

2016 PROVIDER NETWORKS AND MEMBER BENEFIT PLANS

TABLE OF CONTENTS

COMMERCIAL NETWORKS	75
GHI Underwritten Commercial Networks	76
EmblemHealth HDHP Programs: ConsumerDirect EPO and ConsumerDirect PPO	78
HealthEssentials	78
HIP Underwritten Commercial Networks	79
Prime Network	80
EmblemHealth Prime Network Expands into Connecticut	81
Child Health Plus	81
Premium Network aka Vytra Premium Network	81
Select Care Network	82
Changes for 2017	85
MEDICAID NETWORK	85
Medicaid Managed Care (MMC): EmblemHealth Enhanced Care	86
Health and Recovery Plan (HARP): EmblemHealth Enhanced Care Plus	87
NYSDOH Medicaid Provider Non-Interference	87
Permanent Placement in Nursing Homes	88
Mandatory Enrollment of the New York City Homeless Population	89
Medicaid Health Home Program	90
Restricted Recipient Program	91
Essential Plan	92
MEDICARE NETWORKS	94
Medicare Plans	94
Maximum Out-of-Pocket Threshold	95
Wellness Exams	95
Medicare Network and Plan Summary	96
Changes for 2017	100

2016 PROVIDER NETWORKS AND MEMBER BENEFIT PLANS

MEDICARE SPECIAL NEEDS PLANS	101
SNPs Meet Our Members' Special Needs	101
The SNP Interdisciplinary Team	102
Medicare Special Needs Plans	102
Provider Obligations/Responsibilities for Participation	104
APPENDIX A: MEDICAID MANAGED CARE MODEL CONTRACT, APPENDIX K	105
APPENDIX B: BENEFIT SUMMARIES	106
APPENDIX C: MEDICARE PREVENTIVE SERVICES	106

2016 PROVIDER NETWORKS AND MEMBER BENEFIT PLANS

This chapter contains information about our provider networks and member benefit plans, including commercial, Medicaid Managed Care, Medicare and Special Needs Plans (SNPs).

Overview

EmblemHealth’s HIP HMO, GHI HMO and Vytra HMO plans are underwritten by HIP Health Plan of New York, HIP POS plans are underwritten by both HIP Health Plan of New York and HIP Insurance Company of New York, and HIP EPO/PPO plans are underwritten by HIP Insurance Company of New York (HIPIC). EmblemHealth’s GHI EPO/PPO plans are underwritten by Group Health Incorporated. EmblemHealth may amend the benefit programs and networks from time to time by providing advance notice to affected providers.

Use Network Practitioners

It’s important to remember that our HIP-underwritten HMO plans offer in-network coverage only for non-emergent services. Why is this so important? Because if you see a member who is NOT in a plan associated with your participating networks, they may incur a surprise bill. So when a member calls for an appointment, be sure to check that you participate in the member’s plan at that location. If you do not participate in their plan, please refer them back to our online directory, **Find-A-Doctor** to find an in network provider.

Providers may be required to sign multiple agreements in order to participate in all the benefit plans associated with our provider networks. For more information, please see the table below:

PROVIDER NETWORK & MEMBER BENEFIT PLAN CROSSWALK			
Company	Provider Network	Member Benefit Plan	
GHI	Commercial: CBP Network, National Network, Tristate Network	EmblemHealth EPO EmblemHealth PPO	
	Network Access Network	Network Access Plan	
	Medicare: Medicare Choice PPO Network	EmblemHealth Medicare ASO EmblemHealth Medicare PPO Medicare Dual Eligible (PPO) SNP	
HIP/ HIPIC	Commercial: NY Metro Network	EmblemHealth CompreHealth EPO	
	Select Care Network	All Select Care-Based Plans, including EmblemHealth Healthy NY	
	Prime Network	Access I Prime HMO Access II Prime POS GHI HMO Plans Connecticare	Prime EPO Select EPO Prime PPO Select PPO Child Health Plus
	Premium Network aka Vytra Premium Network	Access I Prime HMO Access II Prime POS Vytra	Prime EPO Select EPO Prime PPO Select PPO
	Medicaid: Enhanced Care Prime Network	EmblemHealth Enhanced Care (MMC) EmblemHealth Enhanced Care Plus (HARP) Essential Plan (BHP)	

2016 PROVIDER NETWORKS AND MEMBER BENEFIT PLANS

Medicare: Medicare Essential Network	EmblemHealth Essential (HMO) EmblemHealth VIP High Option (HMO)
VIP Prime Network	EmblemHealth VIP (HMO) EmblemHealth Dual Eligible (HMO SNP) Medicare Supplemental (cost plan)
FIDA: EmblemHealth Dual Assurance Network	EmblemHealth Dual Assurance FIDA Plan (non-renewing 12/31/15)
Associated Dual Assurance Network	ArchCare Community Advantage FIDA Plan (non-renewing 10/31/15) GuildNet Gold Plus FIDA Plan (ASO)

COMMERCIAL NETWORKS

This chapter contains information about our provider networks and member benefit plans, including commercial, Medicaid Managed Care, Medicare and Special Needs Plans (SNPs).

Overview

EmblemHealth’s HIP HMO, GHI HMO and Vytra HMO plans are underwritten by HIP Health Plan of New York, HIP POS plans are underwritten by both HIP Health Plan of New York and HIP Insurance Company of New York, and HIP EPO/PPO plans are underwritten by HIP Insurance Company of New York (HIPIC). EmblemHealth’s GHI EPO/PPO plans are underwritten by Group Health Incorporated. EmblemHealth may amend the benefit programs and networks from time to time by providing advance notice to affected providers.

Use Network Practitioners

It’s important to remember that our HIP-underwritten HMO plans offer in-network coverage only for non-emergent services. Why is this so important? Because if you see a member who is NOT in a plan associated with your participating networks, they may incur a surprise bill. So when a member calls for an appointment, be sure to check that you participate in the member’s plan at that location. If you do not participate in their plan, please refer them back to our online directory, **Find-A-Doctor** to find an in network provider.

Providers may be required to sign multiple agreements in order to participate in all the benefit plans associated with our provider networks. For more information, please see the table below:

PROVIDER NETWORK & MEMBER BENEFIT PLAN CROSSWALK		
Company	Provider Network	Member Benefit Plan
GHI	Commercial: CBP Network, National Network, Tristate Network	EmblemHealth EPO EmblemHealth PPO
	Network Access Network	Network Access Plan
	Medicare: Medicare Choice PPO Network	EmblemHealth Medicare ASO EmblemHealth Medicare PPO Medicare Dual Eligible (PPO) SNP
HIP/ HIPIC	Commercial: NY Metro Network	EmblemHealth CompreHealth EPO
	Select Care Network	All Select Care-Based Plans, including EmblemHealth Healthy NY

2016 PROVIDER NETWORKS AND MEMBER BENEFIT PLANS

Prime Network	Access I Prime HMO Access II Prime POS GHI HMO Plans Connecticare	Prime EPO Select EPO Prime PPO Select PPO Child Health Plus
Premium Network aka Vytra Premium Network	Access I Prime HMO Access II Prime POS Vytra	Prime EPO Select EPO Prime PPO Select PPO
Medicaid: Enhanced Care Prime Network	EmblemHealth Enhanced Care (MMC) EmblemHealth Enhanced Care Plus (HARP) Essential Plan (BHP)	
Medicare: Medicare Essential Network	EmblemHealth Essential (HMO) EmblemHealth VIP High Option (HMO)	
VIP Prime Network	EmblemHealth VIP (HMO) EmblemHealth Dual Eligible (HMO SNP) Medicare Supplemental (cost plan)	
FIDA: EmblemHealth Dual Assurance Network	EmblemHealth Dual Assurance FIDA Plan (non-renewing 12/31/15)	
Associated Dual Assurance Network	ArchCare Community Advantage FIDA Plan (non-renewing 10/31/15) GuildNet Gold Plus FIDA Plan (ASO)	

GHI Underwritten Commercial Networks

The tables that follow summarize the benefit plans through which our commercial members receive their health care benefits and services. Certain plans allow members to self-refer to network specialists for office visits; however, Prior Approval is still required before certain procedures can be performed.

GHI Underwritten Commercial Networks

GHI-UNDERWRITTEN COMMERCIAL NETWORK AND PLAN SUMMARY FOR 2016 CBP, NATIONAL, NETWORK ACCESS & TRISTATE NETWORKS								
Network	Plan Name	Plan Type	PCP/ Referral Req'd	Deductibles (Individual / Family)	PCP/ Specialist/ ER Copay	OON Coverage	MOOP (Individual/ Family)	Co-insurance
CBP Network	Federal Employee Health Benefit (FEHB) ¹	EPO	No/No	N/A	\$30/\$30/\$150	No	\$6,600/\$13,200	No
CBP Network	Federal Employee Health Benefit	PPO	No/No	IN: N/A OON: \$150	\$20/\$20/\$150	Yes	\$6,600/\$13,200	OON only

2016 PROVIDER NETWORKS AND MEMBER BENEFIT PLANS

	(FEHB) ¹							
CBP Network/ National Network	EPO HD6300 (Bronze)	EPO	No/No	\$6,300/\$12,600 (Includes Rx)	No	No	\$6,300/\$12,600	No
CBP Network/ National Network	CBP (Non-standard legacy GHI plan)	PPO	No/No	IN: N/A OON: Various	Various	Yes	\$6,850/\$13,700	OON Only
Network Access Network	Network Access	EPO/PPO network lease	No/No	Various	Various	EPO: No PPO: Yes	\$6850/ \$13,700	EPO: No PPO: Yes
CBP Network	City of New York	PPO (medical only)	No/No	In: N/A OON: \$200/\$500	\$15/\$20/ N/A	Yes	\$6,850/\$13,700	No
CBP Network	DC 37 Med-Team	PPO	No/No	IN: N/A OON: \$150	\$10/\$10/\$50	Yes	\$6,850/ \$13,700	OON only
CBP Network	EPO HD Bronze	EPO	No/No	\$6,300/\$12,600 (includes Rx)	No	No	\$6,300/\$12,600	No
CBP Network	EPO HD Gold	EPO	No/No	\$1,800/\$12,600 (includes Rx)	No	No	\$2,200/ \$4,400	Yes (10% after deductible)
CBP Network	EPO HD Platinum	EPO	No/No	\$900/\$1,800 (includes Rx)	No	No	\$900/\$1,800	No
CBP Network	EPO HD Silver	EPO	No/No	\$2,000/\$4,000 (includes Rx)	No	No	\$6,350/ \$12,700	Yes (20% after deductible)
National Network	EmblemHealth EPO	EPO	No/No	N/A	Various	No	Up to \$6,850/\$13,700	No
National Network	EmblemHealth PPO	PPO	No/No	IN: N/A OON: Various	Various	Yes	Up to \$6,850/ \$13,700	OON only
National Network	EmblemHealth Consumer Direct EPO	EPO	No/No	Various (includes Rx)	No	No	Up to \$6,850/ \$13,700	Yes
National Network	EmblemHealth Consumer Direct PPO	PPO	No/No	Various (includes Rx)	No	Yes	Up to \$6,850/ \$13,700	Yes
National Network	EmblemHealth Essentials Plus	EPO	No/No	N/A	\$40 (limited to 3 outpatient visits only)	No	\$3,000/\$6,000	No

2016 PROVIDER NETWORKS AND MEMBER BENEFIT PLANS

National Network	EmblemHealth InBalance EPO	EPO	No/No	Various on facility/ non-preventive surgical services	Various	No	Up to \$6,850/ \$13,700	Yes
National Network	EmblemHealth InBalance PPO	PPO	No/No	IN: Various on facility/ non-preventive surgical services OON: Various	Various	Yes	Up to \$6,850/ \$13,700	Yes

ER = emergency room; IN = in-network; N/A = not applicable; OON = out-of-network; MOOP = maximum out-of-pocket; PCP = primary care provider; FPL = federal poverty level.

¹ Copays are \$10 for Telemedicine physician and \$5 for dietitian/nutritionist for Federal Employee Health Benefit (FEHB) plans telemedicine coverage.

Note: Member Identification Cards for plans associated to the Comprehensive Benefits Plan (CBP) Network may display the network name as CBP, EPO, EPO1, PPO, PPO1 or PPO4.

EmblemHealth HDHP Programs: ConsumerDirect EPO and ConsumerDirect PPO

To meet the growing demand for consumer-directed health care, EmblemHealth has two high-deductible health plans (HDHP), ConsumerDirect EPO and ConsumerDirect PPO. These benefit plans allow employers and employees more power and choice in how to spend their health care dollars and make health care decisions.

Members may also choose to activate a separate health savings account (HSA) to pay for qualified medical expenses with tax-free dollars. Individual HSAs are member owned, and contributions, interest and withdrawals are tax-free.

For members, ConsumerDirect EPO and ConsumerDirect PPO benefit plans feature:

- Lower monthly premiums based on higher annual deductibles
- Two- and four-tier rate structures
- Network and out-of-network coverage for the PPO plan
- No non-emergent coverage for out-of-network services for the EPO plan
- No out-of-pocket costs for covered preventive care in network

HealthEssentials

HealthEssentials is an EmblemHealth EPO plan designed for people seeking health coverage primarily for catastrophic injury or illness. Its core benefits are hospital and preventive care services and three additional office visits.

The HealthEssentials plan features:

- **Network hospital or ambulatory surgical center benefits**
 - Inpatient and outpatient hospital services provided in and billed by a network hospital or

2016 PROVIDER NETWORKS AND MEMBER BENEFIT PLANS

facility

- o Well baby and child care provided by a network practitioner
- o Emergency room services (provided in and billed by a hospital or facility)
- o Inpatient **and** outpatient mental health and chemical dependency services provided in and billed by a network hospital or facility

- **Covered preventive care services consistent with guidelines of the Patient Protection and Affordable Care Act**

- o Preventive care services covered at 100 percent when provided by a network practitioner
- o Sick visits not covered

- **Pharmacy benefit**

- o \$15 generic drug card

Note: With the exception of preventive care services provided by network practitioners, services billed by a practitioner are not covered under this plan except for three office visits.

HIP Underwritten Commercial Networks

HIP-UNDERWRITTEN COMMERCIAL NETWORK AND PLAN SUMMARY FOR 2016 NY METRO, PREMIUM & PRIME NETWORKS								
Network	Plan Name	Plan Type	PCP/ Referral Req'd	Deductibles (Individual / Family)	PCP/ Specialist/ ER Copay	OON Coverage	MOOP (Individual/ Family)	Co-insurance
NY Metro Network	EmblemHealth Comprehensive EPO	EPO	No/No	N/A	Various	No	Up to \$6,850/ \$13,700	No
Premium Network or Prime Network	HIP Prime® POS	POS	Yes/Yes	IN: N/A OON: Various	Various	Yes	Up to \$6,850/\$13,700	OON only
Premium Network or Prime Network	HIP Prime® PPO	PPO	No/No	IN: N/A OON: Various	Various	Yes	Up to \$6,850/ \$13,700	OON only
Premium Network or Prime Network	HIP Prime® EPO	EPO	No/No	N/A	Various	No	Up to \$6,850/ \$13,700 ³	No
Premium Network or Prime Network	HIPaccess® II	POS	Yes/No	IN: N/A OON: Various	Various	Yes	Up to \$6,850/ \$13,700	OON only
Premium Network or Prime Network (includes upstate)	HIP Prime® HMO	HMO	Yes/Yes	N/A	Various	No	Up to \$6,850/ \$13,700	No

2016 PROVIDER NETWORKS AND MEMBER BENEFIT PLANS

Premium Network or Prime Network (includes upstate)	HIPaccess® I	HMO	Yes/No	N/A	Various	No	Up to \$6,850/ \$13,700	No
Premium Network or Prime Network (with QualCare and MultiPlan)	HIP Select® EPO	EPO	No/No	Various on facility services	Various	No	Up to \$6,850/ \$13,700	Yes
Premium Network or Prime Network (with QualCare and MultiPlan)	HIP Select® PPO	PPO	No/No	IN: Various on facility services OON: Various	Various	Yes	Up to \$6,600/ \$13,200	Yes
Prime Network	Child Health Plus ²	HMO	Yes/Yes	N/A	No	No	N/A	No
Prime Network	GHI HMO	HMO	Yes/Yes	N/A	Various	No	Up to \$6,850/ \$13,700	No
Prime Network	GHI HMO Value Plan	HMO	Yes/Yes	N/A	Various	No	Up to \$6,850/ \$13,700	No
Prime Network	HIP HMO Preferred	HMO	Yes/Yes	N/A	Prime Network Preferred PCP/Specialist \$0 All other PCP/Specialist \$10 /\$10 ER \$50	No	N/A	No
Vytra Network	Vytra HMO	HMO	Yes/Yes	N/A	Various	No	Up to \$6,850/ \$13,700	No

ER = emergency room; IN = in-network; N/A = not applicable; OON = out-of-network; MOOP = maximum out-of-pocket; PCP = primary care provider; FPL = federal poverty level.

¹ The MOOP for the Brookhaven National Lab HIP Prime EPO plan is up to \$5,100 individual / \$10,200 family.

² Members can access certain services from county departments of health and academic dental centers (See the **Direct Access (Self-Referral) Services** section of the **Access to Care and Delivery Systems** chapter for a list of these services).

Prime Network

The Prime Network includes a robust network of practitioners, hospitals and facilities in 28 NY State counties that services a variety of HMO, POS, EPO and PPO members.

2016 PROVIDER NETWORKS AND MEMBER BENEFIT PLANS

The Prime Network is located in the following New York State counties: Albany, Bronx, Broome, Columbia, Delaware, Dutchess, Fulton, Greene, Kings, Montgomery, Nassau, New York, Orange, Otsego, Putnam, Queens, Rensselaer, Richmond, Rockland, Saratoga, Schenectady, Schoharie, Suffolk, Sullivan, Ulster, Warren, Washington and Westchester.

EmblemHealth Prime Network Expands into Connecticut

On January 1, 2017, EmblemHealth will expand its Prime Network to the Tristate region by adding ConnectiCare's HMO provider network to the EmblemHealth Prime Network. Members will now have access to providers in CT – just as they do NY and NJ. Prime Network members will be able to select any eligible* provider in the Prime Network as their PCP, regardless of where a member is domiciled and regardless of where the Prime provider offers services, e.g., provider may offer services in NY, NJ or CT.

*Providers must have an open panel (accepting new members), and be a provider that can be considered a primary care physician following all existing business rules.

Child Health Plus

Child Health Plus (CHP) is a New York State-sponsored program that provides uninsured children under 19 years of age with a full range of health care services for free or for a low monthly cost, depending on family income. In addition to immunizations and well-child care visits, CHP covers pharmaceutical drugs, vision, dental and mental health services. There are no copays for CHP members for any covered services. CHP members may visit any one of our Prime Network providers that see children.

The service area for CHP includes the following New York State counties: Bronx, Kings, Nassau, New York, Queens, Richmond, Suffolk and Westchester.

CHP members are covered for emergency care in the U.S., Puerto Rico, the Virgin Islands, Mexico, Guam, Canada and the Northern Mariana Islands.

Enrollment period restrictions do not apply to CHP. Eligible individuals may enroll in CHP throughout the year via the **NY State of Health Marketplace** or through enrollment facilitators.

Premium Network aka Vytra Premium Network

The Premium Network includes a robust network of practitioners, hospitals and facilities in 28 NY State counties that services a variety of HMO, POS, EPO and PPO members.

The Premium Network is located in the following New York State counties: Albany, Bronx, Broome, Columbia, Delaware, Dutchess, Fulton, Greene, Kings, Montgomery, Nassau, New York, Orange, Otsego, Putnam, Queens, Rensselaer, Richmond, Rockland, Saratoga, Schenectady, Schoharie, Suffolk, Sullivan, Ulster, Warren, Washington and Westchester.

Effective January 1, 2016, Vytra HMO plan will be associated with the Vytra Premium Network. Vytra HMO providers will have access to an expanded network of radiologists as the Vytra Radiology Program will sunset on December 31, 2015. At that time, all utilization management

2016 PROVIDER NETWORKS AND MEMBER BENEFIT PLANS

program exemptions for our Vytra HMO providers and members will end. Going forward providers will follow our standard HIP policies and submit all requests (referrals, prior approvals, etc.) directly through our secure provider website at emblemhealth.com/Providers.

Additionally, if you are employed by a New York company and reside in New Jersey, you and your dependents now have access to the NJ QualCare Network. Beginning January 1, 2017, if you are employed by a New York company, you and your dependents will also have access to the ConnectiCare Network.

Select Care Network

EmblemHealth has membership in a suite of commercial benefit plans that use the Select Care network. EmblemHealth offers Select Care Network benefit plans to individuals and small groups – both on and off the **NY State of Health: The Official Health Plan Marketplace**.

The Select Care Network is located in the following New York State counties: Albany, Bronx, Broome, Columbia, Delaware, Dutchess, Fulton, Greene, Kings, Montgomery, Nassau, New York, Orange, Otsego, Putnam, Queens, Rensselaer, Richmond, Rockland, Saratoga, Schenectady, Schoharie, Suffolk, Sullivan, Ulster, Warren, Washington and Westchester.

The Select Care Network, a subset of our existing HMO network, is a tailored network that helps keep costs down and supports an integrated model of care. Providers in the Select Care Network are chosen on measures such as geographic location, hospital affiliations and sufficiency of services.

Starting November 1, 2015, a sub-population of applicable current Select Care Silver members and the current Medicaid "legally residing immigrant" population will transition into the new Essential Plan via auto-enrollment or standard NY State of Health enrollment for plans effective January 1, 2016. Essential Plans will either automatically include an adult vision and dental benefit, or individuals can purchase the benefit for an additional premium cost. For more information, see the Enhanced Care Prime Network section.

All Select Care plans are HMOs and all non-emergency care must be provided by Select Care Network providers. The network includes a full complement of physicians, hospitals, community health centers, facilities and ancillary services. Urgent care and immediate care are also available. To locate the closest care to your patient, please use the Find a Doctor online directory at www.emblemhealth.com/find-a-doctor.

Note: Most of these plans have a deductible that applies to in-network services.

