Prime Perspective

Prime Perspective provides information and updates about Prime services.

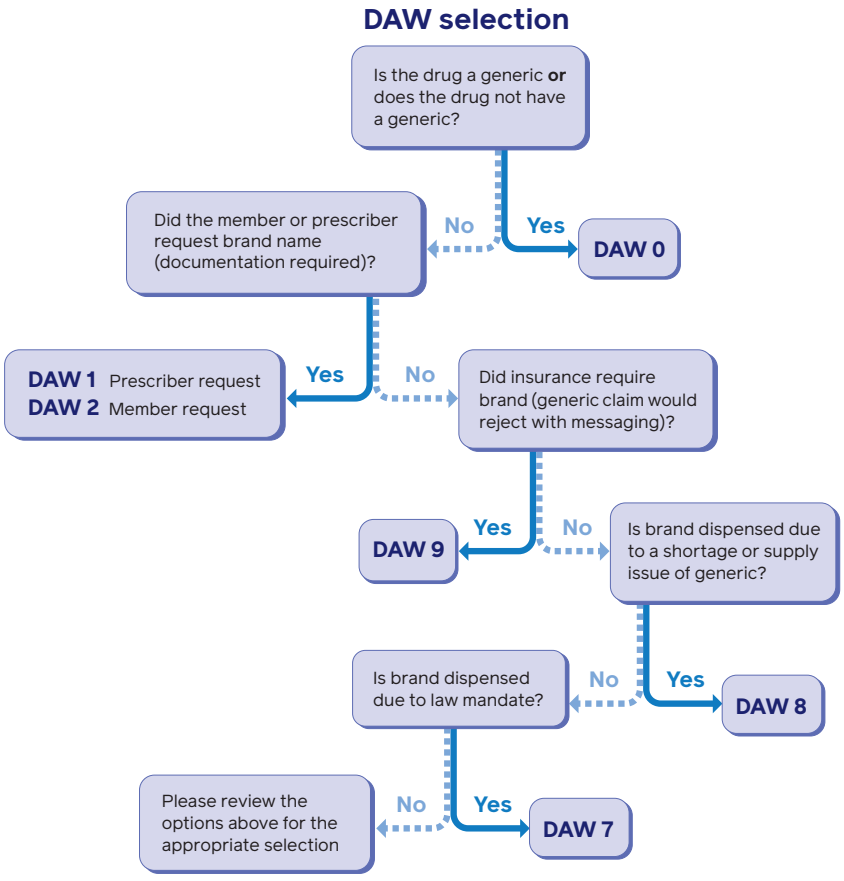
December 2025: Issue 94

Inside

Fraud, waste and abuse (FWA) updates

Dispense as Written (DAW) code selection

Prime Therapeutics (Prime) continues to see inappropriate DAW code selections. Below, we have provided a guide to help you select the appropriate DAW code. Choosing the correct DAW code helps control costs and keeps your Pharmacy compliant with the standards set by the National Council for Prescription Drug Programs (NCPDP). Please refer to this decision tree each time you apply a DAW code to a claim.



These are DAW codes that are uncommon for use and will reject at point of sale. Pharmacies should review the table above to identify the appropriate code to use.

- **DAW 3** Pharmicists selected product (do not use if prescriber authorized multiple products based on coverage)
- **DAW 4** Generic not in stock (not due to any other reasons on this chart)
- **DAW 5** Brand name dispensed as generic (note that reimbursement is for generic)
- **DAW 6** Other (not used at Prime)

If Pharmacy is not able to identify the appropriate code to use, please contact the Prime help desk for support.

Important reminder regarding the False Claims Act (FCA) and pharmacy practices

This communication serves as an important reminder about the FCA and its critical implications for Pharmacies, especially concerning issues such as attesting to claims and backdating prescriptions.

What is the FCA?

The FCA (31 U.S.C 3729-3733) is a federal law designed to protect the government from fraudulent claims for payment. It is particularly relevant to health care providers, including Pharmacies, as it prohibits knowingly submitting false or misleading claims for reimbursement to government programs like Medicare, Medicaid and others.

Key violations to avoid

As a Pharmacy, you are expected to ensure that all claims for payment or reimbursement submitted to these programs are truthful and accurate. Common violations related to the FCA include:

1. **Attesting to a false claim:**
   This occurs when a Pharmacy knowingly submits a claim for reimbursement that is not supported by the actual services provided or products dispensed. For instance, attesting to the delivery of medication that was never dispensed, or submitting claims for services not rendered, can result in severe penalties.
2. **Backdating prescriptions:**
   Another violation is backdating prescriptions — the practice of altering the date on a prescription or creating a prescription that was issued after the fact. This practice is illegal and misleading, as it can be seen as an attempt to falsely document the dispensation of medication or services to receive payment when it was not actually provided at that time.

Consequences of violating the FCA

The FCA carries significant consequences for Pharmacies and their staff, including:

Civil penalties: Fines per false claim may be issued.

Treble damages: The government can recover three times the amount of damages it incurred due to the false claim.

Criminal charges: In extreme cases, individuals may face criminal charges for intentionally submitting false claims.

Exclusion from government programs: Pharmacies involved in fraudulent activities may be excluded from participating in Medicare, Medicaid or other government programs.

Best practices for compliance

To ensure compliance with the FCA, we strongly recommend the following practices:

Verify all prescriptions: Ensure that every prescription is accurate and valid before submitting claims for reimbursement.

Document accurately: Maintain proper records for all prescriptions, dispensed medications and services provided. These records should reflect the true dates of issuance and dispensing.

Train staff: Regularly educate all pharmacy staff on the importance of compliance with federal regulations and the potential consequences of fraudulent practices.

Audit and monitor: Implement internal audits and monitoring systems to identify and address any potential issues related to false claims before they escalate.

It is essential that our Pharmacy Network operates with the highest level of integrity and professionalism to ensure that we comply with federal regulations and avoid potential violations under the FCA. By following proper procedures, maintaining transparency and adhering to the law, we can protect both our patients and our business.

Please take the time to review your current practices and ensure that all claims submitted for reimbursement are accurate and based on legitimate prescriptions and services provided. If you have any questions or concerns regarding these guidelines, please do not hesitate to contact us.

Payment integrity

Payment integrity refers to the process of ensuring health care claims are paid accurately, encompassing both prepayment and postpayment verification. Prime proactively drives payment integrity to improve provider relationships and member experience. Prime strives to simplify the payment system, improving accuracy and reducing overall costs.

Prime encourages Pharmacies to follow best practices for payment integrity, including:

- Maintaining accurate and complete documentation to support billing
- Utilizing guidelines to identify potential errors or inconsistencies in claims before payment
- Collecting proper cost share from covered persons

Combating FWA can help:

- Identify and recover inappropriate claim payments and overpayments
- Simplify and reduce the administrative cost of the payment cycle
- Avoid and prevent inappropriate claim payments and overpayments
- Drive out unnecessary and inappropriate pharmacy costs

Collaborative practice

Collaborative practice is defined as a formal partnership between a pharmacist and a prescriber that allows the pharmacist to manage a member's drug therapy. Collaborative practice agreements are written, executed, reviewed and renewed according to the terms set between the collaborating health care professionals. Providers should follow state laws, which determine the guidelines surrounding collaborative practice agreements. Documentation is critical to ensure proper payment of the pharmacy claims and services rendered. In the event of an audit, claim submissions with records that do not support the code billed will be denied or recouped. If claims are denied or recouped, a corrected claim for the services supported by the documentation provided for the audit or an appeal with additional supporting documentation must be submitted.

Pharmacy audit information

Please visit **PrimeTherapeutics.com/Providers-and-Physicians** for more information regarding pharmacy audits, including common billing errors, pharmacy audit appeals and pharmacy audit guidelines.

Medicare & Medicaid news

Biosimilar-forward formularies — 2026 coverage update for Humira and Stelara

Effective Jan. 1, 2026, Prime will remove coverage for the brand-biologic products Humira and Stelara from most formularies.

Instead, the following FDA-designated interchangeable biosimilars will be covered:

Humira biosimilars	Stelara biosimilars
Hadlima	Steqeyma
Simlandi	Pyzchiva 45/0.5ml Vial
	Ustekin-AEKN (Teva)

A biosimilar is a biologic product that is highly similar to an existing FDA-approved reference product, with no clinically meaningful differences in safety, purity or potency. Biosimilars may offer significant cost savings for patients and the health care system.

