HIP CHILD HEALTH PLUS

Guide To Your Benefits and Services

EmblemHealth®

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FOR MORE INFORMATION ABOUT YOUR COVERAGE, VISIT
WWW.EMBLEMHEALTH.COM.

INTRODUCTION

This is your child's Member Handbook. It explains your child's coverage and how you can help make it work for your child. It is not your child's Subscriber Contract. The Subscriber Contract defines your child's benefits as well as the terms, conditions, limitations and exclusions applied to your child's coverage. Please refer to your child's Subscriber Contract when you have questions about your child's benefits.

Este es su Manual del Miembro. Explica su cobertura HIP y cómo podrá aprovecharla al máximo. No es su Constancia de Cobertura. Su Constancia de Cobertura define sus beneficios, así como los términos, condiciones y exclusiones aplicables a su cobertura Refiérase a su Constancia de Cobertura cuando tiene preguntas acerca de sus beneficios. Si necesita una copia de este Manual del Miembro en español, llame al **1-800-447-8255**.

WELCOME

Your child is now a member of the HIP Child Health Plus (CHPlus). Thank you for choosing HIP, an EmblemHealth company, for their health plan! As a member of our plan, your child enjoys many special advantages and several important choices.

As a member of our plan, you will choose your child's personal physician from the plan's network of network physicians. That physician is called a primary care physician, or PCP. You may choose a PCP who practices independently in a private office or a PCP at a conveniently located physician group practice. Either way, your child's PCP provides or arranges all of your child's care. If you have more than one child enrolled in our plan, you may select the same PCP or a different PCP for each of your children.

You can learn more about what we have to offer by logging on to our Web site at **www.emblemhealth.com**. If you don't have access to the Internet at home, many local public libraries can provide you with free Internet access. You can also call Customer Service; our Customer Service Representatives are ready to help you with answers to questions about your child's coverage and how to access our system. Just call **1-800-447-8255**, Monday through Friday, from 8 am to 6 pm. If you have a hearing or speech impairment, you can call **1-888-447-4833**, Monday through Friday, from 8:30 am to 5 pm.

Please remember to read your child's Subscriber Contract. The Subscriber Contract and your child's Member Handbook together will give you the information you need to completely understand our health care delivery system, our policies affecting your child's coverage and your child's benefits, terms, conditions, limitations and exclusions.

HIP going forward is referred to as "us," "our," "we," "your plan" and "our plan."

Some Important Definitions

As you read this handbook, you may find it helpful to know the definitions of the terms below.

Physician group practice— A medical group that manages many of your child's medical needs in the same office or building. Your child has access to PCPs and such key specialists as dermatologists, orthopedists, and ophthalmologists, as well as ancillary services such as laboratory and X-rays. Many physician group practices offer the convenience of scheduling same-day appointments. No referrals are required within the group. Please call one of the physician group practices to find out what types of medical services are available within the practice.

HMO benefits—Coverage for care that is provided by your child's network PCP or through referral by that doctor. When you receive HMO benefits, you have no out-of-pocket expenses.

Referred services—Care arranged for your child by the PCP prior to the services being rendered and/or approved in advance by the Care Management program. Referred services result in HMO benefits. PCPs usually make referrals to specialists they know and trust – usually other physicians within the

same physician group practice the PCP belongs to. Network PCPs in private practice most likely refer your child to specialists with whom they already have a working relationship.

Self-referred services—Care you seek for your child directly from a network provider or any other provider without a referral from your child's PCP. CHPlus plan members do not usually receive benefits when they are self-referred. There are certain exceptions for self referrals, which are spelled out in your child's Subscriber Contract.

SUMMARY OF BENEFITS

INPATIENT HOSPITAL CARE	
Semi-private room and board, as medically necessary	Covered in full
Surgeon and physician fees	Covered in full
Operating and recovery room fees	Covered in full
Intensive and special care units	Covered in full
General nursing care	Covered in full
Delivery and care of mother and baby	Covered in full
Well-baby and nursery care	Covered in full
X-rays, lab tests	Covered in full
Presurgical testing	Covered in full
Anesthesia	Covered in full
Prescribed drugs	Covered in full
Physical therapy and rehabilitation	Covered in full
Radiation therapy, chemotherapy	Covered in full
Hemodialysis	Covered in full
Alcohol and Substance Use Disorders & Rehabilitation and Mental Health	Covered in full
OUTPATIENT CARE	
Office visits, specialist visits, preventive care, physical exams, allergy tests and treatment, eye exams, immunizations, sick-child care, maternity care.	Covered in full
Well-baby and well-child care.	Covered in full
X-rays, lab tests, hearing evaluations, nutrition counseling.	Covered in full
Ambulatory surgery.	Covered in full
Alcohol and Substance Use Disorders	Covered in full
EMERGENCY CARE	
Emergency room care, doctor and specialist care.	Covered in full
HOME HEALTH CARE	
Home Health Care	Covered in full
DIABETIC EDUCATION AND MANAGEMENT	
Including insulin, supplies and equipment.	Covered in full
PRESCRIPTION DRUGS	
Prescription drugs and Over the Counter drugs prescribed by a doctor.	Covered in full when prescribed by an affiliated physician and filled at a participating pharmacy.
DURABLE MEDICAL EQUIPMENT	
Wheelchairs, canes, crutches, walkers, commodes.	Covered in full

Services are covered when medically necessary and provided or arranged by your child's affiliated physician, except in case of treatment of an emergency condition.

This summary is provided for information only. It does not contain complete details of the plan, which are available only in the contract, and it does not constitute an agreement. General exclusions apply, which are: dental care, cosmetic surgery, custodial care, benefits covered by Worker's Compensation and No-Fault Auto Insurance.

Network physicians are those physicians with whom we contract to provide care to our members. They are not employees, agents, servants or representatives of our plan.

GETTING STARTED

Your Child's Identification Card

Your Child's ID card contains important information that your child will need to get medical care, wherever your child happens to be. Keep it safe and make sure that your child has it when he or she travels, in case of an emergency.

Keep your child's ID card handy, too, when calling a network provider for an appointment or Customer Service at **1-800-447-8255** for information and advice. That way you will be ready to provide the information you'll be asked to give. If you have more than one child enrolled in Child Health Plus, each of your covered children will receive his or her own ID card. Be sure each one knows how important the ID card is for receiving our benefits.

If one of your covered children did not receive an ID card, or if a card has been lost or stolen, please request a new one. If you have Internet access, you may log on to **www.emblemhealth.com** to request a card. Or, use the Interactive Voice Response (IVR) system by calling **1-800-447-8255** to make an automated card request. If you prefer, you may also speak with a Customer Service Representative by calling **1-800-447-8255**.

Please read the back of your child's ID card carefully for special mailing or telephone contacts. We work with several organizations affiliated with health care providers to perform certain administrative operations, such as claims processing or case management. In these cases, your child's contact information may differ. These are the contacts you should use.

Your Child's Primary Care Physician (PCP)

When you enroll your child (ren) in our plan, you must choose a network physician as your primary care physician (PCP). Children's PCPs are usually pediatricians.

Whomever you choose, your child's PCP is now your child's personal physician who will provide or arrange the care your child needs. Your child's PCP's name and telephone number appear on your child's ID card for easy reference.

Scheduling Your Child's First Visit

Call your child's PCP's office to schedule an introductory visit. This visit will help you establish a relationship with your child's PCP. When you go for your appointment, the PCP will ask about your child's health history and start a confidential medical record. If you changed your child's PCP it is important for you to ask your child's former physician to send your child's previous medical records to your child's new PCP's office. If at all possible, the records should be there before your child's first visit.

Scheduling Other Appointments

To continue receiving primary care for your child, just call your child's PCP's office for appointments when you need them. When you call, be ready to explain why you want your child to see the doctor. Being clear about the reason will help the office schedule your child's appointment appropriately.

Changing Your Child's PCP

If you wish to change your child's PCP or if your child's PCP stops participation with our plan, you may choose another PCP by following these simple instructions:

- First, choose a PCP who is accepting new patients. If a doctor is not currently accepting new patients, the listing will be footnoted to that effect. You can find our network provider list on our Web site, **www.emblemhealth.com**. More information about physicians is available from the State of New York. You can call **1-888-338-6999** or visit their Web site at **http://www.nydoctorprofile.com**
- Next, you may select your child's PCP and also update your selection using **www.emblemhealth.com**. You can also call **1-800-447-8255** and select a PCP by using our Interactive Voice Response (IVR) system. If you prefer, a Customer Service Representative can help you when you call.

