HIP FAMILY HEALTH PLUS

2013 Guide To Your Benefits and Services

EmblemHealth®

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WELCOME TO HIP HEALTH PLAN OF NEW YORK

You are now a member of the HIP Family Health Plus (FHPlus) Plan. Thank you for choosing HIP, an EmblemHealth company, as your health plan!

Our network providers will now provide or arrange all of your covered health care services. This means that you must use our network of high quality doctors for your care. We hope that you will use your benefits and the services and programs that HIP offers to keep you and your family healthy.

We also hope that you remain a member in our plan for many years to come. To keep your membership, you must have an active FHPlus case. Most members will need to renew their eligibility with their Local Department of Social Services (LDSS) at least once a year. Complete the process on time and you won't have a break in your HIP coverage.

From here on, HIP is referred to as "your plan," "our plan," "us" or "our."

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HOW TO USE THIS HANDBOOK

This handbook tells you how our health care system works and how you can get the most from your benefits through our Family Health Plus plan. It is your guide to getting the most from your health plan. **Keep it handy**.

Part I of this handbook tells you what you need to know right away. The rest of the handbook can wait until you need it. When you have a question:

- Check this handbook; **or**
- Go to the EmblemHealth Web site, to find answers to your questions; or
- Call our Customer Service Department.

You can also call the New York Medicaid Choice Help Line at **1-800-505-5678**. TDD users call the New York Medicaid Choice TDD number: **1-888-329-1541**.

Getting Help From the Plan

Our Web site Has Answers to Many of Your Questions

Go to **www.emblemhealth.com** to get information about your plan. There you can:

- Search for doctors
- Get answers to Frequently Asked Questions (FAQs) specific to your plan.
- Check out the member newsletters
- See your benefits

Want to manage your health care quickly and efficiently? Register on our Web site. It's easy. Within minutes you'll be using the time-saving features of myEmblemHealth at **www.emblemhealth.com** to:

- Check your enrollment status
- Request a new ID card and/or print a temporary ID card
- Change your PCP
- Check the status of your referrals and claims
- Update your telephone number, address, e-mail address and other personal information

To register online:

1. Type **www.emblemhealth.com** into your Web browser. Be sure your new ID card is handy. You'll need it to enter your member ID number.
2. On the EmblemHealth home page, under Sign in to myEmblemHealth, click on Register Now.
3. Fill in requested information.

Automated Telephone System: Always Available! 24/7

If you don't have access to the Web, just call **1-800-447-8255** at any time of day or night, seven days a week, and use our automated telephone system — we call it the IVR, or Interactive Voice Response system. This is an automated self-service option that lets you check your enrollment and claims status, ask for a new ID card, change your PCP and request various forms and materials.

Speak Live With Our Customer Service Department

Our Customer Service staff is here to help you. Call Customer Service at **1-800-447-8255,** from 8 am to 8 pm, Monday through Friday, when you:

- Want to choose or change your primary care physician (PCP).
- Have questions about benefits and services.
- Have questions about how to get a referral.
- Need to replace your health plan member ID card.
- Want to report a pregnancy or the birth of your new baby.
- Want a copy of our Provider Directory.
- Change your telephone number.
- Have a change in FHPlus eligibility.
- There is a change in insurance for you or your children.
- Have any other questions.

There are also other fast and easy ways to get the information you need, to make changes and to request materials.

If you want to hear from us but don't have time to call during business hours, you can call **1-800-447-8255** any time and leave a message, including the best phone number and time to call you back.

There is certain information that neither you nor your health plan can change. These include your date of birth, your gender and your name (when you get married or have it legally changed). Report these kinds of changes/corrections to your Local Department of Social Services (LDSS). Your LDSS will then give us the changes.

If you don't speak English, we can help. We want you to know how to use your health plan benefits no matter what language you speak. Just call us at **1-800-447-8255** and we will find a way to talk to you in your own language. We have Customer Service staff that can help and we can help you find a PCP who speaks your language. You can also ask about member materials available in other languages.

For members with disabilities: If you use a wheelchair, are blind, have trouble hearing or understanding, call us if you need extra help. We can tell you which doctors' offices are wheelchair accessible or have special communications devices. We also offer the following services:

- A TDD machine. Our TDD phone number is **1-888-447-4833**.

- Information in large print.
- Case management.
- Help in making or getting to doctor's appointments.
- Names and addresses of providers who specialize in your disability.

No matter what your question, you can call Customer Service. We're here to help you.

How Managed Care Works: HIP, Our Network Providers and You

No doubt you have heard about the changes in health care. Many people now get their health benefits through managed care plans. We are a managed care plan. In addition to FHPlus, our membership includes private direct-pay members, employees of private corporations, small businesses and federal, state, and local government agencies. It also includes members enrolled in the Medicare, Medicaid and Child Health Plus programs.

We have been providing health care coverage for over 68 years. We have a contract with the State Department of Health to provide health care services to people with FHPlus coverage who live in the five boroughs of New York City, Nassau, Suffolk and Westchester counties.

We have contracts with doctors and other health care providers to help us meet your health care needs. These doctors, specialists, hospitals, labs and other health care facilities make up our provider network. You'll find a list of these providers on our Web site at **www.emblemhealth.com** or in our Provider Directory. It also lists the languages spoken by the provider, whether or not they are accepting new patients and which have wheelchair accessible offices. You can call Customer Service at **1-800-447-8255** to get a copy of a provider directory.

As a member of our plan, one of our network providers will take care of you. Most of the time, that person will be your primary care physician (PCP). If you need to have a test, see a specialist or go into the hospital, your PCP will arrange it. If you have an urgent health care problem and need to speak to your PCP after hours or on weekends, leave a message and your phone number. Your PCP will get back to you as soon as possible.

While your PCP will provide or arrange most of your health care, there are some health care services to which you can "self-refer." These services are listed and discussed later in this handbook. Except for those services listed, your PCP will make sure you get the care you need and will keep a record of that care.

You may be restricted to certain plan providers if we or the State Department of Health determines that you 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 your health.
- Allowing someone else to use your plan ID card.
- Using or accessing care in other inappropriate ways.

Important Telephone Numbers

The following telephone numbers can save you time and worry when you need help.

Customer Service

If you have any questions or would like more information you can call **1-800-447-8255**, Monday through Friday, from 8 am to 8 pm. If you have a hearing or speech impairment and use a TDD, you can call **1-888-447-4833**, Monday through Friday, from 8 am to 8 pm.

Pharmacy Customer Service

Call **1-888-447-7364** for information about your pharmacy benefits or to locate a network pharmacy near you.

Emblem Behavioral Health Services Program

Call **1-888-447-2526** for information about mental health, alcohol and substance use disorder services.

Healthy Beginnings PATH Program

Call **1-877-736-2229** if you are pregnant and ask about joining our *Healthy Beginnings* PATH program.

Dental Customer Services

Our dental benefits are provided by Healthplex. You can call **1-800-468-9868**, Monday through Friday, from 8 am to 6 pm, with questions about your dental coverage. You can also call this number to select or change your network dentist.

Fraud Abuse Hotline

Call **1-877-835-5447** to report any suspected fraud or abuse. All calls are confidential. A representative will look into the reason for your call.

TDD Line for the Hearing or Speech Impaired

If you have a hearing or speech impairment you can call **1-888-447-4833** when you have questions about your membership.

Interpreter Services

If you need interpreter services call **1-800-447-8255** or call your network medical center or PCP to ask for an interpreter. All calls to request interpreter service should be made at least three business days before your appointment. A Customer Service representative can use the Language Line Service, which offers telephone interpretation services in more than 100 languages and dialects.

New York State Department of Health Complaint Line

If you have a complaint about the medical care that you are getting, you can call **1-800-206-8125**.

Don't forget — our Web site, www.emblemhealth.com, is available to you 24 hours a day, seven days a week!

Click on the link to State Sponsored Programs for specific benefit information and frequently asked questions (FAQs).

Other Important Telephone Numbers

Use the space below to fill in other important telephone numbers.

Your PCP
Your child's pediatrician
Your dentist
Your child's dentist
Nearest urgent care center
Nearest hospital emergency room
Your pharmacy
Your Local Department of Social Services
Other health care providers

PART I: FIRST THINGS YOU SHOULD KNOW

Your Next Steps as a Member

Learn About Your Health Plan and Benefits

Within 30 days of your effective date of enrollment, we will call to welcome you as a member, give you important information, answer your questions and help you in any way we can. If we are unable to reach you, we will send you a letter asking you to call us.

During the welcome call, we will go over the most important parts of this handbook. We will also answer any questions you may have and:

- Help you select your PCP, if you haven't already done so.
- Help you schedule your first visit with your PCP.
- Find out if you need to see your health plan PCP right away or need to continue seeing your current non-network doctor for a certain length of time.
- Give you other important telephone numbers.

We will also offer to go over all of the information in this handbook, and collect your contact information — e-mail address, cell phone number and current mailing address.

Know Your Effective Date of Enrollment

Your effective date of enrollment is the date you can start to get services with your health plan member ID card. It is not the date you signed your application. Before your effective date of enrollment with the plan you must continue to use the doctors you were using before joining our plan.

Use Your Health Plan Member ID Card

Your member ID card should arrive within 14 days of your effective date of enrollment. Your member ID card tells you your member ID number and your PCP's name and telephone number, the services for which you must make copayments and the amount of each copayment. It also lists what you and your doctors should do in an emergency. If any information on your member ID card is wrong, or if you lose it, please call Customer Service at **1-800-447-8255** right away. If there is no PCP listed on your card, please follow the instructions in the *Getting Help from the Plan* section of this handbook to select a PCP.

Carry your member ID card at all times. Have it handy when you make health care appointments with your network PCP and other doctors to whom you are referred. Your doctors may ask for your member ID card to see if you have to make copayments. If you need care before the card comes, don't worry. Your PCP will have your name and member ID number and will provide or arrange the care you need.

Choosing Your PCP

We have three types of primary care physicians (PCPs). Pediatricians are doctors who treat only children. Family practice doctors treat older children and adults. Internal medicine doctors treat only adults.

Your PCP will:

- Provide most of your primary and preventive health care.
- Refer you to specialists when needed.
- Coordinate the care you get from specialists.
- Arrange for your hospital admissions.

You may want to choose a PCP who:

- You have seen before.
- Has an office on your bus or subway route.
- Understands your health problems.
- Speaks your language.

Each family member can choose a different PCP or you can choose one PCP to take care of the whole family.

You can choose a PCP who works in:

- A network medical center — Many of our network medical centers are full-service. They have large staffs of PCPs, specialists and support personnel. This makes it easy to get a full range of services in one place. If you need lab work or X-rays, our network medical centers can perform most basic tests and procedures. If your PCP wants you to get a special procedure that can't be done at your medical center, you'll be referred to a place that will meet your needs. Your PCP will arrange for all such services.
- A network doctor's office — If you prefer you can choose a PCP that has a private office. In this case, your PCP may have to refer you to another network doctor or facility for care that he or she cannot provide because private PCP offices do not have all of the same services as medical centers.
- A Federally Qualified Health Center (FQHC) — You can also choose to get care at one of our contracted FQHCs, neighborhood health centers that give primary and specialty care. Just choose a PCP who works at one of the following FQHCs:

Bronx

- Doctors United, Inc
- Hunts Point Multi-Service Center, Inc. - 2 locations
- Morris Heights Health Center

Brooklyn

- Bedford Stuyvesant Family Health Center
- Brooklyn Plaza Medical Center
- Brownsville Multi-Service Family Health Center – 2 locations
- Community Healthcare Network – 3 locations
- Joseph P. Addabbo Family Health Center

- Lutheran Family Health Center – 8 locations
- ODA Health Center

Manhattan

- Betances Health Center
- Boriken Neighborhood Health Center
- Callen-Lorde Community Health Center
- Charles B. Wang Community Health Center – 2 locations
- Community Healthcare Network Helen B. Atkinson Center
- Heritage Health Care Center
- William F. Ryan Community Health Center – 3 locations

Queens

- Charles B. Wang Community Health Center
- Community Healthcare Network Queens Center
- Damian Family Care Center
- Joseph P. Addabbo Family Health Center – 5 locations

Staten Island

- Beacon Christian Community Health Center, Inc.

Westchester

- Doctors United, Inc – 3 locations
- Mount Vernon Neighborhood Health Center – 3 locations

When you call Customer Service, just mention the name of the FQHC or doctor that you would like to see.

Whether you choose a network medical center, a network private office doctor or a network FQHC, all of our network doctors must meet the same high standards for quality.

If you do not choose a PCP within 30 days of your effective date of enrollment, we will choose one for you. If you are not restricted to a PCP, you have the right to change your PCP any time, for any reason. Just follow the instructions in the *Getting Help from the Plan* section of this handbook to select a PCP.

If you are restricted to a PCP, you may change your PCP 45 days after your initial appointment with the PCP and after that you can only change your PCP every three months, unless you have good cause to change PCPs. If you are restricted to any other provider(s), you can only change the provider(s) to whom you are restricted every six months without good cause. Good cause includes:

- Your provider no longer wishes to be your provider.
- Your provider closes the office where you get care or moved to a location more than 30 minutes or 30 miles from your home.
- Your provider leaves our network.
- You move beyond 30 minutes or 30 miles from your provider's office.
- Other circumstances exist that make it necessary to change providers.

Choose an OB/GYN

Women can also choose a network OB/GYN. OB/GYNs work in our network medical centers, FQHC centers and in private offices. No referral is needed from your PCP to see your network OB/GYN. Services that OB/GYNs provide include, routine checkups, cervical and breast cancer screenings, family planning, prenatal and postpartum care.

How to Get Routine Medical Care

"Routine care" includes exams, regular checkups, shots, tests or other treatments that keep you well. It is also medical advice and referrals to hospitals or specialists when needed. Visiting your PCP for routine care is how you and your PCP work together to keep you well. Day or night, your PCP is only a phone call away. Be sure to call him or her whenever you have a medical question or concern.

Only "medically needed" services are covered by your benefit plan. This means that the services you get must:

- Prevent or diagnose and correct what could cause more suffering.
- Deal with a danger to your life.
- Treat a condition that could cause illness or disability.
- Correct a condition that could limit your normal activities.

Medically needed services covered by your benefit plan must be provided, approved or arranged by your PCP or other network doctors (except for emergency care).

You must have an appointment to see your PCP. Don't wait until you're sick to see your PCP. Call your PCP as soon as possible to set up your first visit. You should also set up a visit for any other family members who just joined our plan. This will help your PCP(s) take better care of you and your family.

During your first visit, your PCP will:

- Get your medical history.
- Give you a medical exam.
- Schedule you for preventive care tests and lab tests, if needed.
- Give you immunizations and other shots, if needed.
- Provide any other health care you need at the time.
- Discuss any health problems you have.
- Give you important tips on how to stay healthy.

Prepare for your first appointment. Your PCP will need to know as much as possible about your medical history. Write down your medical history, any medications you are taking, any problems you have now and the questions you want to ask. You should also give your PCP written permission to get your medical record from your previous doctor.

If you need care before your first appointment, call your PCP. He or she will give you an earlier appointment.

Unless you have a medical emergency (see *Emergency Care* section), always call ahead to make an appointment to see your PCP or another network doctor. Even when you are sick and need urgent care, please call ahead for a same-day visit with your doctor. Urgent care is defined in the *Urgent Care* section of this handbook.

If you can't keep an appointment, please call your PCP to cancel. Try to call at least a day before your appointment. This will let your doctor see other patients during the time that your appointment was scheduled.

Your network doctors will try to make your appointments within the number of days shown below:

- Urgent care or behavioral problems: 24 hours.
- Nonurgent sick visits: three days.
- Routine or preventive care: four weeks.
- Adult baseline and routine physicals: 12 weeks of enrollment (six weeks from then on).
- First family planning visit: two weeks.
- First prenatal visit: three weeks during the first trimester, two weeks during the second trimester and one week during the third trimester.
- First newborn visit: two weeks of hospital discharge.
- Well-baby care: four weeks after date of birth.
- Follow up visit after a mental health/substance use disorder ER or inpatient stay: five days (or as clinically indicated).
- Nonurgent mental health/substance use disorder visit: two weeks.
- Nonurgent specialty care: four to six weeks.

The above waiting times are from the date you call for an appointment to the date when the appointment is scheduled. Your doctor will do his or her best to see you within 30 minutes of your scheduled appointment time.

How to Get Specialty Care and Referrals

Your PCP will refer you to a specialist if you:

- Need care that your PCP can't give.
- Have a condition or disease that needs the ongoing care of a specialist.
- Are terminally ill and need hospice services.

