Law on behalf of, or in regard to, all employees providing services under this Agreement

B. Within 10 Days of award of this Agreement or as otherwise specified by the Department, and as required by N.Y. Workers' Compensation Law §§ 57 and 220(8), the Contractor shall submit proof of Contractor's workers' compensation insurance and disability benefits insurance (or proof of a legal exemption) to the Department in a form acceptable to the New York State Workers' Compensation Board. ACORD forms are not acceptable proof of such insurance. The following forms are acceptable:

1. Form C-105.2, *Certificate of Workers' Compensation Insurance*;

2. Form U-26.3, *State Insurance Fund Certificate of Workers' Compensation Insurance*;

3. Form SI-12, *Certificate of Workers' Compensation Self-Insurance*;

4. Form GSI-105.2, *Certificate of Participation in Worker's Compensation Group Self-Insurance*;

5. Form DB-120.1, *Certificate of Disability Benefits Insurance*;

6. Form DB-155, *Certificate of Disability Benefits Self-Insurance*;

7. Form CE-200 – *Affidavit of Exemption*;

8. Other forms approved by the New York State Workers' Compensation Board; or

9. Other proof of insurance in a form acceptable to the City.

Section 7.03 Other Insurance

A. *Commercial General Liability Insurance.* The Contractor shall maintain commercial general liability insurance in the amounts specified in Schedule A covering operations under this Agreement. Coverage must be at least as broad as the coverage provided by the most recently issued ISO Form CG 00 01, primary and non-contributory, and "occurrence" based rather than "claims-made." Such coverage shall list the City, together with its officials and employees, and any other entity that may be listed on Schedule A as an additional insured with coverage at least as broad as the most recently issued ISO Form CG 20 10 or CG 20 26 and, if construction is performed as part of the services, ISO Form CG 20 37.

B. *Commercial Automobile Liability Insurance.* If indicated in Schedule A and/or if vehicles are used in the provision of services under this Agreement, the Contractor shall maintain commercial automobile liability insurance for liability arising out of ownership, maintenance or use of any owned, non-owned, or hired vehicles to be used in connection with this Agreement. Coverage shall be at least as broad as the most recently issued ISO Form CA 00 01. If vehicles are used for transporting hazardous materials, the commercial automobile liability insurance shall be endorsed to provide pollution liability broadened coverage for covered vehicles (endorsement CA 99 48) as well as proof of MCS-90.

C. Professional Liability Insurance.

1. If indicated in Schedule A, the Contractor shall maintain and submit evidence of professional liability insurance or errors and omissions insurance appropriate to the type(s) of such services to be provided under this Agreement. The policy or policies shall cover the liability assumed by the Contractor under this Agreement arising out of the negligent performance of professional services or caused by an error, omission, or negligent act of the Contractor or anyone employed by the Contractor.

2. All subcontractors of the Contractor providing professional services under this Agreement for which professional liability insurance or errors and omissions insurance is reasonably commercially available shall also maintain such insurance in the amount specified in Schedule A. At the time of the request for subcontractor approval, the Contractor shall provide to the Department, evidence of such professional liability insurance on a form acceptable to the Department.

3. Claims-made policies will be accepted for professional liability insurance. All such policies shall have an extended reporting period option or automatic coverage of not less than two years. If available as an option, the Contractor shall purchase extended reporting period coverage effective on cancellation or termination of such insurance unless a new policy is secured with a retroactive date, including at least the last policy year.

D. *Crime Insurance.* If indicated in Schedule A, the Contractor shall maintain crime insurance during the term of the Agreement in the minimum amounts listed in Schedule A. Such insurance shall include coverage, without limitation, for any and all acts of employee theft including employee theft of client property, forgery or alteration, inside the premises (theft of money and securities), inside the premises (robbery or safe burglary of other property), outside the premises, computer fraud, funds transfer fraud, and money orders and counterfeit money. The policy shall name the Contractor as named insured and shall list the City as loss payee as its interests may appear.

E. *Cyber Liability Insurance.* If indicated in Schedule A, the Contractor shall maintain cyber liability insurance covering losses arising from operations under this Agreement in the amounts listed in Schedule A. Contractor shall provide the City with certificates of insurance and specific policy terms/endorsements with respect to cyber liability insurance. If additional insured status is commercially available under the Contractor's cyber liability insurance, the insurance shall cover the City, together with its respective officials and employees, as additional insured.

F. *Other Insurance.* The Contractor shall provide such other types of insurance in the amounts specified in Schedule A.

Section 7.04 General Requirements for Insurance Coverage and Policies

A. Unless otherwise stated, all insurance required by Section 7.03 of this Agreement must:

1. be provided by companies that may lawfully issue such policies;

2. have an A.M. Best rating of at least A- / VII, a Standard & Poor's rating of at least A, a Moody's Investors Service rating of at least A3, a Fitch Ratings rating of at least A- or a similar rating by any other nationally recognized statistical rating organization acceptable to the New York City Law Department unless prior written approval is obtained from the New York City Law Department; and

3. be primary (and non-contributing) to any insurance or self-insurance maintained by the City (not applicable to professional liability insurance/errors and omissions insurance) and any other entity listed as an additional insured in Schedule A.

B. The Contractor shall be solely responsible for the payment of all premiums for all required insurance policies and all deductibles or self-insured retentions to which such policies are subject, whether or not the City is an insured under the policy.

C. The City and Contractor agree that with regard to any insurance required under Section 7.03, Contractor may utilize a self-insurance retention, exceeding $1,000,000.00. Any such self-insurance program shall provide the City and any other additional insured listed on Schedule A with all rights that would be provided by traditional insurance required under this Article 7, including but not limited to the defense obligations that insurers are required to undertake in liability policies. Contractor agrees to disclose all deductibles and self-insured retentions on its Certificates of Insurance (COIs) and agrees that the City is not responsible for self-insured retentions or deductibles.

D. The limits of coverage for all types of insurance for the City, including its officials and employees, and any other additional insured listed on Schedule A that must be provided to such additional insured(s) shall be the greater of (i) the minimum limits set forth in Schedule A or (ii) the limits provided to the Contractor as named insured under all primary, excess, and umbrella policies of that type of coverage.

Section 7.05 Proof of Insurance

A. For each policy required under Section 7.03 and Schedule A of this Agreement, the Contractor shall file proof of insurance and, where applicable, proof that the City, including its officials and employees, is an additional insured with the Department within ten Days of award of this Agreement. The following proof is acceptable:

1. A certificate of insurance accompanied by a completed certification of insurance broker or agent (included in Schedule A of this Agreement) and any endorsements by which the City, including its officials and employees, have been made an additional insured; or

2. A copy of the insurance policy, including declarations and endorsements, certified by an authorized representative of the issuing insurance carrier.

B. Proof of insurance confirming renewals of insurance required under Section 7.03 must be submitted to the Department prior to the expiration date of the coverage. Such proof must meet the requirements of Section 7.05(A).

C. The Contractor shall provide the City with a copy of any policy required under this Article 7 in the event of a claim against the City or its officials or employees that the City believes should be covered under such policy for which both (i) the insurer has not provided the City or its officials or employees with a defense thereunder and (ii) the Contractor has failed to provide a defense and failed to indemnify the City or its officials or employees.

D. Acceptance by the Commissioner of a certificate or a policy does not excuse the Contractor from maintaining policies consistent with all provisions of this Article 7 (and ensuring that subcontractors maintain such policies) or from any liability arising from its failure to do so.

E. If the Contractor receives notice, from an insurance company or other person, that any insurance policy required under this Article 7 shall expire or be cancelled or terminated for

any reason, the Contractor shall immediately forward a copy of such notice to both the address referred to in Section 14.04 and Schedule A and to the New York City Comptroller, Attn: Office

of Contract Administration, Municipal Building, One Centre Street, Room 1005, New York, New York 10007.

Section 7.06 Miscellaneous

A. Whenever notice of loss, damage, occurrence, accident, claim, or suit related to Contractor's performance under this Agreement is required under a policy required by Section 7.03 and Schedule A, the Contractor shall provide the insurer with timely notice thereof on behalf of the City. Such notice shall be given even where the Contractor may not be covered under such policy if this Agreement requires that the City be an additional insured (for example, where one of Contractor's employees was injured). Such notice shall expressly specify that "this notice is being given on behalf of the City of New York, including its officials and employees, as additional insured" (such notice shall also include the name of any other entity listed as an additional insured on Schedule A) and contain the following information to the extent known: the number of the insurance policy; the name of the named insured; the date and location of the damage, occurrence, or accident; the identity of the persons or things injured, damaged, or lost; and the title of the claim or suit, if applicable. The Contractor shall simultaneously send a copy of such notice to the City of New York c/o Insurance Claims Specialist, Affirmative Litigation Division, New York City Law Department, 100 Church Street, New York, New York 10007. If the Contractor fails to comply with the requirements of this paragraph, the Contractor shall indemnify the City, together with its officials and employees, and any other entity listed as an additional insured on Schedule A for all losses, judgments, settlements and expenses, including reasonable attorneys' fees, arising from an insurer's disclaimer of coverage citing late notice by or on behalf of the City together with its officials and employees, and any other entity listed as an additional insured on Schedule A.