HIP-UNDERWRITTEN COMMERCIAL NETWORK AND PLAN SUMMARY FOR 2016 SELECT CARE NETWORK								
Network	Plan Name	Plan Type	PCP/ Referral Req'd	Deductibles (Individual / Family)	PCP/ Specialist/ ER Copay	OON Coverage	MOOP (Individual/ Family)	Co-insurance
Select Care Network	Select Care Platinum	HMO	Yes/Yes	\$0/\$0	\$15/\$35/\$100	No	\$2,000/\$4,000	No

2016 PROVIDER NETWORKS AND MEMBER BENEFIT PLANS

	DHMO							
Select Care Network	Select Care Gold D HMO	HMO	Yes/Yes	\$600/\$1,200 (does not include Rx)	\$25/\$40/\$150	No	\$4,000/\$8,000	No
Select Care Network	Select Care Silver D HMO	HMO	Yes/Yes	\$2,000/\$4,000 (does not include Rx)	\$30/\$50/\$150	No	\$5,500/\$11,000	No
Select Care Network	Select Care Bronze D HMO	HMO	Yes/Yes	\$3,500/\$7,000 (includes Rx)	50% cost-sharing after deductible	No	\$6,850/\$13,700	yes
Select Care Network	Select Care Platinum	HMO	Yes/Yes	\$0/\$0	\$15/\$35/\$100	No	\$2,000/\$4,000	No
Select Care Network	Select Care Gold	HMO	Yes/Yes	\$600/\$1,200 (does not apply to Rx)	\$25/\$40/\$150	No	\$4,000/\$8,000	No
Select Care Network	Select Care Silver (Standard)	HMO	Yes/Yes	\$2,000/\$4,000 (does not apply to Rx)	\$30/\$50/\$150	No	\$5,500/\$11,000	No
Select Care Network	Select Care Silver (200-250 % FPL)	HMO	Yes/Yes	\$1,500/\$3,000 (does not apply to Rx)	\$30/\$50/\$150	No	\$5,450/\$10,900	No
Select Care Network	Select Care Silver (150-200 % FPL)	HMO	Yes/Yes	\$250/\$500 (does not apply to Rx)	\$15/\$35/\$75	No	\$2,000/\$4,000	No
Select Care Network	Select Care Silver (100-150 % FPL)	HMO	Yes/Yes	\$0/\$0	\$10/\$20/\$50	No	\$1,000/\$2,000	No
Select Care Network	Select Care Bronze	HMO	No/No	\$3,500/\$7,000 (includes Rx)	50% cost-sharing after deductible	No	\$6,850/\$13,700	Yes
Select Care Network	Select Care Basic	HMO	Yes/Yes	\$6,850/\$13,700 (includes Rx)	0% cost-sharing after deductible	No	\$6,850/\$13,700	No
Select Care Network	Healthy NY HMO (Gold)	HMO	Yes/Yes	\$600/\$1,200 (does not apply to Rx)	\$25/\$40/\$150	No	\$4,000/\$8,000	No
Select Care Network	Brooklyn HealthWorks Healthy NY HMO (Gold)	HMO	Yes/Yes	\$600/\$1,200 (does not apply to Rx)	\$25/\$40/\$150	No	\$4,000/\$8,000	No
Select Care Network	HMO 40/60 (Gold)	HMO	Yes/Yes	\$200/\$400 Rx:	\$40/\$60/\$200	No	\$5,500/\$11,000	No

2016 PROVIDER NETWORKS AND MEMBER BENEFIT PLANS

				\$100/\$200				
Select Care Network	HMO 35/55 (Silver)	HMO	Yes/Yes	\$3,000/\$6,000 on facility services Rx: \$100/\$200	\$35/\$55/\$200	No	\$6,000/\$12,000	Yes
Select Care Network	HMO HD6300 (Bronze)	HMO	Yes/Yes	\$6,300/\$12,600 (includes Rx)	0% cost-sharing after deductible	No	\$6,300/\$12,600	No
Select Care Network	EmblemHealth HMO 15/35 (Platinum)	HMO	Yes/Yes	\$0/\$0	\$15/\$35/\$100	Yes	\$2,000/\$4,000	No
Select Care Network	Select Care Platinum S	HMO	Yes/Yes	\$0/\$0	\$15/\$35/\$100	No	\$2,000/\$4,000	No
Select Care Network	Select Care Gold S	HMO	Yes/Yes	\$600/\$1,200 (does not apply to Rx)	\$25/\$40/\$150	No	\$4,000/\$8,000	No
Select Care Network	EmblemHealth HMO 40/60 S (Gold)	HMO	Yes/Yes	\$200/\$400 Rx: \$100/\$200	\$40/\$60/\$200	No	\$5,500/\$11,000	No
Select Care Network	Select Care Silver S	HMO	Yes/Yes	\$2,000/\$4,000 (does not apply to Rx)	\$30/\$50/\$150	No	\$5,500/\$11,000	No
Select Care Network	EmblemHealth HMO 35/55 S (Silver)	HMO	Yes/Yes	\$3,000/\$6,000 on facility services Rx: \$100/\$200	\$35/\$55/\$200	No	\$6,000/\$12,000	Yes
Select Care Network	Select Care Bronze S	HMO	Yes/Yes	\$3,500/\$7,000 (includes Rx)	50% cost-sharing after deductible	No	\$6,850/\$13,700	Yes
Select Care Network	EmblemHealth HMO HD6300 S (Bronze)	HMO	Yes/Yes	\$6,300/\$12,600 (includes Rx)	0% cost-sharing after deductible	No	\$6,300/\$12,600	Yes

ER = emergency room; IN = in-network; N/A = not applicable; OON = out-of-network; MOOP = maximum out-of-pocket; PCP = primary care provider; FPL = federal poverty level.

¹ Qualifying individuals will be eligible for added cost-sharing subsidies that further lower their costs. Please check the member's ID card for exact cost-sharing. Qualified Native Americans can have an individual Select Care network plan with \$0 cost-sharing (except for the Select Care Basic plan).

² Copays are \$10 for telemedicine physician and \$5 for dietitian/nutritionist for Select Care members.

³ Child-only plans mirror the individual Select Care plans.

2016 PROVIDER NETWORKS AND MEMBER BENEFIT PLANS

Changes for 2017

Below is a summary of changes for Select Care plans in 2017:

- Pediatric Dental Benefits: New for 2017, pediatric dental benefits are embedded in all individual and small group Select Care plans both on- and off-exchange. EmblemHealth's standalone dental plan FirstSmiles is discontinued.
- Two Nonstandard Plans: New for 2017, Select Care Silver Value and Select Care Bronze Value plans, both on- and off-exchange, provide a specific number of primary care physician (PCP) visits at no cost before the deductible and also offer dental and vision benefits for adults and children, no-cost lab services, and no-cost telemedicine. Standard plans follow the standardized plan designs established by New York State and nonstandard plans can change the cost-sharing required in any benefit category.
- Telemedicine: All EmblemHealth individual and small group Select Care plans both on- and off-exchange and the Essential Plan offer telemedicine services at no cost.

Learn more about changes in the EmblemHealth Select Care plans for 2017.

MEDICAID NETWORK

The table below summarizes the network and benefit plans through which our Medicaid members receive their health care benefits and services.

HIP-UNDERWRITTEN MEDICAID NETWORK AND PLAN SUMMARY FOR 2016 ENHANCED CARE PRIME NETWORK							
Network	Plan Name	Plan Type	PCP/Referral Req'd	OON Coverage	In-Network Cost Sharing	Service Area ¹	Comments
Enhanced Care Prime Network ¹	EmblemHealth Enhanced Care	HMO	Yes/Yes ²	Yes ³	Rx Copays	8 county	Medicaid Managed Care plan for Medicaid-eligible individuals ⁵
Enhanced Care Prime Network ¹	EmblemHealth Enhanced Care Plus	HMO	Yes/Yes ²	Yes ³	Rx Copays	NYC	MedHARP for Medicaid-eligible individuals aged 21 and older ⁴

ER = emergency room; IN = in-network; N/A = not applicable; OON = out-of-network; MOOP = maximum out-of-pocket; PCP = primary care provider; FPL = federal poverty level.

8 county = Bronx, Kings (Brooklyn), New York (Manhattan), Queens, Richmond (Staten Island), Nassau, Suffolk & Westchester counties

NYC = Bronx, Kings (Brooklyn), New York (Manhattan), Queens & Richmond (Staten Island)

2016 PROVIDER NETWORKS AND MEMBER BENEFIT PLANS

counties

¹ Medicaid and HARP members traveling outside of the United States can get coverage for urgent and emergency care only in the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands and American Samoa. Members needing any type of care while in any other country (including Canada and Mexico) will be responsible for payment.

² Except for self-referral services and services that Medicaid members can access from Medicaid FFS providers.

³ Medicaid Members can access certain services from county departments of health and academic dental centers. (See the **Access to Care and Delivery Systems** chapter for a list of applicable services where OON coverage applies.)

⁴ See **Medicaid Managed Care Model Contract** for more details.

Medicaid Managed Care (MMC): EmblemHealth Enhanced Care

EmblemHealth's Medicaid Managed Care Plan is now called EmblemHealth Enhanced Care.

The plan name "Enhanced Care" can be found in the upper right corner of the member's ID card. The letter "R" will appear after the plan name on the ID cards of members who are in the Restricted Recipient Program (RRP). This will help you and your staff quickly identify our MMC members.

Our Medicaid members are entitled to a standard set of benefits as set out in the **Medicaid Managed Care Model Contract**. They may directly access certain services. See the **Direct Access (Self-Referral) Services** section of the **Access to Care and Delivery Systems** chapter for a list of services that do not require a referral.

On **October 1, 2015**, EmblemHealth replaced Medicaid FFS for the coverage of behavioral health services for its MMC members aged 21 and older who reside in the five boroughs of New York City.

Behavioral Health Covered Services

EmblemHealth covers the following additional behavioral health benefits:

- Medically supervised outpatient withdrawal services
- Outpatient clinic and opioid treatment program services
- Outpatient clinic services
- Comprehensive psychiatric emergency program services
- Continuing day treatment
- Partial hospitalization
- Personalized recovery oriented services
- Assertive community treatment
- Intensive and supportive case management
- Health home care coordination and management
- Inpatient hospital detoxification
- Inpatient medically supervised inpatient detoxification
- Rehabilitation services for residential substance use disorder treatment
- Inpatient psychiatric service

For more information on the Behavioral Health Services Program, please see the **Behavioral**

2016 PROVIDER NETWORKS AND MEMBER BENEFIT PLANS

Health Services chapter.

Health and Recovery Plan (HARP): EmblemHealth Enhanced Care Plus

Under the Federal Patient Protection and Affordable Care Act (PPACA), New York has developed a set of Health Home services for Medicaid members who have been identified and diagnosed with any of the following conditions:

- Two or more conditions, such as asthma, diabetes, high blood pressure or heart disease
- HIV+ or AIDS
- Severe mental illness or substance use disorder

The Health Home Program is offered at no cost to all eligible EmblemHealth Medicaid members. All HARP members are assigned a Medicaid Health Home to provide care plan coordination; however, members may opt out of the program at any time. EmblemHealth will then notify the member, and their PCP, of the Health Home assignment by letter. The member's assigned Health Home Care Manager will contact the member's PCP to ensure the treatment plan is included in the member's comprehensive care plan.

The following services are available through the Medicaid Health Home program:

- Comprehensive case management with an assigned, personal care manager
- Assistance with getting necessary tests and screenings
- Help and follow-up when leaving the hospital and going to another setting
- Personal support and support for their caregiver or family
- Referrals and access to community and social support services

Health Home Services and Information is also available in the **Forms, Brochure & More**

chapter. More information on the **NYS Medicaid Health Home Program** can be found on the NYSDOH website: http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes.

Medicaid Members who are not eligible to participate in the Medicaid Health Home Program may still meet our criteria for Case Management services. If you think a member would benefit from case management, please refer the patient to the program by calling **1-800-447-0768**, Monday through Friday, from 9 am to 5 pm.

A listing of EmblemHealth network Health Homes that support our Medicaid and HARP benefit plans are listed in the **Directory** chapter.

NYSDOH Medicaid Provider Non-Interference

MMC and HARP members are placed in the Restricted Recipient Program (RRP) when a review of their service utilization and other information reveals that they are:

- Getting care from several doctors for the same problem
- Getting medical care more often than needed
- Using prescription medicine in a way that may be dangerous to their health

2016 PROVIDER NETWORKS AND MEMBER BENEFIT PLANS

- Allowing someone else to use their plan ID card
- Using or accessing care in other inappropriate ways

The Office of Medicaid Inspector General (OMIG) refers members to EmblemHealth for restricted services.

RRP members are restricted to certain provider types (dentists, hospitals, pharmacies, behavioral health professionals, etc.) based on a history of overuse or inappropriate use of specific services. Members are further restricted to using a specific provider of that type.

EmblemHealth is required to continue the Medicaid FFS program restrictions for MMC and HARP members until their existing restriction period ends. EmblemHealth is also required to identify members already enrolled that need to be restricted. All EmblemHealth RRP members are in an Employer Group that begins with "1R0".

Additionally, EmblemHealth RRP member ID cards have an "R" after the plan name on the front of the card so that providers will know that they are restricted. (i.e., Enhanced Care - R or Enhanced Care Plus - R) Neither the provider nor enrollee may be held liable for the cost of services when the provider could not have reasonably known that the enrollee was restricted to another provider. To report suspicious activity, please contact EmblemHealth's Special Investigations Unit in one of the following ways:

- E-mail: KOfraud@emblemhealth.com
- Toll-free hotline: **1-888-4KO-FRAUD** (1-888-456-3728)
- Mail:
EmblemHealth
Attention: Special Investigations Unit
441 Ninth Avenue
New York, NY 10001

A trained investigator will address your concerns. The informant may remain anonymous. For more information, please see the **Fraud and Abuse** chapter.

Permanent Placement in Nursing Homes

The Medicaid Managed Care (MMC) nursing home benefit now includes coverage of permanent stays in residential health care facilities for Medicaid recipients aged 21 and over who reside in the five boroughs of New York City.

Medicaid recipients in permanent nursing home status prior to February 1, 2015 continued to be covered by Medicaid FFS, however they may choose to voluntarily enroll in a MMC plan as of October 1, 2015. MMC plans will be responsible for members who enter permanent resident status on and after February 1, 2015, and these members will no longer be disenrolled from a Medicaid Managed Care plan.

Voluntary Enrollment

Effective **October 1, 2015**, eligible New York City, Westchester, Nassau and Suffolk county Medicaid recipients who were in permanent residence in a nursing home are able to enroll in

2016 PROVIDER NETWORKS AND MEMBER BENEFIT PLANS

managed care on a voluntary basis. Covered nursing home services include:

- Medical supervision
- 24-hour nursing care
- Assistance with daily living
- Physical therapy
- Occupational therapy
- Speech-language pathology and other services

Effective **April 1, 2015**, the MMC nursing home benefit was expanded to include Medicaid recipients aged 21 and over who reside in Nassau, Suffolk and Westchester counties.

Veterans' Nursing Homes

Eligible Veterans, Spouses of Eligible Veterans, and Gold Star Parents of Eligible Veterans may choose to stay in a Veterans' nursing home.

If EmblemHealth does not have a Veterans' home in their provider network and a member requests access to a Veterans' home, the member will be allowed to change enrollment into a MMC plan that has the Veterans' home in their network. While the member's request to change plans is pending, EmblemHealth will allow the member access to the Veterans' home and pay the home the benchmark Medicaid rate until the member has changed plans.

We make every effort to assist new members whose current providers are not participating with one of our plans. See the **Continuity/Transition of Care - New Members** section of the **Care Management** chapter for information on transition of care.

Mandatory Enrollment of the New York City Homeless Population

According to the New York State Department of Health (NYSDOH), all of New York City's homeless population must be enrolled into Medicaid Managed Care.

Identifying Homeless and HARP Members Enrolled with EmblemHealth

Since homeless and HARP members may present with unique health needs, we have identified which of your Medicaid Managed Care patients are homeless and/or HARP members. The following symbols are included within the secure provider website's panel report feature:

- "H" next to the name of homeless members
- "R" next to the name of HARP members
- "P" next to the name of homeless HARP members

A homeless indicator is present on eligibility extracts. The homeless indicator "H" is included if the member is homeless and blank if the member is not homeless.

Primary Care Services Offered in Homeless Shelters

Homeless members can select any participating PCP. However, to improve access to care for our

2016 PROVIDER NETWORKS AND MEMBER BENEFIT PLANS

members with no place of usual residence, we've expanded our provider network to include practitioners who practice in homeless shelters. A PCP practicing at a homeless shelter is available only to members who reside in that shelter.

NYSDOH Medicaid Provider Non-Interference

Medicaid and MLTC providers and their employees or contractors are not permitted to interfere with the rights of Medicaid recipients in making decisions about their healthcare coverage. Medicaid and MLTC providers and their employees or contractors are free to inform Medicaid recipients about their contractual relationships with Medicaid or MLTC plans. However, they are prohibited from directing, assisting or persuading Medicaid recipients on which plan to join or keep.

In addition, if a Medicaid recipient expresses interest in a Medicaid Managed Care or MLTC program, providers and their employees or contractors must not dissuade or limit the recipient from seeking information about Medicaid Managed Care or MLTC programs. Instead, they should direct the recipient to New York Medicaid Choice, New York State's enrollment broker responsible for providing Medicaid recipients with eligibility and enrollment information for all MMC and MLTC plans.

For assistance, please call New York Medicaid Choice: **1-800-505-5678**, Monday - Friday, 8:30 a.m. to 8:00 pm, Saturday, 10:00 am to 6:00 pm.

Any suspected violations will be turned over to the New York Office of the Medicaid Inspector General (OMIG) and potentially the Federal Office of Inspector General (OIG) for investigation.

Medicaid Health Home Program

Under the Federal Patient Protection and Affordable Care Act (PPACA), New York has developed a set of Health Home services for Medicaid members who have been identified and diagnosed with any of the following conditions:

- Two or more conditions, such as asthma, diabetes, high blood pressure or heart disease
- HIV+ or AIDS
- Severe mental illness or substance use disorder

The Health Home Program is offered at no cost to all eligible EmblemHealth Medicaid members. All HARP members are assigned a Medicaid Health Home to provide care plan coordination; however, members may opt out of the program at any time. EmblemHealth will then notify the member, and their PCP, of the Health Home assignment by letter. The member's assigned Health Home Care Manager will contact the member's PCP to ensure the treatment plan is included in the member's comprehensive care plan.

The following services are available through the Medicaid Health Home program:

- Comprehensive case management with an assigned, personal care manager
- Assistance with getting necessary tests and screenings

2016 PROVIDER NETWORKS AND MEMBER BENEFIT PLANS

- Help and follow-up when leaving the hospital and going to another setting
- Personal support and support for their caregiver or family
- Referrals and access to community and social support services

More information on the **NYS Medicaid Health Home Program** can be found on the NYSDOH website: http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes.

Medicaid Members who are not eligible to participate in the Medicaid Health Home Program may still meet our criteria for Case Management services. If you think a member would benefit from case management, please refer the patient to the program by calling **1-800-447-0768**, Monday through Friday, from 9 am to 5 pm.

A listing of EmblemHealth network Health Homes that support our Medicaid and HARP benefit plans are listed in the **Directory** chapter.

Restricted Recipient Program

MMC and HARP members are placed in the Restricted Recipient Program (RRP) when a review of their service utilization and other information reveals that they are:

- Getting care from several doctors for the same problem
- Getting medical care more often than needed
- Using prescription medicine in a way that may be dangerous to their health
- Allowing someone else to use their plan ID card
- Using or accessing care in other inappropriate ways

The Office of Medicaid Inspector General (OMIG) refers members to EmblemHealth for restricted services.

RRP members are restricted to certain provider types (dentists, hospitals, pharmacies, behavioral health professionals, etc.) based on a history of overuse or inappropriate use of specific services. Members are further restricted to using a specific provider of that type.

EmblemHealth is required to continue the Medicaid FFS program restrictions for MMC and HARP members until their existing restriction period ends. EmblemHealth is also required to identify members already enrolled that need to be restricted. All EmblemHealth RRP members are in an Employer Group that begins with "1R0".

Additionally, EmblemHealth RRP member ID cards have an "R" after the plan name on the front of the card so that providers will know that they are restricted. (i.e., Enhanced Care - R or Enhanced Care Plus - R) Neither the provider nor enrollee may be held liable for the cost of services when the provider could not have reasonably known that the enrollee was restricted to another provider. To report suspicious activity, please contact EmblemHealth's Special Investigations Unit in one of the following ways:

- E-mail: KOfraud@emblemhealth.com
- Toll-free hotline: **1-888-4KO-FRAUD** (1-888-456-3728)
- Mail:

2016 PROVIDER NETWORKS AND MEMBER BENEFIT PLANS

EmblemHealth
 Attention: Special Investigations Unit
 55 Water Street
 New York, NY 10041

A trained investigator will address your concerns. The informant may remain anonymous. For more information, please see the Fraud and Abuse chapter.

Essential Plan

HIP-UNDERWRITTEN COMMERCIAL NETWORK AND PLAN SUMMARY FOR 2016 ENHANCED CARE PRIME NETWORK									
Network	Plan Name	Plan Type	PCP/Referral Req'd	Deductibles (Individual/Family)	PCP/Specialist/ER Copay	OON Coverage	MOOP (Individual/Family)	Service Area	Coinsurance
Enhanced Care Prime Network 1	Essential Plan 1	HMO	Yes/Yes	N/A	\$15/\$25/\$75	No	\$2000	8 county	Yes, for certain services
Enhanced Care Prime Network 1	Essential Plan 1 Plus	HMO	Yes/Yes	N/A	\$15/\$25/\$75	No	\$2000	8 county	Yes, for certain services
Enhanced Care Prime Network 1	Essential Plan 2	HMO	Yes/Yes	N/A	\$0 copay	No	\$200	8 county	No
Enhanced Care Prime Network 1	Essential Plan 2 Plus	HMO	Yes/Yes	N/A	\$0 copay	No	\$200	8 county	No
Enhanced Care Prime Network 1	Essential Plan 3	HMO	Yes/Yes	N/A	\$0 copay	No	\$200	8 county	No
Enhanced Care	Essential Plan	HMO	Yes/Yes	N/A	\$0 copay	No	\$0	8 county	No

2016 PROVIDER NETWORKS AND MEMBER BENEFIT PLANS

Prime Network 1	4								
-----------------	---	--	--	--	--	--	--	--	--

ER = emergency room; IN = in-network; N/A = not applicable; OON = out-of-network; MOOP = maximum out-of-pocket; PCP = primary care provider; FPL = federal poverty level.

8 county = Bronx, Kings (Brooklyn), New York (Manhattan), Queens, Richmond (Staten Island), Nassau, Suffolk & Westchester counties.

¹ Enhanced Care Prime Network members traveling outside of the United States can get coverage for urgent and emergency care only in the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands and American Samoa. Members needing any type of care while in any other country (including Canada and Mexico) will be held responsible for payment.

The Essential Plan is a new, lost-cost plan for adult individuals to be purchased on the NY State of Health marketplace, effective January 1, 2016. The Essential Plan is modeled after our Select Care Silver Plan. As with Qualified Health Plans (QHPs), the Essential Plan includes all benefits under the 10 categories of the ACA-required Essential Health Benefits. Premiums for the Essential Plan are either \$20 or \$0.

The Essential Plan pulls member from two already existing member populations – the current QHP Select Care Silver CSR 2&3 and the current Medicaid Aliessa population. The Aliessa population is New York’s legally residing immigrant population. Eligible individuals in the Aliessa population, who previously were only eligible for coverage through state-only-funded Medicaid, will also transition into the Essential Plan. Essential Plan Members are covered for emergency care in the U.S., Puerto Rico, the Virgin Islands, Mexico, Guam, Canada and the Northern Mariana Islands.