Most referrals will be to network specialists. Talk with your PCP to be sure you know how referrals work. If you think the specialist does not meet your needs, talk to your PCP. Your PCP can help you if you need to see a different specialist. There are some treatments and services that your PCP must ask the health plan to approve before you can get them. Your PCP will be able to tell you what these services are and will get our approval when needed. If you are having trouble getting a referral you think you need, call our Customer Services at **1-800-447-8255**.

If your PCP refers you to another doctor, you are not responsible for any costs except copayments, when they apply.

Standing Referral to See a Specialist

If you have a condition or disease that needs the ongoing care of a specialist, your PCP may arrange a "standing referral" to that specialist. A standing referral means that you can make appointments with your specialist for a specified number of visits or length of time. If you have a standing referral, you will not need a new referral each time you need to see your specialist.

Specialists as PCPs

If you have a long-term disease or disability that gets worse over time, you may request that a specialist act as your PCP. Speak to your PCP. If you, the specialist, your PCP and your health plan agree, the specialist will then provide your routine and specialty care.

Referral to Out-of-Network Specialty Providers

If you can't get the specialty care you need within our network, your PCP will request that we approve you to see an outside specialist as described in *The Quality of Your Care* section of this handbook. When you need care from an out-of-network provider, your PCP will request prior approval from us. If your PCP and health plan agree that you need a referral to an out-of-network specialist, your PCP will refer you at no cost for the services, except for any applicable copayments as described in this handbook.

If we do not approve your PCP's request, you may appeal our decision as described in the *If You Disagree With an Adverse Determination* section of this handbook.

Access to Specialty Care Centers

If you have a condition or disability that needs special medical care for a long period of time, your PCP may refer you to a center that specializes in treating your condition. These centers are called specialty care centers. If no specialty care center for your condition is available in our network, you will be referred to an out-of-network specialty care center.

Second Opinions

You are entitled to a second opinion by a network doctor anytime, for any reason. Your PCP will arrange the referral to an appropriate specialist.

If you want a second opinion for a cancer diagnosis or for advice on cancer treatment, you can talk to a cancer specialist either in or out of our network. First speak to your PCP. Your PCP will refer you to an appropriate specialist. A second opinion for cancer consists only of a consultation. To be covered, follow-up tests, procedures and treatments must be provided by a network doctor.

Prenatal Care

Prenatal care — the care an expectant mother gets during pregnancy — is extremely important.

If you become pregnant, you will be eligible for Medicaid. You should contact your Local Department of Social Services (LDSS) to find out about your health insurance options. You may want to change coverage from FHPlus to Medicaid. This is because Medicaid covers more services than FHPlus. If you decide to change your coverage from FHPlus to Medicaid, don't worry. You can stay a member in our health plan and in most cases, you will be able to keep your same doctors because we are also a Medicaid Managed Care Plan.

Your newborn can't be covered under FHPlus because this program is only for adults 19 through 64 years of age. However, your newborn will automatically be eligible for Medicaid. After your baby is born, you should call Customer Service to give us your baby's name, sex, date of birth and birth weight so that we can enroll him/her in our health plan.

Whether enrolled in our Medicaid or FHPlus Plan, if you think that you're pregnant, make an appointment with your PCP, your network OB/GYN or midwife right away. Your PCP, OB/GYN or midwife will check your overall health and may order blood tests to make sure you're pregnant. As soon as you know that you are pregnant, report your pregnancy to us by calling Customer Service at **1-800-447-8255**. We will send you information about the benefits of switching to Medicaid Managed Care and a form for you to sign telling us that you want to switch. If you decide to remain in FHPlus, we will change your status so that you will not have to make copayments.

You should also call us at **1-877-736-2229** to ask about joining our *Healthy Beginnings* PATH program. This program will help you during your pregnancy by providing you information about prenatal care, childbirth and parenting classes. It also provides you access to the 24 hour, 7-day-a-week ***BabyLine.*** You can call the *BabyLine* to ask nurses questions about your pregnancy and to ask for additional educational material. If you go to your PCP or midwife, they will refer you to your network OB/GYN for your prenatal care. A midwife may also provide your prenatal care, unless there is a medical reason for an OB/GYN to provide your care instead. Then schedule your first visit with your OB/GYN or midwife as soon as possible.

During the last three months of your pregnancy, you will be asked to choose a pediatrician to care for your baby. It is important that you choose a pediatrician you like before your baby is born. You can also request a conference with the pediatrician you choose.

As soon as you know you are pregnant, you should tell your LDSS case worker and call our Customer Service. Your LDSS will send you a letter telling you your unborn baby's Medicaid Client Identification Number (CIN). Your unborn baby will then be pre-enrolled in our Medicaid Managed Care Plan and you will get a temporary member ID card for your unborn baby.

Your baby will be covered by us from birth and his/her enrollment in our plan should be completed shortly after birth. However, as soon as possible after you give birth call Customer Service with your newborn's name, birth date, sex and birth weight and the name of the birth hospital, so that we can update your baby's membership file. You must also show your LDSS proof of your baby's birth, such as a birth certificate so that your baby's Medicaid file can be updated. Your baby will then get a permanent member ID card.

It is important that you make an appointment for your baby to see his/her pediatrician within two weeks of discharge from the hospital. You also need to schedule a postpartum visit with your obstetrician between 21 and 56 days of your baby's birth. This is a good time to talk to your doctor about your plans for future pregnancies. Also, if you are feeling "down" or having problems coping with your new role as a mother, talk to your doctor about your feelings.

Finally, you should make and keep regular well-child appointments for your baby for shots, checkups and other services that infants and children need to stay healthy.

When You Can Use Non-Network Doctors

In almost all cases, your doctors will be network doctors. But there are five instances when you can see non-network doctors.

1. When You Need Services That We Don't Cover
When you need services that we don't cover, you can use any doctor that you want but you will have to pay the doctor for those services.

2. When You Need HIV Counseling and Testing
You can get these services from network doctors at any time. You don't need a referral from your PCP. Just make an appointment. For help in finding a network provider, ask your PCP, check our provider directory or call Customer Service at **1-800-447-8255**. You can also visit our Web site at **www.emblemhealth.com** and use the provider search function. If you want, you can visit an Anonymous HIV Counseling and Testing Center.

You must have a referral and use a HIP network doctor for all HIV/AIDS treatment services. HIP has network doctors experienced in treating individuals with HIV/AIDS and will approve treatment at Designated AIDS Centers (facilities that specialize in treating patients with HIV/AIDS) when needed. HIP also offers HIV/AIDS case management services. You can call **1-800-447-0768** to speak with a case manager who specializes in supporting members with HIV/AIDS to learn more about our services.

For information about HIV/AIDS counseling and testing sites, call the New York State HIV Counseling Hotline at **1-800-872-2777** or **1-800-541-AIDS** (1-800-541-2437). You can also call the following AIDS Community Research Initiative of America (ACRIA) or New York State Department of Health numbers:

- HIV Counseling Information and the Confidentiality Law Hotline: **1-800-962-5065**
- Experimental treatments for people with HIV: **1-212-924-3934** or e-mail to **info@acria.org**.

3. When Your Doctor Leaves Our Network
If your doctor leaves our network, we will tell you within 15 days from the date we know. If you wish, you may be able to see that doctor if you are more than three months pregnant or are getting ongoing care for a specific condition. If you are pregnant, you may continue to see your doctor for up to 60 days after delivery. If you are being treated for a condition that needs ongoing care, you may continue your present course of treatment for up to 90 days. Your doctor must agree to work with us during this time. After this time, you must select and use a network doctor for the ongoing or specialty care you need. If any of these conditions apply to you, check with your PCP or call Customer Services at **1-800-447-8255**.

4. When You Are Getting Ongoing or Specialty Care Prior to Your Effective Date of Enrollment
If you are a new member and you're getting care from a doctor who is out of network, you may be able to continue using that doctor. We will allow you to continue an ongoing course of treatment with your out-of-network doctor for up to 60 days after your effective date of enrollment in our plan. However, you must have a life threatening or degenerative and disabling disease or condition. If you are more than 3 months pregnant, you may continue to see your doctor until after delivery and follow-up care. After this time, you must use a network doctor for the ongoing or specialty care you need.

In the case of both #3 and #4 above, we must approve your continued use of your doctor. To obtain approval, your doctor must call our Pre-service Review at **1-866-447-9717** and agree to:

- Accept our payment rates as payment in full for the services provided to you.
- Follow our quality of care requirements and give us all necessary medical information about your care.
- Follow all other health plan policies and procedures, including getting our approval for referrals.

5. When You Need TB Diagnosis and Treatment Services
You can choose to go either to your PCP or to the county public health agency for diagnosis and/or treatment of TB. You do not need a referral to go to the county public health agency.

Get These Services Without a Referral

When covered by our plan, you don't need a referral from or the approval of your PCP to get the services listed below. Just refer yourself to a network doctor or dentist for:

Women's Health Services

Include, but are not limited to, OB/GYN services such as family planning, advice and/or prescription for birth control and medically necessary abortions. Services also include prenatal care, midwife services, breast and pelvic exams, and mammographies.

HIV Counseling and Testing Services

See #2 in the previous section "*When You Can Use an Non-Network Doctors*" for details.

Eye Exams and Eyeglasses

Covered services include emergency vision care and the following preventive and routine vision care provided once in any 24-month period:

- Services of an ophthalmic dispenser, ophthalmologist and optometrist.
- One eye exam. Members diagnosed with diabetes may self-refer for a dilated eye (retinal) exam once in any 12-month period.
- Either one pair of prescription eyeglass lenses and a frame, or prescription contact lenses when medically necessary. Scratch and break resistant eyeglass lenses are covered. Progressive lenses are not covered.
- One pair of medically necessary occupational eyeglasses. Occupational eyeglasses are special glasses that help you perform your job duties.
- Specialist referrals for eye diseases and defects.

Notes:
1. Replacement of lost, damaged or destroyed eyeglasses is only covered for 19 and 20 year old FHPlus members.
2. FHPlus members must choose from our selection of Medicaid approved eyeglass frames or lenses and **cannot** choose more expensive glasses and pay the difference.

Mental Health

You can get one assessment within any 12-month period and mental health treatment from a network provider at any time without a referral. Routine outpatient mental health treatment does not require a prior approval. You can contact providers directly, or if you need assistance, you can call the Emblem Behavioral Health Services program number at **1-888-447-2526**.

Chemical Dependence (Alcohol and Substance Use Disorder)

You can get one chemical dependence assessment (including alcohol and/or substance use disorder) within any 12-month period from a network provider at any time without a referral or approval from your PCP. If you need more visits, your PCP will help you get a referral.

Dental Services

You may self-refer to your assigned participating dentist or to a dental clinic operated by an academic dental center for covered services. Services include routine preventive dental care, supplies and devices required to improve health conditions. It's important for you and your family members enrolled in our plan to see a dentist at least once a year for preventive care.

Emergency Care

You are always covered for emergencies. An emergency is a medical or behavioral condition that comes on all of a sudden and has serious pain or other symptoms. The condition must be one that makes a person with an average knowledge of health care fear that someone will suffer serious harm to body parts or functions or serious disfigurement without care right away. Examples of an emergency are:

- A heart attack or severe chest pain.
- Bleeding that won't stop.
- A bad burn.
- Broken bones.
- Trouble breathing.
- Convulsions.
- Loss of consciousness.
- When you feel like you might hurt yourself or others.
- If you are pregnant and have signs like pain, bleeding, fever or vomiting.

Examples of **nonemergencies** are colds, sore throat, upset stomach, minor cuts and bruises and strained muscles.

How to Get Emergency Care

In an emergency as defined above, go to the nearest emergency room or call **911** to get immediate help. You do not need to call us or your PCP first.

All network PCPs have arranged for 24-hour coverage of their telephones. So, you will be able to reach your PCP or another doctor at any time. If you are not sure if you have an emergency, call your PCP at the telephone number on your member ID card. Your PCP or the doctor covering for your PCP will tell you:

- Tell you what you can do at home.
- Tell you to come to his or her office.

- Tell you to go to the nearest network urgent care center.
- Tell you to go to the nearest emergency room.

When you get care, you or someone acting on your behalf should notify your PCP within 48 hours, or as soon as possible after you get emergency care. We also suggest that you or someone acting on your behalf contact Care Management at **1-888-447-2884** if you are admitted to a hospital in an emergency.

If you are admitted to a hospital within our service area that is not in our network, we may move you to a network hospital as soon as it is safe to do so.

Remember

- You do not need prior approval for emergency services.
- Use the emergency room only if you have a TRUE EMERGENCY.
- The emergency room should NOT be used for problems like the flu, sore throats, or ear infections.
- If you have questions, call your PCP at the phone number on your member ID card.

Urgent Care

You may have an injury or an illness that is not an emergency but still needs prompt care. This could be:

- An episode of persistent vomiting or diarrhea.
- A sprained ankle.
- A bad splinter you can't remove.

You can get urgent care 24 hours a day, every day.

How to Get Urgent Care

Your PCP or the doctor covering for your PCP will arrange a:

- Same-day or next-day appointment.
- Referral to a specialist, or
- You can go to a network urgent care center or other treatment facility.

To locate a network urgent care center near you, visit our Web site at **www.emblemhealth.com** or call **1-877-447-2911** anytime, day or night. On holidays, urgent care center hours of operation are subject to change. Please contact the urgent care center nearest you to confirm its hours.

Important Tips

- Put your PCP's telephone number near your telephone.
- Have your member ID number ready.
- If your call is not answered by an operator or a recording, hang up and dial the number again.
- If you are told to expect a call back, keep your telephone line free for the call. If you are calling from a pay telephone, let the person answering your call know. If you need to, you can speak to someone right away.
- Be ready to answer questions, such as:
  - — What are your symptoms?
  - — Do you have a fever? What's your temperature? (Try to take your temperature before you call.)
  - — Are you taking medication? (Know the names of your medications and the amount you take daily, including over-the-counter drugs, such as aspirin, Tylenol, cough or cold medicines.)

Have the name and telephone number of your pharmacy in case you need a prescription. If your PCP refers you somewhere for treatment, take your member ID card with you. Call your PCP back if your symptoms worsen or if you have any questions.

Care Outside of the United States

If you travel outside of the United States, you can get urgent and emergency care only in the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands and American Samoa. If you need medical care while in any other country (including Canada and Mexico), you will have to pay for it.

PART II: YOUR BENEFITS

The rest of this handbook is for your information when you need it. Part II lists the benefits covered and not covered by your health plan. If you have a complaint, Part II also tells you what to do.

FHPlus covers a comprehensive set of medically needed health care benefits and services. All covered services must be provided by network providers. Except for the self-referral services listed in the *Get These Services Without a Referral* section, services must also be approved or arranged by your PCP.

Copayments

FHPlus members are required to make copayments when receiving certain medical care and services. Some members are exempt and do not have to make these payments. See the following list of services that require copayments and information about who is exempt. If you have questions, you may call Member Services at **1-800-447-8255** or the Department of Health's FHPlus Information Line at **1-877-934-7587**.

Services	**Copay**
Generic Prescription Drugs.	$ 3.00 for each prescription & refill
Brand Name Prescription Drugs.	$ 6.00 for each prescription & refill
Clinic Visits.	$ 5.00 per visit
Doctor's Office Visits.	$ 5.00 per visit
Dental Visits.	$ 5.00 per visit, up to $25.00/year
Lab Services.	$ 0.50 per test
Radiology Services (like diagnostic X-rays, ultra-sound, nuclear medicine and oncology services)	$ 1.00 per service
Inpatient Hospital Stay.	$ 25.00 per stay
Nonurgent Emergency Room Visit.	$ 3.00 per visit
Over-the-Counter (OTC) Drugs.	$ 0.50 per item (e.g., smoking cessation products, insulin).
Medical Supplies (e.g., hearing aid batteries, enteral formula, diabetes test strips, lancets and syringes).	$ 1.00 per item

Note: There will be one copay charge for each new prescription and each refill regardless of the number of days' supply of the prescription.

Services for Which Copayments DO NOT Apply

- Emergency room visits for needed emergency care.
- Family planning services, drugs, and supplies.
- Mental health clinic visits.

- Chemical dependency clinic visits.
- Drugs to treat mental illness (psychotropic).
- Drugs to treat tuberculosis.
- Prescription drugs for residents of Adult Care Facilities.

To get certain medications we may require that your doctor get prior authorizations from us before writing your prescription. Your doctor can work with us to make sure that you get the medications that you need. Learn more about prior authorization later in this handbook.