Point-of-sale (POS) messaging:

Real-time messaging will support Pharmacies in identifying and dispensing preferred biosimilars.

- *Example:* Humira secondary reject message: Preferred = Hadlima & Simlandi

Pharmacy action required:

To help ensure a smooth transition, Participating Pharmacies are encouraged to assist covered persons in switching to the preferred biosimilar products.

Pharmacists may substitute biologics with FDA-designated interchangeable biosimilars, in accordance with state pharmacy laws.

Reminder of preferred coverage for blood glucose test strips and meters

Beginning Jan. 1, 2026, blood glucose test strips and meters from Abbott (e.g., FreeStyle Freedom Lite, FreeStyle Precision, Precision Xtra) and Ascensia (e.g., Contour Next, Contour Plus) will be the only preferred products for the below Medicare Advantage plan. Other glucose test strips will be nonpreferred and, in most cases, will require a prior authorization (PA). To help ensure a smooth transition for impacted covered persons, Pharmacies are encouraged to assist their covered persons to get a new prescription for the chosen preferred-brand blood glucose meter and test strips from their prescribing provider prior to the change. Members can switch to Ascensia or Abbott testing supplies during the 2025 contract year.

Starting Jan. 1, 2026, pharmacists can use the information below to dispense these newly preferred meters. If covered persons choose to use these manufacturer coupon codes, the product will not count toward their deductible or out-of-pocket maximum.

To process an Ascensia Contour meter:

BIN **018844**

RxPCN **3F**

Group ..... **MGDCARE**

ID **CNMC7246982**

Expiration date **12/31/26**

To process an Abbott FreeStyle meter:

BIN **610020**

Group **99992432**

ID ..... **ERXACTMETER**

This affects the following Medicare plan:

- Capital Health Plan

Reminder of preferred coverage for blood glucose test strips and meters

Beginning Jan. 1, 2026, blood glucose test strips and meters from Ascensia (e.g., Contour Next, Contour Plus) will be the preferred products for the Medicare Advantage plans below. LifeScan (e.g. OneTouch) blood glucose test strips and meters will be nonpreferred, with a higher coinsurance for PPO and HMO plans. Other glucose test strips will be nonpreferred with a higher coinsurance for PPO plans and not covered by HMO plans. To help ensure a smooth transition for impacted covered persons, Pharmacies are encouraged to assist their covered persons to get a new prescription for the chosen preferred-brand blood glucose meter and test strips from their prescribing provider prior to the change.

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BIN **018844**

RxPCN **3F**

Group ..... **MGDCARE**

ID **CNMC7246982**

Expiration date **12/31/26**

This affects the following BCBS Medicare plans:

- Capital Blue Cross Basic (PPO)
- Capital Blue Cross Classic (PPO)
- Capital Blue Cross Complete (PPO)
- Capital Blue Cross Enhanced (PPO)
- Capital Blue Cross Prime (PPO)
- Capital Blue Cross Select (PPO)
- Capital Blue Cross Value (PPO)
- Capital Blue Cross Essential (HMO)
- Capital Blue Cross Premier (HMO)
- Capital Blue Cross Value (HMO)

This affects the following Medicare plan:

- Capital Blue Cross

Reminder of preferred coverage for blood glucose test strips and meters

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Expiration date **12/31/26**

To process an Abbott FreeStyle meter:

BIN **610020**

Group **99992432**

ID ..... **ERXACTMETER**

This affects the following BCBS Medicare plans:

- BlueMedicare Classic (HMO)
- BlueMedicare Premier (HMO)
- BlueMedicare Preferred (HMO)
- BlueMedicare Select (PPO)
- BlueMedicare Value (PPO)

This affects the following Medicare plan:

- Florida Blue

Reminder of preferred coverage for blood glucose test strips and meters

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Starting Jan. 1, 2026, pharmacists can use the information below to dispense these newly preferred meters. If covered persons choose to use these manufacturer coupon codes, the product will not count toward their deductible or out-of-pocket maximum.

To process an Ascensia Contour meter:

BIN **018844**

RxPCN **3F**

Group ..... **MGDCARE**

ID **CNMC7246982**

Expiration date **12/31/26**

To process an Abbott FreeStyle meter:

BIN **610020**

Group **99992432**

ID ..... **ERXACTMETER**

This affects the following BCBS Medicare plans:

- Blue Cross Medicare Advantage of Health Care Service Corporation (HCSC) – Illinois
- Blue Cross Medicare Advantage of Health Care Service Corporation (HCSC) – Montana
- Blue Cross Medicare Advantage of Health Care Service Corporation (HCSC) – New Mexico
- Blue Cross Medicare Advantage of Health Care Service Corporation (HCSC) – Oklahoma
- Blue Cross Medicare Advantage of Health Care Service Corporation (HCSC) – Texas

This affects the following Medicare plan:

- HCSC

Medicare E1 eligibility query

An E1 eligibility query is a real-time transaction submitted by a Pharmacy to RelayHealth, the transaction facilitator contracted by the Centers for Medicare & Medicaid (CMS) to house Medicare eligibility information and respond to transaction requests. An E1 helps determine a member's Medicare Part D coverage and payer order if the member has insurance through more than one benefit plan.

Pharmacies generally submit E1 queries when members do not have their Medicare Part D identification card. Pharmacies should not submit an E1 query for pharmaceutical manufacturer copay assistance coupon programs.

You can visit **Medifacd.McKesson.com/E1/** for additional information on E1 transactions.

CMS standardized pharmacy notice

CMS requires all Medicare Part D benefit plan sponsors to use a single uniform exceptions and appeals process with respect to the determination of prescription drug coverage for a member under the plan. Medicare Part D claims will be rejected when a claim cannot be covered under the Medicare Part D benefit plan at the POS.

- *Example:* Pharmacy POS reject code messaging:
  - NCPDP Reject Code 569

Pharmacies are required to provide members with the CMS Medicare Drug Coverage and Your Rights notice when they receive NCPDP Reject Code 569. The CMS notice is posted on Prime's website at **PrimeTherapeutics.com/Additional-Resources**.

Home infusion Pharmacies receiving the NCPDP Reject Code 569 must distribute the CMS notice to the member either electronically, by fax, in person or by first-class mail within 72 hours of receiving the claim rejection.

Long-term care (LTC) Pharmacies receiving the NCPDP Reject Code 569 must contact the prescribing provider or LTC facility to resolve the rejected claim to ensure the member receives their needed medication or an appropriate substitute. If the Pharmacy must distribute the CMS notice, they must fax or deliver the notice to the member, the member's representative, the prescribing provider or the LTC facility within 72 hours of receiving the claim rejection.

A copy of the CMS Medicare Drug Coverage and Your Rights notice is included on Page 7.

National Plan and Provider Enumeration System (NPPES) updates

To ensure pharmacy directory accuracy, the NPPES now allows Pharmacies to certify their National Provider Identifier (NPI) data. Please submit any changes to your Pharmacy's demographic information — including pharmacy name, address, specialty and telephone number — as soon as you are aware of these changes.

Florida news

Florida Blue utilization management program

We will post to **PrimeTherapeutics.com/Resources** any utilization management (UM) program updates for the upcoming quarter, when available.

Enrolle name: _____(optional)

Drug and prescription number: _____(optional)

Medicare Drug Coverage and Your Rights

You have the right to ask for a coverage determination from your Medicare drug plan to provide or pay for a drug you think should be covered, provided or continued. You also have the right to ask for a special type of coverage determination called an "exception" if you:

- Need a drug that's not on your plan's list of covered drugs
- Believe a coverage rule (like prior authorization or a quantity limit) shouldn't apply to you for medical reasons
- Need to take a nonpreferred drug and you want the plan to cover the drug at a preferred drug price

How to ask for a coverage determination

To ask for a coverage determination, you or your prescriber can call your Medicare drug plan's toll-free phone number on the back of your plan membership card, or you can go to your plan's website. You can ask for an expedited (24-hour) decision if your health could be seriously harmed by waiting up to 72 hours for a decision.

Be ready to tell your Medicare drug plan:

- The name of the prescription drug, including dose and strength (if known)
- The name of the pharmacy that tried to fill the prescription
- The date you tried to fill the prescription
- If you ask for an exception, your prescriber will need to explain why you need the off-formulary or nonpreferred drug, or why a coverage rule shouldn't apply to you

Your Medicare drug plan will send you a written decision. If coverage isn't approved and you disagree with this decision, you have the right to appeal. The plan's notice will explain why coverage was denied and how to ask for an appeal.