Eligibility

The Essential Plan covers adult individuals only. If eligible, spouses and children must enroll into EP separately under an individual policy. To qualify for the Essential Plan, individuals must:

- Be a New York State resident
- Be between the ages of 19 and 64 (US citizens) or 21 to 64 (legally residing immigrants)
- Not be eligible for Medicare, Medicaid, Child Health Plus, affordable health care coverage from an employer, or another type of minimum essential health coverage
- Be either:
 - US citizen with an income between 138% and 200% of FPL (in 2015 that comes to between \$16,242.60 and \$23,540)
 - These individuals were formerly eligible for eligible for a QHP Silver Plan, but will now transition to EP based on income status.
 - Legally residing immigrant with an income of less than 138% of FPL (in 2015 this comes to \$16,242.60)
 - These individuals were formerly eligible for Medicaid, but have been transitioned to EP based on immigration status (also known as Aliessa population).
- Not be pregnant or eligible for long-term care. In both of these cases, members would be eligible for Medicaid instead of the Essential Plan.

2016 PROVIDER NETWORKS AND MEMBER BENEFIT PLANS

Covered Services

Ten categories of essential health benefits are covered with no cost-sharing (no deductible, copay or coinsurance) on preventive care services, such as screenings, tests and shots. For more information, please see the **Preventive Health Guidelines** located on our **Health and Wellness** webpage. Information in our guidelines comes from medical expert organizations, such as the American Academy of Pediatrics, the US Department of Health and Human Services, the Advisory Committee on Immunization Practices and the Centers for Disease Control and Prevention (CDC).

Unlike QHP Select Care Plans, some Essential Plan members are also eligible for adult vision and dental benefits for a small additional monthly cost. The Aliessa population receives six extra benefits embedded in the plan at no extra cost. These include: dental, vision, non-emergency transportation, non-prescription drugs, orthopedic footwear, and orthotic devices.

How to enroll

There are four ways to apply:

- Online. Visit NYSOH online and go to the Individuals & Families section. Once there, start an account and begin shopping for a plan.
- In person. Get help from a Navigator, certified application counselor (CAC), Marketplace Facilitated Enroller (MFEs) or broker/agent. People can also get help applying from MFEs aboard the EmblemHealth vans.
- By phone. Call EmblemHealth at 1-877-411-3625, daily from 8 a.m. to 8 p.m., and the NYSOH at 1-855-355-5777, Monday through Friday from 8 a.m. to 8 p.m., and Saturday from 9 a.m. to 1 p.m.
- By mail. Print an application at nystateofhealth.ny.gov and send it back to NYSOH, who will then confirm eligibility and enroll them in the chosen plan.

Enrollment period restrictions do not apply to Essential. Eligible individuals may enroll in CHP throughout the year via the **NY State of Health Marketplace** or through enrollment facilitators.

MEDICARE NETWORKS

Medicare Plans

EmblemHealth companies HIP and GHI underwrite all Medicare plans associated with the VIP Prime Network (HIP Health Plan of New York), Medicare Essential Network (HIP Health Plan of New York) and Medicare Choice PPO Network (Group Health Incorporated). EmblemHealth Medicare plans are authorized by Medicare through two contracts:

1. Plans associated with the Medicare Choice PPO Network utilize the H5528 Medicare Contract.

2016 PROVIDER NETWORKS AND MEMBER BENEFIT PLANS

- Plans associated with the Medicare Essential Network and VIP Prime Network utilize the H3330 Medicare Contract.

As a reminder, providers are deemed participating in all benefit plans associated with their participating networks and may not terminate participation in an individual benefit plan. Providers can subscribe to receive updates to this chapter by clicking the subscribe icon above.

Maximum Out-of-Pocket Threshold

The maximum out-of-pocket (MOOP) threshold for Medicare Parts A and B services covered under the EmblemHealth Medicare Advantage plans has changed. This includes the in-network MOOP under the EmblemHealth Medicare HMO plans and both the in-network and combined (in- and out-of-network) MOOPs under the EmblemHealth Medicare PPO plans. The MOOP for each plan is contained within the **Medicare Network and Plan Summary** section of this chapter.

Coinsurance and Copay Changes

- **Transferability of Maximum Out-of-Pocket (MOOP):** If a member makes a mid-year change from an EmblemHealth Medicare HMO to an EmblemHealth Medicare PPO plan, or vice versa, the MOOP accumulated thus far in the contract year now follows the member and counts toward the MOOP in the new EmblemHealth Medicare plan.
- **Cost-Sharing May Apply to Some EmblemHealth Dual Eligible Special Needs Plan (HMO SNP) Members:** Cost-sharing for many of our HMO SNP benefits will increase from the current amount of \$0. The change will affect most services and will vary depending on the benefit.

A statement of members' out-of-pocket spending to date will appear on their Explanation of Benefits. Members will continue to be notified by mail upon reaching the MOOP for their plan. This notice will also list services with \$0 cost-sharing available to the member for the remainder of the calendar year. Sign in to the provider section of the EmblemHealth website at www.emblemhealth.com/providers to confirm MOOPs for your members who are enrolled in any of the EmblemHealth Medicare plans associated with the EmblemHealth Medicare Choice PPO Network, VIP Prime Network or Medicare Essential Network.

Members can consult their Evidence of Coverage (EOC) for a list of covered services and the associated cost-sharing. Many HMO SNP plan members are qualified Medicare beneficiaries (QMB), which means they receive help from New York State Medicaid to pay their cost-sharing. As a result, the provider must bill Medicaid for the cost-sharing upon receipt of payment from EmblemHealth. The correct address to bill Medicaid is located on these members' Common Benefits Identification Card (CBIC).

Wellness Exams

Medicare Part B services now include an annual wellness exam in addition to the "Welcome to Medicare" physical exam.

- **"Welcome to Medicare" Physical Exam:** Our Medicare plans cover a one-time "Welcome to Medicare" physical exam. This exam includes a health review, education and counseling about preventive services (including screenings and vaccinations) and referrals for care, if necessary.
Note: Members must have the "Welcome to Medicare" physical exam within 12 months of

2016 PROVIDER NETWORKS AND MEMBER BENEFIT PLANS

enrolling in Medicare Part B. When making their appointment, they should let you know they are scheduling their "Welcome to Medicare" physical exam.

- **Annual Wellness Visit:** A Health Risk Assessment (HRA) is to be used as part of the Annual Wellness Visits (AWV). Members enrolled in Medicare Part B for over 12 months are eligible for an annual wellness visit to develop or update a personalized prevention plan based on their health needs and risk factors. This is covered once every 12 months. **Note:** Following their "Welcome to Medicare" physical exam, members must wait 12 months before having their first annual wellness visit. However, once members have been enrolled in Medicare Part B for at least 12 months, they do not need to have had a "Welcome to Medicare" physical exam to be covered for annual wellness visits. Providers may bill for this service using HCPCS codes G0438 and G0439 for initial and subsequent visits, respectively.
- **No Cost-Sharing for Preventive Care Services:** CMS has released National Coverage Determinations for preventive services that are to be offered without cost-sharing. All of the services are listed in **Appendix C**. For HMO members, including Dual Eligible, Medicare-required covered services that are not available in network and receive prior approval from our plan, or the member's assigned managing entity, as applicable, will be allowed at \$0 cost-sharing as well. For PPO Dual Eligible members, all of the services outlined in **Appendix C** are covered at \$0 cost-sharing. For EmblemHealth PPO I and EmblemHealth Advantage (PPO) members, all of the services listed in **Appendix C** are covered at the out-of-network cost-sharing percentage.

Medicare Network and Plan Summary

To view benefit summaries and copies of members' Evidences of Coverage for each of these Medicare plans, please visit www.emblemhealth.com/Our-Plans/Medicare.aspx:

Medicare Choice PPO Network

- EmblemHealth PPO I (PPO)
- EmblemHealth Advantage (PPO)
- EmblemHealth Group Access Rx PPO
- EmblemHealth Group Access PPO

Medicare Essential Network

- EmblemHealth Essential (HMO)
- EmblemHealth VIP High Option (HMO)

VIP Prime Network

- EmblemHealth VIP (HMO)
- EmblemHealth VIP Premier (HMO)
- EmblemHealth VIP Rx Carve-out (HMO)
- EmblemHealth Part A Payers (HMO)

The table below summarizes our Medicare suite of products. Special Needs and FIDA plans are located within the **Medicare Special Needs Plans** section of this chapter.

2016 PROVIDER NETWORKS AND MEMBER BENEFIT PLANS

GHI-UNDERWRITTEN MEDICARE NETWORK AND PLAN SUMMARY FOR 2016 MEDICARE CHOICE PPO NETWORK							
Network	Plan Name	Plan Type	PCP/Referral Req'd	OON Coverage	In-network Cost-Sharing	Service Area	Comments
Medicare Choice PPO Network	EmblemHealth Advantage (PPO)	EmblemHealth Medicare PPO	No/No	Yes	Copays / coinsurance	National	Individual Medicare Advantage prescription drug plan. No drug coverage in the "donut hole."
Medicare Choice PPO Network	EmblemHealth Group Access PPO	EmblemHealth Medicare PPO	No/No	Yes	Copays / coinsurance	National	Employer Group MAPD plan. Each group contracts individually with the plan for benefit design. Pharmacy benefits excluded.
Medicare Choice PPO Network	EmblemHealth Group Access Rx PPO	EmblemHealth Medicare PPO	No/No	Yes	Copays / coinsurance	National	Employer Group MAPD plan. Each group contracts individually with the plan for benefit design. Pharmacy benefits

2016 PROVIDER NETWORKS AND MEMBER BENEFIT PLANS

GHI-UNDERWRITTEN MEDICARE NETWORK AND PLAN SUMMARY FOR 2016 MEDICARE CHOICE PPO NETWORK							
Network	Plan Name	Plan Type	PCP/Referral Req'd	OON Coverage	In-network Cost-Sharing	Service Area	Comments
							included.
Medicare Choice PPO Network	EmblemHealth PPO I (PPO)	EmblemHealth Medicare PPO	No/No	Yes	Copays / coinsurance	8 County	Individual Medicare Advantage plan. No Part D coverage.

ER = emergency room; IN = in-network; N/A = not applicable; OON = out-of-network; MOOP = maximum out-of-pocket; PCP = primary care provider; FPL = federal poverty level.

8 county = Bronx, Kings (Brooklyn), New York (Manhattan), Queens, Richmond (Staten Island), Nassau, Suffolk & Westchester counties

Members can access certain services from county departments of health, academic dental centers and, for Medicaid members, Medicaid FFS providers. (See the **Access to Care and Delivery System** chapter for a list of these services)

Members are covered for urgent and emergency care. HIP covers in all 50 United States, Canada, Mexico, Puerto Rico, the US Virgin Islands, Guam and the Northern Mariana Islands. Medicare members have worldwide urgent and emergency coverage.

HIP-UNDERWRITTEN MEDICARE NETWORK AND PLAN SUMMARY FOR 2016 MEDICARE ESSENTIAL & VIP PRIME NETWORK							
Network	Plan Name	Plan Type	PCP/Referral Req'd	OON Coverage	In-network Cost-Sharing	Service Area	Comments
Medicare Essential Network	EmblemHealth Essential (HMO)	EmblemHealth Medicare HMO	Yes/Yes	No	Copays / coinsurance	8 county ¹	Limited PCP network. Provider should confirm participation as PCP prior to accepting new patients.
Medicare Essential Network	EmblemHealth VIP High Option (HMO)	EmblemHealth Medicare HMO	Yes/Yes	No	Copays / coinsurance	8 county ¹	Individual Medicare Plan. Limited PCP network.

2016 PROVIDER NETWORKS AND MEMBER BENEFIT PLANS

HIP-UNDERWRITTEN MEDICARE NETWORK AND PLAN SUMMARY FOR 2016 MEDICARE ESSENTIAL & VIP PRIME NETWORK							
Network	Plan Name	Plan Type	PCP/Referral Req'd	OON Coverage	In-network Cost-Sharing	Service Area	Comments
							Provider should confirm participation as PCP prior to accepting new patients. No copays for most services, including office visits and hospital stays. Coinsurance does apply to Part B drugs.
N/A	GHI/CNY Enhanced Prescription Drug Plan	EmblemHealth Medicare PDP	N/A	Yes	Copays / coinsurance	New York State	Part D drug coverage.
VIP Prime Network	EmblemHealth Part A Payers (HMO)	EmblemHealth Medicare HMO	Yes/Yes	No	Copays / coinsurance	8 county ¹	Employer Group plan.
VIP Prime Network	EmblemHealth VIP (HMO)	EmblemHealth Medicare	Yes/Yes	No	Copays / coinsurance	8 county ¹	Individual Medicare plan.



2016 PROVIDER NETWORKS AND MEMBER BENEFIT PLANS

HIP-UNDERWRITTEN MEDICARE NETWORK AND PLAN SUMMARY FOR 2016 MEDICARE ESSENTIAL & VIP PRIME NETWORK							
Network	Plan Name	Plan Type	PCP/Referral Req'd	OON Coverage	In-network Cost-Sharing	Service Area	Comments
		re HMO					
VIP Prime Network	EmblemHealth VIP Premier (HMO)	EmblemHealth Medicare HMO	Yes/Yes	No	Copays / coinsurance	8 county ¹	Employer Group plan.
VIP Prime Network	EmblemHealth VIP Rx Carve-Out (HMO)	EmblemHealth Medicare HMO	Yes/Yes	No	Copays / coinsurance	8 county ¹	Employer Group plan.

ER = emergency room; IN = in-network; N/A = not applicable; OON = out-of-network; MOOP = maximum out-of-pocket; PCP = primary care provider; FPL = federal poverty level.

8 county1 = New York City (Bronx, Kings, New York, Queens, Richmond), Nassau, Suffolk & Westchester

Members can access certain services from county departments of health, academic dental centers and, for Medicaid members, Medicaid FFS providers. (See the **Access to Care and Delivery System** chapter for a list of these services)

Members are covered for urgent and emergency care. HIP covers in all 50 United States, Canada, Mexico, Puerto Rico, the US Virgin Islands, Guam and the Northern Mariana Islands. Medicare members have worldwide urgent and emergency coverage.

Changes for 2017

Below is a summary of Medicare benefit plans and networks changes for 2017:

- **Discontinued Plans:** Individual PPO plans including EmblemHealth PPO I, EmblemHealth Advantage PPO and EmblemHealth Dual Eligible (PPO SNP) will sunset.
- **New Plan:** EmblemHealth VIP Value (HMO) provides in-network coverage from providers in our Medicare Essential Network, and benefits with \$30 copay for PCPs and \$50 copay for specialists, plus Part D prescription drug coverage.
- **New Plan Names:** All HMO plans will have new names.
- **Provider Network:** EmblemHealth VIP Gold Plus (HMO), formerly EmblemHealth VIP High Option (HMO) will transition from the Medicare Essential Network to the VIP Prime Network of providers.
- **New Vendors:** Dental services will transition to DentaQuest and vision services will transition to EyeMed.
- **Preferred Pharmacy Network:** Part D prescription drug deductibles will apply to medications on formulary Tier 3, Tier 4 and Tier 5. A subset of “preferred pharmacies” within the Medicare pharmacy network will offer lower cost-sharing with \$0 copay for preferred generic drugs.
- **Fitness Benefit:** Access to membership in SilverSneakers®, an exercise program designed for older adults, are included in some HMO plans.

2016 PROVIDER NETWORKS AND MEMBER BENEFIT PLANS

- **Plan Enhancements:** EmblemHealth VIP Dual (HMO SNP), formerly EmblemHealth Dual Eligible (HMO SNP), will have additional benefits such as acupuncture visits and increased limits on over-the-counter (OTC) items debit card.
- **ID Cards:** Urgent Care copay will display on member ID cards.

2016 Plan Name	2017 Plan Name	2017 Provider Network	2017 Plan Highlights
EmblemHealth VIP (HMO)	EmblemHealth VIP Gold (HMO)	VIP Prime Network	SilverSneakers Fitness, Comprehensive and Preventive Dental Services, \$0 copay for preferred generic drugs, \$0 copay for PCP visits
EmblemHealth VIP High Option (HMO)	EmblemHealth VIP Gold Plus (HMO)	VIP Prime Network	SilverSneakers Fitness, Comprehensive and Preventive Dental Services, \$0 copay for preferred generic drugs, \$0 copay for PCP visits
New Plan for 2017	EmblemHealth VIP Value (HMO)	Medicare Essential Network	Preventive Dental Services, \$0 copay for preferred generic drugs, offered in 6 counties (Manhattan, Queens, Richmond, Nassau, Suffolk and Westchester)
EmblemHealth Dual Eligible (HMO SNP)	EmblemHealth VIP Dual (HMO SNP)	VIP Prime Network	48 acupuncture visits per year, \$720 annual over-the-counter (OTC) debit card, \$0 copay for covered services, \$0 copay for preferred generic drugs, Comprehensive and Preventive Dental Services

MEDICARE SPECIAL NEEDS PLANS

SNPs Meet Our Members' Special Needs

Medicare Special Needs Plans (SNPs) are specially designated Medicare Advantage plans, with custom designed benefits to meet the needs of a specific population. Enrollment in a SNP is limited to Medicare beneficiaries within the target SNP population. The target populations for the EmblemHealth SNPs are individuals who live within the plan service area, are eligible for Medicare Part A and Part B, and are eligible for Medicaid.

As a reminder, providers are deemed participating in all benefit plans associated with their participating networks and may not terminate participation in an individual benefit plan. Providers can subscribe to receive updates to this chapter by clicking the subscribe icon above.

EmblemHealth's SNPs consist of:

Medicare Choice PPO Network

- **EmblemHealth Dual Eligible (PPO SNP)**

- ArchCare Advantage (HMO SNP)
- GuildNet Gold (HMO-POS SNP)

VIP Prime Network

- EmblemHealth Dual Eligible Group (HMO SNP)

2016 PROVIDER NETWORKS AND MEMBER BENEFIT PLANS

- EmblemHealth Dual Eligible (HMO SNP)

EmblemHealth Dual Assurance Network

- EmblemHealth Dual Assurance FIDA Plan – terminated on 12/31/2015

Associated Dual Assurance Network

- ArchCare Community Advantage FIDA Plan – terminated on 10/31/2015
- GuildNet Gold Plus FIDA Plan POS

The Medicare benefit for each of these plans is supplemented by a specific set of Medicaid benefits.

The SNP Interdisciplinary Team

Our SNP goals are to:

- Improve access to medical, mental health, social services, affordable care and preventive health services
- Improve coordination of care through an identified point of contact
- Improve transitions of care across health care settings and providers
- Assure appropriate utilization of services
- Assure cost-effective service delivery
- Improve beneficiary health outcomes

The SNP interdisciplinary team provides the framework to coordinate and deliver the plan of care and to provide appropriate staff and program oversight to achieve the SNP goals. The care management staff assumes an important role in developing and implementing the individualized care plan, coordinating care, and sharing information with the interdisciplinary care team and with the member, their family or caregiver.

Practitioners providing care to our SNP members are important members of the SNP interdisciplinary team. As such, they participate in one of our regularly scheduled care coordination or case rounds meetings to discuss their plan of care and the health status of the SNP-enrolled patient. These practitioners also share their progress with the team to ensure we are meeting our SNP program goals.

The summary table below outlines the key components of the SNPs, such as Medicaid eligibility level, service area and whether referrals are needed.

Required Training for EmblemHealth Practitioners, Providers and Vendors

Each year, all Medicare Choice PPO Network and VIP Prime Network providers are required to complete the Special Needs Plan (SNP) Model of Care Training for each of the Dual Eligible SNPs with which they participate, as mandated by Centers for Medicare & Medicaid Services (CMS). For training presentations and other learning opportunities, please visit our **Learn Online** webpage.

Medicare Special Needs Plans

2016 PROVIDER NETWORKS AND MEMBER BENEFIT PLANS

GHI-UNDERWRITTEN MEDICARE SPECIAL NEEDS NETWORK AND PLAN SUMMARY FOR 2016 MEDICARE CHOICE PPO NETWORK							
Network	Plan Name	Plan Type	PCP/Referral Req'd?	OON Coverage	In-network Cost-Sharing	Service Area	Comments
Medicare Choice PPO Network	Emblem Health Dual Eligible (PPO SNP)	Emblem Health Medicare PPO	No/ No	Yes	Copays/ Coinsurance	8 county ¹	Individual Medicare Advantage prescription drug plan. Special needs plan limited to individuals with both Medicare and Medicaid coverage. Individuals with full Medicaid coverage are not required to pay cost-sharing.
Medicare Choice PPO Network	ArchCare Advantage (HMO SNP)	Emblem Health Medicare ASO	No/No	Yes	Coinsurance	8 county ²	N/A
Medicare Choice PPO Network	GuildNet Gold	Emblem Health Medicare ASO	No/No	No	Part D only	7 county	Third party administration MAPD plan. Plans customized to meet client's health plan needs. Individuals must have Medicare and full Medicaid coverage.

ER = emergency room; IN = in-network; N/A = not applicable; OON = out-of-network; MOOP = maximum out-of-pocket; PCP = primary care provider; FPL = federal poverty level.

8 county¹ = Bronx, Kings (Brooklyn), New York (Manhattan), Queens, Richmond (Staten Island), Nassau, Suffolk & Westchester

8 county² = Bronx, Kings (Brooklyn), New York (Manhattan), Queens, Richmond (Staten Island), Dutchess, Orange & Westchester counties

7 county = Bronx, Kings (Brooklyn), New York (Manhattan), Queens, Richmond (Staten Island), Nassau, Suffolk counties

HIP-UNDERWRITTEN MEDICARE SPECIAL NEEDS NETWORK AND PLAN SUMMARY FOR 2016 VIP PRIME NETWORK							
Network	Plan Name	Plan Type	PCP/Referral Req'd?	OON Coverage	In-network Cost-Sharing	Service Area	Comments

2016 PROVIDER NETWORKS AND MEMBER BENEFIT PLANS

HIP-UNDERWRITTEN MEDICARE SPECIAL NEEDS NETWORK AND PLAN SUMMARY FOR 2016 VIP PRIME NETWORK							
Network	Plan Name	Plan Type	PCP/Referral Req'd?	OON Coverage	In-network Cost-Sharing	Service Area	Comments
VIP Prime Network	Emblem Health Dual Eligible Group (HMO SNP)	Emblem Health Medicare HMO	Yes/Yes	Yes*	Varies by group	8 county	Employer Group plan. Special needs plan limited to individuals with both Medicare and Medicaid coverage. Individuals with full Medicaid coverage are not required to pay cost-sharing.
VIP Prime Network	Emblem Health Dual Eligible (HMO SNP)	Emblem Health Medicare HMO	Yes/Yes	Yes*	Copays/Coinsurance	8 county	Individual Medicare Plan. Special needs plan limited to individuals with both Medicare and Medicaid coverage. Individuals with full Medicaid coverage are not required to pay cost-sharing.
Associated Dual Assurance Network	GuildNet Gold Plus FIDA Plan	Emblem Health Medicare ASO	No/No	N/A	None**	6 county	IDT makes all prior approval/ prior authorization decisions. Medicaid-related services should be billed directly to GuildNet c/o Relay Health.

ER = emergency room; IN = in-network; N/A = not applicable; OON = out-of-network; MOOP = maximum out-of-pocket; PCP = primary care provider; FPL = federal poverty level.