Members Who Do Not Have to Make Copayments

- Children under age 21.
- Pregnant women (through 60 days postpartum).
- Members who are financially unable to make copayments at any time and who tell the provider that they are unable to pay.
- A resident in a community based residential facility licensed by the Office of Mental Health or the Office of People With Developmental Disabilities.

You will not be denied health care services based on your inability to pay the copayment at the time of service. However, you will still owe the unpaid copay to the provider, and the provider may bill you or take other action to collect the owed amount.

Benefits Covered by Your Plan

Routine and Preventive Medical Care

This kind of care helps prevent health problems. It also helps find problems before they get serious. Care includes routine and sick visits to your PCP and other network providers for:

- Regular checkups.
- Eye and hearing exams.
- Eyeglasses and other medically needed vision aids.
- Regular gynecological exams.
- Breast exams (including mammography).
- Allergy testing and treatment.
- HIV counseling and testing services.
- Smoking cessation counseling (all members are eligible for six sessions in a calendar year)
- Child/Teen Health Plan Services (C/THP) for Family Health Plus members 19 and 20 years old, including transportation to obtain these services. For information about covered nonemergency transportation services, see page 26.

When medically needed, your doctor will refer you for:

- Lab work.
- X-rays.
- Specialty care.

Maternity care

- Prenatal care.
- Childbirth classes.
- Doctor/midwife services.

- Hospital delivery.
- Newborn nursery care.

Note: Women in FHPlus who become pregnant will qualify for Medicaid because the financial requirements are different and the family size is changed. If you become pregnant while you are enrolled in FHPlus, you have a choice to make. You may want to change coverage from FHPlus to Medicaid. Medicaid covers more services than FHPlus, which you may or may not need, depending on your medical needs. You should discuss this choice with your doctor and the LDSS office so that you can make the decision that best meets your needs. If you decide to change your coverage from FHPlus to Medicaid, you can stay in our plan and keep your same doctors because we also are a Medicaid Managed Care Plan. If you decide to stay in FHPlus, we will cover your prenatal care, delivery and postpartum care.

Your baby can't be covered under FHPlus because this program is only for adults 19 through 64 years of age. However, your baby will be eligible for Medicaid regardless of the choice you have made for yourself. To ensure that your baby will be covered by Medicaid:

- You must tell your LDSS office when you become pregnant.
- Your doctor must tell us when you are pregnant.

Your LDSS will arrange for Medicaid coverage before your baby is born. You should select your baby's doctor as soon as possible.

Hospital Care

- Inpatient care.
- Outpatient care.
- Emergency care.
- Lab work and other tests.
- X-rays.
- Nursing services.
- Inpatient and outpatient surgery, including dental surgery.
- Inpatient detoxification services.

Emergency Care

Emergency care services are procedures, treatments or services needed to evaluate or stabilize an emergency condition.

Care you need after you have received emergency care to make sure you remain in stable condition. Depending on the need, you may be treated in the emergency room, in an inpatient hospital room, or in another setting. These are called Post Stabilization Services.

For more about emergency services, see page 16.

Specialty Care

Includes, but is not limited to, medically needed:

- Occupational, physical and speech therapy — Limited to 20 visits per therapy per calendar year.
- Respiratory therapy.

- Audiology services.
- Durable medical equipment (DME), including hearing aids, artificial limbs and orthotics.
- Renal and hemodialysis.
- HIV/AIDS treatment services.
- Midwifery services.
- Cardiac rehabilitation.
- Podiatrists if you are diabetic or under age 21.
- Outpatient detoxification services.
- Other covered services as medically needed.

Home Health Care

These services are generally provided so that you do not have to stay in a hospital. Your doctor or case manager must agree that your medical needs can be met at home with this help and request prior approval from your plan. Coverage is for up to 40 home health care visits per year. Services include:

- Two postpartum home health visits, additional visits as medically necessary for high-risk women.
- Other visits as needed and ordered by your PCP/specialist.

Vision Care

FHPlus covers emergency vision care and the following preventive and routine vision care provided once in any 24-month period:

- Services of an ophthalmic dispenser, ophthalmologist and optometrist.
- One eye exam. Members diagnosed with diabetes may self-refer for a dilated eye (retinal) examination once in any 12-month period.
- Either one pair of prescription eyeglass lenses and a frame, or prescription contact lenses when medically necessary. Scratch and break resistant eyeglass lenses are covered. Progressive lenses are not covered.
- One pair of medically necessary occupational eyeglasses. Occupational eyeglasses are special glasses that help you perform your job duties.
- Specialist referrals for eye diseases and defects.

Notes:

1. Replacement of lost, damaged or destroyed eyeglasses is only covered for 19 and 20 year old FHPlus members.
2. FHPlus members must choose from the plan's selection of eyeglass frames or lenses and cannot choose more expensive glasses and pay the difference.

Pharmacy Services

Family Health Plus pharmacy benefit includes:

- Prescription drugs
- Select over-the-counter (OTC) medicines such as Prilosec OTC®, loratadine, Zyrtec®
- Smoking cessation products, including OTC products
- Hearing aid batteries
- Vitamins necessary to treat an illness or condition

- Insulin and diabetic supplies
- Enteral formula
- Emergency contraception (six per calendar year)

Note: Medical supplies, other than diabetic supplies and smoking cessation products, are not covered.

You must use pharmacies that participate in our pharmacy network to fill all of your new drug prescriptions and other covered over-the-counter medications, diabetic supplies, select durable medical equipment and medical supplies.

Network Pharmacies

We offer a large network of well-known pharmacies as well as many independent pharmacies. Ask your pharmacy if they are a network pharmacy. If they are, you can continue to use that pharmacy. If not, you will need to switch pharmacies to one in our network. This is easy to do; and it's important for getting your prescriptions filled in a timely manner and for avoiding out-of-pocket costs.

Your Member ID Card

Please be sure to use your new FHPlus ID card when filling a prescription or obtaining other covered pharmacy benefits at a network pharmacy. To locate a network pharmacy near you, go to **www.emblemhealth.com/ssp-rx** and click on "Pharmacy Locator." You can also call our Pharmacy Customer Service at **1-888-447-7364**.

Our Drug Formulary

Our Medicaid/FHPlus Formulary is a list of medications that our network doctors and other medical experts have approved for treating disease and for maintaining the health of our members. The main purpose of our Medicaid/FHPlus Formulary is to promote the use of safe, effective and affordable drugs and treatments while providing quality care. Your doctors will prescribe medications listed on our Medicaid/FHPlus Formulary unless there is a medical need to prescribe a drug that is not on the list.

Home Delivery of a New Prescription

You may get home delivery of your maintenance drugs through our mail order pharmacy partner, Express Scripts, Inc. (ESI). Maintenance drugs are used to treat chronic conditions and are usually prescribed in quantities greater than 30-day supplies. All you need to do is get a new written prescription from your doctor or other licensed health care provider, and mail it to ESI along with the completed order form. You may request an ESI order form to be mailed to you by calling our Pharmacy Customer Service at **1-888-447-7364**. Mail the form and the original prescription(s) along with the required copayment to ESI as directed on the form. You may include multiple new prescriptions in your order.

If you prefer, your doctor or other licensed health care professional can assist you. You can bring your order form to them and they can fax it to ESI directly with your prescription. Or they can submit your prescription via the Web. In both cases, they must have your member ID number. Only doctors or other licensed health care providers may submit new prescriptions via fax or Web.

To use the Home Delivery tool, go to **www.emblemhealth.com** and register if you haven't already. Click on "Pharmacy Services" and then select "Home Delivery". You will be able to do things like check order status and request refills to existing prescriptions. You will need to register the first time you

use the tool, and you will need your member ID to create an account. You or your doctor will still need to send ESI the actual written prescription when using the online option. Please allow 7 to 10 days for delivery from the day ESI receives the prescription(s) to receive your home delivery.

Check on the Status of a Home Delivery Prescription Order

You can easily check the status of your order via the EmblemHealth/Express Scripts pharmacy benefits tool on this page. You will need to sign in using your member ID and password. You can also call ESI at **1-877-866-4165**. If you have a hearing or speech impairment, and use a TDD, you can call **1-800-899-2114**. You will need your member ID number and your prescription number(s) to access this information.

Specialty Drugs

Specialty drugs are usually injectable, oral or inhaled drugs. They are used to treat chronic conditions such as multiple sclerosis, growth deficiencies, hepatitis C and cancer. They also require special storage and/or handling. You must have your specialty drug prescriptions filled through our select Specialty Pharmacy program. You cannot fill specialty drug prescriptions at a network retail pharmacy or through the ESI mail order program. Your doctor or other licensed health care provider will submit the prescription through our Specialty Pharmacy program. And similar to home delivery your specialty prescriptions will be filled and sent directly to you at home.

For questions, please call EmblemHealth's Specialty Pharmacy program at **1-888-447-0295**.

Dental Services

We believe that providing you with good dental care is important to your overall health care. That is why you and other enrolled family members were assigned to a network primary care dentist as of your effective date of enrollment. The name, address and telephone number of your dentist was included in your New Member Welcome Kit. Call your dentist right away to schedule appointments for you and all other enrolled family members. Just show your dentist your member ID card. After your first visit, you should schedule regular preventive dental visits every six months to keep your teeth and gums healthy. You do not need a referral from your PCP to see a dentist!

If you do not know who your dentist is, or you want to change your dentist, please call Healthplex, our contracted dental provider, at **1-800-468-9868**, Monday through Friday, from 8 am and 8 pm. Healthplex Customer Service Representatives are there to help you. They speak many languages, but if they don't speak yours, they will connect you with a language interpretation service. Hearing impaired members can call the New York State Relay Service or dial **1-800-662-1220** to connect to the Healthplex TDD line. You can change your dentist at any time for any reason. This change will be effective immediately.

You and your other enrolled family members may get the following services from your assigned network dentist or self-refer to a dental clinic operated by an academic dental center:

- Routine exams.
- X-rays.
- Cleanings, fillings and tooth extractions.
- Emergency dental treatment.

- Replacement of missing teeth (full and partial dentures). Covered when conditions meet Medicaid guidelines.
- Root canals. Patients must be evaluated on a case-by-case basis to determine if conditions meet Medicaid coverage guidelines. Coverage will generally be provided when the number of teeth needing or likely to need root canals is “not excessive” and the patient has good oral hygiene, and has a healthy mouth and gums, and:
  - — Has few, if any cavities; and
  - — Has a full complement of natural teeth; and
  - — Has had all other necessary restorations completed; and/or
  - — Is not undergoing orthodontic treatment.

Root canals will not be covered when the prognosis of the tooth is questionable or extraction and replacement is a reasonable alternative course of treatment. Molar root canals will not be covered for patients over the age of 21 except where the tooth is a critical abutment for an existing prosthesis.

- — Crowns will not be routinely approved if restorative materials can restore the teeth.
- — Crowns will not be covered on molar teeth for patients over the age of 21.
- — Fixed bridges are considered beyond the scope of the program and are not covered.

When you need covered dental specialty services, your network dentist will refer you. We do not cover orthodontic services.

Behavioral Health Services

Up to 60 outpatient behavioral health visits per year. Coverage includes chemical dependence services (including alcohol and substance use disorder) and mental health treatment services.

Up to 30 inpatient mental health and chemical dependence days per year.

Detoxification services (inpatient detoxification and inpatient or outpatient withdrawal services do not count towards the limits mentioned above).

TB Diagnosis and Treatment

You can choose to go either to your PCP or to the county public health agency for diagnosis and/or treatment. You do not need a referral to go to the county public health agency.

Foot Care

These services are covered for all children under 21 years of age and members (regardless of age) with physical conditions that pose 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.

Hospice Services

Hospice Services include home and inpatient services that provide medical and support services for members that are terminally ill with a life expectancy of six months or less. Also includes covered curative care for terminally ill members under 21 years of age.

Emergency Transportation Services

Includes land and air ambulance transportation (just call 911 for emergency transportation).

Nonemergency Transportation Services

We only cover Nonemergency rides for our Nassau and Suffolk County Family Health Plus members aged 19 and 20. Nonemergency transportation includes:

- **Public bus and train trips**. No prior approval is needed. At the time of the appointment, you will be reimbursed for your round-trip fare by the network medical center, dentist, PCP or OB/GYN with whom you have the appointment or who is making a referral.
- **Taxi and van trips**. Your network doctor (or dentist) must approve taxi or van transportation based on medical necessity. Your doctor will fill out the medical necessity form and fax it to the number on the form. You can then call our Customer Service department at **1-800-447-8255** to reach a Customer Services representative who will provide you with the phone number of a network taxi or van service so that you can schedule your trip. The network taxi or van service will bill us for the trip. If we give you permission to use a non-network service, you must pay for the taxi directly and we will tell you how to get reimbursed.
- **Ambulette trips**. When medically needed, prior approval is required. To obtain prior approval, your doctor (or dentist) must call us at **1-866-447-9717**. Once the trip is approved, we will arrange the trip with the ambulette company. The ambulette company will bill us for the trip.

If you have an emergency and need an ambulance, you must call 911.

Nutritional Counseling and Assessment

Includes assessment and nutritional counseling sessions with a network registered dietitian. The result of the initial assessment will determine the number of sessions required. Both the assessment and the counseling sessions require a referral by your primary care physician. Members who particularly benefit from these services include those who are pregnant; newly diagnosed or living with diabetes, heart disease and/or kidney disease; have an eating disorder or other digestive problems; or have been diagnosed as overweight or obese by their doctor.

Case Management Services

Includes the coordination of benefits and services for members who have complex or serious diseases or conditions. Members may be assigned to a Case Management nurse, who will work with you and your doctors to insure that you get the care and services you need when you need them. You could be in the program for weeks, months or years depending on your condition and circumstances. The purpose of Case Management is to achieve the best health care outcome.

Social Work Services

Includes help in getting needed community services.

Experimental and Investigational Treatments

These services are covered on a case-by-case basis according to New York State law.

Court Ordered Services

Include any HIP FHPlus Plan covered services ordered by a judge.

Services Not Covered by Our Plan:

- Cosmetic surgery, if not medically needed.
- Services of a podiatrist (for members 21 years of age and older unless you are a diabetic).
- Personal and comfort items.
- Infertility treatments.
- Personal care services.
- Private Duty Nursing.
- Medical supplies (such as bandages).
- Nursing Home stays that are permanent.
- Preschool and School Supportive Services program services.
- Early Start programs.
- Directly Observed Therapy (DOT) for tuberculosis.
- Adult day treatment for persons with HIV.
- Orthodontic services.
- Chiropractic services.
- Non-emergency transportation* (unless you are 19 or 20 and in the C/THP program)

For New York City members 19 or 20 years old to get non-emergency transportation, you or your provider must call LogistiCare at **1-877-564-5922**. If possible, you or your provider should call LogistiCare at least 3 days before your medical appointment and provide your appointment date and time, address where you are going, and doctor you are seeing. Non-emergency transportation includes: personal vehicle, bus, taxi, ambulette and public transportation.

For Westchester members 19 or 20 years old to get non-emergency transportation, you or your provider must call Medical Answering Service (MAS) at **1-866-883-7865**. If possible, you or your provider should call MAS at least 3 days before your medical appointment and provide your appointment date and time, address where you are going, and doctor you are seeing. Non-emergency transportation includes: personal vehicle, bus, taxi, ambulette and public transportation.

*HIP will still cover non-emergency medical transportation services for 19 and 20 year olds in Nassau and Suffolk counties. For information about covered nonemergency transportation services, see page 26.

PART III: ADDITIONAL INFORMATION ABOUT YOUR BENEFITS

We have an ongoing commitment to help our members stay healthy. Following is information about special programs that we offer members.

Special Programs

Positive Actions Toward Health (PATH) Program

Our *Positive Actions Toward Health* (PATH) program can give you important information and support to help you manage your health. The PATH program is for members with asthma, diabetes, or heart failure. As a member of the PATH program, you will receive:

- A welcome telephone call from a health coach.
- Mailings that include the latest information on your condition, medicines, treatment, lifestyle issues such as weight management, diet, exercise, stress management; and more.
- Follow-up calls from a health coach for one-on-one support, health education and help in getting services you need.
- Unlimited telephone contact with a health coach so you can discuss your questions or concerns when you want.

Asthma Program

Have asthma? Together, you and your PCP will develop an asthma management plan just for you. Through the *Better Breathing* PATH program, you can receive various educational tools to help control your condition, including an asthma guidebook peak flow meter and information to help you take the right amount of asthma medication. This program is available for your enrolled family members starting at age five.

Diabetes Program

If your doctor has told you that you have diabetes, you know how important it is to manage your condition. From time to time the *Diabetes Care* PATH program will send you letters encouraging you to take important tests and examinations that will help control your diabetes. These tests and examinations let you and your doctor know if your diabetes is under control. This program is available for your enrolled family members starting at age five.