Get help and more information

Look at your plan materials or call **1.800.MEDICARE (1.800.633.4227)** for more information about how to ask for a coverage determination. TTY users can call **1.877.486.2048**. For help contacting your plan, call **1.800.MEDICARE**.

To get this form in an accessible format (like large print, Braille or audio) contact your Medicare drug plan. You also have the right to file a complaint if you feel you've been discriminated against. Visit **Medicare.gov/About-Us/Accessibility-Nondiscrimination-Notice**, or call **1.800.MEDICARE (1.800.633.4227)** for more information. TTY users can call **1.877.486.2048**.

PRA Disclosure Statement According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0975. This information collection is used to provide notice to enrollees about how to contact their Part D plan to request a coverage determination. The time required to complete this information collection is estimated to average 1 minute per response, including the time to review instructions, search existing data resources, gather the data needed, to review and complete the information collection. This information collection is required under § 423.562(a)(3) and an associated regulatory provision at §423.128(b)(7)(iii). If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Form CMS -10147 OMB Approval No. 0938-0975 (Expires: 12/31/2027)

New plan announcement

EmblemHealth

Effective Jan. 1, 2026, Prime will begin processing for covered members of EmblemHealth.

Processing requirements

To ensure uninterrupted service to Participating Pharmacies and covered members of EmblemHealth, please use the following information to set up your system prior to Jan. 1, 2026.

- Covered member ID number
- Date of birth
- Gender
- Usual and customary (U&C)
- Days' supply
- Pharmacy NPI
- Active/Valid prescriber ID NPI
- Date prescription written
- Prescription origin code

Outstanding claim reversals and processing

- To prepare for this transition, Participating Pharmacies should complete all claims processing and reversals by close of business Dec. 31, 2025.
- For assistance with claims that have a date of fill prior to Jan. 1, 2026, please contact Express Scripts at **800.282.2881**.

For more information:

- Beginning Jan. 1, 2026, if you have questions regarding claims processing, please contact Prime's Contact Center at **866.799.7919**.
- Prime's commercial payer specification sheet is available at: **PrimeTherapeutics.com> Providers and Physicians> Payer Sheets> Commercial> Prime Therapeutics Commercial Payer Sheet D.0**.

2026 processing information

Plan sponsor	Plan name	BIN	PCN
EmblemHealth	HMO Plus	610455	NY1000
EmblemHealth	ConnectiCare	610455	NY1000
EmblemHealth	NYCO PPO	610455	NY1000
EmblemHealth	Select Care Nework (Bronze, Silver, Gold, Platinum, Catastrophic)	610455	NY1000
EmblemHealth	Millennium Network (Bronze, Silver, Gold, Platinum, Catastrophic)	610455	NY1000
EmblemHealth	Essential Plan	610455	NY1000
EmblemHealth	Child Health Plus	610455	NY1000

Pictured below are examples of the most common ID cards used:


EmblemHealth

Essential Plan 1
No Referral Required

MEMBER: Quebec Mb000028-Ep-M1
ID NUMBER: K9850012501

Network: Enhanced Care Prime
Deductible: $0
Copays: PCP $0 SPEC $0 Urgent Care $0 ER $0
Rx $0/$0 NF $0 Dental $0 Vision $0
BIN#: 610455 PCN: NY1000


Go Paperless - Visit my.emblemhealth.com

PROVIDERS: Network providers must provide or arrange nonemergency care. Call 866-447-9717 to request prior approval, confirm eligibility and check claim status.

Customer Service: 888-447-7703 (TTY: 711)
Emblem Behavioral Health Services: 888-447-2526
EmblemHealth Pharmacy Services: 877-793-6253
24-Hour Nurse Advice Line: 877-444-7988
Dental (DentaQuest):844-776-8750 Vision (EyeMed):877-324-6211

Emblem Health Customer Service: 55 Water St, New York, NY 10041
Claims Submission: EmblemHealth, PO Box 2845, New York, NY 10116
Behavioral Health claims to: Emblem Behavioral Health Services, PO Box 1850, Hicksville, NY 11802

Underwritten by Health Insurance Plan of Greater New York
Fully insured coverage


EmblemHealth

EH Gold Premier POS
No Referral Required

MEMBER: December Ms001009-Sg-M3
ID NUMBER: K9850012201
NETWORK: Select Care

Rx BIN#: 610455
PCN: NY1000
Formulary: XCHG
Pediatric Dental / Vision: Y

Copays: PCP $25 (3 $0 PCP Visits) SPEC $50
Urgent Care $100
Coinsurance: ER 40%
Rx $7 / $40 NF $85

	In-Network	Out-of-Network
MOOP:	$8650 / $17300	$12000 / $24000
Deductible:	$500 / $1000	$6000 / $12000


Go Paperless - Visit my.emblemhealth.com

MEMBERS AND PROVIDERS: Network providers must provide or arrange nonemergency care. Call 800-877-7587 to request prior approval and confirm eligibility.

Customer Service: 888-447-7703 (TTY: 711)
Emblem Behavioral Health Services: 888-447-2526
EmblemHealth Pharmacy Services: 877-793-6253
24-Hour Nurse Advice Line: 877-444-7988
Dental (DentaQuest):844-776-8750 Vision (EyeMed):877-324-6211

Behavioral Health claims to: Emblem Behavioral Health Services, PO Box 1850, Hicksville, NY 11802
All other claims to: HealthCare Partners, 501 Franklin Avenue, Suite 300, Garden City, NY 11530.

Underwritten by Health Insurance Plan of Greater New York
Fully insured coverage


EmblemHealth

CHILD

MEMBER: DMeghan Mary
ID NUMBER: K3785673101

PCP Name: Jonathon C Wenke, FNP PCP Phone: 718-634-5448
Copay: PCP $0 SPEC $0 ER $0 Rx $0
Dental: $0
BIN#: 610455 PCN: NY1000

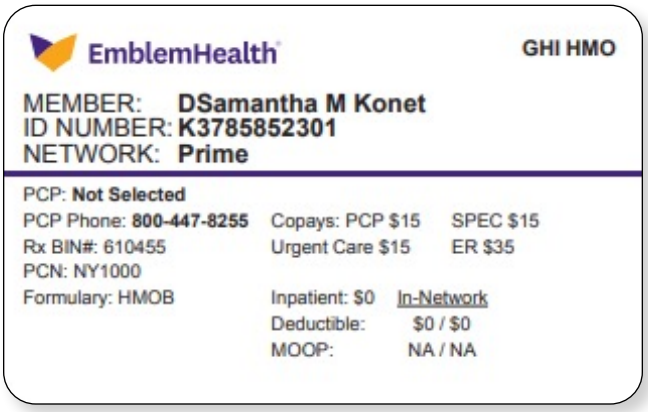

Go Paperless - Visit my.emblemhealth.com

MEMBERS AND PROVIDERS: Network providers must provide or arrange nonemergency care. Call 800-877-7587 to request prior approval and confirm eligibility.

Customer Service: 855-283-2146 (TTY/TDD: 711)
Claims Questions: 800-877-7587
Emblem Behavioral Health Services: 888-447-2526
Dental (DentaQuest): 844-776-8748
Vision (EyeMed): 877-324-2791

Emblem Health Customer Service, 55 Water St, New York, NY 10041
Claims Submission, HealthCare Partners, 501 Franklin Ave, Suite 300, Garden City, NY 11530
Behavioral Health claims to: Emblem Behavioral Health Services, PO Box 1850, Hicksville, NY 11802

Underwritten by Health Insurance Plan of Greater New York
Fully insured coverage


EmblemHealth

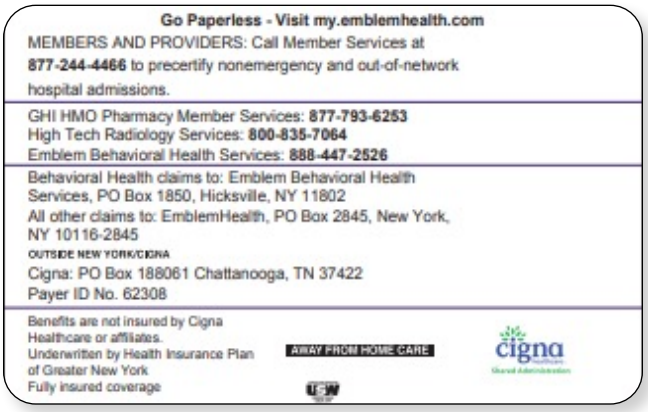
GHI HMO

MEMBER: DSamantha M Konet
ID NUMBER: K3785852301
NETWORK: Prime

PCP: Not Selected
PCP Phone: 800-447-8255
Rx BIN#: 610455
PCN: NY1000
Formulary: HMOB

Copays: PCP $15 SPEC $15
Urgent Care $15 ER $35

Inpatient: $0 In-Network
Deductible: $0 / $0
MOOP: NA / NA


Go Paperless - Visit my.emblemhealth.com

MEMBERS AND PROVIDERS: Call Member Services at 877-244-4466 to precertify nonemergency and out-of-network hospital admissions.