6 county = Bronx, Kings (Brooklyn), New York (Manhattan), Queens, Richmond (Staten Island) & Nassau counties

(Suffolk and Westchester delayed indefinitely)

8 county = Bronx, Kings (Brooklyn), New York (Manhattan), Queens, Richmond (Staten Island), Nassau, Suffolk & Westchester counties

*GuildNet Gold Plus FIDA Plan POS members are not required to have a PCP. However, EmblemHealth is required to populate PCP information on the member's ID card to comply with NYSDOH requirements. The provider listed on the member's ID card may be a participating or non-participating provider in accordance with GuildNet's policy and procedures. For more information, please contact the member's case manager.

**No in-network or out-of-network cost-sharing.

For more information on EmblemHealth's FIDA Plans, see the **Fully Integrated Dual Advantage (FIDA)** chapter.

Provider Obligations/Responsibilities for Participation

2016 PROVIDER NETWORKS AND MEMBER BENEFIT PLANS

Provider Obligations/Responsibilities for Participation in Dual-Eligible Special Needs Plans

1. Members have no copayment for covered services other than for prescriptions drugs. The provider may not collect a copayment for covered services from a Dual Eligible SNP member (including but not limited to ArchCare and GuildNet Inc.).
2. HHS, the Comptroller General or their designees have the right to audit, evaluate and inspect any pertinent information of your medical practice including books, contracts, records, including medical records, and documentation related to CMS' contract with EmblemHealth for a period of 10 years from the final date of the contract period or the completion of any audit, whichever is later.
3. The provider may not hold members liable for payment of fees that are the legal obligation of EmblemHealth or a payor (including but not limited to ArchCare and GuildNet Inc.).

Provider Obligations/Responsibilities for Participation in Medicare-Medicaid Plans (MMPs)

1. Members have no copayment for covered services other than for prescriptions drugs. The provider may not collect a copayment for covered services from a Medicare-Medicaid Plan (MMP) member (including but not limited to ArchCare and GuildNet Inc.).
2. HHS, the Comptroller General or their designees have the right to audit, evaluate and inspect any pertinent information of your medical practice including books, contracts, records, including medical records, and documentation related to CMS' contract with EmblemHealth for a period of 10 years from the final date of the contract period or the completion of any audit, whichever is later.
3. The provider may not hold members liable for payment of fees that are the legal obligation of EmblemHealth or a payor (including but not limited to ArchCare and GuildNet Inc.).
4. For information about provider obligations and responsibilities, see **Medicare/Advantage-Medicaid Required Provisions** in the **Required Provisions to Network Provider Agreements** chapter.

Provider Obligations/Responsibilities for Participation in the GuildNet Inc. d/b/a GuildNet Gold Plus FIDA Plan

1. GuildNet Inc. d/b/a GuildNet Gold Plus FIDA Plan ("GuildNet") has the right to request that a particular provider participating in the EmblemHealth ASO program or practitioner or physician employed by or contracted with a provider no longer render services to a member enrolled in GuildNet Gold Plus FIDA Plan. Upon notice from EmblemHealth, provider shall immediately comply with such request and agrees to remove such practitioner or physician from rendering covered services to such members.
2. If EmblemHealth delegates any services to provider, GuildNet has the right to revoke the delegated activities as they relate to members participating in their FIDA plans.
3. GuildNet has the right to monitor the performance of providers on an ongoing basis.
4. For information about provider obligations and responsibilities, see **Standard Clauses for Managed Care Provider/IPA Contracts for the Fully-Integrated Duals Advantage Program** in the **Required Provisions to Network Provider Agreements** chapter.

APPENDIX A: MEDICAID MANAGED CARE MODEL CONTRACT, APPENDIX K

2016 PROVIDER NETWORKS AND MEMBER BENEFIT PLANS

See **Medicaid Managed Care Model Contract, Appendix K** at the end of this chapter.

APPENDIX B: BENEFIT SUMMARIES

The plan benefit packages available to our members are provided in accordance with the terms of the members' benefit plans. Below we provide links to sample summaries of benefits for the following plans:

- **EmblemHealth Select Care Bronze D HMO**
- **EmblemHealth Select Care Silver**
- **GHI HMO**
- **NYC HMO Base Plan**
- **Vytra HMO**

Note: These sample benefit summaries are provided for informational use only. They do not constitute an agreement, do not contain complete details of the plans and the benefits may vary based on riders purchased. To view a member's actual benefits, sign in to our secure provider website at www.emblemhealth.com/Providers and use the Eligibility/Benefits function.

APPENDIX C: MEDICARE PREVENTIVE SERVICES

The preventive care services listed on this **chart** are those CMS has determined should be provided to all Medicare recipients with no cost-sharing. This requirement applies to original Medicare, as well as to all of our Medicare plans, when provided on an in-network basis.

APPENDIX K

PREPAID BENEFIT PACKAGE DEFINITIONS OF COVERED AND NON-COVERED SERVICES

- K.1** **Chart of Prepaid Benefit Package**
 - Medicaid Managed Care Non-SSI (MMC Non-SSI)
 - Medicaid Managed Care SSI (MMC SSI/SSI-Related)
 - Medicaid Fee-for-Service (MFFS)
 - Family Health Plus (FHPlus)

- K.1 HIV** **Chart of Prepaid Benefit Package**
 - HIV SNP Non-SSI
 - HIV SNP HIV/AIDS SSI
 - HIV SNP Uninfected SSI Children and Homeless Adults
 - Medicaid Fee-for-Service (MFFS)

- K.2** **Prepaid Benefit Package**
Definitions of Covered Services

- K.3** **Medicaid Managed Care Definitions of Non-Covered**
Services

- K.4** **Family Health Plus Non-Covered Services**

APPENDIX K
March 1, 2014
K-1

APPENDIX K PREPAID BENEFIT PACKAGE DEFINITIONS OF COVERED AND NON-COVERED SERVICES

1. General

- a) The categories of services in the Medicaid Managed Care and Family Health Plus Benefit Packages, including optional covered services, shall be provided by the Contractor to MMC Enrollees and FHPlus Enrollees, respectively, when medically necessary under the terms of this Agreement. The definitions of covered and non-covered services herein are in summary form; the full description and scope of each covered service as established by the New York Medical Assistance Program are set forth in the applicable NYS Medicaid Provider Manual, except for the Eye Care and Vision benefit for FHPlus Enrollees which is described in Section 19 of Appendix K.2.
- b) All care provided by the Contractor, pursuant to this Agreement, must be provided, arranged, or authorized by the Contractor or its Participating Providers with the exception of most behavioral health services to SSI or SSI-related beneficiaries, and emergency services, emergency transportation, Family Planning and Reproductive Health services, mental health and chemical dependence assessments (one (1) of each per year), court ordered services, and services provided by Local Public Health Agencies as described in Section 10 of this Agreement. HIV SNP covered benefits may vary.
- c) This Appendix contains the following sections:
 - i) K.1 - “Chart of Prepaid Benefit Package” lists the services provided by the Contractor to all Medicaid Managed Care Non-SSI/Non-SSI Related Enrollees, Medicaid Managed Care SSI/SSI-related Enrollees, Medicaid fee-for-service coverage for carved out and wraparound benefits, and Family Health Plus Enrollees.

K.1 HIV - “Chart of HIV Special Needs Plan Prepaid Benefit Package” lists the services provided by the Contractor to all HIV SNP Non-SSI Enrollees, HIV SNP HIV/AIDS SSI Enrollees, HIV SNP Uninfected SSI Children and Homeless Adults, and Medicaid fee-for-service coverage for carved out and wraparound benefits.
 - ii) K.2 - “Prepaid Benefit Package Definitions Of Covered Services” describes the covered services, as numbered in K.1. Each service description applies to both MMC and FHPlus Benefit Package unless otherwise noted.
 - iii) K.3 - “Medicaid Managed Care Definitions of Non-Covered Services” describes services that are not covered by the MMC Benefit Package. These services are covered by the Medicaid fee-for-service program unless otherwise noted.

APPENDIX K
March 1, 2014
K-2

2016 PROVIDER NETWORKS AND MEMBER BENEFIT PLANS

- iv) K.4 - “Family Health Plus Non-Covered Services” lists the services that are not covered by the FHPlus Benefit Package.

APPENDIX K
March 1, 2014
K-3

2016 PROVIDER NETWORKS AND MEMBER BENEFIT PLANS

K.1

PREPAID BENEFIT PACKAGE

* See K.2 for Scope of Benefits

** No Medicaid fee-for-service wrap-around is available

Note: If cell is blank, there is no coverage.

*	Covered Services	MMC Non-SSI/Non-SSI Related	MMC SSI/SSI-related	MFFS	FHPlus **
1.	Inpatient Hospital Services	Covered, unless admit date precedes Effective Date of Enrollment [see § 6.8 of this Agreement]	Covered, unless admit date precedes Effective Date of Enrollment [see § 6.8 of this Agreement]	Stay covered only when admit date precedes Effective Date of Enrollment [see § 6.8 of this Agreement]	Covered, unless admit date precedes Effective Date of Enrollment [see § 6.8 of this Agreement]
2.	Inpatient Stay Pending Alternate Level of Medical Care	Covered	Covered		Covered
3.	Physician Services	Covered	Covered		Covered
4.	Nurse Practitioner Services	Covered	Covered		Covered
5.	Midwifery Services	Covered	Covered		Covered
6.	Preventive Health Services	Covered	Covered		Covered
7.	Second Medical/Surgical Opinion	Covered	Covered		Covered
8.	Laboratory Services	Covered. Effective 4/1/14, HIV phenotypic, virtual phenotypic and genotypic drug resistance tests and viral tropism testing	Covered. Effective 4/1/14, HIV phenotypic, virtual phenotypic and genotypic drug resistance tests and viral tropism testing	Covered through 3/31/14, HIV phenotypic, virtual phenotypic and genotypic drug resistance tests and viral tropism testing	Covered
9.	Radiology Services	Covered	Covered		Covered
10.	Prescription and Non-Prescription (OTC) Drugs, Medical Supplies, and Enteral Formula	Covered. Coverage excludes hemophilia blood factors.	Covered. Coverage excludes hemophilia blood factors, Risperidone microspheres (Risperdal® Consta®), paliperidone palmitate (Invega® Sustenna®), Abilify Maintena™ and olanzapine (Zyprexa® Relprevv™).	Hemophilia blood factors covered through MA FFS; also Risperidone microspheres (Risperdal® Consta®), paliperidone palmitate (Invega® Sustenna®), Abilify Maintena™ and olanzapine (Zyprexa® Relprevv™) covered through MA FFS for mainstream MMC SSI [see Appendix K.3, 2. b) xi) of this Agreement].	Covered. Coverage includes prescription drugs, insulin and diabetic supplies, smoking cessation agents, select OTCs, vitamins necessary to treat an illness or condition, hearing aid batteries and enteral formulae. Hemophilia blood factors covered through MA FFS.

APPENDIX K
March 1, 2014
K-4

2016 PROVIDER NETWORKS AND MEMBER BENEFIT PLANS

*	Covered Services	MMC Non-SSI/Non-SSI Related	MMC SSI/SSI-related	MFFS	FHPlus **
11.	Smoking Cessation Products	Covered	Covered		Covered
12.	Rehabilitation Services	Covered. Outpatient physical, occupational and speech therapy limited to 20 visits each per calendar year. Limits do not apply to Enrollees under age 21, Enrollees who are developmentally disabled, and Enrollees with traumatic brain injury.	Covered. Outpatient physical, occupational and speech therapy limited to 20 visits each per calendar year. Limits do not apply to Enrollees under age 21, Enrollees who are developmentally disabled, and Enrollees with traumatic brain injury.		Covered for short term inpatient, and limited to 20 visits each per calendar year for outpatient PT, OT, and speech therapy.
13.	EPSDT Services/Child Teen Health Program (C/THP)	Covered	Covered		Covered
14.	Home Health Services	Covered	Covered		Covered for 40 visits in lieu of a skilled nursing facility stay or hospitalization, plus 2 post partum home visits for high risk women
15.	Private Duty Nursing Services	Covered	Covered		Not covered
16.	Hospice	Covered	Covered		Covered
17.	Emergency Services	Covered	Covered		Covered
	Post-Stabilization Care Services (see also Appendix G of this Agreement)	Covered	Covered		Covered
18.	Foot Care Services	Covered	Covered		Covered
19.	Eye Care and Low Vision Services	Covered	Covered		Covered
20.	Durable Medical Equipment (DME)	Covered	Covered		Covered
21.	Audiology, Hearing Aids Services & Products	Covered	Covered		Covered
22.	Family Planning and Reproductive Health Services	Covered if included in Contractor's Benefit Package as per Appendix M of this Agreement.	Covered if included in Contractor's Benefit Package as per Appendix M of this Agreement.	Covered pursuant to Appendix C of Agreement.	Covered if included in Contractor's Benefit Package as per Appendix M of this Agreement or through the DTP Contractor.

APPENDIX K
March 1, 2014
K-5

2016 PROVIDER NETWORKS AND MEMBER BENEFIT PLANS

*	Covered Services	MMC Non-SSI/Non-SSI Related	MMC SSI/SSI-related	MFFS	FHPlus **
23.	Non-Emergency Transportation	Covered if included in Contractor's Benefit Package as per Appendix M of this Agreement until benefit is transferred to MFFS according to a phase-in schedule.	Covered if included in Contractor's Benefit Package as per Appendix M of this Agreement until benefit is transferred to MFFS according to a phase-in schedule.	Covered if not included in Contractor's Benefit Package. Benefit to be covered by MFFS according to a phase-in schedule.	Not covered, except for transportation to C/THP services for 19 and 20 year olds. Benefit to be covered by MFFS according to a phase-in schedule.
24.	Emergency Transportation	Covered if included in Contractor's Benefit Package as per Appendix M of this Agreement until benefit is transferred to MFFS according to a phase-in schedule.	Covered if included in Contractor's Benefit Package as per Appendix M of this Agreement until benefit is transferred to MFFS according to a phase-in schedule.	Covered if not included in Contractor's Benefit Package. Benefit to be covered by MFFS according to a phase-in schedule.	Covered
25.	Dental and Orthodontic Services	Covered.	Covered.	For Enrollees whose orthodontic treatment was prior approved before 10/1/12, MFFS will continue to cover through the duration of treatment and retention.	Covered, if included in Contractor's Benefit Package as per Appendix M of this Agreement, excluding orthodontia.
26.	Court-Ordered Services	Covered, pursuant to court order (see also §10.9 of this Agreement).	Covered, pursuant to court order (see also §10.9 of this Agreement).		Covered, pursuant to court order (see also §10.9 of this Agreement).
27.	Prosthetic/Orthotic Services/Orthopedic Footwear	Covered	Covered		Covered, except for orthopedic shoes
28.	Mental Health Services	Covered		Covered for SSI Enrollees	Covered subject to calendar year benefit limit of 30 days inpatient, 60 visits outpatient, combined with chemical dependency services.
29.	Detoxification Services	Covered	Covered		Covered
30.	Chemical Dependence Inpatient Rehabilitation and Treatment Services	Covered subject to stop loss		Covered for SSI recipients	Covered subject to calendar year benefit limit of 30 days combined with mental health services

APPENDIX K
March 1, 2014
K-6

2016 PROVIDER NETWORKS AND MEMBER BENEFIT PLANS

*	Covered Services	MMC Non-SSI/Non-SSI Related	MMC SSI/SSI-related	MFFS	FHPlus **
31.	Chemical Dependence Outpatient			Covered	Covered subject to calendar year benefit limits of 60 visits combined with mental health services
32.	Experimental and/or Investigational Treatment	Covered on a case by case basis	Covered on a case by case basis		Covered on a case by case basis
33.	Renal Dialysis	Covered	Covered		Covered
34.	Residential Health Care Facility (Nursing Home) Services (RHCF)	Covered, except for Enrollees under age 21 in Long Term Placement Status.	Covered, except for Enrollees under age 21 in Long Term Placement Status.		Covers only non-permanent rehabilitative stays.
35.	Personal Care Services	Covered. When only Level I services provided, limited to 8 hours per week.	Covered. When only Level I services provided, limited to 8 hours per week.		Not covered
36.	Personal Emergency Response System (PERS)	Covered	Covered		Not covered
37.	Consumer Directed Personal Assistance Services	Covered	Covered		Not covered
38.	Observation Services	Covered	Covered		Covered
39.	Medical Social Services	Covered only for those Enrollees transitioning from the LTHHCP and who received Medical Social Services while in the LTHHCP	Covered only for those Enrollees transitioning from the LTHHCP and who received Medical Social Services while in the LTHHCP		Not covered
40.	Home Delivered Meals	Covered only for those Enrollees transitioning from the LTHHCP and who received Home Delivered Meals while in the LTHHCP	Covered only for those Enrollees transitioning from the LTHHCP and who received Home Delivered Meals while in the LTHHCP		Not covered
41.	Adult Day Health Care	Covered	Covered		Not Covered
42.	AIDS Adult Day Health Care	Covered	Covered		Not Covered
43.	Tuberculosis Directly Observed Therapy	Covered	Covered		Not Covered

APPENDIX K
March 1, 2014
K-7

2016 PROVIDER NETWORKS AND MEMBER BENEFIT PLANS

K.1 HIV HIV SNP PREPAID BENEFIT PACKAGE

* See K.2 for Scope of Benefits

Note: If cell is blank, there is no coverage.

*	Covered Services	HIV SNP Non-SSI	HIV SNP HIV/AIDS SSI	HIV SNP Uninfected SSI Children and Homeless Adults	MFFS
1.	Inpatient Hospital Services	Covered, unless admit date precedes Effective Date of Enrollment (see § 6.8 of this Agreement)	Covered, unless admit date precedes Effective Date of Enrollment (see § 6.8 of this Agreement)	Covered, unless admit date precedes Effective Date of Enrollment (see § 6.8 of this Agreement)	Stay covered only when admit date precedes Effective Date of Enrollment (see § 6.8 of this Agreement)
2.	Inpatient Stay Pending Alternate Level of Medical Care	Covered	Covered	Covered	
3.	Physician Services	Covered	Covered	Covered	
4.	Nurse Practitioner Services	Covered	Covered	Covered	
5.	Midwifery Services	Covered	Covered	Covered	
6.	Preventive Health Services	Covered	Covered	Covered	
7.	Second Medical/Surgical Opinion	Covered	Covered	Covered	
8.	Laboratory Services	Covered Effective 4/1/14, includes HIV phenotypic, virtual phenotypic and genotypic drug resistance tests and viral tropism testing.	Covered Effective 4/1/14, includes HIV phenotypic, virtual phenotypic and genotypic drug resistance tests and viral tropism testing.	Covered Effective 4/1/14, includes HIV phenotypic, virtual phenotypic and genotypic drug resistance tests and viral tropism testing.	Covered through 3/31/14. HIV phenotypic, virtual phenotypic and genotypic drug resistance tests and viral tropism testing.
9.	Radiology Services	Covered	Covered	Covered	
10.	Prescription and Non-Prescription (OTC) Drugs, Medical Supplies, and Enteral Formula	Covered. Coverage excludes hemophilia blood factors	Covered. Coverage excludes hemophilia blood factors.	Covered. Coverage excludes hemophilia blood factors, Risperidone microspheres (Risperdal® Consta®), paliperidone palmitate (Invega® Sustenna®) and olanzapine (Zyprexa® Relprevv™)	Hemophilia blood factors covered through MA FFS; also Risperidone microspheres (Risperdal® Consta®), paliperidone palmitate (Invega® Sustenna®) and olanzapine (Zyprexa® Relprevv™) covered through MA FFS for SSI uninfected children and adults. [see Appendix

APPENDIX K
March 1, 2014
K-8

2016 PROVIDER NETWORKS AND MEMBER BENEFIT PLANS

*	Covered Services	HIV SNP Non-SSI	HIV SNP HIV/AIDS SSI	HIV SNP Uninfected SSI Children and Homeless Adults	MFFS
					K.3, 2. b) xi) of this Agreement].
11.	Smoking Cessation Products	Covered	Covered	Covered	
12.	Rehabilitation Services	Covered. Outpatient physical, occupational and speech therapy limited to 20 visits each per calendar year. Limits do not apply to Enrollees under age 21, Enrollees who are developmentally disabled, and Enrollees with traumatic brain injury.	Covered. Outpatient physical, occupational and speech therapy limited to 20 visits each per calendar year. Limits do not apply to Enrollees under age 21, Enrollees who are developmentally disabled, and Enrollees with traumatic brain injury.	Covered. Outpatient physical, occupational and speech therapy limited to 20 visits each per calendar year. Limits do not apply to Enrollees under age 21, Enrollees who are developmentally disabled, and Enrollees with traumatic brain injury.	
13.	EPSDT Services/Child Teen Health Program (C/THP)	Covered	Covered	Covered	
14.	Home Health Services	Covered	Covered	Covered	
15.	Private Duty Nursing Services	Covered	Covered	Covered	
16.	Hospice	Covered	Covered	Covered	Covered
17.	Emergency Services Post-Stabilization Care Services (see also Appendix G of this Agreement)	Covered Covered	Covered Covered	Covered Covered	
18.	Foot Care Services	Covered	Covered	Covered	
19.	Eye Care and Low Vision Services	Covered	Covered	Covered	
20.	Durable Medical Equipment (DME)	Covered	Covered	Covered	
21.	Audiology, Hearing Aids Services and Products	Covered	Covered	Covered	
22.	Family Planning and Reproductive Health Services	Covered	Covered	Covered	Covered pursuant to Appendix C of Agreement

APPENDIX K
March 1, 2014
K-9

2016 PROVIDER NETWORKS AND MEMBER BENEFIT PLANS

*	Covered Services	HIV SNP Non-SSI	HIV SNP HIV/AIDS SSI	HIV SNP Uninfected SSI Children and Homeless Adults	MFFS
23.	Non-Emergency Transportation	Covered if included in Contractor's Benefit Package as per Appendix M of this Agreement until benefit is transferred to MFFS according to a phase-in schedule.	Covered if included in Contractor's Benefit Package as per Appendix M of this Agreement until benefit is transferred to MFFS according to a phase-in schedule.	Covered if included in Contractor's Benefit Package as per Appendix M of this Agreement until benefit is transferred to MFFS according to a phase-in schedule.	Covered if not included in Contractor's Benefit Package. Benefit to be covered by MFFS according to a phase-in schedule.
24.	Emergency Transportation	Covered if included in Contractor's Benefit Package as per Appendix M of this Agreement until benefit is transferred to MFFS according to a phase-in schedule.	Covered if included in Contractor's Benefit Package as per Appendix M of this Agreement until benefit is transferred to MFFS according to a phase-in schedule.	Covered if included in Contractor's Benefit Package as per Appendix M of this Agreement until benefit is transferred to MFFS according to a phase-in schedule.	Covered if not included in Contractor's Benefit Package. Benefit to be covered by MFFS according to a phase-in schedule
25.	Dental and Orthodontic Services	Covered.	Covered.	Covered.	For Enrollees whose orthodontic treatment was prior approved before 10/1/12, MFFS will continue to cover through the duration of treatment and retention.
26.	Court-Ordered Services	Covered, pursuant to court order (see also § 10.9 of this Agreement).	Covered, pursuant to court order (see also § 10.9 of this Agreement).	Covered, pursuant to court order (see also § 10.9 of this Agreement).	
27.	Prosthetic/Orthotic Services/ Orthopedic Footwear	Covered	Covered	Covered	
28.	Mental Health Services	Covered	Covered		Covered for HIV SNP uninfected SSI Enrollees
29.	Detoxification Services	Covered	Covered	Covered	
30.	Chemical Dependence Inpatient Rehabilitation and Treatment Services	Covered subject to stop loss	Covered subject to stop loss		Covered for HIV SNP uninfected SSI Enrollees
31.	Chemical Dependence Outpatient				Covered
32.	Experimental and/or Investigational Treatment	Covered on a case by case basis	Covered on a case by case basis	Covered on a case by case basis	
33.	Renal Dialysis	Covered	Covered	Covered	
34.	Residential Health Care Facility (Nursing Home) Services (RHCF)	Covered, except for Enrollees under age 21 in Long Term Placement Status.	Covered, except for Enrollees under age 21 in Long Term Placement Status.	Covered, except for Enrollees under age 21 in Long Term Placement Status.	
35.	Personal Care Services (PCS)	Covered. When only Level I services	Covered. When only Level I	Covered. When only Level I	

APPENDIX K
March 1, 2014
K-10

2016 PROVIDER NETWORKS AND MEMBER BENEFIT PLANS

*	Covered Services	HIV SNP Non-SSI	HIV SNP HIV/AIDS SSI	HIV SNP Uninfected SSI Children and Homeless Adults	MFFS
		provided, limited to 8 hours per week.	services provided, limited to 8 hours per week.	services provided, limited to 8 hours per week.	
36.	Personal Emergency Response System (PERS)	Covered	Covered	Covered	
37.	Consumer Directed Personal Assistance Services	Covered	Covered	Covered	
38.	Observation Services	Covered	Covered	Covered	
39.	Medical Social Services	Covered only for those Enrollees transitioning from the LTHHCP and who received Medical Social Services while in the LTHHCP	Covered only for those Enrollees transitioning from the LTHHCP and who received Medical Social Services while in the LTHHCP	Covered only for those Enrollees transitioning from the LTHHCP and who received Medical Social Services while in the LTHHCP	
40.	Home Delivered Meals	Covered only for those Enrollees transitioning from the LTHHCP and who received Home Delivered Meals while in the LTHHCP	Covered only for those Enrollees transitioning from the LTHHCP and who received Home Delivered Meals while in the LTHHCP	Covered only for those Enrollees transitioning from the LTHHCP and who received Home Delivered Meals while in the LTHHCP	
41.	Adult Day Health Care	Covered	Covered	Covered	Not Covered
42.	AIDS Adult Day Health Care	Covered	Covered	Covered	Not Covered
43.	Tuberculosis Directly Observed Therapy	Covered	Covered	Covered	Not Covered
44.	HIV SNP Enhanced Services: HIV SNP Care and Benefits Coordination; HIV Treatment Adherence Services; HIV Prevention and Risk Reduction Services	Covered	Covered	Covered	

APPENDIX K
March 1, 2014
K-11

K.2

PREPAID BENEFIT PACKAGE DEFINITIONS OF COVERED SERVICES

Service definitions in this Section pertain to both MMC and FHPlus unless otherwise indicated.