B. The Contractor's failure to maintain any of the insurance required by this Article 7 and Schedule A shall constitute a material breach of this Agreement. Such breach shall not be waived or otherwise excused by any action or inaction by the City at any time.

C. Insurance coverage in the minimum amounts required in this Article 7 shall not relieve the Contractor or its subcontractors of any liability under this Agreement, nor shall it preclude the City from exercising any rights or taking such other actions as are available to it under any other provisions of this Agreement or Law.

D. With respect to insurance required by Section 7.03 and Schedule A (but not including professional liability/errors and omissions insurance), the Contractor waives all rights against the City, including its officials and employees, and any other entity listed as an additional insured on Schedule A for any damages or losses that are covered under any insurance required under this Article 7 (whether or not such insurance is actually procured or claims are paid thereunder) or any other insurance applicable to the operations of the Contractor and/or its subcontractors in the performance of this Agreement.

E. In the event the Contractor requires any subcontractor to maintain insurance with regard to any operations under this Agreement and requires such subcontractor to list the Contractor as an additional insured under such insurance, the Contractor shall ensure that such entity also list the City, including its officials and employees, and any other entity listed as an additional

insured on Schedule A as an additional insured. With respect to commercial general liability insurance, such coverage must be at least as broad as the most recently issued ISO form CG 20 26.

ARTICLE 8 - PROTECTION OF PERSONS AND PROPERTY AND INDEMNIFICATION

Section 8.01 Reasonable Precautions

The Contractor shall take all reasonable precautions to protect all persons and the property of the City and of others from injury, damage, or loss resulting from the Contractor's and/or its subcontractors' operations under this Agreement.

Section 8.02 Protection of City Property

The Contractor assumes the risk of, and shall be responsible for, any loss or damage to City property, including property and equipment leased by the City, used in the performance of this Agreement, where such loss or damage is caused by negligence, any tortious act, or failure to comply with the provisions of this Agreement or of Law by the Contractor, its officers, employees, agents or subcontractors.

Section 8.03 Indemnification

To the fullest extent permitted by Law, the Contractor shall defend, indemnify, and hold harmless the City, including its officials and employees, against any and all claims (even if the allegations of the claim are without merit), judgments for damages on account of any injuries or death to any person or damage to any property, and costs and expenses to which the City or its officials or employees, may be subject to or which they may suffer or incur allegedly arising out of any of the operations of the Contractor and/or its subcontractors under this Agreement to the extent resulting from any negligent act of commission or omission, any intentional tortious act, and/or the failure to comply with Law or any of the requirements of this Agreement. Insofar as the facts or Law relating to any of the foregoing would preclude the City or its officials or employees from being completely indemnified by the Contractor, the City and its officials and employees shall be partially indemnified by the Contractor to the fullest extent permitted by Law.

Section 8.04 Infringement Indemnification

To the fullest extent permitted by Law, the Contractor shall defend, indemnify, and hold harmless the City, including its officials and employees, against any and all claims (even if the allegations of the claim are without merit), judgments for damages, and costs and expenses to which the City or its officials or employees, may be subject to or which they may suffer or incur allegedly arising out of any infringement, violation, or unauthorized use of any copyright, trade

secret, trademark or patent or any other property or personal right of any third party by the Contractor and/or its employees, agents, or subcontractors in the performance of this Agreement. To the fullest extent permitted by Law, the Contractor shall defend, indemnify, and hold harmless the City and its officials and employees regardless of whether or not the alleged infringement, violation, or unauthorized use arises out of compliance with the Agreement's scope of services/scope of work. Insofar as the facts or Law relating to any of the foregoing would preclude the City and its officials and employees from being completely indemnified by the Contractor, the City and its officials and employees shall be partially indemnified by the Contractor to the fullest extent permitted by Law.

Section 8.05 Indemnification Obligations Not Limited By Insurance Obligation

The Contractor's obligation to indemnify, defend and hold harmless the City and its officials and employees shall neither be (i) limited in any way by the Contractor's obligations to obtain and maintain insurance under this Agreement, nor (ii) adversely affected by any failure on the part of the City or its officials or employees to avail themselves of the benefits of such insurance.

Section 8.06 Actions By or Against Third Parties

A. If any claim is made or any action brought in any way relating to this Agreement other than an action between the City and the Contractor, the Contractor shall diligently render to the City without additional compensation all assistance that the City may reasonably require of the Contractor.

B. The Contractor shall report to the Department in writing within five business days of the initiation by or against the Contractor of any legal action or proceeding relating to this Agreement.

Section 8.07 Withholding of Payments

A. If any claim is made or any action is brought against the City for which the Contractor may be required to indemnify the City pursuant to this Agreement, the City shall have the right to withhold further payments under this Agreement for the purpose of set-off in sufficient sums to cover the said claim or action.

B. If any City property is lost or damaged as set forth in Section 8.02, except for normal wear and tear, the City shall have the right to withhold payments under this Agreement for the purpose of set-off in sufficient sums to cover such loss or damage.

C. The City shall not, however, impose a set-off in the event that an insurance company that provided insurance pursuant to Section 7.03 above has accepted the City's tender of the claim or action without a reservation of rights.

D. The Department may, at its option, withhold for purposes of set-off any monies due to the Contractor under this Agreement up to the amount of any disallowances or questioned costs resulting from any audits of the Contractor or to the amount of any overpayment to the Contractor with regard to this Agreement.

E. The rights and remedies of the City provided for in this Section 8.07 are not exclusive and are in addition to any other rights and remedies provided by Law or this Agreement.

Section 8.08 No Third Party Rights

The provisions of this Agreement shall not be deemed to create any right of action in favor of third parties against the Contractor or the City or their respective officials and employees.

ARTICLE 9 - CONTRACT CHANGES

Section 9.01 Contract Changes

Changes to this Agreement may be made only as duly authorized by the ACCO or his or her designee and in accordance with the PPB Rules. Any amendment or change to this Agreement shall not be valid unless made in writing and signed by authorized representatives of both parties. The Contractor deviates from the requirements of this Agreement without a duly approved and executed change order document or written contract modification or amendment at its own risk.

Section 9.02 Changes Through Fault of Contractor

If any change is required in the data, documents, deliverables, or other services to be provided under this Agreement because of negligence or error of the Contractor, no additional compensation shall be paid to the Contractor for making such change, and the Contractor is obligated to make such change without additional compensation.

ARTICLE 10 - TERMINATION, DEFAULT, REDUCTIONS IN FUNDING, AND LIQUIDATED DAMAGES

Section 10.01 Termination by the City Without Cause

A. The City shall have the right to terminate this Agreement, in whole or in part, without cause, in accordance with the provisions of Section 10.05.

B. In its sole discretion, the City shall have the right to terminate this Agreement, in whole or in part, upon the request of the Contractor to withdraw from the Contract, in accordance with the provisions of Section 10.05.

C. If the City terminates this Agreement pursuant to this Section 10.01, the following provisions apply. The City shall not incur or pay any further obligation pursuant to this Agreement beyond the termination date set by the City pursuant to Section 10.05. The City shall pay for services provided in accordance with this Agreement prior to the termination date. In addition, any obligation necessarily incurred by the Contractor on account of this Agreement prior to receipt of notice of termination and falling due after the termination date shall be paid by the City in accordance with the terms of this Agreement. In no event shall such obligation be construed as including any lease or other occupancy agreement, oral or written, entered into between the Contractor and its landlord.

Section 10.02 Reductions in Federal, State, and/or City Funding

A. This Agreement is funded in whole or in part by funds secured from the federal, State and/or City governments. Should there be a reduction or discontinuance of such funds by action of the federal, State and/or City governments, the City shall have, in its sole discretion, the right to terminate this Agreement in whole or in part, or to reduce the funding and/or level of services of this Agreement caused by such action by the federal, State and/or City governments, including, in the case of the reduction option, but not limited to, the reduction or elimination of programs, services or service components; the reduction or elimination of contract-reimbursable staff or staff-hours, and corresponding reductions in the budget of this Agreement and in the total amount payable under this Agreement. Any reduction in funds pursuant to this Section 10.02(A) shall be accompanied by an appropriate reduction in the services performed under this Agreement, subject to applicable law and CMS requirements.