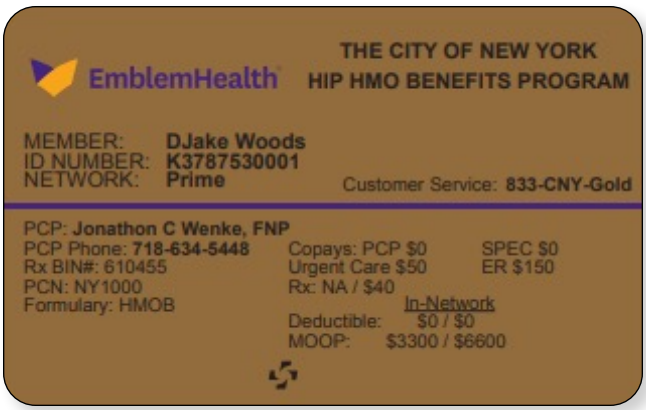
GHI HMO Pharmacy Member Services: 877-793-6253
High Tech Radiology Services: 800-835-7064
Emblem Behavioral Health Services: 888-447-2526

Behavioral Health claims to: Emblem Behavioral Health Services, PO Box 1850, Hicksville, NY 11802
All other claims to: EmblemHealth, PO Box 2845, New York, NY 10116-2845
OUTSIDE NEW YORK/CIGNA
Cigna: PO Box 188061 Chattanooga, TN 37422
Payer ID No. 62308

Benefits are not insured by Cigna Healthcare or affiliates.
Underwritten by Health Insurance Plan of Greater New York
Fully insured coverage

AWAY FROM HOME CARE

cigna


EmblemHealth

THE CITY OF NEW YORK
HIP HMO BENEFITS PROGRAM

MEMBER: DJake Woods
ID NUMBER: K3787530001
NETWORK: Prime

Customer Service: 833-CNY-Gold

PCP: Jonathon C Wenke, FNP
PCP Phone: 718-634-5448
Rx BIN#: 610455
PCN: NY1000
Formulary: HMOB

Copays: PCP $0 SPEC $0
Urgent Care $50 ER $150
Rx: NA / $40

In-Network
Deductible: $0 / $0
MOOP: $3300 / $6600


Go Paperless - Visit www.emblemhealth.com/GOLD

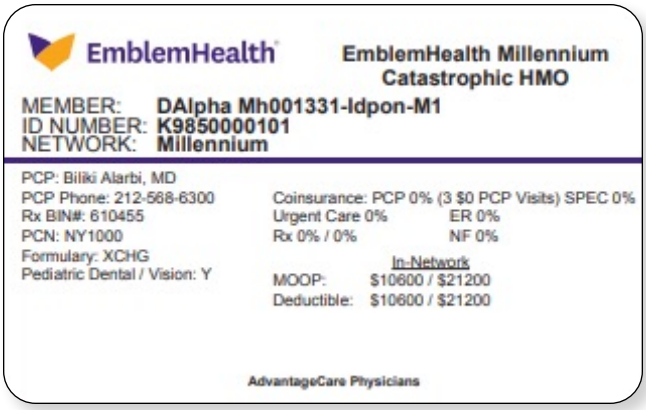
MEMBERS
Customer Service: 833-CNY-GOLD (833-269-4653)
Behavioral Health Services: 888-447-2526
For TTY: 711

PROVIDERS
Provider Services: 800-877-7587
Behavioral Health claims: EmblemHealth Behavioral Health Services, PO Box 1850, Hicksville, NY 11802
All other claims: HealthCare Partners, 501 Franklin Avenue, Suite 300, Garden City, NY 11530.
OUTSIDE NEW YORK/CIGNA
Cigna: PO Box 188061 Chattanooga, TN 37422
Payer ID No. 62308

Benefits are not insured by Cigna Healthcare or affiliates.
Underwritten by Health Insurance Plan of Greater New York. Fully insured coverage.

AWAY FROM HOME CARE

cigna


EmblemHealth

EmblemHealth Millennium
Catastrophic HMO

MEMBER: DAlpha Mh001331-Idpon-M1
ID NUMBER: K9850000101
NETWORK: Millennium

PCP: Biliki Alarbi, MD
PCP Phone: 212-568-6300
Rx BIN#: 610455
PCN: NY1000
Formulary: XCHG
Pediatric Dental / Vision: Y

Coinsurance: PCP 0% (3 $0 PCP Visits) SPEC 0%
Urgent Care 0% ER 0%
Rx 0% / 0% NF 0%

In-Network
MOOP: $10600 / $21200
Deductible: $10600 / $21200

AdvantageCare Physicians


Go Paperless - Visit my.emblemhealth.com

MEMBERS AND PROVIDERS: Network providers must provide or arrange nonemergency care. Providers call 866-447-9717 to request prior approval of a hospital admission.

Customer Service: 888-447-7703 (TTY: 711)
Emblem Behavioral Health Services: 888-447-2526
EmblemHealth Pharmacy Services: 877-793-6253
24-Hour Nurse Advice Line: 877-444-7988
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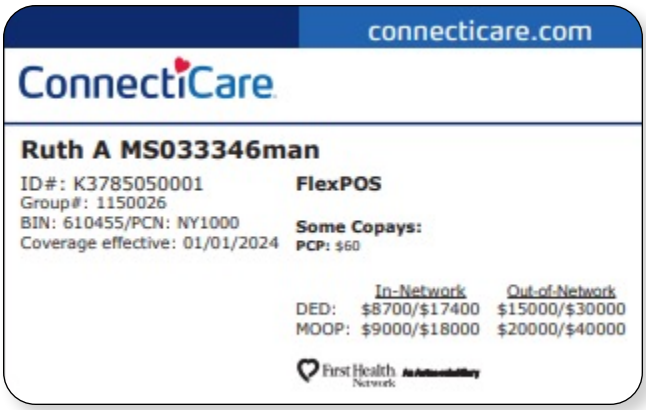
Behavioral Health claims to: Emblem Behavioral Health Services, PO Box 1850, Hicksville, NY 11802
All other claims to: EmblemHealth, PO Box 2845, New York, NY 10116-2845

Underwritten by Health Insurance Plan of Greater New York
Fully insured coverage


connecticare.com

ConnectiCare

Ruth A MS033346man

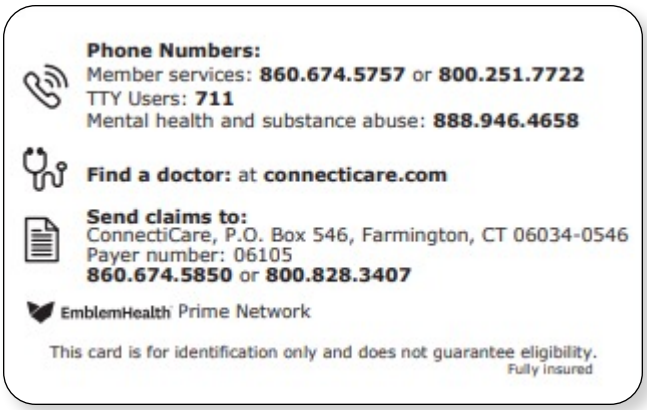
ID#: K3785050001
Group#: 1150026
BIN: 610455/PCN: NY1000
Coverage effective: 01/01/2024

FlexPOS

Some Copays:
PCP: $60

	In-Network	Out-of-Network
DED:	$8700/$17400	$15000/$30000
MOOP:	$9000/$18000	$20000/$40000

First Health Network


Phone Numbers:
Member services: 860.674.5757 or 800.251.7722
TTY Users: 711
Mental health and substance abuse: 888.946.4658

Find a doctor: at connecticare.com

Send claims to:
ConnectiCare, P.O. Box 546, Farmington, CT 06034-0546
Payer number: 06105
860.674.5850 or 800.828.3407

EmblemHealth Prime Network

This card is for identification only and does not guarantee eligibility.
Fully Insured

New plan announcement

EmblemHealth Medicare

Effective Jan. 1, 2026, Prime will begin processing Medicare Part D and B claims for covered members of EmblemHealth.