1. Inpatient Hospital Services

Inpatient hospital services, as medically necessary, shall include, except as otherwise specified, the care, treatment, maintenance and nursing services as may be required, on an inpatient hospital basis, up to 365 days per year (366 days in leap year). Contractor will not be responsible for hospital stays that commence prior to the Effective Date of Enrollment (see Section 6.8 of this Agreement), but will be responsible for stays that commence prior to the Effective Date of Disenrollment (see Section 8.5 of this Agreement). Among other services, inpatient hospital services encompass a full range of necessary diagnostic and therapeutic care including medical, surgical, nursing, radiological, and rehabilitative services. Services are provided under the direction of a physician, certified nurse practitioner, or dentist.

2. Inpatient Stay Pending Alternate Level of Medical Care

Inpatient stay pending alternate level of medical care, or continued care in a hospital, Article 31 mental health facility, or skilled nursing facility pending placement in an alternate lower medical level of care, consistent with the provisions of 18 NYCRR § 505.20 and 10 NYCRR Part 85.

3. Physician Services

- a) “Physicians’ services,” whether furnished in the office, the Enrollee’s home, a hospital, a skilled nursing facility, or elsewhere, means services furnished by a physician:
 - i) within the scope of practice of medicine as defined in law by the New York State Education Department; and
 - ii) by or under the personal supervision of an individual licensed and currently registered by the New York State Education Department to practice medicine.
- b) Physician services include the full range of preventive care services, primary care medical services and physician specialty services that fall within a physician’s scope of practice under New York State law.
- c) The following are also included without limitations:

APPENDIX K
March 1, 2014
K-12

2016 PROVIDER NETWORKS AND MEMBER BENEFIT PLANS

- i) pharmaceuticals and medical supplies routinely furnished or administered as part of a clinic or office visit;
 - ii) physical examinations, including those which are necessary for school and camp;
 - iii) physical and/or mental health, or chemical dependence examinations of children and their parents as requested by the LDSS to fulfill its statutory responsibilities for the protection of children and adults and for children in foster care;
 - iv) health and mental health assessments for the purpose of making recommendations regarding a Enrollee's disability status for Federal SSI applications;
 - v) annual preventive health visits for adolescents;
 - vi) new admission exams for school children if required by the LDSS;
 - vii) health screening, assessment and treatment of refugees, including completing SDOH/LDSS required forms;
 - viii) Child/Teen Health Program (C/THP) services which are comprehensive primary health care services provided to persons under twenty-one (21) years of age (see Section 10 of this Agreement).
- d) Smoking cessation counseling services for all MMC and FHPlus Enrollees who smoke. Up to eight (8) counseling sessions are covered for all eligible Enrollees per calendar year, as described in Appendix K, K.2, 6 Preventive Health Services.

4. Certified Nurse Practitioner Services

- a) Certified nurse practitioner services include preventive services, the diagnosis of illness and physical conditions, and the performance of therapeutic and corrective measures, within the scope of the certified nurse practitioner's licensure and collaborative practice agreement with a licensed physician in accordance with the requirements of the NYS Education Department.
- b) The following services are also included in the certified nurse practitioner's scope of services, without limitation:
 - i) Child/Teen Health Program(C/THP) services which are comprehensive primary health care services provided to persons under twenty-one (21) (see Item 13 of this Appendix and Section 10.4 of this Agreement);
 - ii) Physical examinations, including those which are necessary for school and camp.

5. Midwifery Services

SSA § 1905 (a)(17), Education Law § 6951(i).

APPENDIX K
March 1, 2014
K-13

2016 PROVIDER NETWORKS AND MEMBER BENEFIT PLANS

Midwifery services include the management of normal pregnancy, childbirth and postpartum care as well as primary preventive reproductive health care to essentially healthy women and shall include newborn evaluation, resuscitation and referral for infants. The care may be provided on an inpatient or outpatient basis including in a birthing center or in the Enrollee's home as appropriate. The midwife must be licensed by the NYS Education Department and have a collaborative relationship with a physician or hospital that provides obstetric services, as described in Education Law § 6951.1, that provides for consultation, collaborative management and referral to address the health status and risks of patients and includes plans for emergency medical OB/GYN coverage.

6. Preventive Health Services

- a) Preventive health services means care and services to avert disease/illness and/or its consequences. There are three (3) levels of preventive health services: 1) primary, such as immunizations, aimed at preventing disease; 2) secondary, such as disease screening programs aimed at early detection of disease; and 3) tertiary, such as physical therapy, aimed at restoring function after the disease has occurred. Commonly, the term "preventive care" is used to designate prevention and early detection programs rather than restorative programs.
- b) The Contractor must offer the following preventive health services essential for promoting health and preventing illness:
 - i) General health education classes.
 - ii) Pneumonia and influenza immunizations for at risk populations.
 - iii) Smoking cessation counseling for all MMC and FHPlus Enrollees who smoke. Up to eight (8) counseling sessions are covered for all eligible Enrollees per calendar year. Effective July 1, 2014, up to two (2) of an Enrollee's total counseling sessions can be furnished by a dental practitioner. Smoking cessation classes, with targeted outreach for adolescents and pregnant women.
 - iv) Childbirth education classes.
 - v) Parenting classes covering topics such as bathing, feeding, injury prevention, sleeping, illness prevention, steps to follow in an emergency, growth and development, discipline, signs of illness, etc.
 - vi) Nutrition counseling, with targeted outreach for diabetics and pregnant women.
 - vii) Extended care coordination, as needed, for pregnant women.
 - viii) HIV testing.
 - ix) Hepatitis C screening for individuals born between 1945 and 1965.
 - x) Asthma Self-Management Training (ASMT).

APPENDIX K
March 1, 2014
K-14

1. Enrollees, including pregnant women, with newly diagnosed asthma or with asthma and a medically complex condition (such as an exacerbation of asthma, poor asthma control, diagnosis of a complication, etc.) will be allowed up to ten (10) hours of ASMT during a continuous six-month period.
2. Enrollees with asthma who are medically stable may receive up to one (1) hour of ASMT during a continuous six-month period.
3. Asthma self-management training services may be provided in individual sessions, or in group sessions of no more than eight patients.

xi) Diabetes Self-Management Training

1. Enrollees, including pregnant women, with newly diagnosed diabetes or with diabetes and a medically complex condition (such as poor diabetes control [A1c>8], diagnosis of a complication, diagnosis of a co-morbidity, post-surgery, prescription for new equipment such as an insulin pump, etc.) will be allowed up to ten (10) hours of DSMT during a continuous six-month period.
2. Enrollees with diabetes who are medically stable may receive up to one (1) hour of DSMT during a continuous six-month period.
3. Diabetes self-management training services may be provided in individual sessions, or in group sessions of no more than eight patients.

xii) Screening, Brief Intervention, and Referral to Treatment (SBIRT) for Chemical Dependency provided in hospital outpatient departments, free-standing diagnostic and treatment centers, and in physician offices in accordance with protocols issued by the SDOH, to identify individuals with or at risk of substance use-related problems, assess the severity of substance use and the appropriate level of intervention required and provide brief intervention or brief treatment. Referrals are initiated to chemical dependence providers for evaluation and treatment, when appropriate.

7. Second Medical/Surgical Opinions

The Contractor will allow Enrollees to obtain second opinions for diagnosis of a condition, treatment or surgical procedure by a qualified physician or appropriate specialist, including one affiliated with a specialty care center. In the event that the Contractor determines that it does not have a Participating Provider in its network with appropriate training and experience qualifying the Participating Provider to provide a second opinion, the Contractor shall make a referral to an appropriate Non-Participating Provider. The Contractor shall pay for the cost of the services associated with obtaining a second opinion regarding medical or surgical care, including diagnostic and evaluation services, provided by the Non-Participating Provider.

8. Laboratory Services

APPENDIX K
March 1, 2014
K-15

2016 PROVIDER NETWORKS AND MEMBER BENEFIT PLANS

18 NYCRR § 505.7(a)

- a) Laboratory services include medically necessary tests and procedures ordered by a qualified medical professional and listed in the Medicaid fee schedule for laboratory services.
- b) All laboratory testing sites providing services under this Agreement must have a permit issued by the New York State Department of Health and a Clinical Laboratory Improvement Act (CLIA) certificate of waiver, a physician performed microscopy procedures (PPMP) certificate, or a certificate of registration along with a CLIA identification number. Those laboratories with certificates of waiver or a PPMP certificate may perform only those specific tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests for which they have been certified. Physicians providing laboratory testing may perform only those specific limited laboratory procedures identified in the Physician's NYS Medicaid Provider Manual.
- c) For MMC only: Until April 1, 2014, coverage for HIV phenotypic, HIV virtual phenotypic and HIV genotypic drug resistance tests and viral tropism testing are covered by Medicaid fee-for-service. Effective April 1, 2014, these tests are covered as other laboratory services.

9. Radiology Services

18 NYCRR § 505.17(c)(7)(d)

Radiology services include medically necessary services provided by qualified practitioners in the provision of diagnostic radiology, diagnostic ultrasound, nuclear medicine, radiation oncology, and magnetic resonance imaging (MRI). These services may only be performed upon the order of a qualified practitioner.

10. Prescription and Non-Prescription (OTC) Drugs, Medical Supplies and Enteral Formulas

- a) For Medicaid managed care only: Medically necessary prescription and non-prescription (OTC) drugs, medical supplies, hearing aid batteries and enteral formula are covered by the Contractor when ordered by a qualified provider. Pharmaceuticals and medical supplies routinely furnished or administered as part of a clinic or office visit and self-administered injectable drugs (including those administered by a family member and during a home care visit) not included on the Medicaid outpatient formulary are covered by the Contractor.
- b) For Family Health Plus only: Medically necessary prescription drugs, insulin and diabetic supplies (e.g., insulin syringes, blood glucose test strips, lancets, alcohol swabs), smoking cessation agents, including over-the-counter (OTC) smoking cessation products, select OTC medications covered on the Medicaid Preferred Drug List (e.g., Prilosec OTC, Loratadine, Zyrtec and emergency contraception), vitamins necessary to treat an illness or condition, hearing aid batteries and enteral formula are covered by the Contractor when ordered by a qualified provider. Pharmaceuticals and

APPENDIX K
March 1, 2014
K-16

2016 PROVIDER NETWORKS AND MEMBER BENEFIT PLANS

medical supplies routinely furnished or administered as part of a clinic or office visit and self-administered injectable drugs (including those administered by a family member and during a home care visit) not included on the Medicaid outpatient formulary are covered by the Contractor. Medical supplies (except for diabetic supplies and smoking cessation agents) are not covered.

- c) For Medicaid Managed Care and Family Health Plus:
- i) Prescription drugs may be limited to generic medications when medically acceptable. All drug classes containing drugs used for preventive and therapeutic purposes are covered, as well as family planning and contraceptive medications and devices, if Family Planning is included in the Contractor's Benefit Package.
 - ii) Pharmaceuticals and medical supplies routinely furnished or administered as part of a clinic or office visit are covered by the Contractor. Self-administered injectable drugs (including those administered by a family member) and injectable drugs administered during a home care visit are also covered by the Contractor. The following drugs are covered by Medicaid fee-for-service: 1) hemophilia blood factors, whether furnished or administered as part of a clinic or office visit or administered during a home care visit; and 2) Risperidone microspheres (Risperdal® Consta®), paliperidone palmitate (Invega® Sustenna®), Abilify Maintena™ and olanzapine (Zyprexa® Relprevv™) when administered to SSI and SSI-related Enrollees in mainstream Medicaid managed care plans.
 - iii) Coverage of enteral formula is limited to individuals who cannot obtain nutrition through any other means, and to the following three conditions: 1) Individuals who are fed via nasogastric, gastrostomy or jejunostomy tube; 2) Individuals with inborn metabolic disorders; and, 3) Children up to 21 years of age who require liquid oral enteral nutritional formula when there is a documented diagnostic condition where caloric and dietary nutrients from food cannot be absorbed or metabolized. Coverage for certain inherited diseases of amino acid and organic acid metabolism shall include modified solid food products that are low-protein or which contain modified protein.
 - iv) Fluoride supplements are covered for children up to age 17.
 - v) Experimental and investigational drugs are generally excluded, except where included in the course of Contractor-authorized experimental/investigational treatment or ordered under the External Appeal program authorized under Article 49 of the Public Health Law.
 - vi) The following drugs are not covered:
 - 1. Vitamins except when necessary to treat a diagnosed illness or condition, including pregnancy;

APPENDIX K
March 1, 2014
K-17

2. Drugs prescribed for cosmetic purposes;
 3. Drugs prescribed for anorexia, weight loss or weight gain;
 4. Drugs prescribed to promote fertility;
 5. Drugs used for the treatment of sexual or erectile dysfunction unless used to treat a condition, other than sexual or erectile dysfunction, for which the drug has been approved by the Food and Drug Administration; and
 6. Covered outpatient drugs when the manufacturer seeks to require, as a condition of sale, that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee.
- vii) The Contractor may establish a prescription formulary, including a therapeutic category formulary, as long as the formulary includes all categories of drugs as listed on the New York State Medicaid formulary, and as long as the Contractor has in place a brand name and therapeutic category exception process for providers to use when the provider deems medically necessary.

11. Smoking Cessation Products

Smoking cessation products are covered by the Contractor. The Contractor may not require prior authorization for smoking cessation products that are included in the Contractor's formulary and ordered by a qualified provider. The Contractor is responsible for up to two courses of smoking cessation therapy per year. A course of therapy is defined as no more than a 90-day supply (an original order and two refills, even if less than a 30-day supply is dispensed on any fill).

12. Rehabilitation Services

18 NYCRR § 505.11

- a) Rehabilitation services are provided for the maximum reduction of physical or mental disability and restoration of the Enrollee to his or her best functional level. Rehabilitation services include care and services rendered by physical therapists, speech-language pathologists and occupational therapists. Rehabilitation services may be provided in an Article 28 inpatient or outpatient facility, an Enrollee's home, in an approved home health agency, in the office of a qualified private practicing therapist or speech pathologist, or for a child in a school, pre-school or community setting, or in a Residential Health Care Facility (RHCF) as long as the Enrollee's stay is classified as a rehabilitative stay and meets the requirements for covered RHCF services as defined herein.
- b) For the MMC Program, rehabilitation services provided in Residential Health Care Facilities are subject to the stop-loss provisions specified in Section 3.13 of this Agreement. Rehabilitation services are covered as medically necessary, when ordered by the Contractor's Participating Provider. Outpatient visits for physical, occupational and speech therapy are limited to twenty (20) visits each per calendar year. Limits do

APPENDIX K
March 1, 2014
K-18

2016 PROVIDER NETWORKS AND MEMBER BENEFIT PLANS

not apply to Enrollees under age 21, Enrollees who are developmentally disabled, and Enrollees with traumatic brain injury.

- c) For Family Health Plus only: Outpatient visits for physical and occupational therapy are limited to twenty (20) visits each per calendar year. Coverage for speech therapy services is limited to those required for a condition amenable to significant clinical improvement within a two month period. Outpatient visits for speech therapy are also limited to twenty (20) visits each per calendar year.
- d) For both Medicaid Managed Care and Family Health Plus, cardiac rehabilitation services are covered as medically necessary, when ordered by the Contractor's Participating Provider, and rendered in physician offices, Article 28 hospital outpatient departments, freestanding diagnostic and treatment centers, and Federally Qualified Health Centers.

13. Early Periodic Screening Diagnosis and Treatment (EPSDT) Services Through the Child Teen Health Program (C/THP) and Adolescent Preventive Services 18 NYCRR § 508.8

Child/Teen Health Program (C/THP) is a package of early and periodic screening, including inter-periodic screens and, diagnostic and treatment services that New York State offers all Medicaid eligible children under twenty-one (21) years of age. Care and services shall be provided in accordance with the periodicity schedule and guidelines developed by the New York State Department of Health. The care includes necessary health care, diagnostic services, treatment and other measures (described in §1905(a) of the Social Security Act) to correct or ameliorate defects, and physical and mental illnesses and conditions discovered by the screening services (regardless of whether the service is otherwise included in the New York State Medicaid Plan). The package of services includes administrative services designed to assist families obtain services for children including outreach, education, appointment scheduling, administrative case management and transportation assistance.

14. Home Health Services 18 NYCRR § 505.23(a)(3)

- a) Home health care services are provided to Enrollees in their homes by a home health agency certified under Article 36 of the PHL (Certified Home Health Agency - CHHA). Home health services mean the following services when prescribed by a Provider and provided to a Enrollee in his or her home:
 - i) nursing services provided on a part-time or intermittent basis by a CHHA or, if there is no CHHA that services the county/district, by a registered professional nurse or a licensed practical nurse acting under the direction of the Enrollee's PCP;
 - ii) physical therapy, occupational therapy, or speech pathology and audiology services; and

APPENDIX K
March 1, 2014
K-19

2016 PROVIDER NETWORKS AND MEMBER BENEFIT PLANS

- iii) home health services provided by a person who meets the training requirements of the SDOH, is assigned by a registered professional nurse to provide home health aid services in accordance with the Enrollee's plan of care, and is supervised by a registered professional nurse from a CHHA or if the Contractor has no CHHA available, a registered nurse, or therapist.
- b) Personal care tasks performed by a home health aide incidental to a certified home health care agency visit, and pursuant to an established care plan, are covered.
- c) Services include care rendered directly to the Enrollee and instructions to his/her family or caretaker such as teacher or day care provider in the procedures necessary for the Enrollee's treatment or maintenance.
- d) The Contractor will provide home health services to pregnant or postpartum women when medically necessary. This includes skilled nursing home health care visits to pregnant or postpartum women designed to: assess medical health status, obstetrical history, current pregnancy related problems, and psychosocial and environmental risk factors such as unstable emotional status, inadequate resources or parenting skills; and to provide skilled nursing care for identified conditions requiring treatment, counseling, referral, instructions or clinical monitoring. Criteria for medical necessity are as follows:
 - i) High medical risk pregnancy as defined by the American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics (AAP) Guidelines for Prenatal Health (Early Pregnancy Risk Identification for Consultation); or
 - ii) Need for home monitoring or assessment by a nurse for a medical condition complicating the pregnancy or postpartum care; or
 - iv) Woman otherwise unengaged in prenatal care (no consistent visits) or postpartum care; or
 - iv) Need for home assessment for suspected environmental or psychosocial risk including, but not limited to, intimate partner violence, substance abuse, unsafe housing and nutritional risk.

Home health service visits may be provided by agencies that are certified or licensed under Article 36 of the PHL and are either a Certified Home Health Agency (CHHA) or a Licensed Home Care Service Agency (LHCSA). The home health visit must be ordered by the woman's attending (treating) physician and documented in the plan of treatment established by the woman's attending physician.

All women enrolled are presumed eligible for one medically necessary postpartum home health care visit which may include assessment of the health of the woman and newborn, postoperative care as appropriate, nutrition education including breastfeeding, family planning counseling to ensure optimal birth spacing, and parenting guidance. Referrals to the attending physician and/or health plan case

APPENDIX K
March 1, 2014
K-20

2016 PROVIDER NETWORKS AND MEMBER BENEFIT PLANS

manager of the pregnant woman or infant shall be made as needed. Other than the initial postpartum visit, additional home health visits must meet one of the four medical necessity criteria listed above.