B. In the case of the reduction option referred to in Section 10.02(A), above, any such reduction shall be effective as of the date set forth in a written notice thereof to the Contractor, which shall be not less than 30 Days from the date of such notice. Prior to sending such notice of reduction, the Department shall advise the Contractor that such option is being exercised and afford the Contractor an opportunity to make within seven Days any suggestion(s) it may have as to which program(s), service(s), service component(s), staff or staff-hours might be reduced or eliminated, provided, however, that the Department shall not be bound to utilize any of the Contractor's suggestions and that the Department shall have sole discretion as to how to effectuate the reductions.

C. If the City reduces funding pursuant to this Section 10.02, the following provisions apply. The City shall pay for services provided in accordance with this Agreement prior to the reduction date. In addition, any obligation necessarily incurred by the Contractor on account of this Agreement prior to receipt of notice of reduction and falling due after the reduction date shall be paid by the City in accordance with the terms of this Agreement. In no event shall such obligation be construed as including any lease or other occupancy agreement, oral or written, entered into between the Contractor and its landlord.

D. To the extent that the reduction in public funds is a result of the State determining that the Contractor may receive medical assistance funds pursuant to title eleven of article five of the Social Services Law to fund the services contained within the scope of a program under this Agreement,

then the notice and effective date provisions of this Section 10.02 shall not apply, and the Department may reduce such public funds authorized under this Agreement by informing the Contractor of the amount of the reduction and revising attachments to this Agreement as appropriate.

Section 10.03 Contractor Default

A. The City shall have the right to declare the Contractor in default:

1. Upon a breach by the Contractor of a material term or condition of this Agreement, including unsatisfactory performance of the services;

2. Upon insolvency or the commencement of any proceeding by or against the Contractor, either voluntarily or involuntarily, under the Bankruptcy Code or relating to the insolvency, receivership, liquidation, or composition of the Contractor for the benefit of creditors;

3. If the Contractor refuses or fails to proceed with the services under the Agreement when and as directed by the Commissioner;

4. If the Contractor or any of its officers, directors, partners, five percent or greater shareholders, principals, or other employee or person substantially involved in its activities are indicted or convicted after execution of the Agreement under any state or federal law of any of the following:

a. a criminal offense incident to obtaining or attempting to obtain or performing a public or private contract;

b. fraud, embezzlement, theft, bribery, forgery, falsification, or destruction of records, or receiving stolen property;

c. a criminal violation of any state or federal antitrust law;

d. violation of the Racketeer Influence and Corrupt Organization Act, 18 U.S.C. §§ 1961 *et seq*., or the Mail Fraud Act, 18 U.S.C. §§ 1341 *et seq*., for acts in connection with the submission of bids or proposals for a public or private contract;

e. conspiracy to commit any act or omission that would constitute grounds for conviction or liability under any statute described in subparagraph (d) above; or

f. an offense indicating a lack of business integrity that seriously and directly affects responsibility as a City vendor.

5. If the Contractor or any of its officers, directors, partners, five percent or greater shareholders, principals, or other employee or person substantially involved in its activities are subject to a judgment of civil liability under any state or federal antitrust law for acts or omissions in connection with the submission of bids or proposals for a public or private contract; or

6. If the Contractor or any of its officers, directors, partners, five percent or greater shareholders, principals, or other employee or person substantially involved in its activities makes or causes to be made any false, deceptive, or fraudulent material statement, or fail to make a required material statement in any bid, proposal, or application for City or other government work.

B. The right to declare the Contractor in default shall be exercised by sending the Contractor a written notice of the conditions of default, signed by the Commissioner, setting forth the ground or grounds upon which such default is declared ("Notice to Cure"). The Contractor shall have ten Days from receipt of the Notice to Cure or any longer period that is set forth in the Notice to Cure to cure the default. The Commissioner may temporarily suspend services under the Agreement pending the outcome of the default proceedings pursuant to this Section 10.03.

C. If the conditions set forth in the Notice to Cure are not cured within the period set forth in the Notice to Cure, the Commissioner may declare the Contractor in default pursuant to this Section 10.03. Before the Commissioner may exercise his or her right to declare the Contractor in default, the Commissioner shall give the Contractor an opportunity to be heard upon not less than five business days' notice. The Commissioner may, in his or her discretion, provide for such opportunity to be in writing or in person. Such opportunity to be heard shall not occur prior to the end of the cure period but notice of such opportunity to be heard may be given prior to the end of the cure period and may be given contemporaneously with the Notice to Cure.

D. After the opportunity to be heard, the Commissioner may terminate the Agreement, in whole or in part, upon finding the Contractor in default pursuant to this Section 10.03, in accordance with the provisions of Section 10.05.

E. The Commissioner, after declaring the Contractor in default, may have the services under the Agreement completed by such means and in such manner, by contract with or without public letting, or otherwise, as he or she may deem advisable in accordance with applicable PPB Rules. After such completion, the Commissioner shall certify the expense incurred in such completion, which shall include the cost of re-letting. Should the expense of such completion, as certified by the Commissioner, exceed the total sum which would have been payable under the Agreement if it had been completed by the Contractor, any excess shall be promptly paid by the Contractor upon demand by the City. The excess expense of such completion, including any and all related and incidental costs, as so certified by the Commissioner, and any liquidated damages assessed against the Contractor, may be charged against and deducted out of monies earned by the Contractor.

Section 10.04 Force Majeure

A. For purposes of this Agreement, a force majeure event is an act or event beyond the control and without any fault or negligence of the Contractor ("Force Majeure Event"). Such events may include, but are not limited to, fire, flood, earthquake, storm or other natural disaster, civil commotion, war, terrorism, riot, and labor disputes not brought about by any act or omission of the Contractor.

B. In the event the Contractor cannot comply with the terms of the Agreement (including any failure by the Contractor to make progress in the performance of the services) because of a Force Majeure Event, then the Contractor may ask the Commissioner to excuse the nonperformance and/or terminate the Agreement. If the Commissioner, in his or her reasonable discretion, determines that the Contractor cannot comply with the terms of the Agreement because of a Force Majeure Event, then the Commissioner shall excuse the nonperformance and may terminate the Agreement. Such a termination shall be deemed to be without cause.

F. If the City terminates the Agreement pursuant to this Section 10.04, the following provisions apply. The City shall not incur or pay any further obligation pursuant to this Agreement beyond the termination date. The City shall pay for services provided in accordance with this Agreement prior to the termination date. Any obligation necessarily incurred by the Contractor on account of this Agreement prior to receipt of notice of termination and falling due after the termination date shall be paid by the City in accordance with the terms of this Agreement. In no event shall such obligation be construed as including any lease or other occupancy agreement, oral or written, entered into between the Contractor and its landlord.

Section 10.05 Procedures for Termination

A. The Department and/or the City shall give the Contractor written notice of any termination of this Agreement. Such notice shall specify the applicable provision(s) under which the Agreement is terminated and the effective date of the termination. Except as otherwise provided in this Agreement, the notice shall comply with the provisions of this Section 10.05 and Section 14.04. For termination without cause, the effective date of the termination shall not be less than thirty Days from the date the notice is personally delivered, or from the date the notice is either sent by certified mail, return receipt requested, delivered by overnight or same day courier service in a properly addressed envelope with confirmation, or sent by email and, unless the receipt of the email is acknowledged by the recipient by email, deposited in a post office box regularly maintained by the United States Postal Service in a properly addressed postage pre-paid envelope. In the case of termination for default, the effective date of the termination shall be as set forth above for a termination without cause or such earlier date as the Commissioner may determine. If the City terminates the Agreement in part, the Contractor shall continue the performance of the Agreement to the extent not terminated, subject to CMS requirements and applicable law.

B. Upon termination or expiration of this Agreement, the Contractor shall comply with the City close-out procedures, including but not limited to:

1. Accounting for and refunding to the Department, within 45 Days, any unexpended funds which have been advanced to the Contractor pursuant to this Agreement;

2. Furnishing within 45 Days an inventory to the Department of all equipment, appurtenances and property purchased through or provided under this Agreement and carrying out any Department or City directive concerning the disposition of such equipment, appurtenances and property;

3. Turning over to the Department or its designees all books, records, documents and material specifically relating to this Agreement that the Department has requested be turned over, subject to the requirements and limitations of HIPAA;

4. Submitting to the Department, within 90 Days, a final statement and report relating to the Agreement. The report shall be made by a certified public accountant or a licensed public accountant, unless the Department waives, in writing, the requirement that a certified public accountant or licensed public accountant make such report; and

5. Providing reasonable assistance to the Department in the transition, if any, to a new contractor.

Section 10.06 Miscellaneous Provisions

A. The Commissioner, in addition to any other powers set forth in this Agreement or by operation of Law, may suspend, in whole or in part, any part of the services to be provided under this Agreement whenever in his or her judgment such suspension is required in the best interest of the City. If the Commissioner suspends this Agreement pursuant to this Section 10.06, the City shall not incur or pay any further obligation pursuant to this Agreement beyond the suspension date until such suspension is lifted. The City shall pay for services provided in accordance with this Agreement prior to the suspension date. In addition, any obligation necessarily incurred by the Contractor on account of this Agreement prior to receipt of notice of suspension and falling due during the suspension period shall be paid by the City in accordance with the terms of this Agreement.