Processing requirements

To ensure uninterrupted service to Participating Pharmacies and covered members of EmblemHealth, please use the following information to set up your system prior to Jan. 1, 2026.

- Covered member ID number
- Date of birth
- Gender
- Rx group number
- U&C
- Days' supply
- Pharmacy NPI
- Active/Valid prescriber ID NPI
- Date prescription written
- Prescription origin code
- Pharmacy service type
- Patient residence

Outstanding claim reversals and processing

- To prepare for this transition, Participating Pharmacies should complete all claims processing and reversals by close of business Dec. 31, 2025.
- For assistance with claims that have a date of fill prior to Jan. 1, 2026, please contact Express Scripts at **800.282.2881**.

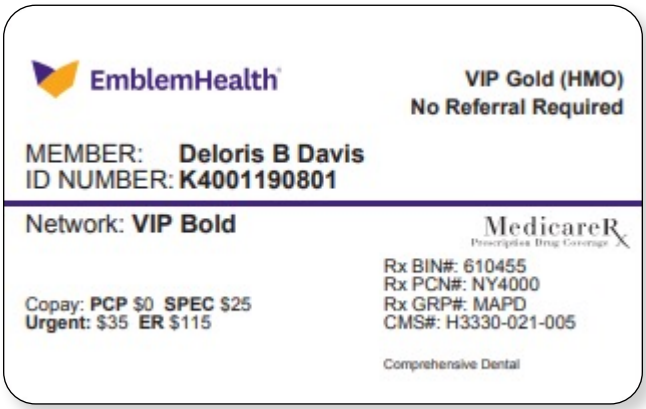
For more information:

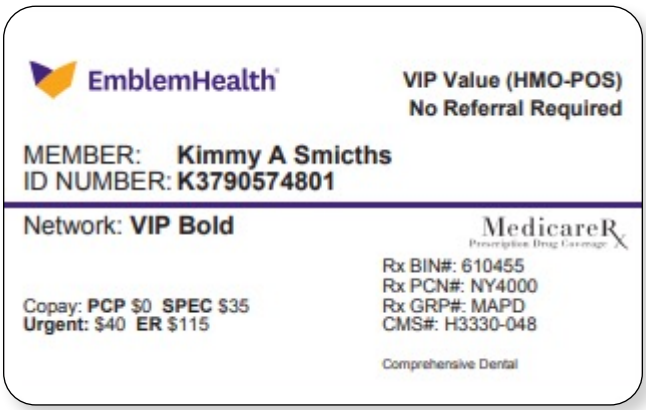
- Beginning Jan. 1, 2026, if you have questions regarding claims processing, please contact Prime's Contact Center at **866.799.778**.
- Prime's Medicare Part D payer specification sheet is available at: **PrimeTherapeutics.com> Providers and Physicians> Payer Sheets> Medicare> Prime Therapeutics Medicare Payer Sheet D.0**.
- Prime's Medicare Prescription Payment Plan (M3P) payer specification sheet is available at: **PrimeTherapeutics.com> Providers and Physicians> Inflation Reduction Act - M3P> M3P Payer Sheets> Prime Therapeutics M3P Payer Sheet**.

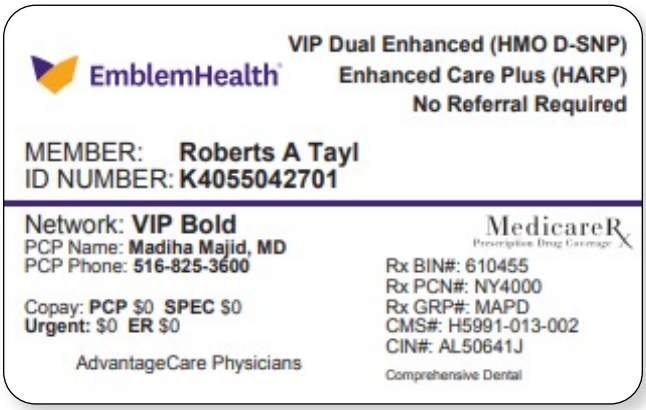
2026 processing information

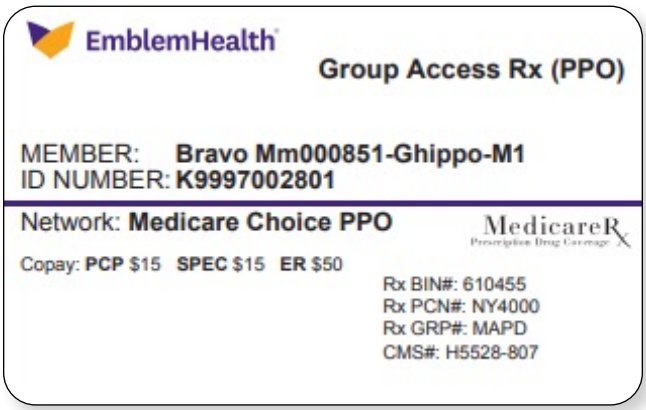
Plan sponsor	Plan name	BIN	PCN	M3P PCN	Rx group number
EmblemHealth	VIP Gold (HMO)	610455	NY4000	MPPPMAPD	MAPD
EmblemHealth	VIP Gold Plus (HMO)	610455	NY4000	MPPPMAPD	MAPD
EmblemHealth	VIP Value (HMO-POS)	610455	NY4000	MPPPMAPD	MAPD
EmblemHealth	VIP Dual (HMO-DSNP)	610455	NY4000	MPPPMAPD	MAPD
EmblemHealth	VIP Dual Enhanced (HMO-DSNP)	610455	NY4000	MPPPMAPD	MAPD
EmblemHealth	VIP Dual Reserve (HMO-DSNP)	610455	NY4000	MPPPMAPD	MAPD
EmblemHealth	Group Access Rx (PPO)	610455	NY4000	MPPPMAPD	MAPD
EmblemHealth	VIP Premier (HMO) Group	610455	NY4000	MPPPMAPD	MAPD
EmblemHealth	City of NY GHI Enhanced City of NY GHI Standard	610455	NY4000	MPPPPDP	PDP
EmblemHealth	VIP Rx Carveout (HMO) Group	610455	NY4020	N/A	N/A

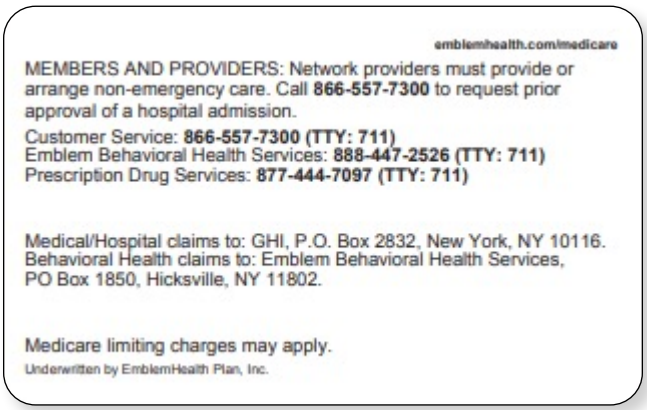
Pictured below are examples of the most common ID cards used:

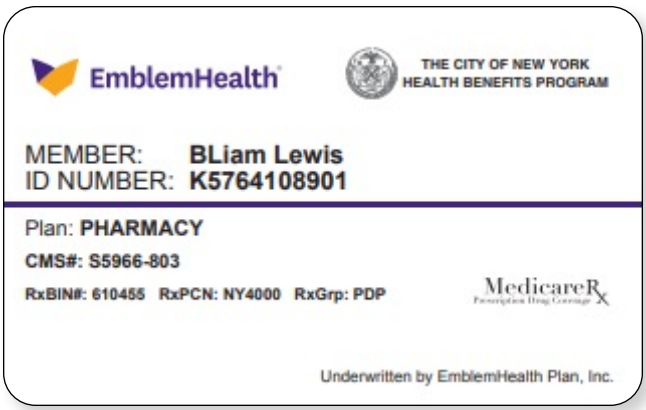











EmblemHealth

THE CITY OF NEW YORK HEALTH BENEFITS PROGRAM

MEMBER: **BLiam Lewis**
ID NUMBER: **K5764108901**

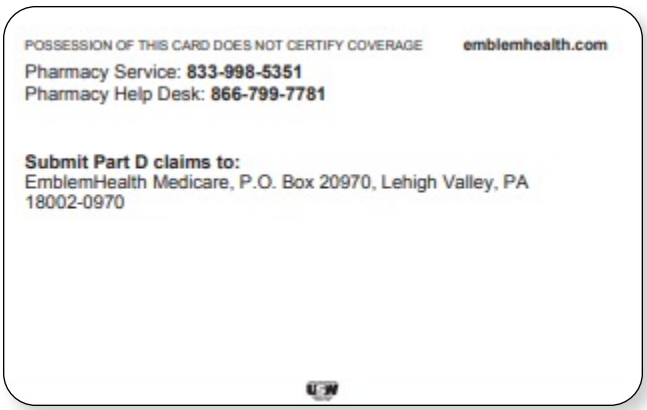
Plan: **PHARMACY**

CMS#: S5966-803

RxBIN#: 610455 RxPCN: NY4000 RxGrp: PDP

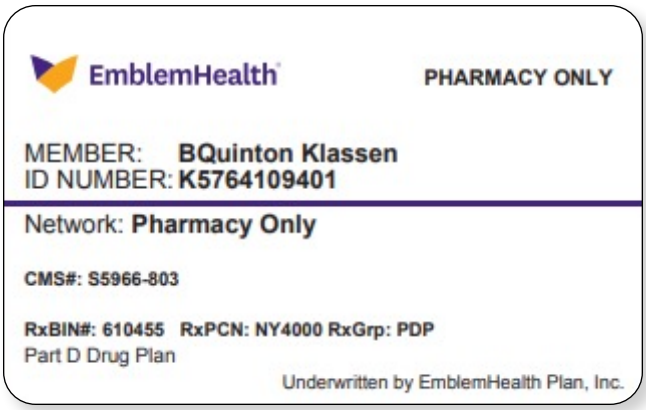
MedicareRx

Underwritten by EmblemHealth Plan, Inc.


POSSESSION OF THIS CARD DOES NOT CERTIFY COVERAGE **emblemhealth.com**

Pharmacy Service: **833-998-5351**
Pharmacy Help Desk: **866-799-7781**

Submit Part D claims to:
EmblemHealth Medicare, P.O. Box 20970, Lehigh Valley, PA 18002-0970


EmblemHealth

PHARMACY ONLY

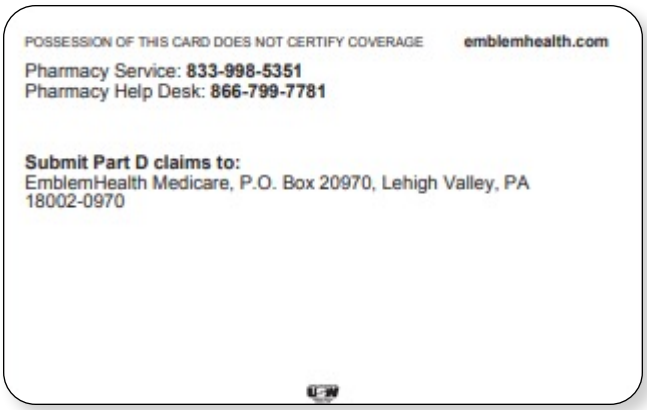
MEMBER: **BQuinton Klassen**
ID NUMBER: **K5764109401**

Network: **Pharmacy Only**

CMS#: S5966-803

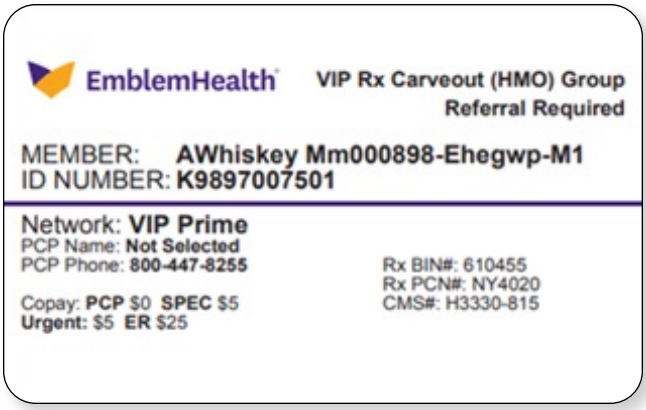
RxBIN#: 610455 RxPCN: NY4000 RxGrp: PDP
Part D Drug Plan

Underwritten by EmblemHealth Plan, Inc.


POSSESSION OF THIS CARD DOES NOT CERTIFY COVERAGE **emblemhealth.com**

Pharmacy Service: **833-998-5351**
Pharmacy Help Desk: **866-799-7781**

Submit Part D claims to:
EmblemHealth Medicare, P.O. Box 20970, Lehigh Valley, PA 18002-0970


EmblemHealth

VIP Rx Carveout (HMO) Group
Referral Required

MEMBER: **AWhiskey Mm000898-Ehegwp-M1**
ID NUMBER: **K9897007501**

Network: **VIP Prime**
PCP Name: **Not Selected**
PCP Phone: **800-447-8255**

Copay: **PCP** $0 **SPEC** $5
Urgent: $5 **ER** $25

Rx BIN#: 610455
Rx PCN#: NY4020
CMS#: H3330-815


emblemhealth.com/medicare

Customer Service: **877-344-7364 (TTY: 711)**
Behavioral Health: **888-447-2526**
Pharmacy: **877-444-7097**
Routine Vision (EyeMed): **844-790-3878**

PROVIDERS: Use **emblemhealth.com/providers** to check eligibility, find network providers, and see all preauthorization requirements and UM programs.

Provider Service: **800-877-7587**

Medical/Hospital Claims: HealthCare Partners, 501 Franklin Ave, Suite 300, Garden City, NY 11530.
Behavioral Health Claims: Emblem Behavioral Health Services, PO Box 1850, Hicksville, NY 11802.
Underwritten by Health Insurance Plan of Greater New York (HIP)

New plan announcement

Coupe Health

Effective Jan. 1, 2026, Prime will begin processing claims for covered persons of Blue Cross Alternative Health Plan designed by Coupe Health.

Processing requirements

To ensure uninterrupted service to Pharmacies and covered persons, please use the following information to set up your system prior to Jan. 1, 2026.

Coupe Health

BIN **004915**

PCN ..... **CPAL**

- Covered person ID number
- Date of birth
- Gender
- Group number
- U&C
- Days' supply
- Pharmacy NPI
- Active/Valid prescriber ID NPI
- Date prescription written
- Prescription origin code

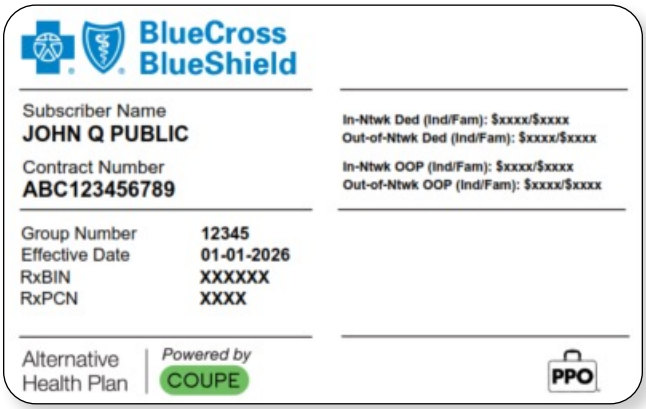
2025 outstanding claim reversals and processing

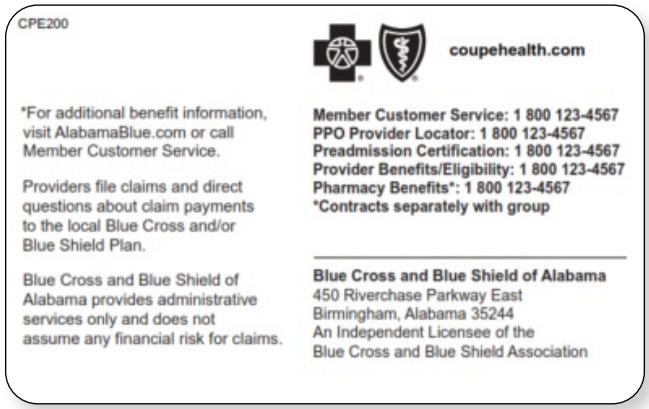
To prepare for this transition, Pharmacies should complete all claims processing and reversals by close of business Dec. 31, 2025, for employer group Koch Foods.