The Contractor agrees to require that providers of home health services to pregnant or postpartum women document the following in the case records:

- i) A comprehensive written plan of care developed and based on the comprehensive assessment of the mother and/or infant after a minimum of an initial home visit;
 - ii) Timely notification to treating providers and case manager concerning significant changes in the woman or infant's condition;
 - iii) Referral and coordination with appropriate health, mental health and social services and other providers;
 - iv) Review and revision of the plan of care at least monthly or more frequently if the maternal/infant conditions warrant it; and
 - v) An appropriate discharge plan.
- e) For Medicaid Managed Care only, home telehealth services are covered, pursuant to Section 3614.3-c. of the Public Health Law, when provided by agencies approved by the SDOH for Enrollees who have conditions or clinical circumstances requiring frequent monitoring and when the provision of telehealth services can appropriately reduce the need for on-site or in-office visits or acute or long term care facility admission. To be eligible for reimbursement, approved agencies must obtain any necessary prior approvals and services must be deemed medically necessary by the Contractor. Approved agencies must assess the Enrollee in person, prior to providing telehealth services, using a SDOH approved patient risk assessment tool.
- f) For Family Health Plus only: coverage is limited to forty (40) home health care visits per calendar year in lieu of a skilled nursing facility stay or hospitalization, plus two post partum home visits for high risk mothers. For the purposes of this Section, visit is defined as the delivery of a discreet service (e.g. nursing, OT, PT, ST, audiology or home health aide). Four (4) hours of home health aide services equals one visit.

15. Private Duty Nursing Services – For MMC Program Only

- a) Private duty nursing services shall be provided by a person possessing a license and current registration from the NYS Education Department to practice as a registered professional nurse or licensed practical nurse. Private duty nursing services must be provided in the MMC Enrollee's home. Enrollees authorized to receive private duty nursing services in the home may also use approved hours outside the home when the Enrollee's normal life activities take him or her outside of the home. Private duty nursing services can be provided through a licensed home care agency or a private Practitioner. For a child, full time private duty nursing is also covered in a school, an approved pre-school, or a natural environment, including home and community

APPENDIX K
March 1, 2014
K-21

2016 PROVIDER NETWORKS AND MEMBER BENEFIT PLANS

settings, where such child would otherwise be found, pursuant to an Individualized Education Program under the School Supportive Health Services Program or an Individualized Family Services Plan under the Early Intervention Program.

- b) Private duty nursing services are covered only when determined by the attending physician to be medically necessary. Nursing services may be intermittent, part-time or continuous and must be provided in an Enrollee's home in accordance with the ordering physician's or certified nurse practitioner's written treatment plan.

16. Hospice Services

- a) Hospice is a coordinated program of home and/or inpatient non-curative medical and support services for terminally ill persons and their families. Care focuses on easing symptoms rather than treating disease. The patient and his or her family receive physical, psychological, social and spiritual support and care. Hospice provides four levels of care: 1) routine home care, 2) respite care, 3) continuous care, and 4) general inpatient care. The program is available to persons with a medical prognosis of six months or less to live for FHPlus or one (1) year or less to live for MMC, if the terminal illness runs its normal course.
- b) Hospice services are provided following an interdisciplinary model, and include palliative and supportive care provided to an Enrollee to meet the special needs arising out of physical, psychological, spiritual, social and economic stress which are experienced during the final stages of illness and during dying and bereavement.
- c) The Hospice provider all-inclusive per diem reimbursement rate includes all services, durable medical equipment and medicine related to the hospice diagnosis.
- d) For children under age 21 who are receiving Hospice services, medically necessary curative services are covered, in addition to palliative care.
- e) Hospice services are provided consistent with licensure requirements, and State and Federal regulations. All services must be provided by qualified employees and volunteers of the hospice or by qualified staff through contractual arrangements to the extent permitted by state and federal requirements. All services must be provided pursuant to a written plan of care which reflects the changing needs of the Enrollee and the Enrollee's family.
- f) The Contractor's Enrollees must receive hospice services through Participating Providers.
- g) Medicaid recipients in receipt of Hospice services prior to October 1, 2013, regardless of enrollment status, shall remain covered under the fee for service (FFS) Medicaid Program (per diem reimbursement) for the duration of the approved Hospice services.
- h) The Contractor shall be responsible for Hospice services provided to MMC Enrollees new to Hospice care on and after October 1, 2013.

APPENDIX K
March 1, 2014
K-22

17. Emergency Services

- a) Emergency conditions, medical or behavioral, the onset of which is sudden, manifesting itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of medical attention to result in (a) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy; (b) serious impairment of such person's bodily functions; (c) serious dysfunction of any bodily organ or part of such person; or (d) serious disfigurement of such person are covered. Emergency services include health care procedures, treatments or services, needed to evaluate or stabilize an Emergency Medical Condition including psychiatric stabilization and medical detoxification from drugs or alcohol. Emergency Services also include hospital emergency room observation services provide in a SDOH approved hospital emergency room observation unit that meets New York State regulatory operating standards and Screening, Brief Intervention, and Referral to Treatment (SBIRT) for Chemical Dependency, provided in accordance with protocols issued by the SDOH, when rendered in emergency departments. See also Appendix G of this Agreement.
- b) Post Stabilization Care Services means services related to an emergency medical condition that are provided after an Enrollee is stabilized in order to maintain the stabilized condition, or to improve or resolve the Enrollee's condition. These services are covered pursuant to Appendix G of this Agreement.

18. Foot Care Services

- a) Covered services must include routine foot care provided by qualified provider types other than podiatrists when any Enrollee's (regardless of age) physical condition poses a hazard due to the presence of localized illness, injury or symptoms involving the foot, or when performed as a necessary and integral part of otherwise covered services such as the diagnosis and treatment of diabetes, ulcers, and infections.
- b) Services provided by a podiatrist for persons under twenty-one (21) must be covered upon referral of a physician, registered physician assistant, certified nurse practitioner or licensed midwife. Services provided by a podiatrist for adults with diabetes mellitus are covered.
- c) Routine hygienic care of the feet, the treatment of corns and calluses, the trimming of nails, and other hygienic care such as cleaning or soaking feet, is not covered in the absence of a pathological condition.

19. Eye Care and Low Vision Services

18 NYCRR §505.6(b)(1-3)
SSL §369-ee (1)(e)(xii)

- a) For Medicaid Managed Care only:

APPENDIX K
March 1, 2014
K-23

2016 PROVIDER NETWORKS AND MEMBER BENEFIT PLANS

- i) Emergency, preventive and routine eye care services are covered. Eye care includes the services of ophthalmologists, optometrists and ophthalmic dispensers, and includes eyeglasses, medically necessary contact lenses and polycarbonate lenses, artificial eyes (stock or custom-made), low vision aids and low vision services. Eye care coverage includes the replacement of lost or destroyed eyeglasses. The replacement of a complete pair of eyeglasses must duplicate the original prescription and frames. Coverage also includes the repair or replacement of parts in situations where the damage is the result of causes other than defective workmanship. Replacement parts must duplicate the original prescription and frames. Repairs to, and replacements of, frames and/or lenses must be rendered as needed.
- ii) If the Contractor does not provide upgraded eyeglass frames or additional features (such as scratch coating, progressive lenses or photo-gray lenses) as part of its covered vision benefit, the Contractor cannot apply the cost of its covered eyeglass benefit to the total cost of the eyeglasses the Enrollee wants and bill only the difference to the Enrollee. For example, if the Contractor covers only standard bifocal lenses and the Enrollee wants no-line bifocal lenses, the Enrollee must choose between taking the standard bifocal or paying the full price of the no-line bifocal lenses (not just the difference between the cost of the bifocal lenses and the no-line lenses). However, the Enrollee may pay for upgraded lenses as a private customer and have the Contractor pay for the frames or pay for upgraded frames as a private customer and have the Contractor pay for the lenses. The Enrollee must be informed of this fact by the vision care provider at the time that the glasses are ordered.
- iii) Examinations for diagnosis and treatment for visual defects and/or eye disease are provided only as necessary and as required by the Enrollee's particular condition. Examinations which include refraction are limited to once every twenty four (24) months unless otherwise justified as medically necessary.
- iv) Eyeglasses do not require changing more frequently than once every twenty four (24) months unless medically indicated, such as a change in correction greater than ½ diopter, or unless the glasses are lost, damaged, or destroyed.
- v) An ophthalmic dispenser fills the prescription of an optometrist or ophthalmologist and supplies eyeglasses or other vision aids upon the order of a qualified practitioner.
- vi) MMC Enrollees may self-refer to any Participating Provider of vision services (optometrist or ophthalmologist) for refractive vision services not more frequently than once every twenty four (24) months, or if otherwise justified as medically necessary or if eyeglasses are lost, damaged or destroyed as described above. Enrollees diagnosed with diabetes may self-refer to any Participating Provider of vision services (optometrist or ophthalmologist) for a dilated eye (retinal) examination not more frequently than once in any twelve (12) month period.

APPENDIX K
March 1, 2014
K-24

2016 PROVIDER NETWORKS AND MEMBER BENEFIT PLANS

- vii) As described in Sections 10.15 and 10.28 of this Agreement, Enrollees may self-refer to Article 28 clinics affiliated with the College of Optometry of the State University of New York to obtain covered optometry services.
- b) For Family Health Plus only:
 - i) Covered Services include emergency vision care and the following preventive and routine vision care provided once in any twenty four (24) month period:
 - A) one eye examination;
 - B) either: one pair of prescription eyeglass lenses and a frame, or prescription contact lenses when medically necessary; and
 - C) one pair of medically necessary occupational eyeglasses.
 - ii) An ophthalmic dispenser fills the prescription of an optometrist or ophthalmologist and supplies eyeglasses or other vision aids upon the order of a qualified practitioner.
 - iii) FHPlus Enrollees may self-refer to any Participating Provider of vision services (optometrist or ophthalmologist) for refractive vision services not more frequently than once every twenty-four (24) months. Enrollees diagnosed with diabetes may self-refer to any Participating Provider of vision services (optometrist or ophthalmologist) for a dilated eye (retinal) examination not more frequently than once in any twelve (12) month period.
 - iv) If the Contractor does not provide upgraded eyeglass frames or additional features (such as scratch coating, progressive lenses or photo-gray lenses) as part of its covered vision benefit, the Contractor cannot apply the cost of its covered eyeglass benefit to the total cost of the eyeglasses the Enrollee wants and bill only the difference to the Enrollee. For example, if the Contractor covers only standard bifocal lenses and the Enrollee wants no-line bifocal lenses, the Enrollee must choose between taking the standard bifocal or paying the full price of the no-line bifocal lenses (not just the difference between the cost of the bifocal lenses and the no-line lenses). However, the Enrollee may pay for upgraded lenses as a private customer and have the Contractor pay for the frames or pay for upgraded frames as a private customer and have the Contractor pay for the lenses. The Enrollee must be informed of this fact by the vision care provider at the time that the glasses are ordered.
 - v) Contact lenses are covered only when medically necessary. Contact lenses shall not be covered solely because the FHPlus Enrollee selects contact lenses in lieu of receiving eyeglasses.
 - vi) Coverage does not include the replacement of lost, damaged or destroyed eyeglasses.

APPENDIX K
March 1, 2014
K-25

- vii) The occupational vision benefit for FHPlus Enrollees covers the cost of job-related eyeglasses if that need is determined by a Participating Provider through special testing done in conjunction with a regular vision examination. Such examination shall determine whether a special pair of eyeglasses would improve the performance of job-related activities. Occupational eyeglasses can be provided in addition to regular glasses but are available only in conjunction with a regular vision benefit once in any twenty-four (24) month period. FHPlus Enrollees may purchase an upgraded frame or lenses for occupational eyeglasses by paying the entire cost of the frame or lenses as a private customer (See Section 19. b) iv) above). Sun-sensitive and polarized lens options are not available for occupational eyeglasses.

20. Durable Medical Equipment (DME)

18 NYCRR §505.5(a)(1) and Section 4.4 of the NYS Medicaid DME, Medical and Surgical Supplies and Prosthetic and Orthotic Appliances Provider Manual

- a) Durable Medical Equipment (DME) are devices and equipment, other than medical/surgical supplies, enteral formula, and prosthetic or orthotic appliances, and have the following characteristics:
 - i) can withstand repeated use for a protracted period of time;
 - ii) are primarily and customarily used for medical purposes;
 - iii) are generally not useful to a person in the absence of illness or injury; and
 - iv) are usually not fitted, designed or fashioned for a particular individual's use. Where equipment is intended for use by only one (1) person, it may be either custom made or customized.
- b) Coverage includes equipment servicing but excludes disposable medical supplies.

21. Audiology, Hearing Aid Services and Products

18 NYCRR §505.31 (a)(1)(2) and Section 4.7 of the NYS Medicaid Hearing Aid Provider Manual

- a) Hearing aid services and products are provided in compliance with Article 37-A of the General Business Law when medically necessary to alleviate disability caused by the loss or impairment of hearing. Hearing aid services include: selecting, fitting and dispensing of hearing aids, hearing aid checks following dispensing of hearing aids, conformity evaluation, and hearing aid repairs.
- b) Audiology services include audiometric examinations and testing, hearing aid evaluations and hearing aid prescriptions or recommendations, as medically indicated.
- c) Hearing aid products include hearing aids, earmolds, special fittings, and replacement parts.

APPENDIX K
March 1, 2014
K-26

d) Hearing aid batteries

Hearing aid batteries are covered by the Contractor for all Enrollees as part of the prescription drug benefit.

22. Family Planning and Reproductive Health Care

a) Family Planning and Reproductive Health Care services means the offering, arranging and furnishing of those health services which enable Enrollees, including minors who may be sexually active, to prevent or reduce the incidence of unwanted pregnancy, as specified in Appendix C of this Agreement.

b) HIV counseling and testing is included in coverage when provided as part of a Family Planning and Reproductive Health visit.

c) All medically necessary abortions are covered, as specified in Appendix C of this Agreement.

d) Fertility services are not covered.

e) If the Contractor excludes Family Planning and Reproductive Health services from its Benefit Package, as specified in Appendix M of this Agreement, the Contractor is required to comply with the requirements of Appendix C.3 of this Agreement and still provide the following services:

i) screening, related diagnosis, ambulatory treatment, and referral to Participating Provider as needed for dysmenorrhea, cervical cancer or other pelvic abnormality/pathology;

ii) screening, related diagnosis, and referral to Participating Provider for anemia, cervical cancer, glycosuria, proteinuria, hypertension, breast disease and pregnancy.

23. Non-Emergency Transportation

a) Transportation expenses are covered for MMC Enrollees when transportation is essential in order for a MMC Enrollee to obtain necessary medical care and services which are covered under the Medicaid program (either as part of the Contractor's Benefit Package or by Medicaid fee-for-service). The non-emergency transportation benefit shall be administered based on the LDSS's approved transportation plan.

b) Transportation services means transportation by ambulance, ambulette (invalid coach), fixed wing or airplane transport, invalid coach, taxicab, livery, public transportation, or other means appropriate to the MMC Enrollee's medical condition; and a transportation attendant to accompany the MMC Enrollee, if necessary. Such services may include the transportation attendant's transportation, meals, lodging and

APPENDIX K
March 1, 2014
K-27

2016 PROVIDER NETWORKS AND MEMBER BENEFIT PLANS

salary; however, no salary will be paid to a transportation attendant who is a member of the MMC Enrollee's family.

- c) The Contractor is required to use only approved Medicaid ambulette vendors to provide transportation services to MMC Enrollees.
- d) When the Contractor is capitated for non-emergency transportation, the Contractor is also responsible for providing transportation to Medicaid covered services that are not part of the Contractor's Benefit Package.
- e) Non-emergency transportation is covered for FHPlus Enrollees that are nineteen (19) or twenty (20) years old and are receiving C/THP services. Subject to implementation of a Medicaid fee-for-service non-emergency medical transportation (NEMT) manager, and according to a county-by-county phase in schedule to be determined by SDOH, this benefit will be removed from the Contractor's benefit package and covered through the Medicaid fee-for-service program. SDOH will notify the Contractor, as far in advance as possible but at least sixty (60) days in advance of the NEMT beginning operations in the Contractor's service area(s).
- f) For MMC Enrollees with disabilities, the method of transportation must reasonably accommodate their needs, taking into account the severity and nature of the disability.
- g) For MMC plans that cover non-emergency transportation only, subject to implementation of a Medicaid fee-for-service non-emergency medical transportation (NEMT) manager, and according to a county-by-county phase in schedule to be determined by SDOH, this benefit will be removed from the Contractor's benefit package and covered through the Medicaid fee-for-service program. SDOH will notify the Contractor, as far in advance as possible but at least sixty (60) days in advance of the NEMT beginning operations in the Contractor's service area(s).

24. Emergency Transportation

- a) Emergency transportation can only be provided by an ambulance service including air ambulance service. Emergency ambulance transportation means the provision of ambulance transportation for the purpose of obtaining hospital services for an Enrollee who suffers from severe, life-threatening or potentially disabling conditions which require the provision of Emergency Services while the Enrollee is being transported.
- b) Emergency Services means the health care procedures, treatments or services needed to evaluate or stabilize an Emergency Medical Condition including, but not limited to, the treatment of trauma, burns, respiratory, circulatory and obstetrical emergencies.
- c) Emergency ambulance transportation is transportation to a hospital emergency room generated by a "Dial 911" emergency system call or some other request for an immediate response to a medical emergency. Because of the urgency of the transportation request, insurance coverage or other billing provisions are not addressed until after the trip is completed. When the Contractor is capitated for this

APPENDIX K
March 1, 2014
K-28

2016 PROVIDER NETWORKS AND MEMBER BENEFIT PLANS

benefit, emergency transportation via 911 or any other emergency call system is a covered benefit and the Contractor is responsible for payment. Contractor shall reimburse the transportation provider for all emergency ambulance services without regard for final diagnosis or prudent layperson standard.

- d) The emergency transportation benefit shall be administered based on the LDSS's approved transportation plan.
- e) For MMC plans that cover emergency transportation only, according to a county-by-county phase in schedule to be determined by SDOH, and concomitantly with the assumption of the MMC non-emergency benefit by a Medicaid fee-for-service non-emergency medical transportation (NEMT) manager, this benefit will be removed from the Contractor's benefit package. SDOH will notify the Contractor, as far in advance as possible but at least sixty (60) days in advance of the NEMT beginning operations in the Contractor's service area(s).

25. Dental and Orthodontic Services

- a) Dental care includes preventive, prophylactic and other routine dental care, services, supplies and dental prosthetics required to alleviate a serious health condition, including one which affects employability.
- b) For Medicaid Managed Care only:
 - i) As described in Sections 10.15 and 10.27 of this Agreement, Enrollees may self-refer to Article 28 clinics operated by academic dental centers to obtain covered dental services.
 - ii) The dental benefit includes up to four annual fluoride varnish treatments for children from birth until age 7 years when applied by a dentist, physician or nurse practitioner.
- c) Orthodontia (for Medicaid Managed Care only)
 - i) Effective October 1, 2012, orthodontia is a plan-covered benefit, consistent with 18 NYCRR 506.4, for Enrollees:
 - A) under twenty-one (21) years of age for up to three years of active orthodontic care, plus one year of retention care, to treat a severe physically handicapping malocclusion. Part of such care could be provided after the Enrollee reaches the age of 21, provided that the treatment was approved and active therapy began prior to the Enrollee's 21st birthday.
 - B) 21 years and over in connection with necessary surgical treatment (e.g. approved orthognathic surgery, reconstructive surgery or cleft palate treatment).

APPENDIX K
March 1, 2014
K-29

2016 PROVIDER NETWORKS AND MEMBER BENEFIT PLANS

- ii) Effective October 1, 2012, for cases prior approved by the Contractor, orthodontic services are covered by the Contractor. The Contractor will be responsible for prior approval of all such cases, monitoring treatment progress and quality of care, and reimbursing orthodontists for services provided to Enrollees whose treatment was prior approved by the Contractor. The Contractor must use the same guidelines for approval of orthodontic services that are used by the Medicaid fee-for-service program.
 - iii) The Contractor's provider network must include a sufficient array of orthodontic providers. The Contractor will assist Enrollees in identifying participating orthodontia providers.
 - iv) Transitional Care: When an Enrollee changes MCOs after orthodontic appliances are in place and active treatment has begun, transitional care policies will apply if the orthodontist is not a Participating Provider in the provider network of the Enrollee's new MCO. Under the transitional care policy, the Contractor must permit a new Enrollee to continue an ongoing course of treatment with an out-of-network orthodontist during a transitional period of up to sixty (60) days. If the out-of-network orthodontist wishes to continue treating the Enrollee during the transition period, the orthodontist must agree to accept the new MCO's reimbursement as payment in full and adhere to that MCO's policies and procedures. The Enrollee must be transferred to an orthodontist in the new MCO's provider network by the end of the transitional care period.
- d) Effective July 1, 2014, dental practitioners can provide smoking cessation counseling services for all MMC and FHPlus Enrollees who smoke. Up to two (2) of an Enrollee's total counseling sessions can be furnished by a dental practitioner within any calendar year, as described in Appendix K, K.2, 6 Preventive Health Services.

26. Court Ordered Services

Court ordered services are those services ordered by a court of competent jurisdiction which are performed by or under the supervision of a physician, dentist, or other provider qualified under State law to furnish medical, dental, behavioral health (including treatment for mental health and/or alcohol and/or substance abuse or dependence), or other covered services. The Contractor is responsible for payment of those services included in the benefit package.

27. Prosthetic/Orthotic Orthopedic Footwear

Section 4.5, 4.6 and 4.7 of the NYS Medicaid DME, Medical and Surgical Supplies and Prosthetic and Orthotic Appliances Provider Manual

- a) Prosthetics are those appliances or devices which replace or perform the function of any missing part of the body. Artificial eyes are covered as part of the eye care benefit.

APPENDIX K
March 1, 2014
K-30

2016 PROVIDER NETWORKS AND MEMBER BENEFIT PLANS

- b) Orthotics are those appliances or devices which are used for the purpose of supporting a weak or deformed body part or to restrict or eliminate motion in a diseased or injured part of the body.
- c) Medicaid Managed Care: Orthopedic Footwear means shoes, shoe modifications, or shoe additions which are used to correct, accommodate or prevent a physical deformity or range of motion malfunction in a diseased or injured part of the ankle or foot; to support a weak or deformed structure of the ankle or foot, or to form an integral part of a brace.

28. Mental Health Services

a) Inpatient Services

All inpatient mental health services, including voluntary or involuntary admissions for mental health services. The Contractor may provide the covered benefit for medically necessary mental health inpatient services through hospitals licensed pursuant to Article 28 of the PHL.

b) Outpatient Services

Outpatient services including but not limited to: assessment, stabilization, treatment planning, discharge planning, verbal therapies, education, symptom management, case management services, crisis intervention and outreach services, chlozapine monitoring and collateral services as certified by the New York State Office of Mental Health (OMH). Services may be provided in-home, office or the community. Services may be provided by licensed OMH providers or by other providers of mental health services including clinical psychologists and physicians. The Contractor must make available in an accessible manner all services required by OMH regulations 14 NYCRR Part 599. When contracting with mental health clinics licensed under Article 31 of the Mental Hygiene Law, the Contractor is not required to contract for each Part 599 service at every clinic with which it has a contract, provided that as a whole the Contractor's network of mental hygiene services, as described in paragraph 21.19 (c) (ii) of this Agreement, is adequate.

- c) Family Health Plus Enrollees have a combined mental health/chemical dependency benefit limit of thirty (30) days inpatient and sixty (60) outpatient visits per calendar year.
- d) MMC SSI and SSI-related Enrollees obtain all mental health services through the Medicaid fee-for-service program. Applicable to HIV SNP program only, the Contractor provides these benefits to SSI Enrollees who are HIV+.