Once you have completed this process, you should receive your child's new ID card in the mail within seven to ten business days.

SEEING A SPECIALIST

With A Referral From Your Child's PCP

While your child's PCP will provide your child with much of the care your child needs, there may be times when the PCP will refer your child to a specialist. Your child will receive such a referral whenever the PCP believes your child's medical issue requires the attention of a physician who is specially-trained in that area.

You can expect that your child's PCP will refer your child to specialists he or she knows and trusts. Usually these are other physicians within the same physician group practice to which the PCP belongs. For example:

- A PCP practicing in a physician group practice will generally refer your child to specialists within that medical group office or another medical group office run by the same group of doctors.
- A PCP who participates with our plan through an Independent Practice Association (IPA) or Integrated Health System (IHS) will usually refer your child to specialists within the same IPA or IHS.
- A PCP who participates independently with our plan will also tend to refer your child to specialists with whom the PCP works regularly.

Here are the steps involved in receiving referred care from a network specialist:

1) Call your child's PCP for an appointment.
2) After your child's physical examination, if your child's PCP feels it is necessary, he or she will provide your child with a written referral or create an electronic referral for your child to see a specialist.
3) Call the specialist to schedule an appointment.

If you prefer for your child to obtain services from a network specialist other than the one recommended by your child's PCP, you may choose another specialist from your child's provider network. Call **1-800-447-8255**, Monday through Friday, from 8 am to 6 pm, and we will help you select the most appropriate specialist for your child's needs.

Note: In some unique situations, your child's PCP might want to refer your child to an out-of-network specialist. The PCP must call us, prior to any visit or service provided by the out-of-network specialist, to get our approval. **If we approve the referral, you will receive CHPlus coverage when you obtain services from the out-of-network specialist**.

When your child's PCP refers your child to a network physician or we approve your child's referral to an out-of-network physician, your child will receive CHPlus benefits. This means you will have no out-of-pocket expenses.

To change your child's specialist, simply call your child's PCP. Your child's PCP can refer your child to another network specialist (or, if necessary, to an out-of-network specialist approved by us).

Without A Referral

If your child has a medical problem and you choose to go directly to a specialist without first getting a referral from your child's PCP, your child will not receive CHPlus benefits for those services. **In most instances, you must pay the specialist directly, whether that specialist is a network physician or not**.

In some cases, however, you don't need a referral from your child's PCP and may self-refer your child within our network for certain services. You may schedule an appointment for your child with an network mental health provider for outpatient treatment of mental illness. You may also self-refer your child to a chiropractor, a network optometrist for refractive eye examinations and to a network ophthalmologist for diabetic eye examinations. Be sure to check your child's Subscriber Contract for complete information about when self-referrals are allowed.

Note: If you do not receive prior approval from us for out-of-network services, you will incur financial liability for the services received.

Special Situations

Standing Specialty Referrals and Specialists as Coordinators Of Care

If your child has a condition or disease that needs the ongoing care of a specialist, a standing referral to see that specialist can be arranged. A standing referral means that you can make an appointment with your child's specialist and your child may visit the specialist directly. Please refer to your child's Subscriber Contract for more information. The Subscriber Contract provides a detailed explanation of the standing specialty referral process.

Access to Specialty Care Centers

If your child has a life-threatening or degenerative and disabling disease or condition that requires special medical treatment for a prolonged period of time, your child may need to go to a center that specializes in the care for that particular condition. Specialty care centers are those centers designated by an agency of the state or federal government, or by a voluntary national health organization, as having expertise in the treatment of life-threatening or degenerative and disabling diseases or conditions. Your child's PCP may arrange treatment at a specialty care facility. Please refer to the Subscriber Contract for more information. The Subscriber Contract provides a detailed explanation of how to access specialty care centers.

Notice and Transitional Care When a Physician No Longer Participates in Our Network of Providers

We will provide you with written notice within 15 days of learning that your child's PCP will no longer be a network physician. You will then need to select a new PCP for your child. You may, however, request continuation of an ongoing course of treatment for a period of up to 90 days. The 90-day period begins when your child's PCP's contractual obligation to provide services to your child ends.

To receive transitional care for your child, you must notify Customer Service at **1-800-447-8255** prior to continuing care with the physician. Such care shall be approved by us, only if the physician:

- Continues to accept our rates of reimbursement for your child's care.
- Adheres to our quality assurance requirements and provides us with all necessary information related to your child's care.

- Adheres to all of our other administrative policies and procedures, including those about referrals and prior approval requirements.

Please refer to the Subscriber Contract for more information. The Subscriber Contract provides a detailed explanation of the transition process. If you choose to have your child continue to receive care from your child's current physician during this transitional period, you must notify the Pre Service Review Department at **1-866-447-9717**, **Option 4**, prior to continuing care with the physician. Such care shall be approved by us, only if the physician agrees to the conditions described above.

The above procedures shall not require us to provide coverage for care that is otherwise excluded due to a pre-existing condition limitation, is not medically necessary or conforms to any other exclusion or limitation contained in the Subscriber Contract.

Second Opinions

As a member of our plan, your child is entitled to two kinds of second opinions:

- A second opinion related to the diagnosis and treatment of cancer from an appropriate specialist that may or may not be a network physician.
- A second medical opinion from a network physician at any time, for any reason.

To obtain a second opinion, simply speak with your child's PCP. A referral from your child's PCP is required in both cases. Keep in mind that a second opinion consists only of a consultation. Any required treatment must be provided or arranged through a network physician.

Please refer to the Subscriber Contract for details concerning your child's second opinion benefits.

INFORMATION ABOUT YOUR CHILD'S COVERAGE

Understanding Your Child's CHPlus Coverage

The Child Health Plus Welcome Kit provides information designed to help you understand your child's coverage. Your child's Welcome Kit contains three major documents, the Member Handbook and the Subscriber Contract and the Schedule of Benefits. Please carefully read the information in your child's Welcome Kit.

The Member Handbook contains information on the special features of your child's coverage. The Member Handbook explains how you can make the most of your child's coverage.

In addition to the Member Handbook, your child's Welcome Kit contains the Subscriber Contract and Schedule of Benefits. The Subscriber Contract and Schedule of Benefits are legal documents that provide the most complete information about covered services and the terms, conditions, exclusions and limitations that apply to your child's coverage.

Note also that your child's benefit descriptions appear on our Web site at **www.emblemhealth.com.**

- **With a referral**—Your child may see either network or out-of-network physicians. Usually, however, your child will receive referrals to network physicians, unless the service you require is not available within the network. Also note that all referrals to out-of-network physicians must be approved in advance through us. Contacting us is the responsibility of your child's PCP.
- **Without a referral**—Services will not be covered (with a few exceptions) as part of your child's CHPlus benefits and you will be responsible for the cost.

Should your child's network provider become an out-of-network provider for any reason (other than for reasons relating to imminent harm to patient care, a determination of fraud or a final disciplinary action by a state licensing board or governmental agency), we will allow your child to continue an ongoing course of treatment with this provider for up to 90 days from the date the provider's contract ends. If your child is in her second trimester of pregnancy, the transitional period will include post-partum care directly related to the child's delivery.

If You Need to File Claims for Your Child's Benefits

With CHPlus benefits, you rarely need to file claims. But sometimes you may need to pay a provider's bill and then submit a claim for reimbursement. This might occur, for example, if your child receives emergency care when your child is outside of our service area.

To submit a claim, consult your child's PCP or call Customer Service at **1-800-447-8255** to ask for a claim form. Submit a paid itemized bill for the services your child received, along with the completed claim form, to the address on the back of your child's ID card.

Please read the back of your child's ID card carefully for special mailing or telephone contacts for claims processing.

We work with several organizations affiliated with providers to handle certain operations, such as claims processing. In these cases, your contact information may differ. These are the contacts you should use to mail your claim form and bill.

You'll be reimbursed as long as the service for which you are submitting a claim meets the terms of your child's CHPlus Subscriber Contract.

Coordination of Benefits

Some members also receive benefits from another health plan – for example, it may be a plan in which a spouse is insured. If that is true, in your child's case, please be sure that all claims are filed first with your child's primary insurer — the insurer with whom your child has a Subscriber Contract. If the reimbursement you receive is less than the full charge for the service you are claiming, you can then submit a claim to a secondary insurer — the insurer that covers your child as a dependent of the person who has the Contract with that plan. Please check your child's Subscriber Contract for details on how Coordination of Benefits (COB) works.