We also offer diabetes education classes for those with high needs. These free classes are offered at select medical centers throughout our service area. Certified Diabetes Educators share valuable information on various topics.

Heart Care PATH Program for Heart Failure

Our *Congestive Heart Failure* (CHF) program provides members with information to manage their condition. The program also alerts the member's physician of CHF-related health issues to help avoid unnecessary hospitalizations and ER visits.

The program provides:

- An electronic scale with a speaker and an interactive communication device to ask yes/no questions about symptoms.
- A dedicated nurse to track the weights and symptoms twice a day, 7 days a week.
- Member access to a registered nurse from 8 am to 8 pm EST.
- Member education about medication, nutrition and lifestyle as it relates to Congestive Heart Failure.

Healthy Beginnings PATH Program

This program gives pregnant members the support needed to improve their chances of having healthy pregnancies and healthy babies. Program enrollees can receive:

- Health Risk Assessments (HRAs) that are shared with their prenatal care doctors.
- Nutritional counseling and assessment and referral to the WIC program.
- A prenatal book and other information about pregnancy. Educational materials also include information about the Women, Infants and Children (WIC) program, breastfeeding, HIV, and how to make healthy choices for you and your baby.
- A newsletter about pregnancy e-mailed to you and access to online information on pregnancy.
- Access to our 24-hour, 7-days-a-week *BabyLine* staffed by nurses. Members can call to ask questions about their pregnancy and ask for more educational materials. No medical advice is given.
- Nurses who speak both English and Spanish, including written materials in both English and Spanish.
- Receive help with transportation to and from your prenatal care visits.

Members should call our Pregnancy hotline at **1-877-736-2229** as soon as they learn that they are pregnant. We answer any questions you have about the *Healthy Beginnings* PATH program and help you enroll. We will also tell you about other services available to our members who are pregnant. Finally, we will ask your LDSS for a Medicaid Client Identification Number (CIN) so that your child can be enrolled in our plan as soon as he or she is born.

Parenting Classes

We offer parenting classes to members who are pregnant and to new parents. Parenting classes teach members about:

- The importance of prenatal care.
- What to expect and how to care for themselves and their unborn babies during pregnancy.
- Helpful parenting skills.
- Breast feeding.
- The importance of well-baby and well-child preventive health services to the health of their new babies.

To find out about our parenting classes, call **1-888-447-0337** and speak with a *Healthy Beginnings* team member.

Lamaze Classes

We offer Lamaze classes to members who are pregnant through their expected birth hospitals and existing community programs. To find out about Lamaze classes, call **1-888-447-0337** and speak with a *Healthy Beginnings* team member. You may be able to receive help with transportation to and from your prenatal care visits.

Quit Smoking

The Quit Smoking program is an all-inclusive educational self-help behavior modification program that provides members who want to stop smoking with an educational kit, which contains detailed materials about stopping smoking and support calls from a smoking cessation specialist. The program provides:

- Unlimited telephone access to professional counselors.
- Educational information tailored to your stage of readiness to quit.
- Follow-up report sent to your primary care physician.

Call the NYS State Quit Line at **1-866-NY QUITS** (1-866-697-8487) or visit **http://www.nysmokefree.com** to learn about more free educational resources. You can also visit **www.emblemhealth.com** and click on Health & Wellness, Quit Smoking, for tips.

Note: Family Health Plus members have coverage for the nicotine patch, gum, lozenge, bupropion (generic Zyban®) and Chantix™) through your pharmacy benefit. Members must get a prescription from their network provider and fill it at a network pharmacy. Coverage includes an original 30-day supply with up to two refills, for a total 90-day supply.

Healthy Living With Chronic Conditions (HLCC)

If you are living with a chronic health condition we have a program for you. HLCC is a 15-hour course developed by experts at Stanford University's School of Medicine. Conducted by trained leaders who themselves are living with a chronic condition. The course focuses on problems common to patients suffering from any chronic condition. HLCC classes stress goal setting and problem solving, and are highly engaging. Through instructor-led programs, course participants develop skills aimed at improving their self-confidence in managing their illnesses, dealing with symptoms, and learning effective strategies such as action planning and feedback, behavior modeling, problem-solving techniques, and decision-making.

Offered in community settings such as senior centers, community colleges, libraries, and clinics, HLCC classes are held for two-and-a-half hours, once a week for six weeks. All of our members with a chronic condition are eligible for this program. Visit **www.emblemhealth.com/livebetter** and Integrative Wellness, and Healthy Living with Chronic Conditions, to find out more about this program.

Quality of Life Care and Easy Care Programs

No one likes to think about it, but dealing with a terminal illness brings its own set of challenges. Our *Quality of Life Care* program supports members with cancer while our *Easy Care* program assists members with multiple health conditions. Both programs provide educational resources and a

personal nurse case manager to aid in the management of treatments, medications, and coordination of care. In addition, our *Easy Care* team of social workers provide grief/loss counseling for our members and their respective caregivers.

Dignified Decisions Program

Offered through our integrative Wellness Department, the *Dignified Decisions* program is designed to support our members dealing with terminal illness. Working closely with members, their doctors, family caregivers, and hospice care providers, the Dignified Decisions End-of-Life-Care Specialist:

- Addresses the member's questions and concerns about hospice care.
- Provides information to help members and their families make decisions about their care.
- Refers members to supportive community services, such as grief/loss counseling, while staying in contact throughout the decision-making process and after hospice election.

You can visit **www.emblemhealth.com/livebetter** and click on Integrative Wellness and Dignified Decisions for more information.

PART IV: YOUR RIGHTS, RESPONSIBILITIES AND OTHER IMPORTANT INFORMATION

How Our Network Providers Are Paid

You have the right to ask us whether we have any special financial arrangement with our network providers that may affect your use of health care services. Call Member Services at **1-800-447-8255** if you have specific concerns.

We pay our network doctors on either a capitation or a fee-for-service basis. Capitation is usually a set fee paid to doctors each month for each member for whom they provide care. This fee is for specific services and is the same for each member. Some doctors are capitated just for the services they provide. Others are capitated for other services that may include hospitalization, diagnostic services and more. Fee-for-service is usually an agreed-upon fee paid for each service provided to members.

Some providers may be eligible for bonus payments (money in addition to their capitation or fee-for-service payments) for their performance in specific areas. These areas include quality improvement, quality of care, customer satisfaction and operations. We do not hold back any part of capitation or fee-for-service payments for the bonuses.

The type of payment that providers get depends on:

- The type of provider they are (individual doctor, doctor's group, hospital, or other health care facility).
- How they are organized (individual doctor or a doctor in a small or large group practice).
- Where they practice (in a network medical center or in their own private offices).

We use different methods to pay our providers:

Medical Center Doctors

If you get care from a doctor at a network medical center, we make capitation payments to the medical groups for which your doctor works. The capitation includes the cost of the medical services that the medical group provides. The group as a whole is at risk (responsible for the cost) for the services it provides and for the cost of certain specialty care services that are not provided at your medical center. This means that the group must pay for the services it provides even if the cost is more than the capitation we pay the group. The group is not usually at risk for certain other services to which it refers members (hospital, mental health, etc.). We pay these costs. The group can also get additional

payments in the form of incentive bonuses (extra money) for meeting certain quality improvement, quality of care, customer satisfaction and operational goals.

Private Practice PCPs

If you get care from a doctor in private practice, your doctor may either have a contract directly with our plan or a contract with an independent practice association (IPA for short) or other group which contracts directly with our plan. If your doctor contracts with us directly, he or she is likely to be paid on a fee-for-service basis and is not at risk for the services he or she provides. If your doctor contracts with an IPA or group that contracts with us, we may pay the IPA or group on a capitation basis or pay your doctor directly on a fee-for-service basis. If the IPA or group is paid capitation, it is likely to be at risk for the medical services provided. It is also likely to be at risk for other services, including specialty care, laboratory, hospital, etc. The IPA or group, in turn, pays your doctor on either a fee-for-service or capitation basis. Your doctor will only be at risk for the services he or she provides.

Hospitals

If you get care in a network hospital, the hospital is likely to be paid on a "per diem" basis. This means that the hospital gets an agreed upon payment per day of service, rather than for all services it provides. Per diem payments to hospitals that serve a large number of our members may be adjusted if the number of services provided does not meet certain goals.

Specialists

Specialists who don't work for a medical group are usually paid on a fee-for-service basis.

The way we pay our network providers has no impact on the quality of care they give you. All network doctors are expected to practice medicine with only the best interests of their patients in mind.

You Can Help With Plan Policies

We value your ideas. If you would like to share your opinions and ideas with us, you can attend one of the Member Forums held each year. You can also write our Customer Service Department We will tell you how you can share your ideas with us.

Other Information You Can Request

Here is information you can get by calling or writing to Customer Service:

- A list of names, business addresses and official positions of our Board of Directors, officers and owners.
- A copy of our most recent certified financial statements/balance sheets, and summaries of income and expenses.
- A copy of the most recent individual direct pay subscriber contract.
- Information from the State Department of Financial Services about consumer complaints about us.
- How we keep your medical records and member information private.
- Information about how our company is organized and how it works.
- We will tell you with which hospitals our network providers work.

The following information can be given to you when requested in writing:

- How we check on the quality of care of our members.
- Guidelines we use to review conditions or diseases that are covered by our network.
- Qualifications needed and how health care providers can apply to be part of our network.
- Whether our contracts or subcontracts include doctor incentive plans that affect the use of referral services and, if so:
  — Information on the type of incentive arrangements used; and
  — Whether stop loss protection is provided for doctors and doctor groups.

To request any of these items, write or call us at:

EmblemHealth
Customer Service Department
55 Water Street
New York, NY 10041-8190
1-800-447-8255

Keep Us Informed

Call Member Services whenever the following changes happen in your life:

- You have a change in circumstances that will affect your eligibility for FHPlus.
- You are pregnant.
- You give birth.
- You become covered under another health insurance policy, including another insurance policy through our plan.

When the following things change, your member file will need to be updated:

- Your home address changes.
- Your e-mail address changes.
- Your home or cell telephone number changes.

You can make these changes in two ways:

- **Online**: go to **www.emblemhealth.com** and sign in using your member ID and password. Then click on "Update Personal Info." You can update this information online anytime, as often as necessary.
- **Customer Service**: call **1-800-447-8255**, Monday through Friday, from 8 am and 8 pm, to inform a Customer Service representative about your new information.

You should not call Customer Service with name, date of birth or gender changes\corrections. Give these changes to your LDSS. Your LDSS will update your Medicaid file and then give us the changes.

Options

1. If You Want to Leave Our Plan

You can try our plan for 90 days. You can ask to leave our plan for any reason, at any time during those 90 days, if there is another FHPlus plan available where you live. If you do not leave during the

first 90 days of your coverage, you must stay in our plan for nine more months, unless you have a good reason, such as when:

- We cannot provide a suitable PCP for you within 30 minutes or 30 miles from where you live when providers are routinely available within this distance/travel time.
- We do not meet New York State requirements and you are harmed because of it.
- You move out of our service area.
- You, our plan and your LDSS agree that disenrollment is best for you.
- We have not provided services as required to under our contract with the state.

At the end of your first year of enrollment in our plan, if you want to, you can change to another FHPlus plan available where you live. If you want to leave our plan for any reason during your try-out period, you must call New York Medicaid Choice at **1-800-505-5678**. If you have a hearing or speech impairment and use a TDD, you can call the New York Medicaid Choice TDD number: **1-888-329-1541**.

When you call, tell them you want to transfer to another FHPlus plan. You can transfer over the phone or ask for a Transfer Package. You will get a notice that the change will take place by a certain date. We will provide the care you need until then.

It will take between two and six weeks after your call to process your request depending on when you call. You can ask for faster action if you believe that the timing of the regular process will cause added harm to your health. You can also ask for faster action if you complained because you did not agree to be enrolled in our plan. Just call your LDSS or New York Medicaid Choice.

2. You Could Become Ineligible for Our FHPlus Program
You could lose your coverage with our plan if you:

- Move out of the county or service area.
- Have a change in income that makes you ineligible for FHPlus.
- Join an HMO or other insurance plan through your place of employment.
- Receive Medicare coverage.
- Join a long-term Home Health Care program.
- Are incarcerated.
- Turn 65 years of age.

You are **guaranteed** coverage by our plan during the first six (6) months of your enrollment, even if you are no longer eligible for FHPlus. During this time, you will continue to get all of the services that we cover. Guaranteed coverage does **not** apply if you choose to leave our plan, move out of state, or if you become incarcerated.

Renew Your FHPlus Eligibility

To keep your coverage, you must have an active FHPlus case. Most members will need to renew their eligibility with their LDSS at least once a year. If you don't renew on time, your LDSS may terminate your membership with our plan. If you learn that you have been involuntarily disenrolled from our plan, it may be because:

- You moved and did not advise your LDSS of your new address. (The LDSS, not our plan sends renewal notices by mail.)

- You received your renewal packet, but forgot to complete and return it.
- You received but found the renewal forms too confusing to complete.
- You mailed your renewal form after the "respond by" date or forgot to enclose all the required documents.
- Your LDSS found that you were no longer eligible for coverage.

To Avoid Losing Your Membership in Our Plan:

- Always update your LDSS records if you move or change your phone number.
- Open and review all mail from your LDSS right away.
- If you have difficulty understanding the instructions in the renewal packet, call your LDSS at the number in your renewal packet. You may also call us for help at **1-800-447-9490**.
- Make sure your LDSS receives your renewal application by the "respond by" date indicated in your renewal packet.

3. We Can Ask You to Leave Our Plan
You can also lose your membership in our plan, if you often:

- Refuse to work with your PCP with regard to your care.
- Don't keep appointments.
- Go to the emergency room for nonemergency care.
- Don't follow our rules.
- Don't fill out forms honestly or do not give true information (fraud).
- Cause abuse or harm to our members, providers or staff.
- Act in ways that make it hard for us to do our best for you and other members even after we have tried to fix the problems.

4. You May Want to Change From FHPlus to Medicaid with a "Spend Down."
FHPlus doesn't cover all the services that Medicaid does (e.g., medical supplies), and some FHPlus services have limits.

If you have medical needs that could be better met by Medicaid and you qualify, you may be eligible for Medicaid with a "spend down."

If your income is more than is allowed for Medicaid eligibility, but you have medical bills that are greater than the amount that your income is over the Medicaid level, those bills could help you qualify for Medicaid. This only applies to people who:

- Are under age 21.
- Are disabled or blind.
- Have children under age 21.
- Are over age 65.
- Are pregnant (see below).

You should contact your LDSS to see if this is an option for you. If so, your LDSS will disenroll you from our plan and you will receive your health care from the regular Medicaid program. You can ask that this be done quickly if you believe that waiting will damage your health or if you have complained because you did not agree to the FHPlus enrollment.

5. If You Become Pregnant While Enrolled in Family Health Plus

If you become pregnant, you are eligible for Medicaid. You have the choice of staying in FHPlus or changing to Medicaid. You may want to change to Medicaid because it covers more services. If you decide to change to Medicaid, you can stay in our plan. However, you should ask your doctor if he or she provides services to our Medicaid members. If not, you will have to change your doctor.

Your newborn will automatically be eligible for Medicaid and will be enrolled in our plan. You should contact us and your LDSS to discuss these options and your decision.

The Quality of Your Care

Our goal is to give you access to quality care. We start by making sure that all network doctors meet our standards. We also make sure that our network hospitals are among the finest in the nation.

Care Management Program

In addition, our Care Management program will help you with the medical care decisions that you and your doctor must make. The Care Management program is staffed by a team of doctors, nurses, social workers and other staff members as necessary. Team members help you and your doctor make the best decisions by checking your treatment plan against medically acceptable standards. Such reviews will occur whenever judgments about medical necessity, experimental or investigational treatment and services must be made.

The Care Management team will review care that you are seeking (service authorization or prior approvals), care that you are now getting and want to continue or get more of (concurrent review), and care you already got (retrospective review).

Care That You Are Seeking

The Care Management team's goal is to ensure that you get the right services, for the right reasons, at the right place, by the right provider and at the right time. To achieve this goal, we require you or your doctors to get approval from Care Management **before** you get the following services:

- Inpatient nonemergency procedures that provide acute, rehabilitation and skilled nursing care.
- All outpatient surgery for procedures and treatment in a facility or doctor's office.
- All procedures that require an assistant surgeon or co-surgeon.
- Inpatient treatment of mental illness and substance use disorder and dependence.
- Detoxification and rehabilitation treatment of substance use disorder, including outpatient detoxification.
- Nonemergency medically needed transportation services.
- Home Health care.
- Hospice care.
- Pre-transplant evaluation and transplant services.
- Outpatient cardiac and pulmonary rehabilitation.
- Radiation therapy.
- Outpatient diagnostic radiology services.
- Outpatient physical and occupational therapies.
- Sleep studies.
- Psychological testing services.
- Neuropsychological testing services.