B. Notwithstanding any other provisions of this Agreement, the Contractor shall not be relieved of liability to the City for damages sustained by the City by virtue of the Contractor's breach of the Agreement, and the City may withhold payments to the Contractor for the purpose of set-off in the amount of damages due to the City from the Contractor.

C. The rights and remedies of the City provided in this Article 10 shall not be exclusive and are in addition to all other rights and remedies provided by Law or under this Agreement.

Section 10.07 Liquidated Damages

If Schedule A or any other part of this Agreement includes liquidated damages for failure to comply with a provision of this Agreement, the sum indicated is fixed and agreed as the liquidated damages that the City will suffer by reason of such noncompliance and not as a penalty.

ARTICLE 11 - PROMPT PAYMENT AND ELECTRONIC FUNDS TRANSFER

Section 11.01 Prompt Payment

A. The prompt payment provisions of PPB Rule § 4-06 are applicable to payments made under this Agreement. With some exceptions, the provisions generally require the payment to the Contractor of interest on payments made after the required payment date, as set forth in the PPB Rules.

B. The Contractor shall submit a proper invoice to receive payment, except where the Agreement provides that the Contractor will be paid at predetermined intervals without having to submit an invoice for each scheduled payment.

C. Determination of interest due will be made in accordance with the PPB Rules and the applicable rate of interest shall be the rate in effect at the time of payment.

Section 11.02 Electronic Funds Transfer

A. In accordance with Admin. Code § 6-107.1, the Contractor agrees to accept payments under this Agreement from the City by electronic funds transfer. An electronic funds transfer is any transfer of funds, other than a transaction originated by check, draft, or similar paper instrument, which is initiated through an electronic terminal, telephonic instrument or computer or magnetic tape so as to order, instruct, or authorize a financial institution to debit or credit an account. Prior to the first payment made under this Agreement, the Contractor shall designate one financial institution or other authorized payment agent and shall complete the "EFT Vendor Payment Enrollment Form" available from the Agency or at http://www.nyc.gov/dof in order to provide the commissioner of the Department of Finance with information necessary for the Contractor to receive electronic funds transfer payments through the designated financial institution or authorized payment agent. The crediting of the amount of a payment to the appropriate account on the books of a financial institution or other authorized payment agent designated by the Contractor shall constitute full satisfaction by the City for the amount of the payment under this Agreement. The account information supplied by the Contractor to facilitate the electronic funds transfer shall remain confidential to the fullest extent provided by Law.

B. The Agency Head may waive the application of the requirements of this Section 11.02 to payments on contracts entered into pursuant to Charter § 315. In addition, the

commissioner of the Department of Finance and the Comptroller may jointly issue standards pursuant to which the Department may waive the requirements of this Section 11.02 for payments in the following circumstances: (i) for individuals or classes of individuals for whom compliance imposes a hardship; (ii) for classifications or types of checks; or (iii) in other circumstances as may be necessary in the best interest of the City.

C. This Section 11.02 is applicable to contracts valued at $25,000.00 and above.

ARTICLE 12 - CLAIMS

Section 12.01 Choice of Law

This Agreement shall be deemed to be executed in the City and State of New York, regardless of the domicile of the Contractor, and shall be governed by and construed in accordance with the Laws of the State of New York (notwithstanding New York choice of law or conflict of law principles) and the Laws of the United States, where applicable.

Section 12.02 Jurisdiction and Venue

Subject to Section 12.03, the parties agree that any and all claims asserted by or against the City arising under or related to this Agreement shall solely be heard and determined either in the courts of the United States located in the City or in the courts of the State located in the City and County of New York. The parties shall consent to the dismissal and/or transfer of any claims asserted in any other venue or forum to the proper venue or forum. If the Contractor initiates any action in breach of this Section 12.02, the Contractor shall be responsible for and shall promptly reimburse the City for any attorneys' fees incurred by the City in removing the action to a proper court consistent with this Section 12.02.

Section 12.03 Resolution of Disputes

A. Except as provided in Subparagraphs (A)(1) and (A)(2) below, all disputes between the City and the Contractor that arise under, or by virtue of, this Agreement shall be finally resolved in accordance with the provisions of this Section 12.03 and PPB Rule § 4-09. This procedure shall be the exclusive means of resolving any such disputes.

1. This Section 12.03 shall not apply to disputes concerning matters dealt with in other sections of the PPB Rules or to disputes involving patents, copyrights, trademarks, or trade secrets (as interpreted by the courts of New York State) relating to proprietary rights in computer software, or to termination other than for cause.

2. For construction and construction-related services this Section 12.03 shall apply only to disputes about the scope of work delineated by the Agreement, the interpretation of Agreement documents, the amount to be paid for extra work or disputed work performed in connection with the Agreement, the conformity of the Contractor's

work to the Agreement, and the acceptability and quality of the Contractor's work; such disputes arise when the City Engineer, City Resident Engineer, City Engineering Audit Officer, or other designee of the Agency Head makes a determination with which the Contractor disagrees. For construction, this Section 12.03 shall not apply to termination of the Agreement for cause or other than for cause.

B. All determinations required by this Section 12.03 shall be clearly stated, with a reasoned explanation for the determination based on the information and evidence presented to the party making the determination. Failure to make such determination within the time required by this Section 12.03 shall be deemed a non-determination without prejudice that will allow application to the next level.

C. During such time as any dispute is being presented, heard, and considered pursuant to this Section 12.03, the Agreement terms shall remain in full force and effect and, unless otherwise directed by the ACCO or Engineer, the Contractor shall continue to perform work in accordance with the Agreement and as directed by the ACCO or City Engineer, City Resident Engineer, City Engineering Audit Officer, or other designee of the Agency Head. Failure of the Contractor to continue the work as directed shall constitute a waiver by the Contractor of any and all claims being presented pursuant to this Section 12.03 and a material breach of contract.

D. Presentation of Dispute to Agency Head.

1. Notice of Dispute and Agency Response. The Contractor shall present its dispute in writing ("Notice of Dispute") to the Agency Head within the time specified herein, or, if no time is specified, within 30 Days of receiving written notice of the determination or action that is the subject of the dispute. This notice requirement shall not be read to replace any other notice requirements contained in the Agreement. The Notice of Dispute shall include all the facts, evidence, documents, or other basis upon which the Contractor relies in support of its position, as well as a detailed computation demonstrating how any amount of money claimed by the Contractor in the dispute was arrived at. Within 30 Days after receipt of the complete Notice of Dispute, the ACCO or, in the case of construction or construction-related services, the City Engineer, City Resident Engineer, City Engineering Audit Officer, or other designee of the Agency Head, shall submit to the Agency Head all materials he or she deems pertinent to the dispute. Following initial submissions to the Agency Head, either party may demand of the other the production of any document or other material the demanding party believes may be relevant to the dispute. The requested party shall produce all relevant materials that are not otherwise protected by a legal privilege recognized by the courts of New York State. Any question of relevancy shall be determined by the Agency Head whose decision shall be final. Willful failure of the Contractor to produce any requested material whose relevancy the Contractor has not disputed, or whose relevancy has been affirmatively determined, shall constitute a waiver by the Contractor of its claim.

2. Agency Head Inquiry. The Agency Head shall examine the material and may, in his or her discretion, convene an informal conference with the Contractor and the ACCO and, in the case of construction or construction-related services, the City Engineer, City Resident Engineer, City Engineering Audit Officer, or other designee of the Agency Head, to resolve the issue by mutual consent prior to reaching a determination. The Agency Head may seek such technical or other expertise as he or she shall deem appropriate, including the use of neutral mediators, and require any such additional material from either or both parties as he or she deems fit. The Agency Head's ability to render, and the effect of, a decision hereunder shall not be impaired by any negotiations in connection with the dispute presented, whether or not the Agency Head participated therein. The Agency Head may or, at the request of any party to the dispute, shall compel the participation of any other contractor with a contract related to the work of this Agreement and that contractor shall be bound by the decision of the Agency Head. Any contractor thus brought into the dispute resolution proceeding shall have the same rights and obligations under this Section 12.03 as the Contractor initiating the dispute.