Premiums

You must pay all Child Health Plus premiums in advance. If you are responsible for paying a premium for your child's coverage, rest assured that we will make every effort to keep costs as affordable as possible.

Special note: We will notify you in writing of any change in premiums at least 30 days before the new premiums go into effect. All premiums are due and payable in advance. Except for the first premium, we allow a 30-day grace period in which to pay. If the premium is paid within this grace period, you will be covered for the period of the payment. If your income has significantly changed, you may request a review of your premium contribution. You must submit proof of current family income (must be for an entire month and dated within one month of your request). You will be informed of the result of the review. In some cases, you may still need to pay a family contribution. Also understand that if you do not pay your current family contribution during the review period, your child will be disenrolled for non payment of premium.

PRESCRIPTION DRUG COVERAGE

Prescription Drug Coverage

Details on your child's prescription drug coverage are in your child's prescription drug rider.

Note: Child Health Plus members are covered for certain over-the-counter drugs. Please refer to your child's Subscriber Contract for more information.

Our Formulary

Our prescription drug coverage is usually for prescription drugs that are listed in the Formulary (list of preferred drugs) and are filled at a network retail or home delivery pharmacy.

The Formulary is a continually updated list of prescription drugs that our network physicians and other experts have approved for disease treatment and preservation of our members' health. The primary purpose of the formulary is to promote the use of safe, effective and affordable drugs and treatments while maintaining and promoting quality patient care.

Please Note: Some preferred drugs may be excluded from your child's coverage. Please refer to the prescription drug rider and/or Subscriber Contract to find out which drugs are excluded from your child's coverage.

When your child's doctor wants to prescribe a drug that is not on our Formulary, he or she must call Pharmacy Services Clinical department at **1-877-444-3657** to obtain prior approval. There is a phone line dedicated for this purpose.

Our network physicians receive regular communications about changes to the Formulary. If you have access to the Internet, you can log on to our Web site at **www.emblemhealth.com** and go to Visit the Pharmacy Center to check the formulary status of a drug. If you don't have access to the Internet at home, many local public libraries can provide you with free Internet access. You can also call Customer Service at **1-800-447-8255**.

Helpful Definitions

These definitions may help you understand your child's drug coverage.

Brand-Name Medication — A brand-name medication is the first version of a particular drug marketed by a specific drug company.

Formulary — The formulary is a list of preferred prescription drugs — including both brand name and generic — that are covered under our prescription drug benefit.

Preferred Medication — A preferred medication is one that is listed on our formulary. Depending on the prescription benefit, members are covered for preferred items minus any applicable coinsurance, copayment and/or deductible.

Generic Medication — When the patent on a specific brand name drug expires, a generic version can be marketed, with FDA approval, usually at a much lower price. The FDA regulates generic drugs with the same strict standards used for brand-name drugs. Generic drugs have different ratings. "A"-rated generics are deemed as safe and efficacious as their brand counterparts. Our formulary has only "A"-rated generic drugs.

Maintenance Medication — We have a list of drugs that are considered maintenance medications. These medications are used in the treatment of chronic "lifelong" conditions. Members on approved maintenance medications can receive up to a 90-day supply of medication. Many drugs, although they may be used to treat chronic conditions, are not covered as maintenance medications due to issues of patient safety and the need for constant supervision.

Nonpreferred Medication — A nonpreferred medication is one that is not listed on our Formulary. A member may receive coverage for a non-preferred medication through a prior approval or a nonpreferred copayment. The specific coverage type is dependent upon the member's prescription drug benefit.

Brand-Name vs. Generic Drugs

Generic drugs help promote cost-effective health care. The Food and Drug Administration (FDA) requires that generic drugs meet the same quality standards as their equivalent brand name drugs. In some cases, brand medications will have more than one generic equivalent available. Our corporate and contracted pharmacies will dispense a covered generic equivalent when available and allowed by law.

Filling Your Prescriptions at Network Pharmacies

You can fill your child's prescriptions (issued by a network physician) by visiting one of our more than 60,000 network pharmacies nationwide. Some physician group practices also have on-site pharmacies for your convenience.

When traveling, you may bring a prescription drug bottle from your local pharmacy to any network pharmacy nationwide. The bottle contains all the information needed by pharmacists to arrange the transfer of a prescription filled from the original pharmacy. (All state, federal and plan limitations will apply — e.g., on the number of refills allowed and any early refill limitations.) If a refill is available, a single telephone call by the pharmacist can complete the transfer. The processing time would then be the same as with any other prescription.

Always remember to present your child's ID card when filling your child's prescriptions. Please check the Prescription Drug Coverage Rider in your child's Subscriber Contract for specific details.

Filling Your Prescription through the Internet and Home Delivery Program

We work with Express Scripts, Inc. (ESI) one of the leading Internet and home delivery pharmacies. You may obtain up to a 90-day supply of an approved medication through ESI. Since prescription drug delivery takes 14 business days through ESI Internet/Home Delivery Pharmacy, we recommend

that you have your doctor complete two prescriptions. For new prescriptions, fill the prescription right away at your local participating pharmacy. Submit the second prescription to ESI in enough time to allow for processing before your initial prescription runs out.

Depending on your benefit, your copayments (if any) may be reduced by using the ESI Internet/ Home Delivery Pharmacy. Plus, your medication is shipped right to your home. Reductions in copayments, however, only apply to formulary brand and generic medications.

Ordering Home Delivery Forms

You may obtain mail order forms in one of two ways:

- Call ESI Member Services toll free at **1-877-866-5798** 24 hours a day, seven days a week. If you have a hearing or speech impairment and use a TDD, call **1-800-899-2114**. You can also go to **www.StartHomeDelivery.com** to get started.
- Call Customer Service at **1-800-447-8255**, Monday through Friday, 8 am to 6 pm. If you have a hearing or speech impairment and use a TDD, call **1-888-447-4833**, Monday through Friday, 8:30 am to 5 pm.

Prescription Refills

Ordering prescription refills is easy and can be done by using any of the three options below.

- Online —Sign in to **www.emblemhealth.com** and click Home Delivery. Prescription refills will be displayed. Simply select the items you want to order, and follow the on-screen instructions to complete the request.
- Phone — Call **1-877-866-5798** to request a refill.
- Mail — Use the refill order form that will accompany your prescription. Mail it with your copayment to ESI in the return envelope.

Up-To-Date Formulary Listing

To review the most up-to-date formulary listing, first register as a member at our Web site **www.emblemhealth.com**. After you have successfully registered, just click on the Pharmacy Services icon and follow the step-by-step instructions.

Specialty Pharmacy Program

Members who use a specialty drug must have their prescriptions prescribed by a network physician and get their prescriptions filled at our Specialty Pharmacy. You cannot have a specialty drug filled at a retail pharmacy or through the home delivery pharmacy.

Specialty drugs are almost always injectable drugs used for conditions such as Multiple Sclerosis, growth deficiencies, fertility issues and Hepatitis C. For your convenience, some non-injectable drugs, such as Clomiphene citrate and Ribavarin, are also available through our Specialty Pharmacy.

The Specialty Pharmacy staff understands the complex needs of patients who use a specialty drug and are available 24 hours a day, 7 days a week. Additional benefits of using our Specialty Pharmacy include:

- **Home Delivery** — The pharmacy will fill your child's prescription and deliver your child's drugs directly to your home.
- **Direct Pharmacist and/or Nurse Access** — You will have access to experienced pharmacists and/or nurses who ensure that your child gets continual, prompt, personalized care while on treatments.

- **Educational Materials** — You will receive support and home instruction information.
- **Ancillary Supplies** — You will receive syringes, needles and other needed supplies at no cost.
- **Comprehensive Coordination of Care** — You will get refill reminders and a pharmacy consultation with your child's doctor regarding your child's medication(s).

Specialty drugs that are not in our Formulary may require that your child's physician obtain a Physician's Prior Approval (PPA). Please refer to the description of our Formulary and the PPA process.

All prescriptions must be submitted to our Specialty Pharmacy by fax at **1-866-364-2673** or phoned in by your physician. Any subsequent refills of an existing prescription, filled at a local pharmacy, must be transferred to our Specialty Pharmacy. For more information, you or your child's network physician can call our Specialty Pharmacy Services at **1-888-447-0295**.