For more information:

- Prime's commercial payer specification sheets are available at: **PrimeTherapeutics.com > Pharmacy + Provider Resources > Payer sheets > Commercial > Prime Therapeutics Commercial Payer Sheet D.0**.
- Claims with a fill date on or after Jan. 1, 2026, must be submitted with the BIN/PCN outlined on the left.
- Beginning Jan. 1, 2026, if you have questions regarding claims processing, please contact BCBSAL Pharmacy Help Desk at **800.216.9920**.

Pictured below is an example of the most common ID card used:





New plan announcement

Gold Coast Health Plan Total Care Advantage

Effective Jan. 1, 2026, Prime will begin processing Medicare Part D and B claims (diabetes testing supplies and continuous glucose monitors only) for covered members of Gold Coast Health Plan (GCHP) Total Care Advantage℠.

GCHP launched a new plan for individuals with both Medi-Cal and Medicare called Total Care Advantage for Jan. 1, 2026, which allows individuals to have their care coordinated under one integrated plan.

GCHP Total Care Advantage (HMO D-SNP) is a Medicare Advantage Dual Eligible Special Needs Plan for low-income seniors and individuals with disabilities who qualify for both Medicare and Medi-Cal, known as Medi-Medi members.

Processing requirements

To ensure service to Participating Pharmacies and covered members of GCHP Total Care Advantage (HMO D-SNP), please use the following information to set up your system prior to Jan. 1, 2026.

BIN **610455**

PCN ..... **GCMAPD**

M3P PCN ..... **MPPPGCMAPD**

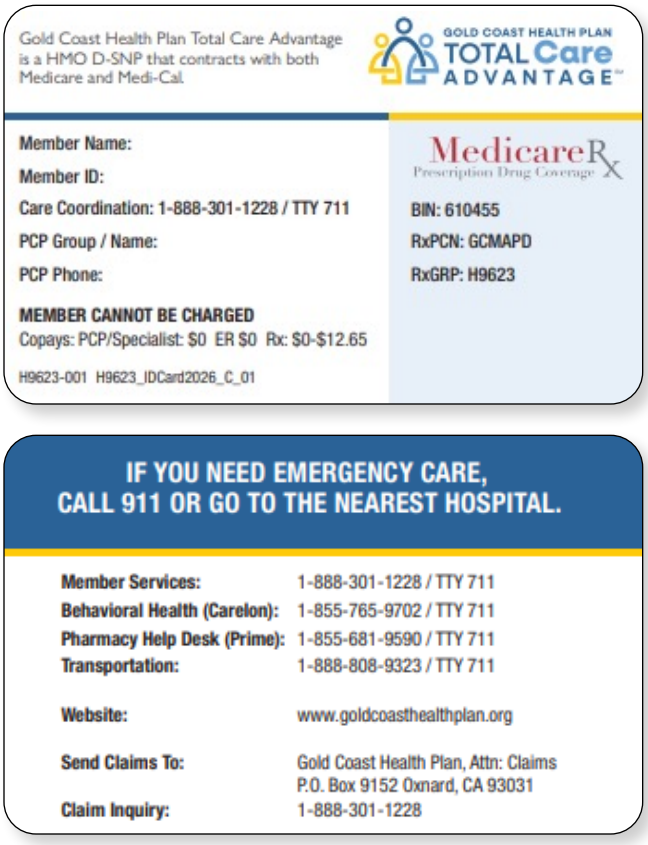
RXGRP **H9623**

- Covered member ID number
- Date of birth
- Gender
- Rx group number
- U&C
- Days' supply
- Pharmacy NPI
- Active/Valid prescriber ID NPI
- Date prescription written
- Prescription origin code
- Pharmacy service type
- Patient residence

For more information:

- If a Pharmacy receives a claim rejection stating that a drug is not covered under Medicare, the Pharmacy must resubmit the claim under the covered member's Medi-Cal coverage.
- Beginning Jan. 1, 2026, if you have questions regarding claims processing, please contact Prime's Pharmacy Help Desk at **855.681.9590**.
- Prime's Medicare Part D payer specification sheet is available at: **PrimeTherapeutics.com> Providers and Physicians> Payer Sheets> Medicare> Prime Therapeutics Medicare Payer Sheet D.0**.
- Prime's Medicare M3P payer specification sheet is available at: **PrimeTherapeutics.com> Providers and Physicians> Inflation Reduction Act - M3P> M3P Payer Sheets> Prime Therapeutics M3P Payer Sheet.**

Pictured below is an example of the most common ID card used:



Processing update

Blue Cross and Blue Shield of North Carolina (BCBSNC) Healthy Blue + Medicare (HMO-POS D-SNP) new covered person ID

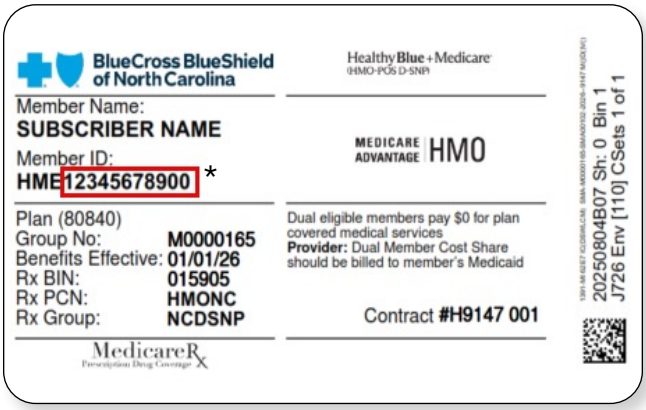
Effective Jan. 1, 2026, BCBSNC covered persons will have new member ID numbers. BCBSNC is issuing new ID cards to Medicare covered persons mid-December. Any claims using a Member ID from 2025 will be denied at POS. Covered persons have been instructed to present their new ID card when filling a prescription. Pharmacies experiencing issues processing claims using the new ID cards are encouraged to contact Prime's Pharmacy Help Desk at **855.457.1351**.

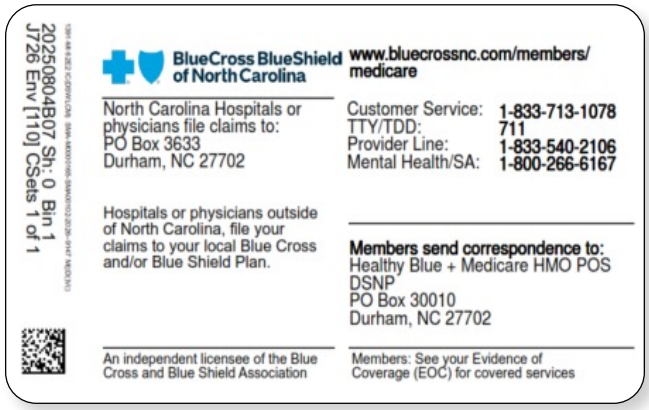
Each covered person's ID number will change from a 12-character alphanumeric ID (HME123456789) to a 14-character alphanumeric ID (HME12345678900). Pharmacies will need to disregard the three-character prefix and just submit the 11-digit ID number.

All claims for covered persons of BCBNC Healthy Blue + Medicare (HMO-POS D-SNP) should be submitting claims with the following information:

Plan sponsor	Plan name	BIN	PCN
BCBSNC	Healthy Blue + Medicare (HMO-POS D-SNP)	015905	HMONC

Pictured below is an example of the most common ID card:





*Omit the first three letters; submit only the 11-digit numeric ID.

Prime news

Vaccine coverage

As a reminder, the following plan sponsors use the commercial vaccine network contracted by Prime:

- BCBS of Alabama
- BCBS of Illinois
- BCBS of Kansas
- BCBS of Minnesota
- BCBS of Montana
- BCBS of Nebraska
- BCBS of New Mexico
- BCBS of North Carolina
- BCBS of North Dakota
- BCBS of Oklahoma
- BCBS of Rhode Island
- BCBS of Texas
- BCBS of Wyoming
- Boeing
- BridgeSpan Health Idaho
- BridgeSpan Health Oregon
- BridgeSpan Health Utah
- BridgeSpan Health Washington
- Capital Blue Cross
- Capital Health Plan
- Florida Blue
- Horizon BCBS of New Jersey
- Regence BlueShield of Idaho
- Regence BlueCross BlueShield of Oregon
- Regence BlueCross BlueShield of Utah
- Regence BlueShield
- Truli for Health

All Medicaid managed care organizations (MCOs) contracted Network Pharmacies must enroll with Minnesota Health Care Programs (MHCP)

The federal 21st Century Cures Act requires all Medicaid MCO-contracted network providers, including Pharmacies, be screened and enrolled with state Medicaid programs.