3. Agency Head Determination. Within 30 Days after the receipt of all materials and information, or such longer time as may be agreed to by the parties, the Agency Head shall make his or her determination and shall deliver or send a copy of such determination to the Contractor and ACCO and, in the case of construction or construction-related services, the City Engineer, City Resident Engineer, City Engineering Audit Officer, or other designee of the Agency Head, together with a statement concerning how the decision may be appealed.

4. Finality of Agency Head Decision. The Agency Head's decision shall be final and binding on all parties, unless presented to the Contract Dispute Resolution Board ("CDRB") pursuant to this Section 12.03. The City may not take a petition to the CDRB. However, should the Contractor take such a petition, the City may seek, and the CDRB may render, a determination less favorable to the Contractor and more favorable to the City than the decision of the Agency Head.

E. Presentation of Dispute to the Comptroller. Before any dispute may be brought by the Contractor to the CDRB, the Contractor must first present its claim to the Comptroller for his or her review, investigation, and possible adjustment.

1. Time, Form, and Content of Notice. Within 30 Days of receipt of a decision by the Agency Head, the Contractor shall submit to the Comptroller and to the Agency Head a Notice of Claim regarding its dispute with the Agency. The Notice of Claim shall consist of (i) a brief statement of the substance of the dispute, the amount of money, if any, claimed and the reason(s) the Contractor contends the dispute was wrongly decided by the Agency Head; (ii) a copy of the decision of the Agency Head; and (iii) a copy of all materials submitted by the Contractor to the Agency, including the Notice of Dispute. The Contractor may not present to the Comptroller any material not presented to the Agency Head, except at the request of the Comptroller.

2. Agency Response. Within 30 Days of receipt of the Notice of Claim, the Agency shall make available to the Comptroller a copy of all material submitted by the Agency to the Agency Head in connection with the dispute. The Agency may not present to the Comptroller any material not presented to the Agency Head, except at the request of the Comptroller.

3. Comptroller Investigation. The Comptroller may investigate the claim in dispute and, in the course of such investigation, may exercise all powers provided in Admin. Code §§ 7-201 and 7-203. In addition, the Comptroller may demand of either party, and such party shall provide, whatever additional material the Comptroller deems pertinent to the claim, including original business records of the Contractor. Willful failure of the Contractor to produce within 15 Days any material requested by the Comptroller shall constitute a waiver by the Contractor of its claim. The Comptroller may also schedule an informal conference to be attended by the Contractor, Agency representatives, and any other personnel desired by the Comptroller.

4. Opportunity of Comptroller to Compromise or Adjust Claim. The Comptroller shall have 45 Days from his or her receipt of all materials referred to in Paragraph (E)(3) above to investigate the disputed claim. The period for investigation and compromise may be further extended by agreement between the Contractor and the Comptroller, to a maximum of 90 Days from the Comptroller's receipt of all the materials. The Contractor may not present its petition to the CDRB until the period for investigation and compromise delineated in this Paragraph has expired. In compromising or adjusting any claim hereunder, the Comptroller may not revise or disregard the terms of the Agreement.

F. Contract Dispute Resolution Board. There shall be a Contract Dispute Resolution Board composed of:

1. the chief administrative law judge of the Office of Administrative Trials and Hearings ("OATH") or his or her designated OATH administrative law judge, who shall act as chairperson, and may adopt operational procedures and issue such orders consistent with this Section 12.03 as may be necessary in the execution of the CDRB's functions, including, but not limited to, granting extensions of time to present or respond to submissions;

2. the City Chief Procurement Officer ("CCPO") or his or her designee; any designee shall have the requisite background to consider and resolve the merits of the dispute and shall not have participated personally and substantially in the particular matter that is the subject of the dispute or report to anyone who so participated; and

3. a person with appropriate expertise who is not an employee of the City. This person shall be selected by the presiding administrative law judge from a prequalified panel of individuals, established, and administered by OATH, with appropriate background to act as decision-makers in a dispute. Such individuals may not

have a contract or dispute with the City or be an officer or employee of any company or organization that does, or regularly represent persons, companies, or organizations having disputes with the City.

G. Petition to CDRB. In the event the claim has not been settled or adjusted by the Comptroller within the period provided in this Section 12.03, the Contractor, within thirty (30) Days thereafter, may petition the CDRB to review the Agency Head determination.

1. Form and Content of Petition by the Contractor. The Contractor shall present its dispute to the CDRB in the form of a petition, which shall include (i) a brief statement of the substance of the dispute, the amount of money, if any, claimed, and the reason(s) the Contractor contends that the dispute was wrongly decided by the Agency Head; (ii) a copy of the decision of the Agency Head; (iii) copies of all materials submitted by the Contractor to the Agency; (iv) a copy of the decision of the Comptroller, if any, and (v) copies of all correspondence with, and material submitted by the Contractor to, the Comptroller's Office. The Contractor shall concurrently submit four complete sets of the petition: one to the Corporation Counsel (Attn: Commercial and Real Estate Litigation Division), and three to the CDRB at OATH's offices, with proof of service on the Corporation Counsel. In addition, the Contractor shall submit a copy of the statement of the substance of the dispute, cited in (i) above, to both the Agency Head and the Comptroller.

2. Agency Response. Within 30 Days of receipt of the petition by the Corporation Counsel, the Agency shall respond to the statement of the Contractor and make available to the CDRB all material it submitted to the Agency Head and Comptroller. Three complete copies of the Agency response shall be submitted to the CDRB at OATH's offices and one to the Contractor. Extensions of time for submittal of the Agency response shall be given as necessary upon a showing of good cause or, upon the consent of the parties, for an initial period of up to 30 Days.

3. Further Proceedings. The CDRB shall permit the Contractor to present its case by submission of memoranda, briefs, and oral argument. The CDRB shall also permit the Agency to present its case in response to the Contractor by submission of memoranda, briefs, and oral argument. If requested by the Corporation Counsel, the Comptroller shall provide reasonable assistance in the preparation of the Agency's case. Neither the Contractor nor the Agency may support its case with any documentation or other material that was not considered by the Comptroller, unless requested by the CDRB. The CDRB, in its discretion, may seek such technical or other expert advice as it shall deem appropriate and may seek, on it own or upon application of a party, any such additional material from any party as it deems fit. The CDRB, in its discretion, may combine more than one dispute between the parties for concurrent resolution.

4. CDRB Determination. Within 45 Days of the conclusion of all submissions and oral arguments, the CDRB shall render a decision resolving the dispute. In an unusually complex case, the CDRB may render its decision in a longer period of

time, not to exceed 90 Days, and shall so advise the parties at the commencement of this period. The CDRB's decision must be consistent with the terms of this Agreement. Decisions of the CDRB shall only resolve matters before the CDRB and shall not have precedential effect with respect to matters not before the CDRB.

5. Notification of CDRB Decision. The CDRB shall send a copy of its decision to the Contractor, the ACCO, the Corporation Counsel, the Comptroller, the CCPO, and, in the case of construction or construction-related services, the City Engineer, City Resident Engineer, City Engineering Audit Officer, or other designee of the Agency Head. A decision in favor of the Contractor shall be subject to the prompt payment provisions of the PPB Rules. The required payment date shall be 30 Days after the date the parties are formally notified of the CDRB's decision.

6. Finality of CDRB Decision. The CDRB's decision shall be final and binding on all parties. Any party may seek review of the CDRB's decision solely in the form of a challenge, filed within four months of the date of the CDRB's decision, in a court of competent jurisdiction of the State of New York, County of New York pursuant to Article 78 of the Civil Practice Law and Rules. Such review by the court shall be limited to the question of whether or not the CDRB's decision was made in violation of lawful procedure, was affected by an error of Law, or was arbitrary and capricious or an abuse of discretion. No evidence or information shall be introduced or relied upon in such proceeding that was not presented to the CDRB in accordance with PPB Rules § 4-09.

H. Any termination, cancellation, or alleged breach of the Agreement prior to or during the pendency of any proceedings pursuant to this Section 12.03 shall not affect or impair the ability of the Agency Head or CDRB to make a binding and final decision pursuant to this Section 12.03.

Section 12.04 Claims and Actions

A. Any claim, that is not subject to dispute resolution under the PPB Rules or this Agreement, against the City for damages for breach of contract shall not be made or asserted in any action, unless the Contractor shall have strictly complied with all requirements relating to the giving of notice and of information with respect to such claims, as provided in this Agreement.