Your child's network physician will know which prescriptions must be filled by the Specialty Pharmacy. If, however, you or your child's -network physician has any questions, please call Pharmacy Services at **1-888-447-0295**. If you have any questions regarding your child's benefits, please call Customer Service at **1-800-447-8255**.

Emblem Behavioral Health Services Program Coverage Information

Inpatient and outpatient mental health and substance use disorders care for Child Health Plus members is the same as for other inpatient and outpatient services. Check the schedule of benefits included in your child's Subscriber Contract for more information.

Your child does not need a referral from his/her PCP to obtain covered mental health services or alcohol or substance use disorders, detoxification and rehabilitation services. Your child also does not need to obtain prior approval for routine outpatient mental health or alcohol/substance use disorders when received from a network provider. Routine services include, but are not limited to, initial assessment, individual, group and family treatment and medication management. Call the Emblem Behavioral Health Services Program at **1-888-447-2526** for help in selecting a provider.

For other services, including inpatient treatment and any service provided by an out-of-network provider, prior approval is required. To obtain prior approval or to find out if a service requires prior approval, just call the Emblem Behavioral Health Services Program. When you call, you will be transferred to a trained professional who will assess your child's treatment and provide prior approval for your child if appropriate. All calls will be treated as confidential.

Note: If you receive services from an out-of-network provider, without prior approval, benefits will not be provided.

CHILD HEALTH PLUS DENTAL BENEFITS

Child Health Plus member coverage includes comprehensive preventive and specialty dental services.

Dental coverage includes the following services*:

- Routine exams
- X-rays
- Cleanings, fillings and tooth pulling
- Emergency treatment
- Replacement of missing teeth
- Root canals on a case-by-case basis when conditions meet coverage guidelines
- Crowns will not routinely be approved if restorative materials can restore the teeth.
- Fixed bridges are not covered.
- Orthodontic services are not covered.

*Note: For more detailed coverage information, refer to your Subscriber Contract.

Healthplex, a dental management organization, provides dental services through a network of participating dentists. Our members are automatically assigned to a participating dentist in the Healthplex network, upon enrollment. Members are generally assigned to the participating dentist closest to where they live. The name, address and telephone number of your child's assigned dentist is provided in your child's New Member Welcome Kit.

If you have questions about your child's dental coverage or would like to change your child's network dentist, call Healthplex at **1-800-468-9868**, Monday through Friday from 8 am to 6 pm.

Important Notes

Participating dentists may recommend that members receive additional services and procedures consistent with generally accepted dental practices. For example, a recent full mouth series of X-rays is required at the time of examination. Frequency of X-rays depends on your child's dentist's judgment in each individual case based upon many of factors. An examination and X-rays are required prior to a cleaning.

SPECIAL PROGRAMS

Positive Actions Toward Health (PATH) Program

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

- A welcome telephone call from a health coach.
- Mailings with the latest information on your child's condition, medicines, treatment and more.
- Follow-up calls from a health coach for one-on-one support, health education and help in getting services your child needs.
- Unlimited telephone contact with a health coach so you can discuss your questions or concerns when you want.

Asthma Program

Most people with asthma can learn to manage their condition. We offer eligible members diagnosed with asthma educational information, a peak flow meter and an *Asthma Action Plan* through our *Better Breathing* PATH program for asthma. This program is available for your enrolled child(ren) starting at age five. To find out more about our *Better Breathing* PATH program, call Customer Service at **1-800-447-8255**, Monday through Friday, from 8 am to 6 pm.

You should always bring a copy of your child's **Asthma Action Plan** to his or her next doctor's appointment. The *Asthma Action Plan*, which you develop with your doctor, shows you how to adjust your child's medicines depending on his or her symptoms and peak flow readings. School-aged children should take the *Asthma Action Plan* to their school nurse. This way, a copy is always available should your child have an asthma attack at school.

Find out more about Asthma.

You can learn more about asthma by visiting the following Web sites:

- The Centers for Disease Control and Prevention: **www.cdc.gov/**
- The National Heart Lung and Blood Institute: **www.nhlbi.nih.gov**

Once you are on the site of your choice, type "asthma" in the Search box.

Diabetes Program

If your child's doctor has told you that your child has diabetes, you know how important it is to manage your child's condition. From time to time, the Diabetes Care PATH program will send you letters encouraging you to take your child for important tests and examinations that will help him or her control his or her diabetes. These tests and examinations will confirm for you, your child and your child's doctor if your child's diabetes is under control. This program is available for your enrolled family members starting

at age twelve. 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 many diabetes related topics.

Healthy Beginnings PATH Program

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

- Get Health Risk Assessments (HRAs) that are shared with their prenatal care doctors.
- Get a prenatal book and other information about pregnancy. Educational materials also include information about the Women, Infant and Children (WIC) program, breastfeeding, HIV, and how to make healthy choices for the pregnant member and her baby.
- The pregnant member can have pregnancy newsletters emailed to her and have access to online pregnancy information.
- Have access to the 24 hour, 7 day a week "*BabyLine*" staffed by nurses. Members can call to ask questions about their pregnancies and newborn care and to ask for more educational material. No medical advice is given.
- Program nurses speak both English and Spanish. Educational materials are also available in both English and Spanish.
- The pregnant member may be able to receive help with transportation to and from her 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 about the *Healthy Beginnings* PATH program and help them to enroll. We will also tell members about other services available for pregnant members. The pregnant mom may apply for Medicaid. If so, we will ask the member's local Department of Social Services for a Medicaid Client Identification Number (CIN) so that the member's child can be enrolled in our plan as soon as he/she is born.

Lamaze Classes

We offer Lamaze classes to pregnant members 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* staff person.

Smoking Cessation

The Quit Smoking program is a comprehensive educational self-help behavior modification program that provides members 18 years and older who want to stop smoking with a comprehensive educational kit and support calls from a smoking cessation specialist. The program provides:

- Help developing a quit plan by phone from trained quit-smoking experts.
- Educational information tailored to the member's stage of readiness to quit.
- Follow-up report to the member's 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 additional free educational resources. You can also visit **www.emblemhealth.com** and click on Health & Wellness, Quit Smoking, for tips.

CARE MANAGEMENT

Introduction

Health care today is complicated. Sometimes it is difficult to understand all the treatment options available in every case. Sometimes it is difficult to be certain exactly what is covered and what is not - even though we provide detailed information to assure full disclosure and to facilitate understanding.

For these reasons, we have developed a series of special information, support and review programs, which are described in this section of your handbook. We have described them in detail, because we want you to understand exactly how we work to help you receive the most appropriate care in the most appropriate settings, and understand exactly what benefits are available to you.

We believe these programs support sound medical choices and optimal health outcomes. In the final analysis, however, it is up to you and your physician to make the final decisions about which health care choices are best for you. We, however, reserve the right to determine if the medical services provided are necessary and/or covered under your Certificate of Coverage.

Care Management Program (CMP)

Our Care Management Program (CMP) gives you important resources to help with the medical care decisions you and your physician must make. The CMP consists of these key utilization review components:

- Pre-service Review Program.
- Concurrent Care Review Program.
- Case Management Program.
- Retrospective Review Program.
- Technology Evaluation Program.

Utilization review will occur whenever we make decisions about medical necessity and the delivery of services or treatments.

As a managed care organization, we are dedicated to providing quality care and service to each of its members. The following policy statement is distributed to all network physicians and members:

Utilization Management (UM) decisions made by us are based solely on the appropriate level of care and proper medical setting. We doe not reward practitioners or other individuals conducting utilization review for issuing -denials of coverage for service or care. In addition, financial incentives provided to UM decision-makers do not encourage decisions that result in underutilization.

Furthermore, all our employees who make utilization-related decisions (and those who supervise them) are required to sign a document acknowledging that they have received the statement. This

includes Medical Directors, Care -Management Directors and Managers, licensed UM staff and other people and organizations who make UM decisions on behalf of us.

Pre-Service Review Program

Our Pre-service Review Program assists in making decisions about care or diagnostic services that members and their physicians anticipate they will need to receive in the near future. Therefore, we require members (or their physicians on their behalf) to contact the Pre-service Review to assure coverage of certain services.