- Covered nonemergency services rendered by nonparticipating providers.
- Some types of durable medical equipment.
- Dental implants and oral appliances (such as braces).
- All genetic testing.
- Certain injectable drugs.

When you need these services or services from an out-of-network provider, your network doctor will call Care Management to request prior approvals. Call your doctor's office before you are scheduled to get these services to be sure they have been approved.

A Care Management decision to deny a service authorization request or to approve services other than those requested is called an **action**. When this happens, we will send you a written denial letter (called an "adverse determination"). An adverse determination will not be made until a Care Management doctor reviews all information about your case and works to resolve any problem issues with your doctor.

Care That You Are Now Getting

The Care Management team will help coordinate the care and services you are getting, such as when you are in a facility or hospital. This includes a request for home health care while you are in the hospital or after you have just left the hospital. The team also will help you get the care you need after your discharge.

If the Care Management team finds that your hospital care is not medically needed or that services are not being provided in a timely and efficient manner, we will send you a written adverse determination. The determination will not be made until a Care Management doctor reviews all information about your case and tries to resolve any problem or issue with your doctor.

Care That You Already Received

The Care Management team will review medical and hospital records after you have received services to determine if the services you got were covered, medically needed and appropriate.

If we deny a provider all or part of a payment for services you already received, we will send the provider of the service a written denial and you will receive a copy. In such cases, you will not have to pay for services covered by us or Medicaid covered services that were medically needed. If you receive a bill from the service provider, call Customer Service right away. We will contact the provider on your behalf.

Contacting Care Management

If you are planning to receive services, you, your designee or your doctor should contact Care Management at least 10 business days in advance by calling **1-888-447-2884**, Monday through Friday, from 9 am to 5 pm.

At other hours:

- If the call concerns an urgent or emergency admission, the caller will be prompted to leave a message and Care Management will call you or your doctor back the following business day.
- If the call concerns an elective admission, the caller will be advised to call back the next business day when representatives are available.

Adverse Determinations (Actions)

Any decision to deny a service authorization request or to approve it for an amount that is less than requested is called an action. You will receive a written notice of the action. This notice is called an Adverse Determination. Adverse Determinations are made by qualified, licensed health care professionals. If we decide that the requested service is not medically necessary, the decision will be made by a clinical peer reviewer, who may be a doctor or may be a health care professional who typically provides the care you requested. You can request the specific medical standards, called **clinical review criteria**, used to make medically needed decisions.

Determination Timeframes

After we get your request we will review it under a **standard** or **fast track** process. You or your doctor can ask for a fast track review if it is believed that a delay will cause serious harm to your health. If your request for a fast track review is denied, we will tell you or your designee and your provider that your case will be handled under the standard review process. If you are in the hospital or have just left the hospital and we receive a request for home health care, we will handle the request as a fast track review. In all cases, we will review your request as fast as your medical condition requires us to do so but no later than the timeframes mentioned below.

We will tell you and your provider both by phone and in writing if your request is approved or denied and the reason for the decision. We will also tell you how to appeal and request a fair hearing if you don't agree with our decision.

Timeframes for prior approval requests

- Standard review — we will make a decision about your request within three business days of getting all needed information. We will let you or your designee and your doctor know of the decision in person or by telephone and in writing within 14 business days of getting the request.
- Fast track review — we will make a decision and you, your designee and your doctor will hear from us within three business days. We will tell you or your designee and your doctor by the third business day after getting the request if we need more information.

Timeframes for concurrent review requests

- Standard review — we will make a decision within one business day of getting all needed information. We will let you or your designee and your doctor know of the decision in person or by telephone and in writing within 14 business days of getting the request. We will tell you or your designee and your doctor by the 14th business day after getting the request if we need more information.
- Fast track review — we will make a decision within one business day of getting all needed information and you, your designee and your provider will hear from us in no more than three business days from your request. We will tell you or your designee and your doctor by the third business day after getting the request if we need more information.

However, if you are in the hospital or have just left the hospital, and you ask for home health care on a Friday or day before a holiday, we will make a decision no later than 72 hours of when we have all the information we need.

In most cases, if we make a decision to reduce, suspend or terminate a service we have already approved and you are now getting, we must tell you at least 10 days before we change the service.

Timeframes for retrospective reviews

If Care Management reviews care that you already received, it will make a decision about paying for it within 30 days of getting all needed information for the retrospective review. If we deny payment, we will let you or your designee and your doctor know of the decision the day the payment is denied. You will not have to pay for any HIP covered services you received even if we later deny payment to the provider.

If Care Management does not make a decision within the above time frames, it also counts as an action. If you do not agree with an action, you can request an appeal through the action appeals processes described in the **"If You Disagree With an Adverse Determination"** section of this handbook.

Requests for More Time to Review Service Authorization Requests

If we need more information to make a decision about your service request, we will send you a letter by the date we must make a decision about your service request. The letter will:

- Tell you what information is needed. If your request is in a fast track review, we will call you right away and send a written notice later.
- Tell you why the delay is in your best interest.
- We will then make a decision no later than 14 business days from the day we asked for more information.

If you disagree with our decision to take more time to review your request, you or your designee can file a complaint (see the *Complaints* section of this handbook). You or your designee can also file a complaint about the review time with the New York State Department of Health by calling **1-800-206-8125**.

You, your designee or your doctor may ask us to take more time to make a decision. This may be because you have more information to give to help Care Management decide your case. This can be done by calling Care Management at **1-888-447-2884**.

Reconsideration of Service Authorization Decisions

If Care Management makes a decision that your service authorization request was not medically necessary or was experimental or investigational, without speaking to your doctor, your doctor may ask our medical director to reconsider its decision. Except in cases of retrospective reviews, we will reconsider our decision within one business day of Care Management's receipt of all information needed to support the reconsideration. If we do not change our decision, you will be notified as described below.

Determination Notices

You or your designee and your doctor will receive both verbal and written notice telling you if your request was approved or denied. The letter will give the reasons for our decision and our clinical rationale, if it applies. It will also explain what options you have for appeals or fair hearings, if you don't agree with our decision. This will include:

- Instructions on how to have our decision reconsidered, appealed or externally reviewed by an independent, New York State approved External Appeal Agent.
- Your right to file a complaint with the New York State Department of Health by calling **1-800-206-8125**.

- A description of your right to a State Fair Hearing, including how to ask for a hearing and your possible right to continue receiving services that you are already getting until a Fair Hearing decision is issued.

Technology Evaluation Program

Experimental and investigational treatments are covered on a case-by-case basis. Also, your coverage does not include any technology that in our sole judgment is:

- Obsolete or ineffective.
- Not generally used for the diagnosis or treatment of your condition.

Your coverage also does not include any hospitalization in connection with such technology.

We believe that our ongoing review of medical technology furthers the best health care outcomes for you. You can still appeal an initial denial of a specific treatment if the basis for the denial was that the treatment is experimental or investigational. You also have a right to appeal to an independent New York State licensed External Appeal Agent. Care Management's written adverse determination will give you the information you need to seek a HIP appeal and an "external appeal." It will also give you information on how to ask for a State Fair Hearing. See the *If You Disagree With an Adverse Determination* section for more information.

If You Disagree With an Adverse Determination

The previous section described adverse determinations related to service authorization requests. This section describes the action appeals processes available to you if you disagree with an action that we take.

Action Appeals

An action appeal is a request for us to reverse an action that we made, such as an adverse determination or the denial of a claim.

To file an action appeal, just follow the steps below. We will not treat you any differently or act badly toward you because you file an appeal. You can call Customer Service at **1-800-447-8255** if you need any help in filing an appeal.

Note that an expedited appeal (fast track) process is also available. You may also be able to ask for a State Fair Hearing.

You, or your designee may appeal any adverse determination. Your action appeal must be filed within 90 calendar days of the date of the adverse determination letter. Just follow the steps below:

Step 1: Contact our Customer Service or Grievance and Appeal department
You may contact us about an action appeal in one of three ways: by phone, in person or in writing.

By phone: **1-800-447-8255**; TTD: **1-888-447-4833**
Customer Service staff are available to help you Monday through Friday, from 8 am to 8 pm. At other times, leave information on the answering machine. Be sure to give enough detail for us to understand your problem. We will return your call within 24 hours.

Fast track action appeals can be made by calling our Expedited Appeal Line at **1-888-447-6855** and do not have to be followed up in writing.

In person: Customer Service Member Access Unit
55 Water Street
New York, NY 10041-8190

The Member Access Unit is wheelchair accessible and open Monday through Friday, from 8:30 am to 5 pm.

In writing: HIP Health Plan of New York
Grievance and Appeal Department
PO Box 2844
New York, NY 10116-2844

Standard action appeals requested by phone must be followed up in writing. Fast track action appeals do not need to be.

Step 2: Acknowledgement of your action appeal
We will mail you a letter within 15 days of getting your action appeal. This letter will tell you that we got your action appeal. It will include the name, address and telephone number of the staff person handling your action appeal. If you filed your action appeal by telephone, this letter will also include a written summary of your action appeal. If you agree with our summary, you should sign and return it to the address provided. You can make any needed changes before signing and returning the summary.

Step 3: Review of your action appeal
Action appeals of clinical matters will be reviewed under a fast track or standard process by qualified medical personnel who did not make the first decision, at least one of whom will be a clinical peer reviewer. Nonclinical decisions will be handled by persons who work at a higher level than the people who worked on your first decision.

Your action appeal will be reviewed under the fast track process if:

- You or your doctor asks to have your action appeal reviewed under the fast track process. Your doctor would have to explain how a delay will cause harm to your health. If your request for fast track is denied we will tell you, and your action appeal will be reviewed under the standard process; or
- Your request was denied when you asked to continue receiving care that you are now getting or need to extend a service that has been provided.

Before and during the action appeal you or your designee can see your case file, including medical records and any other documents being used to make a decision on your case. You and your doctor can also provide in person or in writing information to be used in making the decision in person or in writing. Call us at **1-800-447-8255** if you are not sure what information to give. If you are appealing our decision that the out-of-network service you asked for was not different from a service that is available in our network, ask your doctor to send us:

- A written statement that the service you asked for is different from a service we have in our network; and

- Two pieces of medical evidence (published articles or scientific studies) that show the service you asked for is better for you, and will not cause you more harm than the service we have in our network.

You will be given the reasons for our decision and our clinical rationale, if it applies. If you are still not satisfied, any further appeal rights you have will be explained. You or someone you trust can also file a complaint with the New York State Department of Health at **1-800-206-8125**.

Step 4: Time frames for action appeal decisions

- Standard action appeals — if we have all the information we need, we will tell you our decision within 30 days of getting your action appeal. A written notice of our decision will be sent to you or your designee and your doctor within two business days of making our decision.
- Fast track action appeals — if we have all the information we need, fast track action appeal decisions will be made within two business days of getting your action appeal. We will tell you in three business days after getting your action appeal, if we need more information. We will tell you our decision by phone and send a written notice later.

If we need more information to make decision about your action appeal we will:

- Write you and tell you what information is needed. If your request is in a fast track review, we will call you right away and send a written notice later.
- Tell you why the delay is in your best interest.
- Make a decision no later than 14 business days from the day we asked for more information.

If you disagree with our decision to take more time to review your action appeal, you or your designee can file a complaint with us (see the *Complaints* section of this handbook). You or your designee can also file a complaint about the review time with the New York State Department of Health by calling **1-800-206-8125**.

You, your designee or your provider may also ask us to take more time to make a decision. This may be because you have more information to give to help us decide your case. This can be done by calling Care Management at **1-888-447-2884** or by writing to our Care Management department.

Step 5: Action appeal decisions

You, your designee and your doctor will receive a written determination on your action appeal. If the outcome remains adverse, this decision is called a final adverse determination or "FAD." The FAD will give the reasons for our decision and our clinical rationale, if it applies. It will also provide any further appeal rights you have in case you are not satisfied with our decision. This will include:

- If eligible, a standard description of the external appeal process, including the application form and instructions.
- Your right to file a complaint with the New York State Department of Health by calling **1-800-206-8125**.
- A description of your right to request a State Fair Hearing, the request form and instructions. This notice will also tell you of your possible right to continue receiving services that you are already getting (Aid Continuing) until a Fair Hearing decision is issued.

If your original denial was because we said:

- the service was not medically necessary; or
- the service was experimental or investigational; or
- the out-of-network service was not different from a service that is available in our network; and we do not make our decision about your action appeal within the required time frames, the original denial against you will be reversed. This means your service authorization request will be approved.

If we fully overturn our original adverse decision, we will tell you how to get the services that you or your doctor asked for.

Aid Continuing (Receiving Services While Appealing a Decision About Your Care)

In some cases you may be able to continue to get the services that are scheduled to end or be reduced if you appeal and ask for a fair hearing:

- Within ten days from being told that your request is denied or care is changing; or
- By the date the change in services is scheduled to occur.

If the fair hearing office determines that you are entitled to Aid Continuing, you will continue receiving the services while you wait for your fair hearing to be decided. If your fair hearing results in another denial, you may have to pay for the cost of the services you continued to receive. The decision you receive from the fair hearing officer will be final.

External Appeals

If we decide to deny coverage for a medical service you and your doctor asked for because:

- the service was not medically necessary; or
- the service was experimental or investigational; or
- the out-of-network service was not different from a service that is available in our network; you can ask New York State for an independent external appeal. This is called an external appeal because it is decided by reviewers who do not work for us or the state. These reviewers are qualified people approved by New York State. The service must be in our benefit package or be an experimental treatment, clinical trial, or treatment for a rare disease. You do not have to pay for an external appeal.

Before you ask for an external appeal:

- You must file an action appeal with us and get our final adverse determination; or
- If you have not gotten the service, and you ask for a fast track action appeal with the plan, you may ask for an expedited external appeal at the same time. Your doctor will have to say an expedited external appeal is necessary; or
- You and the plan may agree to skip the plan's appeals process and go directly to external appeal.
- You can prove the plan did not follow the rules correctly when processing your action appeal.
- You have four months after you receive our final adverse determination to ask for an external appeal. If you and the plan agree to skip the plan's appeals process, then you must ask for the external appeal within four months of when you made that agreement.

If you had a fast track action appeal and are not satisfied with the plan's decision, you can choose to file a standard action appeal with the plan or ask for an external appeal. If you choose to file a standard action appeal with the plan, and the plan upholds its decision, you will receive a new final adverse determination and have another chance to ask for an external appeal.

Additional appeals may be available to you if you want to use them. However, if you want an external appeal, you must still file the application with the New York State Department of Financial Services within four months from the time we give you the notice of final adverse determination or when you and the plan agreed to waive the plan's appeal process.

You will lose your right to an external appeal if you do not file an application for an external appeal on time.

To ask for an external appeal, fill out an application and send it to the New York State Department of Financial Services. You can call Member Services at **1-800-447-8255** if you need help filing an appeal. You and your doctors will have to give information about your medical problem. The external appeal application says what information will be needed.

Here are some ways to get an application:

- Call the New York State Department of Financial Services at **1-800-400-8882**
- Go to the New York State Department of Financial Services Web site at **www.dfs.ny.gov**
- Contact us at **1-800-447-8255**.

Your external appeal will be decided in 30 business days. More time (up to five business days) may be needed if the external appeal reviewer asks for more information. You and the plan will be told the final decision within two days after the decision is made.

You can get a faster decision if:

- your doctor says that a delay will cause serious harm to your health; or
- you are in the hospital after an emergency room visit and your hospital care is denied by the plan

This is called an **expedited external appeal**. The external appeal reviewer will decide an expedited appeal in 72 hours or less. The reviewer will tell you and the plan the decision right away by phone or fax. Later, a letter will be sent that tells you the decision.

You may also ask for a fair hearing if we decide to deny, reduce or end coverage for a medical service. You may request a fair hearing and ask for an external appeal. If you ask for a fair hearing and an external appeal, the decision of the fair hearing officer will be the one that counts.

Your Right to a State Fair Hearing

In some cases you may ask for a Fair Hearing from New York State, such as when:

- You disagree with a decision your LDSS or the State Department of Health made about your staying in or leaving your plan.
- You disagree with a decision that we made about medical care you were getting. You feel the decision limits your FHPlus benefits, or that we did not make the decision in a reasonable amount of time.