Action required

To ensure you are compliant with the federal mandate, submit your enrollment application as soon as possible. If you have already enrolled, you may ignore this reminder notice.

If you receive this letter from multiple managed care plans, you only need to submit a single MHCP enrollment request.

Enrolling with MHCP does not mean you are required to deliver services to fee-for-service members.

- For a list of provider types that can enroll, and instructions for how to enroll, please refer to the Eligible Providers section of the MHCP Provider Manual page at **mn.gov/dhs/health-care/eligible-providers**.
- For training on how to use the Minnesota Provider Screening and Enrollment (MPSE) portal to enroll, please refer to the MPSE portal training webpage at **mn.gov/dhs/m hcp/provider-training/mpse**.
- For additional information, please refer to the "Enrollment process for MCO network providers" section of the Enroll with MHCP webpage at **mn.gov/dhs/partners-and-providers/enroll-with-mhcp**.

Please contact the MHCP Provider Resource Center at **mn.gov/dhs/health-care/provider-resources** with any additional questions.

Secure your email, secure your practice: Why multifactor authentication (MFA) is non-negotiable

At Prime, safeguarding the sensitive information you entrust to us — and that your patients entrust to you — is one of our highest priorities. Every day, cybercriminals look for opportunities to exploit weaknesses in provider systems, and one of their favorite targets is email. A single compromised inbox can open the door to every other tool and account you use to care for patients and run your practice.

That's why we're asking all our providers to enable MFA on their business email accounts without delay. MFA is one of the simplest, most effective steps you can take to protect your organization, staff and patients.

Why email is the key to everything

Think about what lives inside — or is connected to — your work email:

- Password-reset links for all of your resources
- Communications with patients and staff that may contain protected health information (PHI)
- Cloud drives, scheduling tools and billing systems
- Vendor accounts, bank notifications and other business services

If an attacker gains access to your email, they can often trigger password resets for nearly every system tied to that address. From there, they may steal PHI, reroute funds, impersonate your staff or shut you out of your own accounts.

In short, your inbox isn't "just" an inbox — it's the master key to your entire digital practice.

The limits of passwords

Many practices still rely on passwords alone to secure email accounts. Unfortunately, passwords can be guessed, stolen through phishing emails, exposed in unrelated breaches or reused across multiple sites. Even complex passwords are vulnerable if an attacker tricks a staff member into entering them on a fake login page.

That's where MFA comes in. By requiring a second verification step — such as a temporary code, security key or push notification — MFA blocks unauthorized access, even if someone has your password.

How MFA stops cybercriminals

With MFA enabled, a would-be intruder needs both your password and the additional proof that you're really you. Most MFA systems deliver that proof through:

- A mobile app that generates or approves a login code
- A hardware token or security key
- A one-time passcode sent to a trusted device or number

Even if an attacker acquires your password through phishing or malware, they're stopped cold when asked for the second factor. That extra step makes your account significantly harder to compromise.

Simple steps to get started

1. **Check your email provider's MFA options.** Most major services — Microsoft 365, Google Workspace, gmail, yahoo and others — offer built-in MFA.
2. **Enable MFA for every user** who accesses business email, including physicians, office staff and temporary personnel.
3. **Favor app-based or hardware authentication** over SMS codes when possible, since text messages can be intercepted.
4. **Document your MFA setup** and create backup codes so you're not locked out if you lose a phone or device.
5. **Review MFA policies annually** to ensure new hires and systems are covered.

Make MFA a part of your security culture

Technology is only part of the solution. Encourage staff to treat MFA as routine, not optional. Incorporate MFA training into onboarding and periodic security refreshers. Emphasize that protecting patient information is an ethical obligation, as well as a regulatory one.

You can also strengthen your defenses by:

- Prohibiting password reuse across work and personal accounts
- Using a reputable password manager to store unique, complex passwords
- Monitoring sign-in alerts from your email provider for unusual activity

These steps work best when MFA is already in place.

The bigger picture: Protecting patient trust

Your patients count on you to keep their health information private. A single breach can cause lasting harm — to your reputation, your finances and the people you serve. Regulators also hold providers accountable for safeguarding PHI under HIPAA and related laws.

By adopting MFA for your business email, you dramatically reduce the risk of unauthorized access. It's a simple investment with an enormous return: peace of mind for you, your staff and your patients.

Final word from Prime

Cyber threats evolve constantly, but the principle remains the same: Security starts with strong controls on your most important accounts. MFA is no longer a nice-to-have — it's a necessity.

We urge every provider in our network to activate MFA on business email accounts immediately and to encourage colleagues to do the same. Together, we can maintain the confidentiality, integrity and availability of the data that drives quality care.

If you need help implementing MFA or would like to discuss additional safeguards for your practice, please contact your Prime representative or our provider support.

Secure your inbox, and you secure the foundation of your practice.

Pharmacy licensure

Pharmacies with independent contracts must provide Prime with a certificate of insurance, with proof of general and professional liability insurance, on an annual basis.

Please visit **PrimeTherapeutics.com/Pharmacy-Credentialing** to update our records.

Choose "Renewal of Pharmacy Certificate of Insurance" from the options and follow the instructions to upload and submit a PDF of your current or renewed certificate of insurance.

Annual attestation requirement

The annual FWA attestation form is part of your Pharmacy NCPDP profile. Please complete the form via the NCPDP website. For your convenience, you can go to **PrimeTherapeutics.com/Compliance-Training1** to find instructions for completing the NCPDP form. Pharmacies are also required to complete the offshoring attestation when applicable. Failure to attest to the annual general compliance, FWA training and offshoring may result in termination of participation in one or more networks or termination of the agreement.

Provider Manual update

You can visit **PrimeTherapeutics.com/Provider-Manual** to find a new version of Prime's Provider Manual with an effective date of Jan. 1, 2026, available for review. Please continue to use the July 2025 Provider Manual until Jan. 1, 2026.

Maximum allowable cost (MAC) list updates

If a Pharmacy would like access to Prime's MAC lists, weekly MAC changes, the sources used to determine MAC pricing and the appeals process, please refer to Prime's website for registration instructions. After network participation is verified, the Pharmacy will receive a secure username and password via email.

How to reach Prime

As a service to Pharmacies, Prime publishes the *Prime Perspective* to provide important information regarding claims processing. Prime values your opinion and participation in our network. If you have comments or questions, please contact us via:

- Phone: Prime's Pharmacy Contact Center **800.821.4795** (24 hours a day, 7 days a week)
- Email: **ProviderRelations@PrimeTherapeutics.com**
- Mail: 2900 Ames Crossing Road, Suite 200, Eagan, MN 55121

Where do I find formularies?

For commercial formularies, access either the Blue Cross and Blue Shield plan website or **PrimeTherapeutics.com/Commercial-Formularies**.

For Medicare Part D formularies, access **PrimeTherapeutics.com/Formularies-Med-D**.

Keep your pharmacy information current

Prime uses the NCPDP database to obtain key pharmacy demographic information. To update your pharmacy information, go to **NCPDP.org** and click on "Pharmacy Login" at the top right.

Report compliance, privacy or FWA concerns

Prime offers the following hotlines to report compliance, privacy and FWA concerns:

Compliance

Report suspected compliance concerns via:

- Phone: **612.777.5523**
- Email: **Compliance@PrimeTherapeutics.com**

Privacy

Report privacy concerns or potential PHI disclosures to Prime via:

- Privacy Hotline: **888.849.7840**
- Email: **Privacy@PrimeTherapeutics.com**

FWA

If you suspect FWA by a covered person, prescribing provider, Pharmacy or anyone else, notify Prime via:

- Phone: **800.731.3269**
- Email: **FraudTipHotline@PrimeTherapeutics.com**

Anonymous reporting

Report a compliance concern or suspected FWA anonymously via:

- Phone: **800.474.8651**
- Email: **Reports@Lighthouse-Services.com**
- Third party vendor's website: **Lighthouse-Services.com/Prime**

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