Prior approval must be obtained from us for the services indicated below:

- Inpatient nonemergency procedures that provide acute, rehabilitation and skilled nursing care.
- All outpatient invasive surgical procedures and surgical treatments in a facility or doctor's office.
- Inpatient treatment of Mental Illness and Substance Use Disorder, Detoxification treatment of Substance Use Disorder, and Rehabilitation treatment of Substance Use Disorder.
- Nonroutine outpatient treatment of Mental Illness and Substance Use Disorder, which includes:
  – partial hospitalization;
  – intensive outpatient treatment;
  – ambulatory detoxification treatment;
  – outpatient ECT (electro-convulsive treatment);
  – neuropsychological testing; and
  – psychological testing.
- Nonemergent transportation.
- Home health care.
- Hospice care.
- Services obtained by non-participating providers with specialty expertise.
- Pre-transplant evaluation and transplant services.
- Outpatient cardiac and pulmonary rehabilitation.
- Outpatient Diagnostic Radiology Services.
- Outpatient Physical, Occupational and Speech Therapies.
- Radiation Oncology.
- Pain management.
- Sleep studies.
- Advanced molecular diagnostics and genetic testing.
- Hyperbaric Oxygen Therapy.
- Experimental and/or Investigational Treatment Procedures.

Generally, when you anticipate receiving these services, your NY Metro network physician will know to contact us for you. Always check with the doctor's office, however, to make sure that our Pre-service Program has been contacted.

Determinations, including written denial notification to you or your designee and your physician, are conducted within 15 days of the request for a utilization management determination. Once all required information is received, we have two business days to render a determination. The maximum time we will take to make a decision is 15 days from the date we receive your request. Notification of all determinations made by us will be made by telephone and in writing.

Contacting Pre-Service Review

Should you need to contact the Pre-service Review Department, just call **1-877-846-3625**. Representatives are available Monday through Friday from 9 am to 5 pm. If you call after those hours, and your call concerns an urgent or emergency admission, you will be prompted to leave a message, and a representative from Pre-service Review will call you or your doctor back, if necessary. If the Pre-service Review Department receives sufficient information, your case will be routed to the appropriate Concurrent Reviewer. If your call concerns an elective admission, you will be advised to call back the next business day when representatives are available. Please refer to your member ID card for the number to call.

The Pre-service Review Department may determine that coverage cannot be provided for a service for a number of reasons. In these instances, a determination may result in no approval being given and, instead, lead to the issuance of a denial, or adverse determination. *(See Care Management: Adverse Determinations.)* Prior to an adverse determination being issued, a physician from CMP will attempt to resolve any outstanding issues with your physician.

We may reverse a prior approval treatment, service or procedure retrospectively if:

(1) the relevant medical information presented to us is materially different from the information that was presented during the prior approval review; and (2) the relevant medical information presented to us upon the retrospective review existed at the time of the prior approval but was withheld from or not made available to us and (3) We where not aware of the existence of the information at the time of the prior approval review and (4) if We had been aware of this information, the treatment, service, or procedure being requested would have not been authorized.

Our Commitment to You For Timely Pre-Service Review Program Determinations And Notifications

Determinations for non-urgent claims – If we have all the information necessary to make a determination regarding a pre-service review, we will make a determination and provide notice to you (or your designee) and your provider, by telephone and in writing, within three business days of receipt of the request. If we need additional information, we will request it within three business days. You or your provider will then have forty-five (45) calendar days to submit the information. We will make a determination and provide notice to you (or your designee) and your provider, by telephone and in writing, within the earlier of three business days of our receipt of the information or, if we do not receive the information, within fifteen (15) calendar days of the end of the forty-five (45) day time period.

Determinations for urgent claims – If we have all information necessary to make a determination, we will make a determination and provide notice to you (or your designee) and your provider, by telephone and in writing, within twenty-four (24) hours of receipt of the request. If we need additional information, we will request it within twenty-four (24) hours. You or your provider will then have forty-eight (48) hours to submit the information. We will make a determination and provide notice to you and your provider by telephone and in writing within forty-eight (48) hours of the earlier of our receipt of the information or the end of the forty-eight (48)-hour time period. If we have approved a course of treatment, we will not reduce or terminate the approved services unless we have given you enough prior notice of the reduction or termination so that you can complete the appeal process before the services are reduced or terminated.

Concurrent Care Review Program

The Concurrent Care Review Program (CCP) facilitates the coordination and continuity of services rendered to a member when in a hospital or other facility. You are automatically entered into the program at the time you are admitted to the hospital.

CCP support begins within 24 hours of your admission to the facility. It's important for the program to start early in the facility, since typically as much as 80 percent of all hospital services are provided within the first 48 hours. When your admission is arranged through the Pre-service Review Program, the team knows in advance that you are being admitted to a facility. When your admission is an emergency, the hospital will usually contact the CCP within 24 hours for you.

Our Commitment To You For Timely Concurrent Review Program Determinations And Notifications

Utilization Review decisions for services during the course of care (concurrent reviews) will be made, and notice provided to you (or your designee) and your provider, by telephone and in writing, within one business day of receipt of all information necessary to make a decision. If we need additional information, we will request it within one business day. You or your provider will then have forty-five (45) calendar days to submit the information. We will make a determination and provide notice to you (or your designee) and your provider, by telephone and in writing, within the earlier of one business day of our receipt of the information or, if we do not receive the information, within fifteen (15) calendar days of the end of the forty-five (45) day time period.

If we receive a request for coverage of home health care services following an inpatient hospital admission, we will notify you or your designee and your provider of our decision by telephone and in writing within one business day of receipt of all necessary information; or, when the day subsequent to the request falls on a weekend or holiday, within 72 hours of receipt of all necessary information unless it is an urgent claim for which the urgent claim time frames are applicable.

When we receive a request for home health care services and all necessary information prior to your discharge from an inpatient hospital admission, we will not deny coverage for home health care services, either on the basis of medical necessity or for failure to obtain prior authorization, while our decision on the request is pending.

For concurrent reviews that involve urgent matters, we will make a determination and provide notice to you (or your designee) and your provider within twenty-four (24) hours of receipt of the request if the request for additional benefits is made at least twenty-four (24) hours prior to the end of the period to which benefits have been approved. Requests that are not made within this time period will be determined within the timeframes specified above for pre-service urgent claims.

If we have approved a course of treatment, we will not reduce or terminate the approved services unless we have given you enough prior notice of the reduction or termination so that you can complete the appeal process before the services are reduced or terminated.

Initial approvals for acute inpatient care, acute rehabilitation or skilled nursing admissions may be extended concurrently by having the utilization management team and/or your physician contact the CCP for medically necessary additional care.

Experimental/Investigational Treatment

We will not provide coverage for any procedure or service, which in our sole judgment is experimental or investigational or for rare diseases, unless required by an external appeals agent. You may request utilization review for experimental or investigational health care services or rare disease treatment. The procedure for filing an external appeal is described in the section of this handbook entitled *If You Disagree With A Decision*.

Case Management Program

This component consists of nurses, behavioral health specialists, social workers, pharmacists and physicians who identify and assist members who have complex needs, serious diseases or chronic conditions and would benefit from clinical support and management. Members are regularly screened for possible candidates and may be referred directly for management.

Members may be in the program from weeks, to months, or longer, and Case Management Program staff contact may be daily, weekly or monthly – it all depends on the individual condition and the circumstances. All contacts and services have one main purpose: the most optimal health care outcome for you.

Retrospective Review Program

This component is the process that provides determinations and electronic or written notification involving retrospective reviews where services have already been delivered and a claim has been submitted.

The Retrospective Review Program reviews medical and hospital records after services have been provided to determine if such services were medically necessary and appropriate. For example, a retrospective review may be triggered by a history of unusually high number of tests ordered by the physician for the service provided.

Reviews may result in a retrospective denial if, for example, the services you received:

- Were not approved prior to your receiving them.
- Were not a medical emergency as defined in *Emergency And Out-Of-Area Care.*
- Were not medically necessary (see definition of medical necessity under *Care Management: Adverse Determinations*) or are otherwise excluded from coverage as provided in your Contract or Certificate of Coverage.

Please remember: We are obligated to administer coverage to ensure that all contract provisions are honored. That means providing all benefits to which members are entitled. It also means not providing benefits that are excluded from coverage. For example, our members are generally not entitled to benefits for experimental or investigational procedures. Please refer to your Contract or Certificate of Coverage for more details.

Retrospective Review Program

If we have all information necessary to make a determination regarding a retrospective claim, we will make a determination and provide notice to you (or your designee) and your provider within thirty (30) calendar days of receipt of the claim. If we need additional information, we will request it within

thirty (30) calendar days. You or your provider will then have forty-five (45) calendar days to submit the information. We will make a determination and provide notice to you and your provider within fifteen (15) calendar days of the earlier of our receipt of the information or the end of the forty-five (45) day time period.