- You disagree with a decision we made that denied medical care you wanted. You feel the decision limits your FHPlus benefits.
- You disagree with a decision that your doctor would not order the services you wanted. You feel that the doctor's decision stops or limits your FHPlus benefits. You must file a complaint with us. If we agree with your doctor, you may ask for a State Fair Hearing.

The decision you receive from the fair hearing officer will be final.

If the services you are now getting are scheduled to end, you can choose to ask to continue the services your doctor ordered while you wait for your case to be decided. However, if you choose to ask for services to be continued, and the fair hearing is decided against you, you may have to pay the cost for the services you received while waiting for a decision.

You can request a Fair Hearing:

By phone: **1-800-342-3334**
By fax: **1-518-473-6735**
By Internet: **www.otda.ny.gov**
By mail:

NYS Office of Temporary and Disability Assistance
Office of Administrative Hearings
Managed Care Hearing Unit
PO Box 22023
Albany, New York 12201

Remember that you can complain anytime to the New York State Department of Health by calling **1-800-206-8125**.

Please call our Customer Service department at **1-800-447-8255** if you have questions.

Complaints

The previous section described the appeals processes available to you if you disagree with our adverse determination. This section describes the complaint process available to you in addressing other concerns.

We hope that we serve you well and that you have a positive experience with our staff. But, if you have a problem with us or our network providers, talk with your PCP, call Customer Service, or write to our Grievance and Appeal Department. Most problems can be solved right away. Problems that are not solved right away on the phone and those that are received in writing will be handled according to the complaint processes described below. You can ask someone you trust (like a legal representative, family member or friend) to file a complaint for you. If you need our help because of a hearing, vision or other physical impairment, or if you don't speak English, we can help you file your complaint. Just call Customer Service. We will not make things hard for you or take any action against you for filing a complaint.

A complaint is an expression of dissatisfaction with us that does not involve a request for us to change an adverse determination (action). Complaints may be concerns regarding administrative, access to care or enrollment issues. If you believe you have a complaint, simply follow the steps listed below.

Step 1: How to file a complaint
You may contact us about a complaint in one of three ways: by phone, in writing or in person.

By phone: **1-800-447-8255**; TDD: **1-888-447-4833**

Customer Service staff are available to help you Monday through Friday, from 8 am to 8 pm. At other times, leave information on the answering machine. Be sure to give enough detail for us to understand your problem. We will return your call the next working day.

In writing: You can write us a letter and mail it to:
HIP Health Plan of New York
Grievance and Appeal Department
PO Box 2844
New York, NY 10116-2844

In person: EmblemHealth
Customer Service Member Access Unit
55 Water Street/First floor
New York, NY 10041-8190

The Member Access Unit is wheelchair accessible and open Monday through Friday, from 8:30 am to 5 pm. No appointment is necessary.

Step 2: Acknowledgement of your complaint
Within 15 workdays of getting your complaint, the Grievance and Appeal Department will send you a letter telling you:

- That we received your complaint.
- If we need more information in order for us to make a decision on your complaint.
- The name, address and telephone number of the person working on your complaint.

If you filed your complaint by telephone, this letter will also include a written summary of your complaint.

Step 3: Time frame for complaint decisions
Your complaint will be reviewed under a fast track or standard process and decided by qualified staff. If your complaint involves clinical matters, your case will be reviewed by one or more licensed certified or registered health care professionals.

- Standard complaint — we will make our decision within 30 calendar days of getting all the information needed to answer your complaint and not more than 60 days from the day we get your complaint. We will write you and will tell you the reasons for our decision.
- Fast track complaints — when a delay would increase risk to your health, we will let you know of our decision within 48 hours of getting all information needed to answer your complaint, but no more than 7 days from the day we get your complaint. You will receive notice of our decision by telephone, or we will try to reach you another way to tell you, followed by a written notice within three business days.

Step 4: Decision on your complaint
You or your designee will get a letter from us telling you of our decision, including the clinical rationale if applicable. This letter will tell you the reasons for our decision. It will also tell you:

- How you can file an appeal of your complaint if you are not satisfied with our decision and include a form that you can use to file.
- Your right to complain anytime to the State Department of Health by calling **1-800-206-8125**.
- If eligible to request a State Fair Hearing, a description of your right to request a State Fair Hearing, including how to ask for a hearing, the request form and instructions.

A notice will be sent even if a decision could not be reached regarding the complaint.

Complaint Appeals

If you are not satisfied with our decision on your complaint and want to ask for an appeal, follow the steps listed below. Your appeal must be filed in writing within 60 business days of the date of the determination letter.

Step 1: How to file a complaint appeal
If you are not satisfied with what we decide about your complaint, you or your designee may file an appeal in one of three ways: by phone, in person or in writing.

By phone: **1-800-447-8255**; TDD: **1-888-447-4833**

Customer Service staff are available to help you Monday through Friday, 8 am to 8 pm. At other times, leave your information on the answering machine. Make sure to give enough detail for us to understand your problem. We will return your call within 24 hours.

In person: Customer Service Member Access Unit
55 Water Street
New York, NY 10041-8190

The Member Access Unit is wheelchair accessible and open Monday through Friday, from 8:30 am to 5 pm.

In writing: HIP Health Plan of New York
Grievance and Appeal Department
PO Box 2844
New York, NY 10116-2844

Step 2: Acknowledgment of your complaint appeal
We will send you a letter within 15 business of getting your appeal. The letter will tell you:

- That we got your appeal request.
- If we need more information to make a decision.
- The name, address and telephone number of the person working on your complaint.

If you filed your appeal by telephone, this letter will also include a written summary of your appeal. If you agree with our summary, you must sign and return it to the address provided. You can make any needed changes before signing and returning the summary.

Step 3: Review of your complaint appeal
Appeals will be reviewed and decided on by qualified staff at a higher level than those who made the initial decision. If your complaint appeal involves clinical matters, your case will be reviewed by one or more qualified health professionals, with at least one clinical peer reviewer who was not involved in making the first decision about your complaint.

- Standard complaint appeal — we will make our decision and let you know in writing within 30 business days of getting all information we need to decide your appeal.
- Fast track complaint appeal — when a delay would increase risk to your health, we will let you know of our decision within 2 working days of getting all needed information to decide your appeal.

Step 4: Decision on your complaint appeal
You or your designee will get a letter from us telling you of our decision on your appeal. This letter will tell you the reasons for our decision, including the clinical rationale if it applies, and your right to:

- File a complaint with the State Department of Health by calling **1-800-206-8125**.
- If eligible to request a State Fair Hearing, a description of your right to request a State Fair Hearing, including how to ask for a hearing, the request form and instructions.

We will maintain a file for each member. These files will contain the dates of the complaint requests; a copy of all acknowledgment and decision letters; date(s) decisions were made and given to you; and the names, titles and qualifications of staff who reviewed and decided the complaints/appeals.

To File a Complaint With the New York State Department of Health

You may also file a complaint directly with the State Department of Health for complaints about medical care at any time at the following addresses and telephone number. You don't need to complain to us first.

New York State Department of Health
Division of Managed Care
Bureau of Managed Care Certification and Surveillance
Corning Tower, ESP, Room 2019
Albany, NY 12237
Tel: **1-800-206-8125**

You may also file a complaint directly with the New York State Department of Financial Services (for complaints about billing) any time by calling **1-800-342-3736**. You don't need to complain to us first.

Member Rights and Responsibilities

As a member you have a right to appropriate treatment in a proper setting. You have a right to know what to expect and also what we expect from you. It is also important that practitioners have the same information about your rights and responsibilities in order to ensure that you, their patient, get the care and services your benefit plan entitles you to. If for any reason you do not understand these rights or how to interpret them, EmblemHealth and its participating physicians will provide you with help.

PART IV: YOUR RIGHTS, RESPONSIBILITIES AND OTHER IMPORTANT INFORMATION

Member Rights and Member Responsibilities are available for your review.

Understanding your rights and responsibilities as a plan member can help you and us make the most of your membership. Below, we have listed what you can expect of us, as well as what we expect from you.

Your Rights

This section explains your rights as a plan member. If for any reason, you do not understand these rights or how to interpret them, we and our participating physicians will provide you with assistance.

- The right to be treated without discrimination, including discrimination based on race, color, religion, gender, national origin, disability, sexual orientation or source of payment.
- The right to participate with physicians in making decisions about your health care.
- The right to a non-smoking environment.
- The right to be treated with fairness and respect at all times, and in a clean and safe environment.
- The right to receive, upon request, a list of the physicians and other health care providers in our participating provider network.
- The right to change your physician.
- The right to information about our plans, networks and your covered services.
- The right to be assured that our participating health care providers have the qualifications stated in our Professional Standards, established by the EmblemHealth credentialing committee, which are available upon request.
- The right to know the names, positions and functions of any participating provider's staff and to refuse their treatment, examination or observation.
- The right to timely access to your covered services and drugs.
- The right to obtain from and discuss with your physician, during practice hours, comprehensive information about your diagnosis, treatment and prognosis, regardless of cost or benefit coverage, in language you can understand. When it is not medically advisable to give such information to you, or when the member is a minor or is incompetent, the information will be made available to a person who has been designated to act on that person's behalf.
- The right to receive from your physician the information necessary to allow you to give informed consent prior to the start of any procedure or treatment and to refuse to participate in, or be a patient for, medical research. In deciding whether to participate, you have the right to a full explanation.
- The right to know any risks involved in your care.
- The right to refuse treatment, to the extent permitted by law, and to be informed of the medical consequences of refusing it.
- The right to have all lab reports, X-rays, specialists' reports and other medical records completed and placed in your chart so they may be available to your physician at the time of consultation.
- The right to be informed about all medication given to you, as well as the reasons for prescribing the medication and its expected effects.
- The right to receive, from your provider, all information you need to give informed consent for an order not to resuscitate. You also have the right to designate an individual to give this consent if you are too ill to do so.
- The right to request a second opinion from a participating physician.

- The right to privacy concerning your medical care. This means, among other things, that no person who is not directly involved in your care may be present without your permission during any portion of your discussion, consultation, examination or treatment. We will give you a written notice, called a "Notice of Privacy Practice" that describes your rights.
- The right to expect that all communications, records and other information about your care or personal condition will be kept confidential, except if disclosure of that information is required by law or permitted by you.
- The right to request that copies of your complete medical records be forwarded to a physician or hospital of your choice at your expense. However, information may be withheld from you if, in the physician's judgment, release of the information could harm you or another person. Additionally, a parent or guardian may be denied access to medical records or information relating to a minor's pregnancy, abortion, birth control or sexually transmitted diseases if the minor's consent is not obtained.
- The right to have a person of your choice accompany you in any meeting or discussion with medical or administrative personnel.
- The right to give someone legal authority to make medical decisions for you.
- The right to consult by appointment, during business hours, with our responsible administrative officials and your participating physician's office to make specific recommendations for the improvement of the delivery of health services.
- The right to make a complaint or file an appeal related to the organization or a determination about seeking care or about care and services you have received.
- For more information on filing an appeal, please call Customer Service: **1-800-447-8255**; TDD: **1-888-447-4833**, Monday through Friday, from 8 am to 8 pm.
- You have the right to receive an explanation from us if a provider has denied care that you believe you should receive. To receive this explanation, you will need to ask us for a copy of the written decision.
- We must provide information in a way that works for you, in languages other than English or other alternate formats, in accordance with company policy and regulatory rules.

  For additional information on filing an appeal, please call Customer Service: **1-800-447-8255**; TDD: **1-888-447-4833**, Monday through Friday, from 8 am to 8 pm

IMPORTANT: State and federal laws give adults in New York State the right to accept or refuse medical treatment, including life-sustaining treatment, in the event of catastrophic illness or injury. EmblemHealth makes available materials on advance directives with written instructions, such as a living will or health care proxy containing your wishes relating to health care should you become incapacitated.

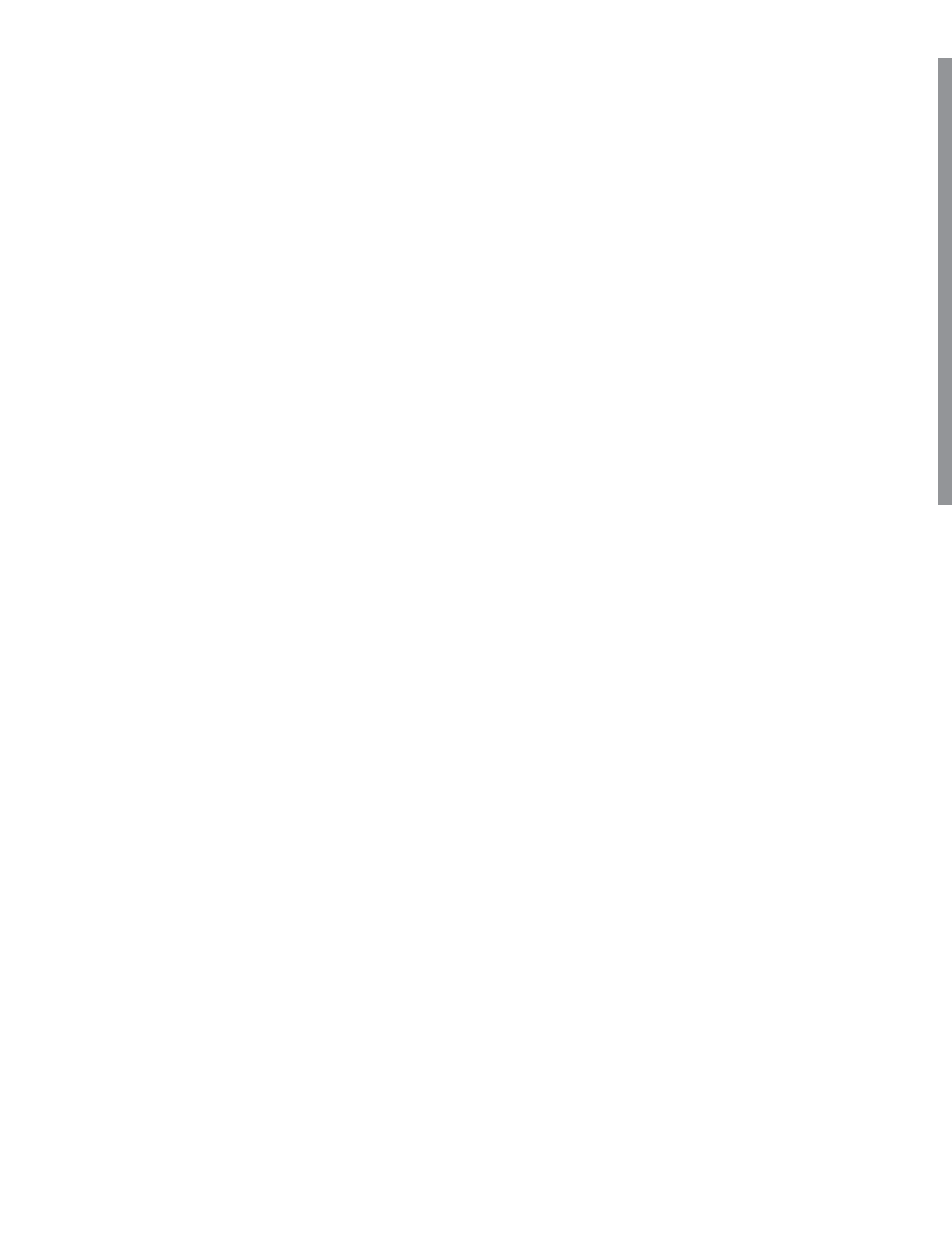
If you live in another state, check with your local state insurance department, if available, for information on additional rights you may have.

- The right to receive information about our organization, our services and our provider network and about member rights and responsibilities
- The right to make recommendations regarding our member rights and responsibilities policies.

Your Responsibilities

Now we come to the section about your responsibilities. It is important to us that you also become familiar with this section because doing so will make it easier to provide you with access to the best health care possible.