B. No action shall be instituted or maintained on any such claims unless such action shall be commenced within six months after the final payment under this Agreement, or within six months of the termination or expiration of this Agreement, or within six months after the accrual of the cause of action, whichever first occurs.

Section 12.05 No Claim Against Officials, Agents, or Employees

No claim shall be made by the Contractor against any official, agent, or employee of the City in their personal capacity for, or on account of, anything done or omitted in connection with this Agreement.

Section 12.06 General Release

The acceptance by the Contractor or its assignees of the final payment under this Agreement, whether by check, wire transfer, or other means, and whether pursuant to invoice, voucher, judgment of any court of competent jurisdiction or any other administrative means, shall constitute and operate as a release of the City from any and all claims of and liability to the Contractor, of which the Contractor was aware or should reasonably have been aware, arising out of the performance of this Agreement based on actions of the City prior to such acceptance of final payment, excepting any disputes that are the subject of pending dispute resolution procedures.

Section 12.07 No Waiver

Waiver by either the Department or the Contractor of a breach of any provision of this Agreement shall not be deemed to be a waiver of any other or subsequent breach and shall not be construed to be a modification of the terms of the Agreement unless and until the same shall be agreed to in writing by the parties as set forth in Section 9.01.

ARTICLE 13 - APPLICABLE LAWS

Section 13.01 PPB Rules

This Agreement is subject to the PPB Rules. If there is a conflict between the PPB Rules and a provision of this Agreement, the PPB Rules shall take precedence.

Section 13.02 All Legal Provisions Deemed Included

Each and every provision required by Law to be inserted in this Agreement is hereby deemed to be a part of this Agreement, whether actually inserted or not.

Section 13.03 Severability / Unlawful Provisions Deemed Stricken

If this Agreement contains any unlawful provision not an essential part of the Agreement and which shall not appear to have been a controlling or material inducement to the making of this Agreement, the unlawful provision shall be deemed of no effect and shall, upon notice by either party, be deemed stricken from the Agreement without affecting the binding force of the remainder.

Section 13.04 Compliance With Laws

The Contractor shall perform all services under this Agreement in accordance with all applicable Laws as are in effect at the time such services are performed.

Section 13.05 Unlawful Discrimination in the Provision of Services

A. *Discrimination in Public Accommodations.* With respect to services provided under this Agreement, the Contractor shall not unlawfully discriminate against any person because of actual or perceived age, religion, creed, sex, gender, gender identity or gender expression, sexual orientation, partnership status, marital status, disability, presence of a service animal, race, color, national origin, alienage, citizenship status, or military status, or any other class of individuals protected from discrimination in public accommodations by City, State or Federal laws, rules or regulations. The Contractor shall comply with all statutory and regulatory obligations to provide reasonable accommodations to individuals with disabilities.

B. *Discrimination in Housing Accommodations.* With respect to services provided under this Agreement, the Contractor shall not unlawfully discriminate against any person because of actual or perceived age, religion, creed, sex, gender, gender identity or gender expression, sexual orientation, status as a victim of domestic violence, stalking, and sex offenses, partnership status, marital status, presence of children, disability, presence of a service or emotional support animal, race, color, national origin, alienage or citizenship status, lawful occupation, or lawful source of income (including income derived from social security, or any form of federal, state, or local public government assistance or housing assistance including Section 8 vouchers), or any other class of individuals protected from discrimination in housing accommodations by City, State or Federal laws, rules or regulations. The Contractor shall comply with all statutory and regulatory obligations to provide reasonable accommodations to individuals with disabilities.

C. *Admin. Code § 6-123*. In accordance with Admin. Code § 6-123, the Contractor will not engage in any unlawful discriminatory practice as defined in and pursuant to the terms of Title 8 of the Admin. Code. The Contractor shall include a provision in any agreement with a first-level subcontractor performing services under this Agreement for an amount in excess of $50,000.00 that such subcontractor shall not engage in any such unlawful discriminatory practice as defined in Title 8 of the Admin. Code.
.

D. *Immigration status*. In connection with the services provided under this Agreement, the Contractor shall not inquire about the immigration status of a recipient or potential recipient of such services unless (i) it is necessary for the determination of program, service or benefit eligibility or the provision of City services or (ii) the Contractor is required by law to inquire about such person's immigration status.

Section 13.05 Americans with Disabilities Act (ADA)

A. This Agreement is subject to the provisions of Subtitle A of Title II of the Americans with Disabilities Act of 1990, 42 U.S.C. §§ 12131 *et seq.* ("ADA") and regulations promulgated pursuant thereto, see 28 CFR Part 35. The Contractor shall not discriminate against an individual with a disability, as defined in the ADA, in providing services, programs, or activities pursuant to this Agreement. If directed to do so by the Department to ensure the

Contractor's compliance with the ADA during the term of this Agreement, the Contractor shall prepare a plan ("Compliance Plan") which lists its program site(s) and describes in detail, how it intends to make the services, programs and activities set forth in the scope of services herein readily accessible and usable by individuals with disabilities at such site(s). If the program site is not readily accessible and usable by individuals with disabilities, contractor shall also include in the Compliance Plan, a description of reasonable alternative means and methods that result in making the services, programs or activities provided under this Agreement, readily accessible to and usable by individuals with disabilities, including but not limited to people with visual, auditory or mobility disabilities. The Contractor shall submit the Compliance Plan to the ACCO for review within ten Days after being directed to do so and shall abide by the Compliance Plan and implement any action detailed in the Compliance Plan to make the services, programs, or activities accessible and usable by the disabled.

B. The Contractor's failure to either submit a Compliance Plan as required herein or implement an approved Compliance Plan may be deemed a material breach of this Agreement and result in the City terminating this Agreement.

Section 13.06 Voter Registration

A. *Participating Agencies.* Pursuant to Charter § 1057-a, if this Agreement is made by and through a participating City agency and the Contractor has regular contact with the public in the daily administration of its business, the Contractor must comply with the requirements of this Section 13.06. The participating City agencies are: the Administration for Children's Services; the City Clerk; the Civilian Complaint Review Board; the Commission on Human Rights; Community Boards; SBS; the Department of Citywide Administrative Services; the Department of Consumer Affairs; the Department of Correction; the Department of Environmental Protection; the Department of Finance; the Department of Health and Mental Hygiene; the Department of Homeless Services; the Department of Housing Preservation and Development; the Department of Parks and Recreation; the Department of Probation; the Taxi and Limousine Commission; the Department of Transportation; and the Department of Youth and Community Development.

B. *Distribution of Voter Registration Forms.* In accordance with Charter § 1057-a, the Contractor, if it has regular contact with the public in the daily administration of its business under this Agreement, hereby agrees as follows:

1. The Contractor shall provide and distribute voter registration forms to all persons together with written applications for services, renewal, or recertification for services and change of address relating to such services. Such voter registration forms shall be provided to the Contractor by the City. The Contractor should be prepared to provide forms written in Spanish or Chinese, and shall obtain a sufficient supply of such forms from the City.

2. The Contractor shall also include a voter registration form with any Contractor communication sent through the United States mail for the purpose of

supplying clients with materials for application, renewal, or recertification for services and change of address relating to such services. If forms written in Spanish or Chinese are not provided in such mailing, the Contractor shall provide such forms upon the Department's request.

3. The Contractor shall, subject to approval by the Department, incorporate an opportunity to request a voter registration application into any application for services, renewal, or recertification for services and change of address relating to such services provided on computer terminals, the World Wide Web or the Internet. Any person indicating that they wish to be sent a voter registration form via computer terminals, the World Wide Web or the Internet shall be sent such a form by the Contractor or be directed, in a manner subject to approval by the Department, to a link on that system where such a form may be downloaded.

4. The Contractor shall, at the earliest practicable or next regularly scheduled printing of its own forms, subject to approval by the Department, physically incorporate the voter registration forms with its own application forms in a manner that permits the voter registration portion to be detached therefrom. Until such time when the Contractor amends its form, the Contractor should affix or include a postage-paid City Board of Elections voter registration form to or with its application, renewal, recertification, and change of address forms.

5. The Contractor shall prominently display in its public office, subject to approval by the Department, promotional materials designed and approved by the City or State Board of Elections.

6. For the purposes of Paragraph A of this Section 13.06, the word "Contractor" shall be deemed to include subcontractors having regular contact with the public in the daily administration of their business.

7. The provisions of Paragraph A of this Section 13.06 shall not apply to services that must be provided to prevent actual or potential danger to life, health, or safety of any individual or of the public.

C. *Assistance in Completing Voter Registration Forms*. In accordance with Charter § 1057-a, the Contractor hereby agrees as follows:

1. In the event the Department provides assistance in completing distributed voter registration forms, the Contractor shall also provide such assistance, in the manner and to the extent specified by the Department.