If we fail to make a decision within the above-noted timeframes, then the denial of the health care service and/or treatment is considered deemed to be an Adverse Determination subject to your Appeal rights.

You will be responsible for the cost of any non-covered treatments and services your child receives and for the inappropriate use of the emergency room.

Technology Evaluation Program

This component consists of the continual clinical identification of new technology and updates information on noncovered experimental and investigational procedures.

Benefits are not available under our plan for services, supplies, procedures and items considered to be investigational or experimental. A drug, device, procedure or treatment may be determined to be investigational or experimental if any of the following applies:

- There are insufficient outcomes data available from controlled clinical trials published in the peer-reviewed literature to substantiate its safety and effectiveness for the disease or injury involved.
- The FDA has not granted the required approval for general use.
- A recognized national medical or dental society, or regulatory agency, has determined, in writing, that it is experimental, investigational or for research purposes.
- The written protocols or informed consent used by the treating facility, or the protocols or informed consent of any other facility studying substantially the same drug, device, procedure or treatment, state it is experimental, investigational or for research purposes.

Also, your coverage does not include any technology or any hospitalization in-connection with such technology if, in our judgment, such technology is obsolete or ineffective for the diagnosis or treatment of the particular condition. Governmental approval of a technology is not necessarily sufficient to render it of proven benefit, or appropriate or effective for a diagnosis or treatment of a particular condition.

We provide you with the opportunity to further pursue your request for coverage of a specific treatment if we have initially denied your benefits. Please refer to *If You Disagree With A Decision* for more information.

Our Technologies and Bioethics -Subcommittee meets a minimum of 10 times a year to decide when certain technologies previously considered experimental have come to satisfy the general medical standards in effect in our service area at the time of their evaluation.

Also, in making a coverage determination in an individual patient case, our professional staff will consult with physicians involved in the care of a member.

Adverse Determinations

In some instances, it may be determined through the Care Management Program that a particular service is not, or in the case of a retrospective review, was not medically necessary and appropriate. All determinations are conducted by qualified personnel, including clinical peer reviews.

For additional information concerning adverse determinations, please refer to *If You Disagree With A Decision.*

What Does Medically Necessary Mean?

Medically necessary and appropriate health care services or supplies are those that are required to prevent, diagnose, correct or cure conditions in the member that cause acute suffering, endanger life, result in illness or infirmity, interfere substantially with the member's capacity for normal activity or threaten some significant disability. Services or supplies that are not provided in the most appropriate setting or level of care are not medically necessary.

All determinations are conducted by qualified personnel as follows:

- Licensed health care professionals who are trained in the principles and procedures of intake screening and data collection. Administrative personnel are used only to perform intake screening, data collection and nonclinical review functions. They are supervised by licensed health care professionals.
- A health care professional who is appropriately trained in the principles, procedures and standards of utilization management.
- A clinical peer reviewer when the review involves an adverse determination.

A clinical peer reviewer is a physician who possesses a current and valid nonrestricted license to practice medicine. A clinical peer reviewer may also be a health care professional other than a licensed physician who, where applicable, possesses a current and valid nonrestricted license, certification or registration.

Where no provision for a license, certification or registration exists, a clinical peer reviewer for a health care professional other than a physician must be credentialed by the national accrediting body appropriate to the profession, and in the same profession/specialty as the health care provider who typically manages the medical condition.

In some instances, an adverse determination is made without providing an opportunity for a discussion with the health care provider who specifically recommended the health care service, procedure or treatment under review. In such a case, the health care provider will have the opportunity to request a provider reconsideration.

Points to remember about a provider reconsideration include:

- Except in cases of retrospective review, such reconsideration will occur within one business day of notice of adverse determination.
- The reconsideration will be conducted by your health care provider and the original clinical peer reviewer who made the initial determination, or a designated clinical peer reviewer if the original clinical peer reviewer is not available.

If the adverse determination is upheld after reconsideration, you will be notified as described above. Please see *If You Disagree With A Decision* for information about appeals of adverse determinations.

Notice of Review Determination. Upon completion of our review, you, your designee and, under certain circumstances, your physician, will receive both a verbal and written notice of the determination that has been made. The written notice will include the clinical rationale, if any, for the determination, instructions on how to initiate an Appeal and notice of the availability, upon request, of the clinical

review criteria relied upon to make the determination. You or your designee have the right to an appeal of a utilization review decision by requesting an expedited, standard or external appeal processes.

Submission Of Grievances

You or your representative may submit a grievance at any time directly to us. To submit a grievance by phone, you may call **1-877-842-3625**. A grievance is either a complaint or a request for a Benefit Determination. If you are dissatisfied with our response to a grievance, you may appeal the response by following the appeal process for a Benefit Determination.

STAYING HEALTHY

Our coverage offers many preventive health services to help you reduce your child's risk for certain diseases and conditions. For instance, routine immunizations and screening tests are available to our members. Immunizations and tests — such as measles, mumps and rubella vaccine or a vision and hearing testing — are a simple and effective way to prevent disease. Our services can also help you and your child manage your child's ongoing health conditions.

If your child has a personal or family history for a particular disease or condition, or if you have specific questions about your child's health, you and your child should sit down with your child's PCP and review your child's particular needs.

Our Preventive Health Care Guidelines can help you learn more about screening tests and shots that you and your family need each year. Save the guidelines and bring them to your next doctor's visit. Together you and your doctor can make sure your family's medical checkups and shots are up to date.

Childhood And Adolescent Care

Parents will want to assure that their children receive all necessary screenings, tests and immunizations.

- Immunizations protect children from various diseases. Immunizations are key to preventive health care.
- Routine physical exams (also called well-child visits) are vital to keeping children healthy. Each visit includes many tests and exams as well as receiving advice about dental health, exercise and physical activity, diet and nutrition, injury and violence prevention. Adolescent teaching should also include a discussion about alcohol, sexual behavior, smoking, depression, and drug use.
- Call your child's pediatrician to schedule an appointment. Reschedule any missed appointments.
- Visit **www.cdc.gov** or **www.aap.org/** to view other preventive guidelines.

Prenatal Care for CHPlus Members

Prenatal care is the care an expectant mother receives during pregnancy. Good health care during pregnancy increases the chances of having a healthy baby. Therefore, if your CHPlus enrolled dependent believes she is pregnant she should schedule an appointment with her PCP. The PCP will order a blood test to confirm pregnancy and check your daughter's overall health.

If the PCP confirms pregnancy, your daughter should select a network OB/GYN or midwife for continued prenatal care (PCP referral is NOT needed).

By receiving medical care early and taking certain precautions, your daughter can make a difference in the health and life of her baby. Following are some tips for expectant mothers:

- Schedule an appointment with your daughter's OB/GYN before the 12th week of pregnancy.

- During that visit with the OB/GYN, be ready to provide the doctor with information on your daughter's family history and current lifestyle.
- Your daughter should speak with the doctor about any prescribed or over-the-counter medications, as some can cause harm to a developing baby.
- Advise your daughter to avoid smoking, drugs and alcohol, as they may harm the developing baby.
- Encourage your daughter to eat a balanced diet to be sure that she is nutritionally fit to support both herself and her baby.

After delivery of the baby:

- You should make an appointment for your daughter to see her OB/GYN between 21 and 56 days after childbirth.
- Schedule an appointment for the baby to be seen by his or her pediatrician between two (2) and four (4) weeks of age.

It is common for new mothers to feel overwhelmed by the emotional stresses and inadequate rest that accompany caring for a newborn. If feelings of sadness or hopelessness persist, it's important for your daughter or you to speak with her OB/GYN, PCP or a mental health practitioner. Call the Mental Health and Substance Abuse number on the back of your daughter's health plan card for the names of providers in your area. Postpartum depression is an illness that can be treated by her health care team.

Your daughter can join our free *Healthy Beginnings* PATH program and receive health risk assessments, a book on pregnancy, and other educational materials, telephone access to a nurse 24 hours a-day and help from a maternity nurse case manager. Call **1-877-736-2229** to enroll.

DIAGNOSTIC SERVICES

Visiting Your Child's Physician Group Practice

Most routine diagnostic services such as lab tests and X-rays will be provided at the physician group practice that you have chosen for your child. If your child's PCP determines that your child needs a specialized service not available at the practice, he or she will make the necessary arrangements. Usually, this will mean going to another facility or network physician. In rare instances when the service is not available from within our network, your child's PCP can seek prior approval from us for your child to see an out-of-network physician without losing your child's CHPlus benefits.