29. Detoxification Services

a) Medically Managed Inpatient Detoxification

APPENDIX K
March 1, 2014
K-31

2016 PROVIDER NETWORKS AND MEMBER BENEFIT PLANS

These programs provide medically directed twenty-four (24) hour care on an inpatient basis to individuals who are at risk of severe alcohol or substance abuse withdrawal, incapacitated, a risk to self or others, or diagnosed with an acute physical or mental co-morbidity. Specific services include, but are not limited to: medical management, bio-psychosocial assessments, stabilization of medical psychiatric / psychological problems, individual and group counseling, level of care determinations and referral and linkages to other services as necessary. Medically Managed Detoxification Services are provided by facilities licensed by OASAS under Title 14 NYCRR § 816.6 and the Department of Health as a general hospital pursuant to Article 28 of the Public Health Law.

b) Medically Supervised Withdrawal

i) Medically Supervised Inpatient Withdrawal

These programs offer treatment for moderate withdrawal on an inpatient basis. Services must include medical supervision and direction under the care of a physician in the treatment for moderate withdrawal. Specific services must include, but are not limited to: medical assessment within twenty four (24) hours of admission; medical supervision of intoxication and withdrawal conditions; bio-psychosocial assessments; individual and group counseling and linkages to other services as necessary. Maintenance on methadone while a patient is being treated for withdrawal from other substances may be provided where the provider is appropriately authorized. Medically Supervised Inpatient Withdrawal services are provided by facilities licensed under Title 14 NYCRR § 816.7.

ii) Medically Supervised Outpatient Withdrawal

These programs offer treatment for moderate withdrawal on an outpatient basis. Required services include, but are not limited to: medical supervision of intoxication and withdrawal conditions; bio-psychosocial assessments; individual and group counseling; level of care determinations; discharge planning; and referrals to appropriate services. Maintenance on methadone while a patient is being treated for withdrawal from other substances may be provided where the provider is appropriately authorized. Medically Supervised Outpatient Withdrawal services are provided by facilities licensed under Title 14 NYCRR § 816.7.

- c) For Medicaid Managed Care only: all detoxification and withdrawal services are a covered benefit for all Enrollees, including those categorized as SSI or SSI-related. Detoxification Services in Article 28 inpatient hospital facilities are subject to the inpatient hospital stop-loss provisions specified in Section 3.12 of this Agreement.

30. Chemical Dependence Inpatient Rehabilitation and Treatment Services

- a) Services provided include intensive management of chemical dependence symptoms and medical management of physical or mental complications from chemical dependence to clients who cannot be effectively served on an outpatient basis and

APPENDIX K
March 1, 2014
K-32

who are not in need of medical detoxification or acute care. These services can be provided in a hospital or free-standing facility. Specific services can include, but are not limited to: comprehensive admission evaluation and treatment planning; individual group, and family counseling; awareness and relapse prevention; education about self-help groups; assessment and referral services; vocational and educational assessment; medical and psychiatric consultation; food and housing; and HIV and AIDS education. These services may be provided by facilities licensed by the New York State Office of Alcoholism and Substance Abuse Services (OASAS) to provide Chemical Dependence Inpatient Rehabilitation and Treatment Services under Title 14 NYCRR Part 818. Maintenance on methadone while a patient is being treated for withdrawal from other substances may be provided where the provider is appropriately authorized.

- b) Family Health Plus Enrollees have a combined mental health/chemical dependency benefit limit of thirty (30) days inpatient and sixty (60) outpatient visits per calendar year.

31. Outpatient Chemical Dependency Services

- a) Medically Supervised Ambulatory Chemical Dependence Outpatient Clinic Programs

Medically Supervised Ambulatory Chemical Dependence Outpatient Clinic Programs are licensed under Title 14 NYCRR Part 822 and provide chemical dependence outpatient treatment to individuals who suffer from chemical abuse or dependence and their family members or significant others.

- b) Medically Supervised Chemical Dependence Outpatient Rehabilitation Programs

Medically Supervised Chemical Dependence Outpatient Rehabilitation Programs provide full or half-day services to meet the needs of a specific target population of chronic alcoholic persons who need a range of services which are different from those typically provided in an alcoholism outpatient clinic. Programs are licensed by as Chemical Dependence Outpatient Rehabilitation Programs under Title 14 NYCRR § 822.9.

- c) Outpatient Chemical Dependence for Youth Programs

Outpatient Chemical Dependence for Youth Programs (OCDY) licensed under Title 14 NYCRR Part 823, establishes programs and service regulations for OCDY programs. OCDY programs offer discrete, ambulatory clinic services to chemically-dependent youth in a treatment setting that supports abstinence from chemical dependence (including alcohol and substance abuse) services.

- d) Medicaid Managed Care Enrollees access outpatient chemical dependency services through the Medicaid fee-for-service program.
- e) Buprenorphine and Buprenorphine Management:
 - i) MMC only: Management of buprenorphine in settings other than outpatient clinics and opioid treatment programs certified by the Office of Alcoholism and Substance Abuse Services under 14 NYCRR Part 822 by Primary Care Providers, and for non-SSI Enrollees by Mental Health Providers, for maintenance or detoxification of patients with chemical dependence. Buprenorphine is a covered benefit except when furnished and administered as part of a Part 822 outpatient clinic or opioid treatment program visit.
 - ii) FHPlus only: Management of buprenorphine in settings other than outpatient clinics and opioid treatment programs certified by the Office of Alcoholism and Substance Abuse Services under 14 NYCRR Part 822 by Primary Care Providers and Mental Health Providers for maintenance or detoxification of patients with chemical dependence. Buprenorphine is a covered benefit except when furnished and administered as part of a Part 822 outpatient clinic or opioid treatment program visit. Buprenorphine management services provided by Mental Health Providers, or in a Part 822 outpatient clinic or opioid treatment program, are subject to the combined mental health/chemical dependency benefit limit of sixty (60) outpatient visits per calendar year.

32. Experimental or Investigational Treatment

- a) Experimental and investigational treatment is covered on a case by case basis.
- b) Experimental or investigational treatment for life-threatening and/or disabling illnesses may also be considered for coverage under the external appeal process pursuant to the requirements of Section 4910 of the PHL under the following conditions:
 - i) The Enrollee has had coverage of a health care service denied on the basis that such service is experimental and investigational, and
 - ii) The Enrollee's attending physician has certified that the Enrollee has a life-threatening or disabling condition or disease:
 - A) for which standard health services or procedures have been ineffective or would be medically inappropriate, or
 - B) for which there does not exist a more beneficial standard health service or procedure covered by the Contractor, or
 - C) for which there exists a clinical trial, and

APPENDIX K
March 1, 2014
K-34

2016 PROVIDER NETWORKS AND MEMBER BENEFIT PLANS

- iii) The Enrollee's provider, who must be a licensed, board-certified or board-eligible physician, qualified to practice in the area of practice appropriate to treat the Enrollee's life-threatening or disabling condition or disease, must have recommended either:
 - A) a health service or procedure that, based on two (2) documents from the available medical and scientific evidence, is likely to be more beneficial to the Enrollee than any covered standard health service or procedure; or
 - B) a clinical trial for which the Enrollee is eligible; and
- iv) The specific health service or procedure recommended by the attending physician would otherwise be covered except for the Contractor's determination that the health service or procedure is experimental or investigational.

33. Renal Dialysis

Renal dialysis may be provided in an inpatient hospital setting, in an ambulatory care facility, or in the home on recommendation from a renal dialysis center.

34. Nursing Home Services – For MMC Program Only

- a) Nursing Home Services means inpatient nursing home services provided by facilities licensed under Article 28 of the New York State Public Health Law, including AIDS nursing facilities. Covered services includes the following health care services: medical supervision, twenty-four (24) hour per day nursing care, assistance with the activities of daily living, physical therapy, occupational therapy, and speech/language pathology services and other services as specified in the New York State Health Law and Regulations for residential health care facilities and AIDS nursing facilities. These services should be provided to an MMC Enrollee:
 - i) Who is diagnosed by a physician as having one or more clinically determined illnesses or conditions that cause the MMC Enrollee to be so incapacitated, sick, invalid, infirm, disabled, or convalescent as to require at least medical and nursing care; and
 - ii) Whose assessed health care needs, in the professional judgment of the MMC Enrollee's physician or a medical team:
 - A) do not require care or active treatment of the MMC Enrollee in a general or special hospital;
 - B) cannot be met satisfactorily in the MMC Enrollee's own home or home substitute through provision of such home health services, including medical and other health and health-related services as are available in or near his or her community; and

APPENDIX K
March 1, 2014
K-35

2016 PROVIDER NETWORKS AND MEMBER BENEFIT PLANS

- C) cannot be met satisfactorily in the physician's office, a hospital clinic, or other ambulatory care setting because of the unavailability of medical or other health and health-related services for the MMC Enrollee in such setting in or near his or her community.
- b) The Contractor is also responsible for respite days and bed hold days authorized by the Contractor.
- c) The Contractor is responsible for all medically necessary and clinically appropriate inpatient nursing home services authorized by the Contractor for MMC Enrollees age 21 and older who are in Long Term Placement Status as determined by LDSS or who are in a non-permanent rehabilitation stay.

35. Personal Care Services (MMC only)

- a) Personal care services (PCS), as defined by 18 NYCRR §505.14(a) and as further described in the SDOH "Guidelines for the Provision of Personal Care Services in Medicaid Managed Care," are the provision of some or total assistance with personal hygiene, dressing and feeding and nutritional and environmental support (meal preparation and housekeeping). Such services must be essential to the maintenance of the Enrollee's health and safety in his or her own home. The service must be ordered by a physician or nurse practitioner, and there must be a medical need for the service. Enrollees receiving PCS must have a stable medical condition that is not expected to exhibit sudden deterioration or improvement; does not require frequent medical or nursing judgment to determine changes in the patient's plan of care; is such that a physically disabled individual in need of routine supportive assistance does not need skilled professional care in the home; or the condition is such that a physically disabled or frail elderly individual does not need professional care but does require assistance in the home to prevent a health or safety crisis from developing. Enrollees receiving PCS must be self-directing, which shall mean that the Enrollee is capable of making choices about his or her activities of daily living, understanding the impact of the choice and assuming responsibility for the results of the choices. Enrollees who are non self-directing, and who require continuous supervision and direction for making choices about activities of daily living shall not receive PCS, except under the following conditions:
 - i) supervision or direction is provided on an interim or part-time basis as part of a plan of care in which the responsibility for making choices about activities of daily living is assumed by a self-directing individual living within the same household;
 - ii) supervision or direction is provided on an interim or part-time basis as part of a plan of care in which the responsibility for making choices about activities of daily living is assumed by a self-directing individual not living within the same household; or
 - iii) supervision or direction is provided on an interim or part-time basis as part of a plan of care in which the responsibility for making choices about activities of

APPENDIX K
March 1, 2014
K-36

2016 PROVIDER NETWORKS AND MEMBER BENEFIT PLANS

daily living is assumed by an outside agency or other formal organization. The LDSS may be the outside agency.

- b) Personal care services are authorized as Level I (environmental and nutritional functions) or Level II (personal care, environmental and nutritional functions) with specific number of hours per day and days per week the PCS are to be provided. Authorization for solely Level I services may not exceed eight (8) hours per week.

36. Personal Emergency Response System (PERS)

- a) Personal Emergency Response System (PERS) is an electronic device which enables certain high-risk patients to secure help in the event of a physical, emotional or environmental emergency. Such systems are usually connected to a patient's phone and signal a response center when a "help" button is activated. In the event of an emergency, the signal is received and appropriately acted upon by a response center.
- b) Assessment of need for PERS services must be made in accordance with and in coordination with authorization procedures for home care services, including personal care services. Authorization for PERS services is based on a physician or nurse practitioner's order and a comprehensive assessment which must include an evaluation of the client's physical disability status, the degree that they would be at risk of an emergency due to medical or functional impairments or disability and the degree of their social isolation. PERS is not provided in the absence of personal care or home care services. Authorization of PERS is not a substitute for or in lieu of assistance with PCS tasks such as transferring, toileting or walking.
- c) The Contractor will be responsible for authorizing and arranging for PERS services through network providers, as described in this Appendix and the SDOH "Guidelines for the Provision of Personal Care Services in Medicaid Managed Care."

37. Consumer Directed Personal Assistance Services (MMC Program Only)

- a) Consumer Directed Personal Assistance Services (CDPAS), as defined by 18 NYCRR §§505.28(a) and (b), means the provision to a chronically ill and/or disabled Consumer of some or total assistance with personal care services, home health aide services and skilled nursing tasks by a consumer directed personal assistant under the instruction, supervision and direction of a Consumer or the Consumer's designated representative. A Consumer must acknowledge in writing that they are willing and able to fulfill their responsibilities as provided by 10 NYCRR §505.28(g)(1)-(7).
- b) For the MMC program, these terms shall have the following meanings:
 - i) "Consumer" means an Enrollee who the Contractor has determined to be eligible to receive CDPAS, pursuant to a nursing and social assessment process consistent with 18 NYCRR §§505.28(c) and (d).
 - ii) "Fiscal Intermediary" means an entity that has an agreement with the Contractor to provide wage and benefit processing for consumer directed personal assistants

APPENDIX K
March 1, 2014
K-37

2016 PROVIDER NETWORKS AND MEMBER BENEFIT PLANS

and other Fiscal Intermediary responsibilities as provided by 18 NYCRR 505.28 (i)(1)(i)-(v), (vii).

38. Observation Services

Observation Services in an Article 28 hospital are post-stabilization services covered by the Contractor for observation, short-term treatment, assessment and re-assessment of an Enrollee for whom diagnosis and a determination concerning inpatient admission, discharge, or transfer cannot be accomplished within eight hours but can reasonably be expected within forty-eight (48) hours. Observation services may be provided in distinct units approved by the Department, inpatient beds, or in the emergency department ONLY for hospitals designated as critical access hospitals or sole community hospitals. An Enrollee shall be assigned to the observation service through a hospital Emergency Department by order of a physician, nurse practitioner, or other medical professional within his/her scope of practice. Observation services may be subject to prior approval and/or notification requirements, as well as retrospective review procedures, established by the Contractor. The Enrollee must be admitted to the inpatient service, transferred to another hospital, or discharged to self-care or the care of a physician or other appropriate follow-up service within forty-eight (48) hours of assignment to the observation unit. Notwithstanding the requirements of this section, the Contractor shall provide the Observation Services benefit consistent with regulations at 10 NYCRR Part 405.32.

39. Medical Social Services

- a) Medical Social Services are covered by the Contractor only for those Enrollees who have transitioned to the Contractor's Medicaid Managed Care plan from the Long Term Home Health Care Program (LTHHCP) and who received Medical Social Services while in the LTHHCP. Medical Social Services is the assessment of social and environmental factors related to the participant's illness, need for care, response to treatment and adjustments to treatment; assessment of the relationship of the participant's medical and nursing requirements to his/her home situation, financial resources and availability of community resources; actions to obtain available community resources to assist in resolving the participant's problems; and counseling services. Such services shall include, but not be limited to, home visits to the individual, family or both; visits preparatory to the transfer of the individual to the community; and patient and family counseling, including personal, financial, and other forms of counseling services.
- b) Medical Social Services must be provided by a qualified social worker licensed by the Education Department to practice social work in the State of New York.

40. Home Delivered Meals

Home Delivered Meals are covered by the Contractor only for those Enrollees who have transitioned to the Contractor's Medicaid Managed Care plan from the Long Term Home Health Care Program (LTHHCP) and who received Home Delivered Meals while in the LTHHCP. Home Delivered Meals must be provided when the Enrollee's needs cannot be met by existing support services, including family and approved personal care aides. The

APPENDIX K
March 1, 2014
K-38

Home Delivered Meals benefit includes up to two meals per day on week days and/or weekends.

41. Adult Day Health Care

- a) Adult Day Health Care means care and services provided to a registrant in a residential health care facility or approved extension site under the medical direction of a physician and which is provided by personnel of the Adult Day Health Care program in accordance with a comprehensive assessment of care needs and the PCSP, ongoing implementation and coordination of the PCSP, and transportation.
- b) Registrant means a person who is a nonresident of the Residential Health Care Facility who is functionally impaired and not homebound and who requires certain preventive, diagnostic, therapeutic, rehabilitative or palliative items or services provided by a general hospital, or Residential Health Care Facility; and whose assessed social and health care needs, in the professional judgment of the physician of record, nursing staff, Social Services and other professional personnel of the Adult Day Health Care program can be met in whole or in part satisfactorily by delivery of appropriate services in such program.

42. AIDS Adult Day Health Care

AIDS Adult Day Health Care Programs (AIDS ADHCP) are programs designed to assist individuals with HIV disease to live more independently in the community or eliminate the need for residential health care services. Registrants in AIDS ADHCP require a greater range of comprehensive health care services than can be provided in any single setting, but do not require the level of services provided in a residential health care setting. Regulations require that a person enrolled in an AIDS ADHCP must require at least three (3) hours of health care delivered on the basis of at least one (1) visit per week. While health care services are broadly defined in this setting to include general medical care, nursing care, medication management, nutritional services, rehabilitative services, and substance abuse and mental health services, the latter two (2) cannot be the sole reason for admission to the program. Admission criteria must include, at a minimum, the need for general medical care and nursing services.

43. Directly Observed Therapy (DOT) of Tuberculosis Disease

Tuberculosis Directly Observed Therapy (TB/DOT) is the direct observation of oral ingestion, or the administration of injectable/infused medication, to assure patient compliance with the physician's prescribed medication regimen. DOT is the standard of care for every individual with active TB. Clinical management of TB, including TB/DOT and all TB medications, is included in the benefit package.

44. HIV SNP Enhanced Services - Applicable to HIV SNP Program Only

The HIV SNP Benefit package includes enhanced services that are essential for promoting wellness and preventing illness. HIV SNP Enhanced Services include the following:

APPENDIX K
March 1, 2014
K-39

2016 PROVIDER NETWORKS AND MEMBER BENEFIT PLANS

a) HIV SNP Care and Benefits Coordination Services

HIV SNP Care and Benefits Coordination Services include medical case management/care coordination services in consultation with the PCP; assessment and service plan development that identifies and addresses the Enrollee's medical and psychosocial needs; service utilization monitoring and care advocacy services that promote Enrollee access to needed care and services; case manager provider participation in quality assurance and quality improvement activities.

b) HIV Treatment Adherence Services

HIV treatment adherence services include treatment education policies and programs to promote adherence to prescribed treatment regimens for all Enrollees, facilitate access to treatment adherence services including treatment readiness and supportive services integrated into the continuum of HIV care services, and the development of a structural network among providers that facilitates the coordination of treatment adherence services as well as promotes, reinforces and supports adherence services for Enrollees while ensuring collaboration between the provider and Enrollee. Treatment adherence services include development and regular reassessment of an individualized treatment adherence plan for each Enrollee consistent with guidelines as developed by the AIDS Institute and assessment of the overall health and psychosocial needs of the Enrollee in order to identify potential barriers that may impact upon the level of adherence and the overall treatment plan.

c) HIV Primary and Secondary Prevention and Risk-Reduction Services

HIV primary and secondary prevention and risk-reduction services include HIV primary and secondary prevention and risk-reduction education and counseling; education and counseling regarding reduction of perinatal transmission; harm reduction education and services; education to Enrollees regarding STDs and services available for STD treatment and prevention; counseling and supportive services for partner/spousal notification (pursuant to Chapter 163 of the Laws of 1998); and HIV community education, outreach and health promotion activities.

APPENDIX K
March 1, 2014
K-40

K.3

Medicaid Managed Care Prepaid Benefit Package Definitions of Non-Covered Services

The following services are excluded from the Contractor's Benefit Package, but are covered, in most instances, by Medicaid fee-for-service:

1. Medical Non-Covered Services

a) Nursing Home Services

Services provided in a nursing home to an Enrollee under age 21 who is determined by the LDSS to be in Long Term Placement Status are not covered for Medicaid Managed Care (MMC) or Family Health Plus Enrollees. Family Health Plus covers only non-permanent rehabilitation stays in nursing homes. Enrollees under age 21 in Long Term Placement Status in a nursing home are excluded from MMC and must be disenrolled. Once disenrolled, the beneficiary will receive these services through Medicaid fee-for-service.

b) Emergency and Non-Emergency Transportation (MMC only)

According to a county-by-county phase-in schedule to be determined by SDOH, and subject to implementation of a Medicaid fee-for-service non-emergency medical transportation (NEMT) manager, this benefit will be covered under Medicaid fee-for-service.

c) Orthodontic Services

i) All existing orthodontic cases that have begun treatment or have been reviewed and approved for treatment prior to October 1, 2012 through Medicaid fee-for-service and issued an eMedNY prior approval number will continue being paid through Medicaid fee-for-service until the completion of the approved course of treatment. Monitoring of such cases will be conducted by SDOH as needed.

ii) If an Enrollee loses eligibility for Medicaid services after appliances are in place and active treatment has begun, the Enrollee will be disenrolled from Medicaid managed care and will be entitled to a maximum of six (6) months of treatment reimbursed by Medicaid fee-for-service.

2. Non-Covered Behavioral Health Services

a) Chemical Dependence Services

i) Outpatient Rehabilitation and Treatment Services Provided by OASAS Licensed Clinics

APPENDIX K
March 1, 2014
K-41

2016 PROVIDER NETWORKS AND MEMBER BENEFIT PLANS

A) Opioid Treatment Program (OTP)

Consists of drug detoxification, drug dependence counseling, and rehabilitation services which include chemical management of the patient with methadone or other approved medications. Facilities that provide opioid treatment do so as their principal mission and are certified by OASAS under 14 NYCRR Part 822.

B) Medically Supervised Ambulatory Chemical Dependence Outpatient Clinic Programs

Medically Supervised Ambulatory Chemical Dependence Outpatient Clinic Programs are licensed under Title 14 NYCRR Part 822 and provide chemical dependence outpatient treatment to individuals who suffer from chemical abuse or dependence and their family members or significant others.

C) Medically Supervised Chemical Dependence Outpatient Rehabilitation Programs

Medically Supervised Chemical Dependence Outpatient Rehabilitation Programs provide full or half-day services to meet the needs of a specific target population of chronic alcoholic persons who need a range of services which are different from those typically provided in an alcoholism outpatient clinic. Programs are licensed by as Chemical Dependence Outpatient Rehabilitation Programs under Title 14 NYCRR § 822.9.

D) Outpatient Chemical Dependence for Youth Programs

Outpatient Chemical Dependence for Youth Programs (OCDY) licensed under Title 14 NYCRR Part 823, establishes programs and service regulations for OCDY programs. OCDY programs offer discrete, ambulatory clinic services to chemically-dependent youth in a treatment setting that supports abstinence from chemical dependence (including alcohol and substance abuse) services.

ii) Chemical Dependence Services Ordered by the LDSS

A) The Contractor is not responsible for the provision and payment of Chemical Dependence Inpatient Rehabilitation and Treatment Services ordered by the LDSS and provided to Enrollees who have:

- I) been assessed as unable to work by the LDSS and are mandated to receive Chemical Dependence Inpatient Rehabilitation and Treatment Services as a condition of eligibility for Public Assistance, or
- II) have been determined to be able to work with limitations (work limited) and are simultaneously mandated by the LDSS into Chemical Dependence Inpatient Rehabilitation and Treatment Services (including alcohol and

APPENDIX K
March 1, 2014
K-42

2016 PROVIDER NETWORKS AND MEMBER BENEFIT PLANS

substance abuse treatment services) pursuant to work activity requirements.