- The responsibility to provide us and our participating physicians and other providers with accurate and relevant information about your medical history and health so that appropriate treatment and care can be rendered. Tell your doctors you are enrolled in our plan and show them your membership card.
- The responsibility to keep scheduled appointments or cancel them, giving as much notice as possible in accordance with the provider's guidelines for cancellation notification.
- The responsibility to update your record with accurate personal data, including changes in name, address, phone number, additional health insurance carriers and an increase or decrease in dependents within 30 days of the change.
- The responsibility to treat with consideration and courtesy all of our personnel and the personnel of any hospital or health facility to which you are referred.
- The responsibility to be actively involved in your own health care by seeking and obtaining information, by discussing treatment options with your physician and by making informed decisions about your health care.
- The responsibility to participate in understanding the member's health issues and to follow through with treatment plans agreed upon by all parties in the member's health care: the member, EmblemHealth and participating physicians.
- The responsibility to follow plans and instructions for care that you have agreed to with your practitioner.
- The responsibility to understand your health problems and participate in developing mutually agreed upon treatment goals, to the degree possible.
- The responsibility to understand our benefits, policies and procedures as outlined in your Contract or Certificate of Coverage and handbook, including policies related to prior approval for all services that require such approval.
- The responsibility to pay premiums on time and to pay copayments, if applicable, at the time services are rendered.
- The responsibility to abide by the policies and procedures of your participating physician's office.
- The responsibility to notify us if you have any other health insurance or prescription drug coverage in addition to our plan.
- The responsibility to be considerate. We expect you to respect the rights of other patients and act in a way that helps the smooth running of your doctor's office, hospitals and other offices.



NOTICE OF PRIVACY PRACTICES

Important information about your privacy rights.

NOTICE OF PRIVACY PRACTICES

IMPORTANT INFORMATION ABOUT YOUR PRIVACY RIGHTS

Effective February 1, 2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

EmblemHealth, Inc. is the parent organization of the following companies that provide health benefit plans: Group Health Incorporated (GHI), HIP Health Plan of New York (HIP), HIP Insurance Company of New York, Inc. (HIPIC) and GHI HMO Select Inc. (d/b/a GHI HMO). All of these entities receive administrative and other services from EmblemHealth Services Company LLC which is also an EmblemHealth, Inc. company.

This notice describes the privacy practices of EmblemHealth companies, including GHI, GHI HMO, HIP and HIPIC (**collectively "the Plan"**).

We respect the confidentiality of your health information. We are required by federal and state laws to maintain the privacy of your health information and to send you this notice.

This notice explains how we use information about you and when we can share that information with others. It also informs you about your rights with respect to your health information and how you can exercise these rights.

We use security safeguards and techniques designed to protect your health information that we collect, use or disclose orally, in writing and electronically. We train our employees about our privacy policies and practices, and we limit access to your information to only those employees who need it in order to perform their business responsibilities. We do not sell information about our customers or former customers.

How We Use or Share Information

We may use or share information about you for purposes of payment, treatment and health care operations, including with our business associates. For example:

- **Payment:** We may use your information to process and pay claims submitted to us by you or your doctors, hospitals and other health care providers in connection with medical services provided to you.

- **Treatment:** We may share your information with your doctors, hospitals, or other providers to help them provide medical care to you. For example, if you are in the hospital, we may give the hospital access to any medical records sent to us by your doctor.
- **Health Care Operations:** We may use and share your information in connection with our health care operations. These include, but are not limited to:
  - Sending you a reminder about appointments with your doctor or recommended health screenings.
  - Giving you information about alternative medical treatments and programs or about health-related products and services that you may be interested in. For example, we might send you information about stopping smoking or weight loss programs.
  - Performing coordination of care and case management.
  - Conducting activities to improve the health or reduce the health care costs of our members. For example, we may use or share your information with others to help manage your health care. We may also talk to your doctor to suggest a disease management or wellness program that could help improve your health.
  - Managing our business and performing general administrative activities, such as customer service and resolving internal grievances and appeals.
  - Conducting medical reviews, audits, fraud and abuse detection, and compliance and legal services.
  - Conducting business planning and development, rating our risk and determining our premium rates. However, we will not use your genetic information for underwriting purposes.
  - Reviewing the competence, qualifications, or performance of our network providers, and conducting training programs, accreditation, certification, licensing, credentialing and other quality assessment and improvement activities.
- **Business Associates:** We may share your information with others who help us conduct our business operations, provided they agree to keep your information confidential.

Other Ways We Use or Share Information

We may also use and share your information for the following other purposes:

- We may use or share your information with the employer or other health-plan sponsor through which you receive your health benefits. We will not share individually identifiable health information with your benefits plan unless they promise to keep it protected and use it only for purposes relating to the administration of your health benefits.
- We may share your information with a health plan, provider, or health care clearinghouse that participates with us in an organized health care arrangement. We will only share your information for health care operations activities associated with that arrangement.
- We may share your information with another health plan that provides or has provided coverage to you for payment purposes. We may also share your information with another health plan, provider or health care clearinghouse that has or had a relationship with you for the purpose of quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, or detecting or preventing health care fraud and abuse.
- We may share your information with a family member, friend, or other person who is assisting you with your health care or payment for your health care. We may also share information about your location, general condition, or death to notify or help notify (including identifying and locating) a person involved with your care or to help with disaster-relief efforts. Before we

share this information, we will provide you with an opportunity to object. If you are not present, or in the event of your incapacity or an emergency, we will share your information based on our professional judgment of whether the disclosure would be in your best interest.

State and Federal Laws Allow Us to Share Information

There are also state and federal laws that allow or may require us to release your health information to others. We may share your information for the following reasons:

- We may report or share information with state and federal agencies that regulate the health care or health insurance system such as the U.S. Department of Health and Human Services, the New York State Department of Financial Services and the New York State Department of Health.
- We may share information for public health and safety purposes. For example, we may report information to the extent necessary to avert an imminent threat to your safety or the health or safety of others. We may report information to the appropriate authorities if we have reasonable belief that you might be a victim of abuse, neglect, domestic violence or other crimes.
- We may provide information to a court or administrative agency (for example, in response to a court order, search warrant, or subpoena).
- We may report information for certain law enforcement purposes. For example, we may give information to a law enforcement official for purposes of identifying or locating a suspect, fugitive, material witness or missing person.
- We may share information with a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also share information with funeral directors as necessary to carry out their duties.
- We may use or share information for procurement, banking or transplantation of organs, eyes or tissue.
- We may share information relative to specialized government functions, such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others, and to correctional institutions and in other law enforcement custodial situations.
- We may report information on job-related injuries because of requirements of your state worker compensation laws.
- Under certain circumstances, we may share information for purposes of research.

Sensitive Information

Certain types of especially sensitive health information, such as HIV-related, mental health and substance abuse treatment records, are subject to heightened protection under the law. If any state or federal law or regulation governing this type of sensitive information restricts us from using or sharing your information in any manner otherwise permitted under this Notice, we will follow the more restrictive law or regulation.

Your Authorization

If one of the preceding reasons does not apply, we must get your written authorization to use or disclose your health information. If you give us written authorization and change your mind, you may revoke your written authorization at any time, except to the extent we have already acted in reliance on your authorization. Once you give us authorization to release your health information, we cannot guarantee that the person to whom the information is provided will not re-disclose the information.

We have an authorization form that describes the purpose for which the information is to be used, the time period during which the authorization form will be in effect, and your right to revoke authorization at any time. The authorization form must be completed and signed by you or your duly authorized representative and returned to us before we will disclose any of your protected health information. You can obtain a copy of this form by calling the Customer Service telephone number on the back of your ID card or by visiting our Web site at **www.emblemhealth.com**.

Your Rights

The following are your rights with respect to the privacy of your health information. If you would like to exercise any of the following rights, please contact us by calling the Customer Service telephone number shown on the back of your ID card.

Restricting Your Information

- **You have the right to ask us to restrict** how we use or disclose your information for treatment, payment or health care operations. You also have the right to ask us to restrict information that we have been asked to give to family members or to others who are involved in your health care or payment for your health care. Please note that while we will try to honor your request, we are not required to agree to these restrictions.

Confidential Communications for Your Information

- **You have the right to ask to receive confidential communications** of information if you believe that you would be endangered if we send your information to your current mailing address (for example, in situations involving domestic disputes or violence). If you are a minor and have received health care services based on your own consent or in certain other circumstances, you also may have the right to request to receive confidential communications in certain circumstances, if permitted by state law. You can ask us to send the information to an alternative address or by alternative means, such as by fax. We may require that your request be in writing and you specify the alternative means or location, as well as the reason for your request. We will accommodate reasonable requests. Please be aware that the explanation of benefits statement(s) that the Plan issues to the contract holder or certificate holder may contain sufficient information to reveal that you obtained health care for which the Plan paid, even though you have asked that we communicate with you about your health care in confidence.

Inspecting Your Information

- **You have the right to inspect and obtain a copy** of information that we maintain about you in your designated record set. A “designated record set” is the group of records used by or for us to make benefit decisions about you. This can include enrollment, payment, claims and case or medical management records. We may require that your request be in writing. We may charge a fee for copying information or preparing a summary or explanation of the information and in certain situations, we may deny your request to inspect or obtain a copy of your information.

Amending Your Information

- **You have the right to ask us to amend** information we maintain about you in your designated record set. We may require that your request be in writing and that you provide a reason for your request. We may deny your request for an amendment if we did not create the information that you want amended and the originator remains available or for certain other reasons. If we deny your request, you may file a written statement of disagreement.

Accounting of Disclosures

- **You have the right to receive an accounting** of certain disclosures of your information made by us for purposes other than treatment, payment or health care operations during the six years prior to your request. We may require that your request be in writing. If you request such an accounting more than once in a 12-month period, we may charge a reasonable fee.

Please note that we are not required to provide an accounting of the following:
- Any information collected prior to April 14, 2003.
- Information disclosed or used for treatment, payment and health care operations purposes.
- Information disclosed to you or following your authorization.
- Information that is incidental to a use or disclosure otherwise permitted.
- Information disclosed to persons involved in your care or other notification purposes.
- Information disclosed for national security or intelligence purposes.
- Information disclosed to correctional institutions or law enforcement officials.
- Information that was disclosed or used as part of a limited data set for research, public health or health care operations purposes.

Collecting, Sharing and Safeguarding Your Financial Information

In addition to health information, the plan may collect and share other types of information about you. We may collect and share the following types of personal information:

- Name, address, telephone number and/or email address;
- Names, addresses, telephone numbers and/or email addresses of your spouse and dependents;
- Your social security number, age, gender and marital status;
- Social security numbers, age, gender and marital status of your spouse and dependents;
- Any information that we receive about you and your family from your applications or when we administer your policy, claim or account;
- If you purchase a group policy for your business, information to verify the existence, nature, location and size of your business.
- We also collect income and asset information from Medicaid, Child Health Plus, Family Health Plus and Healthy New York subscribers. We may also collect this information from Medicare subscribers to determine eligibility for government subsidized programs.

We may share this information with our affiliates and with business associates that perform services on our behalf. For example, we may share such information with vendors that print and mail member materials to you on our behalf and with entities that perform claims processing, medical review and other services on our behalf. These business associates must maintain the confidentiality of the information. We may also share such information when necessary to process transactions at your request and for certain other purposes permitted by law.

To the extent that such information may be or become part of your medical records, claims history or other health information, the information will be treated like health information as described in this notice.

As with health information, we use security safeguards and techniques designed to protect your personal information that we collect, use or disclose in writing, orally and electronically. We train our employees about our privacy policies and practices, and we limit access to your information to only those

employees who need it in order to perform their business responsibilities. We do not sell information about our customers or former customers.

Exercising Your Rights, Complaints and Questions

- **You have the right to receive a paper copy of this notice upon request at any time**. You can also view a copy of this notice on the Web site. See information at the end of this page. We must abide by the terms of this notice.
- **If you have any questions** or would like further information about this notice or about how we use or share information, you may write to the Corporate Compliance Department or call Customer Service. Please see the contact information on this page.
- **If you believe that we may have violated your privacy rights, you may file a complaint**.

We will take no action against you for filing a complaint. Call Customer Service at the telephone number and during the hours of operation listed on this page. You can also file a complaint by mail to the Corporate Compliance Department at the mailing address on this page. You may also notify the Secretary of the U.S. Department of Health and Human Services.

If we become aware that we or one of our business associates has experienced a breach of your personal information, as defined by federal and state laws, we will take action in accordance with applicable
laws, regulations and contracts. This may include notifying you and certain governmental, regulatory and media agencies about the breach.

Contact Information

Please check the back of your ID card to call us or use the following contact information for your plan. Read carefully to select the correct Customer Service number.

Write to:
Corporate Compliance Dept.
P.O. Box 2878
New York, NY 10116-2878

Call:
EmblemHealth program members: M-F, 8 am-6 pm, **1-877-842-3625**, TTY: **1-866-248-0640**
EmblemHealth Medicare members: M-Sun., 8 am-8 pm

PPO: **1-866-557-7300**, TTY: **1-866-248-0640**

HMO: **1-877-344-7364**, TTY: **1-866-248-0460**

PDP (City of NY Retirees): **1-800-624-2414**, TTY: **1-866-248-0640**

PDP (non-City of NY Retirees): **1-877-444-7241**, TTY: **1-866-248-0640**

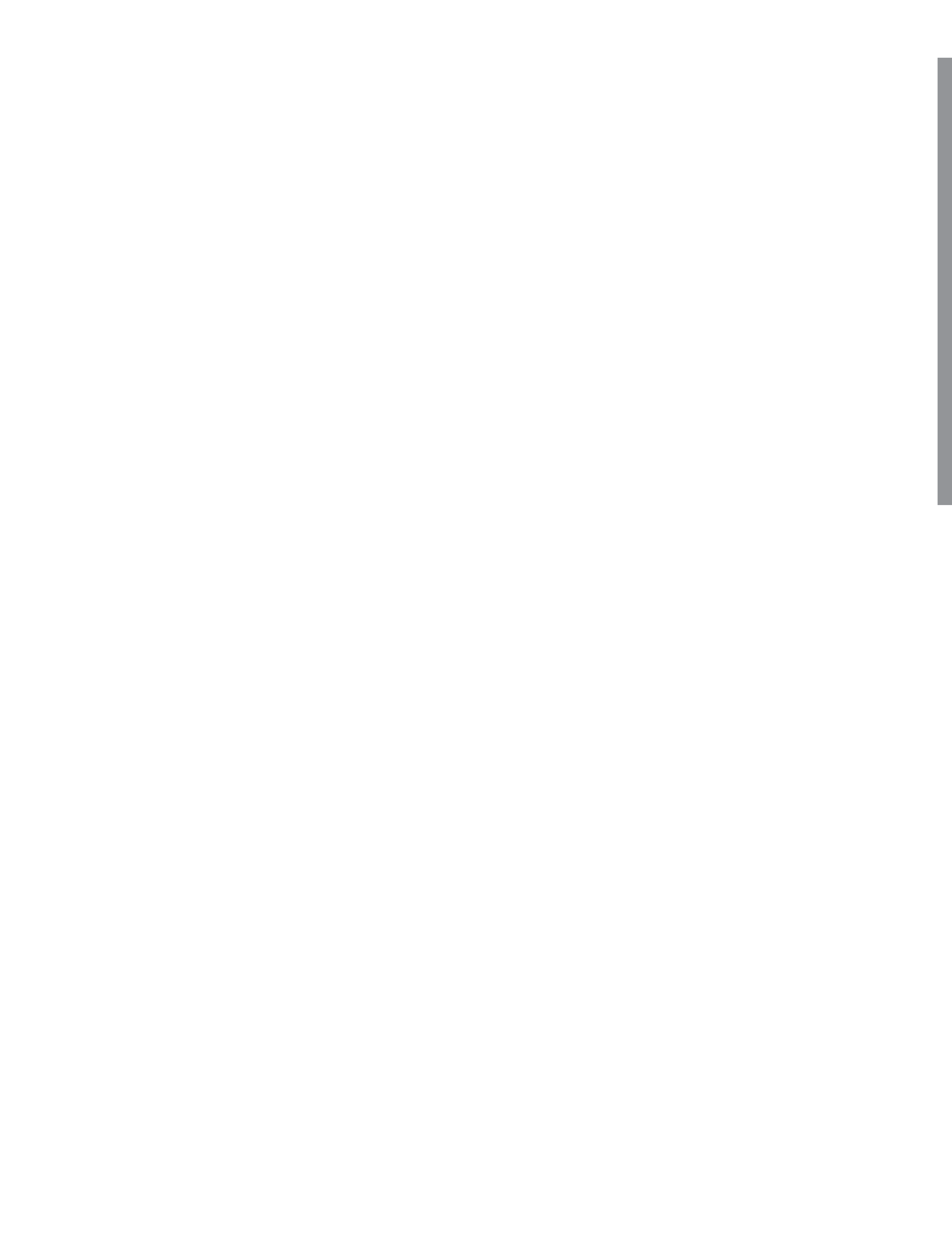
GHI members: M-F, 8 am-6 pm, **1-800-624-2414**, TTY: **1-866-248-0640**
GHI HMO members: M-F, 8 am-6 pm, **1-877-244-4466**, TTY: **1-877-208-7920**
HIP/HIPIC members: M-F, 8 am-8 pm, **1-800-447-8255**, TTY: **1-888-447-4833**

Personal Information After You Are No Longer Enrolled

Even after you are no longer enrolled in any plan, we may maintain your personal information as required by law or as necessary to carry out plan administration activities on your behalf. Our policies and procedures that safeguard that information against inappropriate use and disclosure still apply if you are no longer enrolled in the Plan.