In any case, you will receive a written referral form for your child. You should take this form with you at the time of your child's appointment for the services in question. Review the referral with your child's doctor to be sure that you and your child understand the treatment plan.

Through A Participating Physician In-Independent Practice

If you have chosen for your child to receive primary care from a network physician in independent practice, your child's PCP may provide some diagnostic testing in his or her own office. For other services, your child's PCP will usually refer your child to a medical group office or another network physician. In rare instances where the service is not available from within our network, your child's PCP will seek prior approval from us for a referral to an out-of-network physician.

Before You Obtain Diagnostic Services

Before obtaining diagnostic services, make sure you ask your child's PCP the following questions:

- Where and when will the services be provided? Find out the exact time and location of your child's blood test or
- X-ray services to avoid any last-minute stress. If you have to go farther than "just down the hall," ask for directions, too.
- Are there special instructions? Your child may have to do something (such as drink a special liquid) or not do something (such as eat) in preparation for X-ray or lab services. If your child follows the special instructions, you will avoid having the services postponed or repeated.
- How and when can I get my child's results? If you are anxious about the results, ask how and when you may get them. Your child's physician or the service provider should be able to tell you about how long it will take for the results to come back and how you can find out what they are.
- Do you know how to reach me? We do our best to keep our records up to date. But if you and your child have changed names, address or phone number recently without telling us, make sure you update your child's PCP. Also, please advise us of the change by using **www.emblemhealth.com** or calling us at **1-800-447-8255**.

EMERGENCY AND OUT-OF-AREA CARE

What Constitutes an Emergency

A medical or behavioral condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the person afflicted with such condition (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, or in the case of a behavioral condition, placing the health of the person or others in serious jeopardy.
- Serious impairment of such person's bodily functions.
- Serious dysfunction of any bodily organ or part of such person.
- Serious disfigurement of such person.

Coverage for Emergency Care

If your child needs care for an emergency condition, he or she does not need to get our prior approval.

No claim for such emergency care will be denied because our prior approval was not obtained. Also, emergency services will be covered if an authorized person, acting on behalf of us, has approved the service. However, all claims for coverage of emergency services are subject to our post-service review to determine if the services were medically necessary. Please see Care Management: Adverse Determinations for additional information.

Getting Help In An Emergency

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 your PCP first.

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

- Actions you can take at home;
- To come to his/her office; or
- To go to the nearest emergency room.

When your child gets care, you or someone on your behalf must notify your PCP within 48 hours, or as soon as possible after your child gets emergency care. We also suggest that you or someone on your behalf call us at **1-866-447-9717** if your child is admitted to a hospital in an emergency. This is to ensure that our plan and your PCP know.

If your child is admitted to a hospital within our service area but not in our network, we may move him or her to a network hospital as soon as it is safe to do so. If your child is admitted to a hospital outside our service area that is not in our network, we may also move him or her as soon as it is safe to do so. In both instances, the network physician in our service area must provide the necessary follow-up care.

Remember

- Use the emergency room only if your child has a true emergency.
- The emergency room should NOT be used for problems like the flu, sore throats or ear infections.
- If you have any questions, call your child's PCP at the phone number on your child's ID Card.

Getting Non Emergency, But Urgently Needed Care

In case of nonemergency, but urgent injury or illness, contact your child's PCP. An injury or illness that might require urgent care could be:

- A child with an earache who wakes up in the middle of the night and won't stop crying.
- A sprained ankle, or a bad splinter you can't remove.

Your child's PCP, or the physician covering for your child's PCP, will arrange for the care your child needs, which might include:

- A same-day appointment.
- A visit to an after-hours treatment facility.
- A referral to a specialist.

Care While Traveling In Other Areas Of The Country

Emergency Care

Emergency care is covered in the US territory, Mexico and Canada and does not require making any special arrangements. (See Emergency Care in your child's Subscriber Contract.)

Important Emergency And Urgent Care Tips

- Keep your child's PCP's phone number near your telephone.
- If your call is not answered by either an operator or a recording, your call did not go through. 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.
- Have your child's member ID number ready.

Be ready to answer the following questions:

- What's wrong? What are your child's symptoms?
- Does your child have a fever? What's your child's temperature? (If you can, take your child's temperature before calling the doctor.)
- Is your child taking any medication? (know the names of the medications, including any over-the-counter drugs, such as aspirin, Tylenol, cough or cold medicines.)

Have the name and phone number of your child's pharmacy in case you need a prescription. If your child's PCP refers your child somewhere for treatment, take your child's ID card with you. Also take your child's ID card in case you need to fill a prescription. Call your child's PCP back if your child gets worse or if you have questions.

IF YOU DISAGREE WITH A DECISION

Introduction

Appeals

This section describes the appeals processes available to you if you disagree with a Benefit Determination or Clinical Determination. It begins with some important definitions you will want to refer to as you read on.

If you have questions about how or whether you should appeal our determination, start by calling **1-877-842-3625** Monday through Friday 8 am to 5 pm.

Definitions

Adverse Determination – A determination by a utilization review agent that an admission extension of stay, or other health care service, upon review has been denied, reduced, terminated, or a failure to provide or make payment in whole or in part for a benefit based on a determination that a benefit is experimental, investigational or not medically necessary and appropriate.

Appeal – A request that you, your designee, and under certain circumstances your physician makes for us to reverse a Benefit Determination or a Clinical Determination.

Benefit Determination – A decision we make about benefits, eligibility and claims payments, as well as issues of dissatisfaction with services received under your coverage, including denials or referrals. A Benefit Determination does not include decisions as to whether a service is medically necessary and appropriate, or experimental and/or investigational.

Clinical Determination – A determination of whether a service is medically necessary and appropriate, experimental or investigational in nature.

Complaint – Any issue of dissatisfaction with our operations other than a Benefit Determination.

External Appeal – You may also request that an independent New York State licensed External Review Agent review our internal clinical appeal decision. Please see External Appeals for additional information.

Grievance -– A request for us to reverse a previous plan determination other than an Adverse Determination (see definition of Appeal above).

Out of Network Denials -– A denial of a request for prior approval of an out-of-network health service on the basis that the service is not materially different than the health service available in-network.

Rare Disease – A condition or disease that (1)(a) is currently or has been subject to a research study by the National Institutes of Health Rare Disease Clinical Research Network; or (b) affects fewer than two hundred thousand (200,000) United States residents annually; and (2), for which there does not exist a standard health service or procedure covered by the health care plan that is more clinically beneficial than the requested health service or treatment. A physician, other than your attending physician shall certify in writing that the condition is a Rare Disease.

Internal Appeals

You (or your designee) have up to one-hundred eighty (180) calendar days after you receive notice of the adverse determination to file an appeal.

We will decide internal appeals related to pre-service reviews within fifteen (15) calendar days of receipt of the appeal request. Written notice of the determination will be provided to you or your designee (and, where appropriate, your health care provider) within two business days after the determination is made, but no later than fifteen (15) calendar days after receipt of the appeal request.

We will decide internal appeals related to retrospective reviews within thirty (30) calendar days of receipt of the appeal request. Written notice of the determination will be provided to you or your designee (and, where appropriate, your health care provider) within two business days after the determination is made, but no later than thirty (30) calendar days after receipt of the appeal request.

Reviews of continued or extended health care services, additional services rendered in the course of continued treatment, services in which a provider requests an immediate review, home health care services following an inpatient hospital admission, or any other urgent matter, will be handled on an expedited basis. Expedited appeals are not available for retrospective reviews.

In the case of out-of network treatment, your attending physician, who must be a licensed, board certified or board eligible physician, must submit a written statement that the requested out-of-network health service is materially different from the health service that we approve to treat your health care needs; and two (2) documents from the available medical and scientific evidence, that the out-of-network health service is likely to be more clinically beneficial to you than the alternative recommended in-network health service, and for which the adverse risk of the requested health service would likely not be substantially increased over the in-network health service.

For Expedited Appeals, your provider will have reasonable access to the clinical peer reviewer assigned to the Appeal within twenty-four (24) hours of receipt of the request for an appeal. Your provider and a clinical peer reviewer may exchange information by telephone or fax. Expedited Appeals will be determined within the lesser of seventy-two (72) hours of receipt of the Appeal request or forty-eight (48) hours of receipt of the necessary information. Written notice will follow within twenty-four (24) hours of the determination but no later than seventy-two (72) hours of receipt of the appeal request.