2. In the event the Department receives and transmits completed registration forms from applicants who wish to have the forms transmitted to the City Board of Elections, the Contractor shall similarly provide such service, in the manner and to the extent specified by the Department.

3. If, in connection with the provision of services under this Agreement, the Contractor intends to provide assistance in completing distributed voter registration forms or to receive and transmit completed registration forms from applicants who wish to have the forms transmitted to the City Board of Elections, the Contractor shall do so only by prior arrangement with the Department.

4. The provision of Paragraph B services by the Contractor may be subject to Department protocols, including protocols regarding confidentiality.

D. *Required Statements*. In accordance with Charter § 1057-a, the Contractor hereby agrees as follows:

1. The Contractor shall advise all persons seeking voter registration forms and information, in writing together with other written materials provided by the Contractor or by appropriate publicity, that the Contractor's or government services are not conditioned on being registered to vote.

2. No statement shall be made and no action shall be taken by the Contractor or an employee of the Contractor to discourage an applicant from registering to vote or to encourage or discourage an applicant from enrolling in any particular political party.

3. The Contractor shall communicate to applicants that the completion of voter registration forms is voluntary.

4. The Contractor and the Contractor's employees shall not:

a. seek to influence an applicant's political preference or party designation;

b. display any political preference or party allegiance;

c. make any statement to an applicant or take any action the purpose or effect of which is to discourage the applicant from registering to vote; or

d. make any statement to an applicant or take any action the purpose or effect of which is to lead the applicant to believe that a decision to register or not to register has any bearing on the availability of services or benefits.

E. The Contractor, as defined above and in this Agreement, agrees that the covenants and representations in this Section 13.06 are material conditions of this Agreement.

F. The provisions of this Section 13.06 do not apply where the services under this Agreement are supported by a federal or State grant of funds and the source of funds prohibits the use of federal or State funds for the purposes of this Section.

Section 13.07 Political Activity

The Contractor's provision of services under this Agreement shall not include any partisan political activity or any activity to further the election or defeat of any candidate for public, political, or party office, nor shall any of the funds provided under this Agreement be used for such purposes.

Section 13.08 Religious Activity

There shall be no religious worship, instruction, or proselytizing as part of or in connection with the Contractor's provision of services under this Agreement, nor shall any of the funds provided under this Agreement be used for such purposes.

Section 13.09 Participation in an International Boycott

A. The Contractor agrees that neither the Contractor nor any substantially-owned affiliated company is participating or shall participate in an international boycott in violation of the provisions of the federal Export Administration Act of 1979, as amended, 50 U.S.C. Appendix. §§ 2401 *et seq*., or the regulations of the United States Department of Commerce promulgated thereunder.

B. Upon the final determination by the Commerce Department or any other agency of the United States as to, or conviction of, the Contractor or a substantially-owned affiliated company thereof, of participation in an international boycott in violation of the provisions of the Export Administration Act of 1979, as amended, or the regulations promulgated thereunder, the Comptroller may, at his or her option, render forfeit and void this Agreement.

C. The Contractor shall comply in all respects, with the provisions of Admin. Code § 6-114 and the rules issued by the Comptroller thereunder.

Section 13.10 MacBride Principles

A. In accordance with and to the extent required by Admin. Code § 6-115.1, the Contractor stipulates that the Contractor and any individual or legal entity in which the Contractor holds a ten percent (10%) or greater ownership interest and any individual or legal entity that holds a ten percent (10%) or greater ownership interest in the Contractor either (a) have no business operations in Northern Ireland, or (b) shall take lawful steps in good faith to conduct any business operations they have in Northern Ireland in accordance with the MacBride Principles, and shall permit independent monitoring of their compliance with such principles.

B. The Contractor agrees that the covenants and representations in Paragraph A above are material conditions to this Agreement.

C. This Section does not apply if the Contractor is a not-for-profit corporation.

Section 13.11 Access to Public Health Insurance Coverage Information

A. Participating Agencies. Pursuant to Charter § 1069, if this Agreement is with a participating City agency and the Contractor is one to whom this Section 13.11 applies as provided in Paragraph B of this Section 13.11, the Contractor hereby agrees to fulfill the obligations in Paragraph C of this Section 13.11. The participating City agencies are: the Administration for Children's Services; the City Clerk; the Commission on Human Rights; the Department for the Aging; the Department of Corrections; the Department of Homeless Services; the Department of Housing Preservation and Development; the Department of Juvenile Justice; the Department of Health and Mental Hygiene; the Department of Probation; the Department of Social Services/Human Resources Administration; the Taxi and Limousine Commission; the Department of Youth and Community Development; the Office to Combat Domestic Violence; and the Office of Immigrant Affairs.

B. Applicability to Certain Contractors. This Section 13.11 shall be applicable to a Contractor operating pursuant to an Agreement which (i) is in excess of $250,000.00 and (ii) requires such Contractor to supply individuals with a written application for, or written renewal or recertification of services, or request for change of address form in the daily administration of its contractual obligation to such participating City agency. "Contractors" to whom this Section 13.11 applies shall be deemed to include subcontractors if the subcontract requires the subcontractor to supply individuals with a written application for, or written renewal or recertification of services, or request for change of address form in the daily administration of the subcontractor's contractual obligation.

C. Distribution of Public Health Insurance Pamphlet. In accordance with Charter § 1069, when the participating City agency supplies the Contractor with the public health insurance program options pamphlet published by the Department of Health and Mental Hygiene pursuant to Section 17-183 of the Admin. Code (hereinafter "pamphlet"), the Contractor hereby agrees as follows:

1. The Contractor will distribute the pamphlet to all persons requesting a written application for services, renewal or recertification of services or request for a change of address relating to the provision of services.

2. The Contractor will include a pamphlet with any Contractor communication sent through the United States mail for the purpose of supplying an individual with a written application for services, renewal or recertification of services or with a request for a change of address form relating to the provision of services.

3. The Contractor will provide an opportunity for an individual requesting a written application for services, renewal or recertification for services or change of address form relating to the provision of services via the Internet to request a pamphlet, and will provide such pamphlet by United States mail or an Internet address where such

pamphlet may be viewed or downloaded, to any person who indicates via the Internet that they wish to be sent a pamphlet.

4. The Contractor will ensure that its employees do not make any statement to an applicant for services or client or take any action the purpose or effect of which is to lead the applicant or client to believe that a decision to request public health insurance or a pamphlet has any bearing on their eligibility to receive or the availability of services or benefits.

5. The Contractor will comply with: (i) any procedures established by the participating City agency to implement Charter § 1069; (ii) any determination of the commissioner or head of the participating City agency (which is concurred in by the commissioner of the Department of Health and Mental Hygiene) to exclude a program, in whole or in part, from the requirements of Charter § 1069; and (iii) any determination of the commissioner or head of the participating City agency (which is concurred in by the commissioner of the Department of Health and Mental Hygiene) as to which Workforce Investment Act of 1998 offices providing workforce development services shall be required to fulfill the obligations under Charter § 1069.

D. Non-applicability to Certain Services. The provisions of this Section 13.11 shall not apply to services that must be provided to prevent actual or potential danger to the life, health or safety of any individual or to the public.

Section 13.12 Distribution of Personal Identification Materials

A. Participating Agencies. Pursuant to City Executive Order No. 150 of 2011 ("E.O. 150"), if this Agreement is with a participating City agency and the Contractor has regular contact with the public in the daily administration of its business, the Contractor must comply with the requirements of this Section 13.12. The participating City agencies are: Administration for Children's Services, Department of Consumer Affairs, Department of Correction, Department of Health and Mental Hygiene, Department of Homeless Services, Department of Housing Preservation and Development, Human Resources Administration, Department of Parks and Recreation, Department of Probation, and Department of Youth and Community Development.

B. Policy. As expressed in E.O. 150, it is the policy of the City to provide information to individuals about how they can obtain the various forms of City, State, and Federal government-issued identification and, where appropriate, to assist them with the process for applying for such identification.

C. Distribution of Materials. If the Contractor has regular contact with the public in the daily administration of its business, the Contractor hereby agrees to provide and distribute materials and information related to whether and how to obtain various forms of City, State, and Federal government-issued identification as the Agency directs in accordance with the Agency's plans developed pursuant to E.O. 150.

ARTICLE 14 - MISCELLANEOUS PROVISIONS

Section 14.01 Conditions Precedent

A. This Agreement shall be neither binding nor effective unless and until it is registered pursuant to Charter § 328.

B. The requirements of this Section 14.01 shall be in addition to, and not in lieu of, any approval or authorization otherwise required for this Agreement to be effective and for the expenditure of City funds.