Changes to this Notice

We are required to abide by the terms of this Notice of Privacy Practices as currently in effect.
We reserve the right to change the terms of the notice and to make the new notice effective for all the protected health information that we maintain. Prior to implementing any material changes to our privacy practices, we will promptly revise and distribute our notice to our customers. In addition, for the convenience of our members, the revised privacy notice will also be posted on our Web site: **www.emblemhealth.com**.



HEALTH CARE PROXY

HEALTH CARE PROXY

Appointing Your Health Care Agent In New York State

The New York Health Care Proxy Law allows you to appoint someone you trust — for example, a family member or close friend — to make health care decisions for you if you lose the ability to make decisions yourself. By appointing a health care agent, you can make sure that health care providers follow your wishes. Your agent can also decide how your wishes apply as your medical condition changes. Hospitals, doctors and other health care providers must follow your agent's decisions as if they were your own. You may give the person you select as your health care agent as little or as much authority as you wish. You may allow your agent to make all health care decisions or only certain ones. You may also give your agent instructions that he or she has to follow. This form can also be used to document your wishes or instructions with regard to organ and/or tissue donation.

About The Health Care Proxy Form

This is an important legal document. Before signing, you should understand the following facts:

1. This form gives the person you choose as your agent the authority to make all health care decisions for you, including the decision to remove or provide life-sustaining treatment, unless you say otherwise in this form. "Health care" means any treatment, service or procedure to diagnose or treat your physical or mental condition.
2. Unless your agent reasonably knows your wishes about artificial nutrition and hydration (nourishment and water provided by a feeding tube or intravenous line), he or she will not be allowed to refuse or consent to those measures for you.
3. Your agent will start making decisions for you when your doctor determines that you are not able to make health care decisions for yourself.
4. You may write on this form examples of the types of treatments that you would not desire and/or those treatments that you want to make sure you receive. The instructions may be used to limit the decision-making power of the agent. Your agent must follow your instructions when making decisions for you.
5. You do not need a lawyer to fill out this form.
6. You may choose any adult (18 years of age or older), including a family member or close friend, to be your agent. If you select a doctor as your agent, he or she will have to choose between acting as your agent or as your attending doctor, because a doctor cannot do both at the same time. Also, if you are a patient or resident of a hospital, nursing home or mental hygiene facility, there are special restrictions about naming someone who works for that facility as your agent. Ask staff at the facility to explain those restrictions.
7. Before appointing someone as your health care agent, discuss it with him or her to make sure that he or she is willing to act as your agent. Tell the person you choose that he or she will be your health care agent. Discuss your health care wishes and this form with your agent. Be sure to give him or her a signed copy. Your agent cannot be sued for health care decisions made in good faith.
8. If you have named your spouse as your health care agent and you later become divorced or legally separated, your former spouse will no longer be your agent by law, unless you state otherwise. If you would like your former spouse to remain your agent, you may note this on your current form and date it or complete a new form naming your former spouse.

9. Even though you have signed this form, you have the right to make health care decisions for yourself as long as you are able to do so, and treatment cannot be given to you or stopped if you object, nor will your agent have any power to object.
10. You may cancel the authority given to your agent by telling him or her or your health care provider orally or in writing.
11. Appointing a health care agent is voluntary. No one can require you to appoint one.
12. You may express your wishes or instructions regarding organ and/or tissue donation on the form, Why Should I Choose a Health Care Agent?

Frequently Asked Questions

Why Should I Choose a Health Care Agent?

If you become unable, even temporarily, to make health care decisions, someone else must decide for you. Health care providers often look to family members for guidance. Family members may express what they think your wishes are related to a particular treatment. However, in New York State, only a health care agent you appoint has the legal authority to make treatment decisions if you are unable to decide for yourself. Appointing an agent lets you control your medical treatment by:

- Allowing your agent to make health care decisions on your behalf as you would want them decided.
- Choosing one person to make health care decisions because you think that person would make the best decisions.
- Choosing one person to avoid conflict or confusion among family members and/or significant others.

You may also appoint an alternate agent to take over if your first choice cannot make decisions for you.

Who Can Be A Health Care Agent?

Anyone 18 years of age or older can be a health care agent. The person you are appointing as your agent or your alternate agent cannot sign as a witness on your Health Care Proxy form.

How Do I Appoint A Health Care Agent?

All competent adults, 18 years of age or older, can appoint a health care agent by signing a form called a Health Care Proxy. You don't need a lawyer or a notary, just two adult witnesses. Your agent cannot sign as a witness. You can use the form printed here, but you don't have to use this form.

When Would My Health Care Agent Begin To Make Health Care Decisions For Me?

Your health care agent would begin to make health care decisions after your doctor decides that you are not able to make your own health care decisions. As long as you are able to make health care decisions for yourself, you will have the right to do so.

What Decisions Can My Health Care Agent Make?

Unless you limit your health care agent's authority, your agent will be able to make any health care decision that you could have made if you were able to decide for yourself. Your agent can agree that you should receive treatment, choose among different treatments and decide that treatments should not be provided, in accordance with your wishes and interests. However, your agent can only make decisions about artificial nutrition and hydration (nourishment and water provided by feeding tube or

intravenous line) if he or she knows your wishes from what you have said or what you have written. The Health Care Proxy form does not give your agent the power to make non-health care decisions for you, such as financial decisions.

Why Do I Need To Appoint A Health Care Agent If I'm Young And Healthy?

Appointing a health care agent is a good idea even though you are not elderly or terminally ill. A health care agent can act on your behalf if you become even temporarily unable to make your own health care decisions (such as might occur if you are under general anesthesia or have become comatose because of an accident). When you again become able to make your own health care decisions, your health care agent will no longer be authorized to act.

How Will My Health Care Agent Make Decisions?

Your agent must follow your wishes, as well as your moral and religious beliefs. You may write instructions on your Health Care Proxy form or simply discuss them with your agent.

How Will My Health Care Agent Know My Wishes?

Having an open and frank discussion about your wishes with your health care agent will put him or her in a better position to serve your interests. If your agent does not know your wishes or beliefs, your agent is legally required to act in your best interest. Because this is a major responsibility for the person you appoint as your health care agent, you should have a discussion with the person about what types of treatments you would or would not want under different types of circumstances, such as:

- Whether you would want life support initiated/continued or removed if you are in a permanent coma.
- Whether you would want treatments initiated/continued or removed if you have a terminal illness.
- Whether you would want artificial nutrition and hydration initiated/withheld, continued or withdrawn, and under what types of circumstances.

Can My Health Care Agent Overrule My Wishes Or Prior Treatment Instructions?

No. Your agent is obligated to make decisions based on your wishes. If you clearly expressed particular wishes, or gave particular treatment instructions, your agent has a duty to follow those wishes or instructions unless he or she has a good faith basis for believing that your wishes changed or do not apply to the circumstances.

Who Will Pay Attention To my Agent?

All hospitals, nursing homes, doctors and other health care providers are legally required to provide your health care agent with the same information that would be provided to you and to honor the decisions by your agent as if they were made by you. If a hospital or nursing home objects to some treatment options (such as removing certain treatment), they must tell you or your agent, **BEFORE OR UPON** admission, if reasonably possible.

What If My Health Care Agent Is Not Available When Decisions Must Be Made?

You may appoint an alternate agent to decide for you if your health care agent is unavailable, unable or unwilling to act when decisions must be made. Otherwise, health care providers will make health care decisions for you that follow instructions you gave while you were still able to do so. Any instructions that you write on your Health Care Proxy form will guide health care providers under these circumstances.

What If I Change My Mind?

It is easy to cancel your Health Care Proxy, to change the person you have chosen as your health care agent or to change any instructions or limitations you have included on the form. Simply fill out a new form. In addition, you may indicate that your Health Care Proxy expires on a specified date or if certain events occur. Otherwise, the Health Care Proxy will be valid indefinitely. If you choose your spouse as your health care agent or as your alternate, and you get divorced or legally separated, the appointment is automatically cancelled. However, if you would like your former spouse to remain your agent, you may note this on your current form and date it or complete a new form naming your former spouse.

Can My Health Care Agent Be Legally Liable For Decisions Made On My Behalf?

No. Your health care agent will not be liable for health care decisions made in good faith on your behalf. Also, he or she cannot be held liable for costs of your care just because he or she is your agent.

Is A Health Care Proxy The Same As A Living will?

No. A living will is a document that provides specific instructions about health care decisions. You may put such instructions on your Health Care Proxy form. The Health Care Proxy allows you to choose someone you trust to make health care decisions on your behalf. Unlike a living will, a Health Care Proxy does not require that you know in advance all the decisions that may arise.

Instead, your health care agent can interpret your wishes as medical circumstances change and can make decisions you could not have known would have to be made.

Where Should I Keep My Health Care Proxy Form After It Is Signed?

Give a copy to your agent, your doctor, your attorney and any other family members or close friends you want. Keep a copy in your wallet or purse, or with other important papers, but not in a location where no one can access it, like a safe deposit box. Bring a copy if you are admitted to the hospital, even for minor surgery, or if you undergo outpatient surgery. *Please do not send your Health Care Proxy to HIP.*

May I Use The Health Care Proxy Form To Express My Wishes About Organ And/Or Tissue Donation?

Yes. Use the optional organ and tissue donation section on the Health Care Proxy form and be sure to have the section witnessed by two people. You may specify that your organs and/or tissues be used for transplantation, research or educational purposes. Any limitation(s) associated with your wishes should be noted in this section of the proxy.

Failure to include your wishes and instructions on your Health Care Proxy form will not be taken to mean that you do not want to be an organ and/or tissue donor.

Can My Health Care Agent Make Decisions For Me About Organ And/Or Tissue Donation?

No. The power of a health care agent to make health care decisions on your behalf ends upon your death. Noting your wishes on your Health Care Proxy form allows you to clearly state your wishes about organ and tissue donation.

Who Can Consent To A Donation If I Choose Not To State My Wishes At This Time?

It is important to note your wishes about organ and/or tissue donation so that family members who will be approached about donation are aware of your wishes. However, New York law provides a list of individuals who are authorized to consent to organ and/or tissue donation on your behalf. They are listed in order of priority: your spouse, a son or daughter 18 years of age or older, either of your parents, a brother or sister 18 years of age or older, a guardian appointed by a court prior to the donor's death or any other legally authorized person.

Health Care Proxy Form Instructions

Item (1)

Write the name, home address and telephone number of the person you are selecting as your agent.

Item (2)

If you want to appoint an alternate agent, write the name, home address and telephone number of the person you are selecting as your alternate agent.

Item (3)

Your Health Care Proxy will remain valid indefinitely unless you set an expiration date or condition for its expiration. This section is optional and should be filled in only if you want your Health Care Proxy to expire.

Item (4)

If you have special instructions for your agent, write them here. Also, if you wish to limit your agent's authority in any way, you may say so here, or discuss them with your health care agent. If you do not state any limitations, your agent will be allowed to make all health care decisions that you could have made, including the decision to consent to or refuse life-sustaining treatment.

If you want to give your agent broad authority, you may do so right on the form. Simply write: *I have discussed my wishes with my health care agent and alternate and they know my wishes, including those about artificial nutrition and hydration.*

If you wish to make more specific instructions, you could say: If I become terminally ill, I do/do not want to receive the following types of treatments: ... If I am in a coma or have little conscious understanding, with no hope of recovery, then I do/do not want the following types of treatments: ... If I have brain damage or a brain disease that makes me unable to recognize people or speak and there is no hope that my condition will improve, I do/do not want the following types of treatments: ... I have discussed with my agent my wishes about ____________ and I want my agent to make all decisions about these measures.

Examples of medical treatments about which you may wish to give your agent special instructions are listed below. This is not a complete list:

- Artificial respiration.
- Artificial nutrition and hydration (nourishment and water provided by feeding tube).
- Cardiopulmonary resuscitation (CPR).
- Antipsychotic medication.
- Electric shock therapy.
- Antibiotics.
- Surgical procedures.
- Dialysis.
- Transplantation.
- Blood transfusions.
- Abortion.
- Sterilization.

Item (5)

You must date and sign this Health Care Proxy form. If you are unable to sign yourself, you may direct someone else to sign in your presence. Be sure to include your address.

Item (6)

You may state wishes or instructions about organ and/or tissue donation on this form. A health care agent cannot make a decision about organ and/or tissue donation because the agent's authority ends upon your death. The law does provide for certain individuals, in order of priority, to consent to an organ and/or tissue donation on your behalf: your spouse, a son or daughter 18 years of age or older, either of your parents, a brother or sister 18 years of age or older, a guardian appointed by a court prior to the donor's death or any other legally authorized person.

Item (7)

Two witnesses 18 years of age or older must sign this Health Care Proxy form. The person who is appointed your agent or alternate agent cannot sign as a witness.

Health Care Proxy

(1) I, ______________________________

hereby appoint ______________________________

(name, home address and telephone number)

____

____

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise. This proxy will take effect when and if I become unable to make my own health care decisions.

(2) **Optional:** Alternate Agent. If the person I appoint is unable, unwilling or unavailable to act as my health care agent, I appoint

____

(name, home address and telephone number)

____

____

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise.

(3) Unless I revoke it or state an expiration date or circumstances under which it will expire, this proxy shall remain in effect indefinitely. (*Optional: If you want this proxy to expire, state the date or conditions here*.) This proxy shall expire (*specify date or conditions*):

____

____

____

(4) **Optional:** I direct my health care agent to make health care decisions according to my wishes and limitations, as he or she knows or as stated below. (*If you want to limit your agent's authority to make health care decisions for you or to give specific instructions, you may state your wishes or limitations here.*) I direct my health care agent to make health care decisions in accordance with the following limitations and/or instructions (attach additional pages as necessary):

____

____

73

(5) **Your Identification (Please Print):**

Your Name: ______________________

Your Signature: ______________________

Date: ______________________

Your Address: ______________________

(6) **Optional: Organ And/Or Tissue Donation.**

I hereby make an anatomical gift, to be effective upon my death, of: (check any that apply)

❑ Any needed organs and/or tissues

❑ The following organs and/or tissues

____

____

❑ Limitations

____

If you do not state your wishes or instructions about organ and/or tissue donation on this form, it will not be taken to mean that you do not wish to make a donation or prevent a person, who is otherwise authorized by law, to consent to a donation on your behalf.

Your Signature: ______________________

Date: ______________________

(7) **Statement By Witnesses:** (*Witnesses must be 18 years of age or older and cannot be the health care agent or alternate.*)

I declare that the person who signed this document is personally known to me and appears to be of sound mind and acting of his or her own free will. He or she signed (or asked another to sign for him or her) this document in my presence.

PRIVATE	
Date	Date
Name of Witness 1 (print)	Name of Witness 1 (print)
Signature	Signature
Address	Address

ADVANCE DIRECTIVES

ADVANCE DIRECTIVES

There may come a time when you can't decide about your own health care. By planning in advance, you can arrange now for your wishes to be carried out. Planning should include:

- Telling family, friends and your doctor what kinds of treatment you do or don't want.
- Appointing an adult you trust to make decisions for you.
- Putting your thoughts in writing.

The Health Care Proxy can help. With the Health Care Proxy, you name another adult you trust (usually a friend or a family member) to decide about medical care for you if you're not able to do so. If you decide to use a Health Care Proxy, talk with the person you pick so he or she knows what you want. A Health Care Proxy form is included in your Welcome Kit. You don't have to use a lawyer, but you may wish to speak with one about this. You can change your mind and this form at any time. We can help you understand the form or to get another form. It doesn't change your right to quality health care benefits. The only purpose is to let others know what you want if you can't speak for yourself.

A Do Not Resuscitate Order can help. You also have the right to decide if you want any special or emergency treatment to restart your heart or lungs if your breathing or circulation stops. If you don't want special treatment, such as cardiopulmonary resuscitation (called CPR for short), you should make your wishes known in writing. Your PCP will give you a "Do Not Resuscitate (DNR) Order" for your medical records. You can also get a copy to carry with you.

An Organ Donor Card. An Organ Donor Card is a wallet-sized card that says you are willing to donate parts of your body to help others when you die. Also, check the back of your driver's license to let others know if and how you want to donate your organs.

55 Water Street, New York, New York 10041-8190 | www.emblemhealth.com

EmblemHealth®

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