- B) The Contractor is not responsible for the provision and payment of Medically Supervised Inpatient and Outpatient Withdrawal Services ordered by the LDSS under Welfare Reform (as indicated by Code 83).
- C) The Contractor is responsible for the provision and payment of Medically Managed Detoxification Services in this Agreement.
- D) If the Contractor is already providing an Enrollee with Chemical Dependence Inpatient Rehabilitation and Treatment Services and Detoxification Services and the LDSS is satisfied with the level of care and services, then the Contractor will continue to be responsible for the provision and payment of these services.

b) Mental Health Services

i) Intensive Psychiatric Rehabilitation Treatment Programs (IPRT)

A time limited active psychiatric rehabilitation designed to assist a patient in forming and achieving mutually agreed upon goals in living, learning, working and social environments, to intervene with psychiatric rehabilitative technologies to overcome functional disabilities. IPRT services are certified by OMH under 14 NYCRR Part 587.

ii) Day Treatment

A combination of diagnostic, treatment, and rehabilitative procedures which, through supervised and planned activities and extensive client-staff interaction, provides the services of the clinic treatment program, as well as social training, task and skill training and socialization activities. Services are expected to be of six (6) months duration. These services are certified by OMH under 14 NYCRR Part 587.

iii) Continuing Day Treatment

Provides treatment designed to maintain or enhance current levels of functioning and skills, maintain community living, and develop self-awareness and self-esteem. Includes: assessment and treatment planning; discharge planning; medication therapy; medication education; case management; health screening and referral; rehabilitative readiness development; psychiatric rehabilitative readiness determination and referral; and symptom management. These services are certified by OMH under 14 NYCRR Part 587.

iv) Day Treatment Programs Serving Children

APPENDIX K
March 1, 2014
K-43

2016 PROVIDER NETWORKS AND MEMBER BENEFIT PLANS

Day treatment programs are characterized by a blend of mental health and special education services provided in a fully integrated program. Typically these programs include: special education in small classes with an emphasis on individualized instruction, individual and group counseling, family services such as family counseling, support and education, crisis intervention, interpersonal skill development, behavior modification, art and music therapy.

v) Home and Community Based Services Waiver for Seriously Emotionally Disturbed Children

This waiver is in select counties for children and adolescents who would otherwise be admitted to an institutional setting if waiver services were not provided. The services include individualized care coordination, respite, family support, intensive in-home skill building, and crisis response.

vi) Case Management

The target population consists of individuals who are seriously and persistently mentally ill (SPMI), require intensive, personal and proactive intervention to help them obtain those services which will permit functioning in the community and either have symptomology which is difficult to treat in the existing mental health care system or are unwilling or unable to adapt to the existing mental health care system. Three case management models are currently operated pursuant to an agreement with OMH or a local governmental unit, and receive Medicaid reimbursement pursuant to 14 NYCRR Part 506. Please note: See generic definition of Comprehensive Medicaid Case Management (CMCM) under Item 3 – “Other Non-Covered Services”.

vii) Partial Hospitalization

Provides active treatment designed to stabilize and ameliorate acute systems, serves as an alternative to inpatient hospitalization, or reduces the length of a hospital stay within a medically supervised program by providing the following: assessment and treatment planning; health screening and referral; symptom management; medication therapy; medication education; verbal therapy; case management; psychiatric rehabilitative readiness determination and referral and crisis intervention. These services are certified by OMH under NYCRR Part 587.

viii) Services Provided Through OMH Designated Clinics for Children With A Diagnosis of Serious Emotional Disturbance (SED)

Services provided by designated OMH clinics to children and adolescents through age eighteen (18) with a clinical diagnosis of SED are covered by Medicaid fee-for-service.

ix) Assertive Community Treatment (ACT)

APPENDIX K
March 1, 2014
K-44

2016 PROVIDER NETWORKS AND MEMBER BENEFIT PLANS

ACT is a mobile team-based approach to delivering comprehensive and flexible treatment, rehabilitation, case management and support services to individuals in their natural living setting. ACT programs deliver integrated services to recipients and adjust services over time to meet the recipient's goals and changing needs; are operated pursuant to approval or certification by OMH; and receive Medicaid reimbursement pursuant to 14 NYCRR Part 508.

x) Personalized Recovery Oriented Services (PROS)

PROS, licensed and reimbursed pursuant to 14 NYCRR Part 512, are designed to assist individuals in recovery from the disabling effects of mental illness through the coordinated delivery of a customized array of rehabilitation, treatment, and support services in traditional settings and in off-site locations. Specific components of PROS include Community Rehabilitation and Support, Intensive Rehabilitation, Ongoing Rehabilitation and Support and Clinical Treatment.

xi) Risperidone microspheres (Risperdal® Consta®), paliperidone palmitate (Invega® Sustenna®), Abilify Maintena™ and olanzapine (Zyprexa® Relprevv™) are injectable mental health drugs used for management of patients with schizophrenia, furnished as part of a clinic or office visit. These drugs are covered through Medicaid fee-for-service for mainstream MMC SSI/SSI-related Enrollees, only.

c) Rehabilitation Services Provided to Residents of OMH Licensed Community Residences (CRs) and Family Based Treatment Programs, as follows:

i) OMH Licensed CRs*

Rehabilitative services in community residences are interventions, therapies and activities which are medically therapeutic and remedial in nature, and are medically necessary for the maximum reduction of functional and adaptive behavior defects associated with the person's mental illness.

ii) Family-Based Treatment*

Rehabilitative services in family-based treatment programs are intended to provide treatment to seriously emotionally disturbed children and youth to promote their successful functioning and integration into the natural family, community, school or independent living situations. Such services are provided in consideration of a child's developmental stage. Those children determined eligible for admission are placed in surrogate family homes for care and treatment.

*These services are certified by OMH under 14 NYCRR § 586.3, Part 594 and Part 595.

d) Office for People With Developmental Disabilities (OPWDD) Services

APPENDIX K
March 1, 2014
K-45

2016 PROVIDER NETWORKS AND MEMBER BENEFIT PLANS

i) Long Term Therapy Services Provided by Article 16-Clinic Treatment Facilities or Article 28 Facilities

These services are provided to persons with developmental disabilities including medical or remedial services recommended by a physician or other licensed practitioner of the healing arts for a maximum reduction of the effects of physical or mental disability and restoration of the person to his or her best possible functional level. It also includes the fitting, training, and modification of assistive devices by licensed practitioners or trained others under their direct supervision. Such services are designed to ameliorate or limit the disabling condition and to allow the person to remain in or move to, the least restrictive residential and/or day setting. These services are certified by OPWDD under 14 NYCRR Part 679 (or they are provided by Article 28 Diagnostic and Treatment Centers that are explicitly designated by the SDOH as serving primarily persons with developmental disabilities). If care of this nature is provided in facilities other than Article 28 or Article 16 centers, it is a covered service.

ii) Day Treatment

A planned combination of diagnostic, treatment and rehabilitation services provided to developmentally disabled individuals in need of a broad range of services, but who do not need intensive twenty-four (24) hour care and medical supervision. The services provided as identified in the comprehensive assessment may include nutrition, recreation, self-care, independent living, therapies, nursing, and transportation services. These services are generally provided in ICF or a comparable setting. These services are certified by OPWDD under 14 NYCRR Part 690.

iii) Medicaid Service Coordination (MSC)

Medicaid Service Coordination (MSC) is a Medicaid State Plan service provided by OPWDD which assists persons with developmental disabilities and mental retardation to gain access to necessary services and supports appropriate to the needs of the individual. MSC is provided by qualified service coordinators and uses a person centered planning process in developing, implementing and maintaining an Individualized Service Plan (ISP) with and for a person with developmental disabilities and mental retardation. MSC promotes the concepts of a choice, individualized services and consumer satisfaction. MSC is provided by authorized vendors who have a contract with OPWDD, and who are paid monthly pursuant to such contract. Persons who receive MSC must not permanently reside in an ICF for persons with developmental disabilities, a developmental center, a skilled nursing facility or any other hospital or Medical Assistance institutional setting that provides service coordination. They must also not concurrently be enrolled in any other comprehensive Medicaid long term service coordination program/service including the Care at Home Waiver. Please note: See generic definition of Comprehensive Medicaid Case Management (CMCM) under Item 3 “Other Non-Covered Services.”

APPENDIX K
March 1, 2014
K-46

2016 PROVIDER NETWORKS AND MEMBER BENEFIT PLANS

iv) Home And Community Based Services Waivers (HCBS)

The Home and Community-Based Services Waiver serves persons with developmental disabilities who would otherwise be admitted to an ICF/MR if waiver services were not provided. HCBS waivers services include residential habilitation, day habilitation, prevocational, supported work, respite, adaptive devices, consolidated supports and services, environmental modifications, family education and training, live-in caregiver, and plan of care support services. These services are authorized pursuant to a SSA § 1915(c) waiver from DHHS.

v) Services Provided Through the Care At Home Program (OPWDD)

The OPWDD Care at Home III, Care at Home IV, and Care at Home VI waivers, serve children who would otherwise not be eligible for Medicaid because of their parents' income and resources, and who would otherwise be eligible for an ICF/MR level of care. Care at Home waiver services include service coordination, respite and assistive technologies. Care at Home waiver services are authorized pursuant to a SSA § 1915(c) waiver from DHHS.

3. Other Non-Covered Services

a) The Early Intervention Program (EIP) – Children Birth to Two (2) Years of Age

- i) This program provides early intervention services to certain children, from birth through two (2) years of age, who have a developmental delay or a diagnosed physical or mental condition that has a high probability of resulting in developmental delay. All managed care providers **must** refer infants and toddlers suspected of having a delay to the local designated Early Intervention agency in their area. (In most municipalities, the County Health Department is the designated agency, except: New York City - the Department of Health and Mental Hygiene; Erie County - The Department of Youth Services; Jefferson County - the Office of Community Services; and Ulster County - the Department of Social Services).
- ii) Early intervention services provided to this eligible population are categorized as Non-Covered. These services, which are designed to meet the developmental needs of the child and the needs of the family related to enhancing the child's development, will be identified on eMedNY by unique rate codes by which only the designated early intervention agency can claim reimbursement. Contractor covered and authorized services will continue to be provided by the Contractor. Consequently, the Contractor, through its Participating Providers, will be expected to refer any enrolled child suspected of having a developmental delay to the locally designated early intervention agency in their area and participate in the development of the Child's Individualized Family Services Plan (IFSP). Contractor's participation in the development of the IFSP is necessary in order to coordinate the provision of early intervention services and services covered by the Contractor.

APPENDIX K
March 1, 2014
K-47

2016 PROVIDER NETWORKS AND MEMBER BENEFIT PLANS

- iii) SDOH will instruct the locally designated early intervention agencies on how to identify an Enrollee and the need to contact the Contractor or the Participating Provider to coordinate service provision.
- b) **Preschool Supportive Health Services–Children Three (3) Through Four (4) Years of Age**
 - i) The Preschool Supportive Health Services Program (PSHSP) enables counties and New York City to obtain Medicaid reimbursement for certain educationally related medical services provided by approved preschool special education programs for young children with disabilities. The Committee on Preschool Special Education in each school district is responsible for the development of an Individualized Education Program (IEP) for each child evaluated in need of special education and medically related health services.
 - ii) PSHSP services rendered to children three (3) through four (4) years of age in conjunction with an approved IEP are categorized as Non-Covered.
 - iii) The PSHSP services will be identified on eMedNY by unique rate codes through which only counties and New York City can claim reimbursement. In addition, a limited number of Article 28 clinics associated with approved pre-school programs are allowed to directly bill Medicaid fee-for-service for these services. Contractor covered and authorized services will continue to be provided by the Contractor.
- c) **School Supportive Health Services–Children Five (5) Through Twenty-One (21) Years of Age**
 - i) The School Supportive Health Services Program (SSHSP) enables school districts to obtain Medicaid reimbursement for certain educationally related medical services provided by approved special education programs for children with disabilities. The Committee on Special Education in each school district is responsible for the development of an Individualized Education Program (IEP) for each child evaluated in need of special education and medically related services.
 - ii) SSHSP services rendered to children five (5) through twenty-one (21) years of age in conjunction with an approved IEP are categorized as Non-Covered.
 - iii) The SSHSP services are identified on eMedNY by unique rate codes through which only school districts can claim Medicaid reimbursement. Contractor covered and authorized services will continue to be provided by the Contractor.
- d) **Comprehensive Medicaid Case Management (CMCM)**

A program which provides “social work” case management referral services to a targeted population (e.g.: pregnant teens, mentally ill). A CMCM case manager will assist a client in accessing necessary services in accordance with goals contained in a written case management plan. CMCM programs do not provide services directly, but

APPENDIX K
March 1, 2014
K-48

2016 PROVIDER NETWORKS AND MEMBER BENEFIT PLANS

refer to a wide range of service Providers. Some of these services are: medical, social, psycho-social, education, employment, financial, and mental health. CMCM referral to community service agencies and/or medical providers requires the case manager to work out a mutually agreeable case coordination approach with the agency/medical providers. Consequently, if an Enrollee of the Contractor is participating in a CMCM program, the Contractor must work collaboratively with the CMCM case manager to coordinate the provision of services covered by the Contractor. CMCM programs will be instructed on how to identify a managed care Enrollee on EMEVS and informed on the need to contact the Contractor to coordinate service provision.

e) School-Based Health Centers

A School-Based Health Center (SBHC) is an Article 28 extension clinic that is located in a school and provides students with primary and preventive physical and mental health care services, acute or first contact care, chronic care, and referral as needed. SBHC services include comprehensive physical and mental health histories and assessments, diagnosis and treatment of acute and chronic illnesses, screenings (e.g., vision, hearing, dental, nutrition, TB), routine management of chronic diseases (e.g., asthma, diabetes), health education, mental health counseling and/or referral, immunizations and physicals for working papers and sports.

APPENDIX K
March 1, 2014
K-49

2016 PROVIDER NETWORKS AND MEMBER BENEFIT PLANS

K.4

Family Health Plus Non-Covered Services

1. Non-emergency Transportation Services (except for 19 and 20 year olds receiving C/THP Services per K.2, Section 23. e) of this Appendix, in counties that have not implemented the Medicaid Managed Care transportation carve-out)
2. Personal Care Services
3. Private Duty Nursing Services
4. Long Term Care – Residential Health Care Facility Services
5. Medical Supplies
6. Alcohol and Substance Abuse (ASA) Services Ordered by the LDSS
7. Office of Mental Health/ Office for People With Developmental Disabilities
8. School Supportive Health Services
9. Comprehensive Medicaid Case Management (CMCM)
10. Directly Observed Therapy for Tuberculosis Disease
11. AIDS Adult Day Health Care
12. Home and Community Based Services Waiver
13. Opioid Treatment Program (OTP)
14. Day Treatment
15. IPRT
16. Infertility Services
17. Adult Day Health Care
18. School Based Health Care Services
19. Personal Emergency Response System
20. Consumer Directed Personal Assistance Services
21. Orthodontia

APPENDIX K
March 1, 2014
K-50

2016 PROVIDER NETWORKS AND MEMBER BENEFIT PLANS



EmblemHealth® NYC HMO Base Plan

Coverage Period: 07/01/2014 - 06/30/2015

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual/Family

Plan Type: HMO



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.emblemhealth.com or by calling 1-800-447-8255.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$0	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	----None----	The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, penalties, balanced-bill charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	Yes. See www.EmblemHealth.com or call 1-800-447-8255 for a list of participating providers.	If you use an in-network doctor or other health care <u>provider</u> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a <u>specialist</u> ?	Yes, written approval is required to see a specialist.	This plan will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have the plan's permission before you see the <u>specialist</u> .
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about <u>excluded services</u> .

Questions: Call 1-800-447-8255 or visit us at www.emblemhealth.com/sbc.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.emblemhealth.com/sbc or call 1-800-447-8255 to request a copy.

PHSTD8699

1 of 8



2016 PROVIDER NETWORKS AND MEMBER BENEFIT PLANS



EmblemHealth® NYC HMO Base Plan

Coverage Period: 07/01/2014 - 06/30/2015

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual/Family

Plan Type: HMO



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	No charge	Not covered	----None----
	Specialist visit	No charge	Not covered	----None----
	Other practitioner office visit	Chiropractor: No charge	Not covered	----None----
	Preventive care/screening/immunization	No charge	Not covered	----None----
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	----None----
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	Prior approval required
If you need drugs to treat your illness or condition	Generic drugs	Not covered	Not covered	Must be dispensed by a Participating Pharmacy.
	Preferred brand drugs	Not covered	Not covered	
	Non-preferred brand drugs	Not covered	Not covered	
More information about prescription drug coverage is available at www.EmblemHealth.com .	Specialty drugs	Not covered	Not covered	Must be dispensed by a Specialty Pharmacy. Written referral required.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$50 co-pay	Not covered	Prior approval required
	Physician/surgeon fees	No charge	Not covered	Prior approval required

Questions: Call 1-800-447-8255 or visit us at www.emblemhealth.com/sbc.

PHSTD8699

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.emblemhealth.com/sbc or call 1-800-447-8255 to request a copy.

2 of 8



2016 PROVIDER NETWORKS AND MEMBER BENEFIT PLANS



EmblemHealth® NYC HMO Base Plan

Coverage Period: 07/01/2014 - 06/30/2015

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual/Family

Plan Type: HMO

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	\$50 co-pay/visit	\$50 co-pay/visit	----None----
	Emergency medical transportation	No charge	No charge	----None----
	Urgent care	No charge	Not covered	----None----
If you have a hospital stay	Facility fee (e.g., hospital room)	\$100 per continuous confinement	Not covered	Prior approval required
	Physician/surgeon fee	No charge	Not covered	----None----
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No charge	Not covered	Prior approval may be required
	Mental/Behavioral health inpatient services	\$100 per continuous confinement	Not covered	Prior approval required
	Substance use disorder outpatient services	No charge	Not covered	Prior approval may be required
	Substance use disorder inpatient services	\$100 per continuous confinement	Not covered	Prior approval required Certain services may not be covered, see plan documents for details
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	----None----
	Delivery and all inpatient services	\$100 per continuous confinement	Not covered	Limited to 48 hours for natural delivery and 96 hours for caesarean delivery. Prior approval required.

Questions: Call 1-800-447-8255 or visit us at www.emblemhealth.com/sbc.

PHSTD8699

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.emblemhealth.com/sbc or call 1-800-447-8255 to request a copy.

3 of 8



2016 PROVIDER NETWORKS AND MEMBER BENEFIT PLANS



EmblemHealth® NYC HMO Base Plan

Coverage Period: 07/01/2014 - 06/30/2015

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual/Family

Plan Type: HMO

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Coverage limited to 200 visits/year. Prior approval required.
	Rehabilitation services	Inpatient: \$100 per continuous confinement Outpatient: No charge	Not covered	Inpatient coverage limited to 90 days/year. Outpatient coverage limited to 90 visits/year.
	Habilitation services	Inpatient: \$100 per continuous confinement Outpatient: No charge	Not covered	Inpatient coverage limited to 90 days/year. Outpatient coverage limited to 90 visits/year. Limited to Autism services.
	Skilled nursing care	No charge	Not covered	Prior approval required.
	Durable medical equipment	Not covered	Not covered	----None----
	Hospice service	No charge	Not covered	Coverage limited to 210 days.
If your child needs dental or eye care	Eye exam	No charge	Not covered	----None----
	Glasses	\$45 co-pay/pair	Not covered	Limited to one pair every twenty-four (24) months from an authorized provider.
	Dental check-up	\$5 co-pay/visit	Not covered	One examination (comprehensive or periodic) every six months.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- | | | |
|--|--|---|
| <ul style="list-style-type: none"> • Acupuncture • Cosmetic surgery • Dental care | <ul style="list-style-type: none"> • Hearing aids • Long-term care • Non-emergency care when traveling outside the U.S. | <ul style="list-style-type: none"> • Private-duty nursing • Routine foot care |
|--|--|---|

Benefits paid as a result of injuries caused by another party may need to be repaid to the health plan or paid for by another party under certain circumstances.

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

Questions: Call 1-800-447-8255 or visit us at www.emblemhealth.com/sbc.

PHSTD8699

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.emblemhealth.com/sbc or call 1-800-447-8255 to request a copy.

4 of 8



2016 PROVIDER NETWORKS AND MEMBER BENEFIT PLANS



EmblemHealth® NYC HMO Base Plan

Coverage Period: 07/01/2014 - 06/30/2015

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual/Family

Plan Type: HMO

- | | | |
|---------------------|-------------------------|------------------------|
| • Bariatric surgery | • Infertility treatment | • Routine eye care |
| • Chiropractic care | | • Weight loss programs |

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact EmblemHealth at 1-800-447-8255. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact EmblemHealth.

By phone: 1-800-447-8255. Customer Service Advocates are available to assist You.

In writing: Health Insurance Plan of New York
Grievance and Appeals Department
JAF Station
P.O. Box 2844
New York, NY 10116-2844

In person: Health Insurance Plan of New York
55 Water Street, Lobby
New York, NY 10041-8190
Hours of operation 8:30 am – 5:00 pm

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-447-8255.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-447-8255.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-447-8255.

Navajo (Dine): Dine'kehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-447-8255

Questions: Call **1-800-447-8255** or visit us at www.emblemhealth.com/sbc.

PHSTD8699

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.emblemhealth.com/sbc or call **1-800-447-8255** to request a copy.

5 of 8



2016 PROVIDER NETWORKS AND MEMBER BENEFIT PLANS



EmblemHealth® NYC HMO Base Plan

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 07/01/2014 - 06/30/2015

Coverage for: Individual/Family

Plan Type: HMO

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

Questions: Call 1-800-447-8255 or visit us at www.emblemhealth.com/sbc.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.emblemhealth.com/sbc or call 1-800-447-8255 to request a copy.

PHSTD8699

6 of 8





About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$7260
- Patient pays \$280

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$0
Co-pays	\$100
Co-insurance	\$0
Limits or exclusions	\$180
Total	\$280

Note: These numbers assume the patient has given notice of her pregnancy to the plan. If you are pregnant and have not given notice of your pregnancy, your costs may be higher. For more information, please contact: 1-800-447-8255.

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$4700
- Patient pays \$700

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$0
Co-pays	\$0
Co-insurance	\$0
Limits or exclusions	\$700
Total	\$700

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: 1-800-447-8255.

Questions: Call 1-800-447-8255 or visit us at www.emblemhealth.com/sbc.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.emblemhealth.com/sbc or call 1-800-447-8255 to request a copy.

PHSTD8699

7 of 8





Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

- ✗ **No**. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✗ **No**. Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- ✓ **Yes**. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ **Yes**. An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call 1-800-447-8255 or visit us at www.emblemhealth.com/sbc.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.emblemhealth.com/sbc or call 1-800-447-8255 to request a copy.

PHSTD8699

8 of 8