Section 14.02 Merger

This written Agreement contains all the terms and conditions agreed upon by the parties, and no other agreement, oral or otherwise, regarding the subject matter of this Agreement shall be deemed to exist or to bind either of the parties, or to modify any of the terms contained in this Agreement, other than a written change, amendment or modification duly executed by both parties pursuant to Article 9 of this Appendix A.

Section 14.03 Headings

Headings are inserted only as a matter of convenience and therefore are not a part of and do not affect the substance of this Agreement.

Section 14.04 Notice

A. The Contractor and the Department hereby designate the business addresses and email addresses specified in Schedule A (and if not specified in Schedule A, as specified at the beginning of this Agreement) as the places where all notices, directions, or communications from one such party to the other party shall be delivered, or to which they shall be mailed. Either party may change its notice address at any time by an instrument in writing executed and acknowledged by the party making such change and delivered to the other party in the manner as specified below.

B. Any notice, direction, or communication from either party to the other shall be in writing and shall be deemed to have been given when (i) delivered personally; (ii) sent by certified mail, return receipt requested; (iii) delivered by overnight or same day courier service in a properly addressed envelope with confirmation; or (iv) sent by email and, unless receipt of the e-mail is acknowledged by the recipient by email, deposited in a post office box regularly maintained by the United States Postal Service in a properly addressed, postage pre-paid envelope.

C. Nothing in this Section 14.04 shall be deemed to serve as a waiver of any requirements for the service of notice or process in the institution of an action or proceeding as provided by Law, including the New York Civil Practice Law and Rules.

AFFIRMATION

The undersigned proposer or bidder affirms and declares that said proposer or bidder is not in arrears to the City of New York upon debt, contract or taxes and is not a defaulter, as surety or otherwise, upon obligation to the City of New York, and has not been declared not responsible, or disqualified, by any agency of the City of New York, nor is there any proceeding pending relating to the responsibility or qualification of the proposer or bidder to receive public contract except_.
Full name of Proposer or Bidder *[below]*

Anthem Insurance Companies, Inc.

Address 14 Wall Street
City New York State New York Zip Code 10005

CHECK ONE BOX AND INCLUDE APPROPRIATE NUMBER:

A - ☐ Individual or Sole Proprietorships
SOCIAL SECURITY NUMBER _____

B - ☐ Partnership, Joint Venture or other unincorporated organization
EMPLOYER IDENTIFICATION NUMBER _____

C - X Corporation
EMPLOYER IDENTIFICATION NUMBER 35-0781558

By_____
Signature

President
Title

If a corporation place seal here
Must be signed by an officer or duly authorized representative.

* Under the Federal Privacy Act, the furnishing of Social Security numbers by bidders or proposers on City contracts is voluntary. Failure to provide a Social Security number will not result in a bidder's/proposer's disqualification. Social Security numbers will be used to identify bidders, proposers, or vendors to ensure their compliance with laws, to assist the City in enforcement of laws, as well as to provide the City a means of identifying businesses seeking City contracts

SCHEDULE A

Article 7 -- Insurance	
Types of Insurance (per Article 7 in its entirety, including listed paragraph)	**Minimum Limits and Special Conditions**
■ Workers' Compensation §7.02 ■ Disability Benefits Insurance §7.02 ■ Employers' Liability §7.02	Statutory amounts.
■ Commercial General Liability §7.03(A)	$1,000,000.00 per occurrence $1,000,000.00 personal & advertising injury (unless waived in writing by the Department) $2,000,000.00 aggregate $0 products/completed operations Additional Insureds: 1. City of New York, including its officials and employees, and 2. _____ 3. _____
☐ Commercial Auto Liability §7.03(B)	$1,000,000.00 per accident combined single limit If vehicles are used for transporting hazardous materials, the Contractor shall provide pollution liability broadened coverage for covered vehicles (endorsement CA 99 48) as well as proof of MCS 90
☐ Professional Liability/Errors & Omissions §7.03(C)	$1,000,000.00 per claim
☐ Crime Insurance §7.03(D)	$_____Employee Theft/Dishonesty

	$_____Computer Fraud $_____Funds Transfer Fraud $_____Client Coverage $_____Forgery or Alteration $_____Inside the Premises (theft of money and securities) $_____Inside the Premises (robbery or safe burglary of other property) $_____Outside the Premises $_____ Money Orders and Counterfeit Money City of New York is a loss payee as its interests may appear
■ Cyber Liability Insurance §7.03(E)	$10,000,000 per occurrence $10,000,000 aggregate If additional insured status is commercially available under the Contractor's cyber liability insurance, the insurance shall cover the City, together with its respective officials and employees, as additional insured.
☐ [OTHER]	*[If other type(s) of insurance need to be required under the Contract, the Contracting Agency should (a) check the box and fill in the type of insurance in left-hand column, and (b) in this right-hand column, specify appropriate limit(s) and appropriate Named Insured and Additional Insured(s).]*
☐ [OTHER]	*[If other type(s) of insurance need to be required under the Contract, the Contracting Agency should (a) check the box and fill in the type of insurance in left-hand column, and (b) in this right-hand column, specify appropriate limit(s) and appropriate Named Insured and Additional Insured(s).]*
Section 10.07 – Liquidated Damages	

• Violation of Section 3.02(H), reporting subcontractors in the City's Payee Information Portal	**$100 per day**
• _____	**$_____**
Section 14.04 – Notice	

Department's Mailing Address and Email Address for Notices	
Contractor's Mailing Address and Email Address for Notices	

CERTIFICATES OF INSURANCE

Instructions to New York City Agencies, Departments, and Offices

All certificates of insurance (except certificates of insurance solely evidencing Workers' Compensation Insurance, Employer's Liability Insurance, and/or Disability Benefits Insurance) must be accompanied by one of the following:

(1) the Certification by Insurance Broker or Agent on the following page setting forth the required information and signatures;

-- OR --

(2) copies of all policies as certified by an authorized representative of the issuing insurance carrier that are referenced in such certificate of insurance. If any policy is not available at the time of submission, certified binders may be submitted until such time as the policy is available, at which time a certified copy of the policy shall be submitted.

CITY OF NEW YORK
CERTIFICATION BY INSURANCE BROKER OR AGENT

The undersigned insurance broker or agent represents to the City of New York that the attached Certificate of Insurance is accurate in all material respects.

_____
[Name of broker or agent (typewritten)]

_____
[Address of broker or agent (typewritten)]

_____
[Email address of broker or agent (typewritten)]

_____
[Phone number/Fax number of broker or agent (typewritten)]

_____
[Signature of authorized official, broker, or agent]

_____
[Name and title of authorized official, broker, or agent (typewritten)]

State of.....)
) ss.:
County of.....)

Sworn to before me this_____day of_____20____

_____
NOTARY PUBLIC FOR THE STATE OF _____

SCHEDULE B

As described in Section 3.02(A)(1), the following subcontractors are deemed to be Key Subcontractors as of the Execution Date. [TO BE COMPLETED]

Key Subcontractor	Description of Key Subcontractor Services
<*subcontractor 1*>	**Claims Adjudication**
<*subcontractor 2*>	**Claims Adjudication**
<*subcontractor 3*>	**Claims Review**
<*subcontractor 4*>	**Utilization Management**

WHISTLEBLOWER PROTECTION EXPANSION ACT POSTER

REPORT

CORRUPTION, FRAUD, UNETHICAL CONDUCT

RELATING TO A NYC-FUNDED CONTRACT OR PROJECT

CALL THE NYC DEPARTMENT OF INVESTIGATION

212-825-5959

DOI CAN ALSO BE REACHED BY MAIL OR IN PERSON AT: **New York City Department of Investigation (DOI)** **80 Maiden Lane, 17th floor** **New York, New York 10038** **Attention: COMPLAINT BUREAU** **OR FILE A COMPLAINT ON-LINE AT:** **www.nyc.gov/doi** **All communications are confidential**	**Or scan the QR Code above to make a complaint**

THE LAW PROTECTS EMPLOYEES OF CITY CONTRACTORS WHO REPORT CORRUPTION

- Any employee of a City contractor, or subcontractor of the City, or a City contractor with a contract valued at more than $100,000 is protected under the law from retaliation by his or her employer if the employee reports wrongdoing related to the contract to the DOI.
- **To be protected by this law,** an employee must report to DOI − or to certain other specified government officials − information about fraud, false claims, corruption, criminality, conflict of interest, gross mismanagement, or abuse of authority relating to a City contract valued at more than $100,000.
- Any employee who makes such a report and who believes he or she has been dismissed, demoted, suspended, or otherwise subject to an adverse personnel action because of that report is entitled to bring a lawsuit against the contractor and recover damages