To file a standard or expedited Appeal, please contact us:

By phone:
1-877-842-3625.

Customer Service Advocates are available to assist you Monday through Friday, 8 am to 5 pm.

In writing:
EmblemHealth – Grievance and Appeals Department
JAF Station
PO Box 2844
New York, NY 10116-2844

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

If you are not satisfied with the resolution of your expedited appeal, you may file an internal appeal or an external appeal.

Our failure to render a determination of your internal appeal within sixty (60) calendar days of receipt of the necessary information for a standard appeal or two business days of receipt of the necessary information for an Expedited Appeal shall be deemed a reversal of the initial adverse determination.

Your Right to an Immediate External Appeal. If we fail to adhere to the Grievance requirements described below, you will be deemed to have exhausted the internal claims and Appeals process and may initiate an external appeal.

Grievances

You have the right to file a Complaint or a Grievance in regard to any dispute you may have with us provided that such dispute does not involve a denial of coverage or services on the basis that such service is not Medically Necessary and Appropriate, or is an experimental or investigational treatment. You have up to one-hundred eighty (180) days to file a first level Grievance.

1. Acknowledgement of Your Complaint or first-level Grievance. We will send you a written acknowledgement within five (5) business days but no later than fifteen (15) calendar days of our receipt of your complaint or grievance. This letter will include a notice specifying what information must be provided to us in order for us to make a decision on your complaint or grievance.
2. Review of Your Complaint or first-level Grievance. Any complaint or grievance concerning a medical issue will be reviewed and decided by personnel qualified including licensed, certified or registered health care professionals. Once we have received all the information necessary to review your complaint or grievance, our review must be completed and a decision must be made within the following time limit:
   - Within forty eight (48) hours of our receipt of all necessary information when a delay would significantly increase the risk to your health or within seventy two (72) hours of our receipt of your grievance.
   - Within fifteen (15) calendar days of our receipt of all necessary information in the case of pre-service grievances.
   - Within thirty (30) calendar days of our receipt of all necessary information in the case of post-service grievances.
   - Within forty-five (45) calendar days of our receipt of all necessary information in the case of all other grievances.

3. Decision on Your Complaint or first-level grievance. You or your designee will receive a written decision regarding your complaint or grievance. Complaint decisions that do not include a plan determination that you disagree with are final and may not be pursued any further through our internal review processes. Complaints that deal with allegations concerning quality of care are referred to our quality risk management department and are subject to peer review and quality improvement initiatives. Grievance decisions will include a description, when appropriate, of how you may request to grieve the determination further, including the form to file a second-level grievance.

If you disagree with the outcome of the first-level review of a grievance, we provide the following second-level grievance process. You or your designee may file a second-level grievance by contacting a Service representative between the hours of 8 am and 5 pm, Monday through Friday, at **1-877-842-3625**. You have at least sixty (60) business days from receipt of our written first-level grievance decision to file a second level grievance.

1. Acknowledgement of Your Complaint or second-level grievance. We will send you a written acknowledgement within five (5) business days but no later than fifteen (15) calendar days of our receipt of your complaint or grievance. This letter will include a notice specifying what information must be provided to us in order for us to make a decision on your complaint or second-level grievance.
2. Review of Your Complaint or second-level grievance. Second level grievances of an Appeal on a clinical matter must be made by personnel qualified to review the Appeal, including licensed, certified or registered health professionals who did not make the initial determination, at least one of whom must be a clinical peer reviewer. The determination of an Appeal on a matter which is not clinical shall be made by qualified personnel at a higher level than those who made the initial determination.
3. Decision on Your Complaint or second-level grievance. Any complaint or second level grievance concerning a medical issue will be reviewed and decided by personnel qualified including licensed, certified or registered health care professionals. Once we have received all the information necessary to review your complaint or second level grievance, our review must be completed and a decision must be made within the following time limit:

   - Within forty eight (48) hours of our receipt of all necessary information when a delay would significantly increase the risk to your health or within seventy two (72) hours of our receipt of your grievance.
   - Within fifteen (15) calendar days of our receipt of all necessary information in the case of pre-service grievances.
   - Within thirty (30) calendar days of our receipt of all necessary information in the case of post-service grievances.
   - Within forty-five (45) calendar days of our receipt of all necessary information in the case of all other grievances.

You also have the right to contact the New York State Department of Health at any time. If necessary, please contact:

New York State Department of Health Division of Managed Care
Bureau of Managed Care Certification & Surveillance
Empire State Plaza
Corning Tower, Room 2019
Albany, New York 12237-0062
Complaint Hotline: **1-800-206-8125**

Choice of Law. Your Certificate of Coverage has been issued in the State of New York. In any dispute with us, the law of the State of New York or federal law, as appropriate, shall be applied to determine the rights of all parties hereunder.

External Appeal

Under certain circumstances, you have a right to an external appeal of a denial of coverage. Specifically, if we have denied coverage on the basis that the service is not Medically Necessary and Appropriate; is not provided in the appropriate health care setting, is not the appropriate level of care is not effective care or is an experimental or investigational treatment (including clinical trials and treatments for rare diseases), or you have been denied coverage for a requested pre-authorization of an out-of-network treatment, you or your representative may appeal that decision to an external appeal agent, an independent entity certified by the State to conduct such appeals.

Your Right To Appeal A Determination That A Service Is Not Medically Necessary And Appropriate

If we have denied coverage on the basis that the service is not Medically Necessary and Appropriate, you may appeal to an external appeal agent if you satisfy the following two (2) criteria:

- The service, procedure, or treatment must otherwise be a Covered Service under the Subscriber Contract; and
- You must have received a final adverse determination through the first level of our internal appeal process and we must have upheld the denial or both we and you have jointly agreed to waive any internal appeal.

Your Right To Appeal A Determination That A Service Is Experimental Or Investigational

If we have denied coverage on the basis that the service is an experimental or investigational treatment, you must satisfy the following two (2) criteria:

- The service must otherwise be a Covered Service under this Subscriber Contract; and
- You must have received a final adverse determination through the first level of our internal appeal process and we must have upheld the denial or both we and you have jointly agreed to waive any internal appeal, or you have exhausted or are not required to complete any external appeal.

Your attending physician, or the certifying physician in the case of a Rare Disease, must certify that you have a life threatening or disabling condition or disease. A "life-threatening condition or disease" is one which, according to the current diagnosis of your attending physician, has a high probability of death. A "disabling condition or disease" is any medically determinable physical or mental impairment that can be expected to result in death, or that has lasted or can be expected to last for a continuous period of not less than twelve (12) months, which renders you unable to engage in any substantial gainful activities. In the case of a child under the age of eighteen, a "disabling condition or disease" is any medically determinable physical or mental impairment of comparable severity.

Your attending physician, or the certifying physician in the case of a Rare Disease, must also certify that your life threatening or disabling condition or disease is one for which standard health services are ineffective or medically inappropriate or one for which there does not exist a more beneficial standard service or procedure covered by us or one for which there exists a clinical trial, or Rare Disease treatment (as defined by law).

In addition, your attending physician must be a licensed, board certified or board eligible physician qualified to practice in the area appropriate to treat your life-threatening or disabling condition or disease, and must have recommended one of the following:

- A health service or procedure (including a pharmaceutical product) that, based on two documents from the available medical and scientific evidence, is likely to be more beneficial to you than any covered standard health service or procedure (only certain documents will be considered in support of this recommendation - Your attending physician should contact the State in order to obtain current information as to what documents will be considered or acceptable); or
- A clinical trial for which you are eligible, is likely to benefit you in the treatment of the condition or disease (only certain clinical trials can be considered).

Your Right To Appeal A Determination That A Service Is Out-Of-Network

If we have denied coverage of an out-of-network treatment because it is not materially different than the health service available in-network, you may appeal to an external appeal agent if you satisfy the following three (3) criteria:

- The service must otherwise be a Covered Service under this Subscriber Contract;
- You must have requested pre-authorization for the out-of-network treatment; and
- You must have received a final adverse determination through the first level of our internal appeal process and we must have upheld the denial or both we and you have jointly agreed to waive any internal appeal.

In addition, your attending physician must certify that the out-of-network service is materially different from the alternate recommended in-network health service, and based on two (2) documents from available medical and scientific evidence, is likely to be more clinically beneficial than the alternate in-network treatment and that the adverse risk of the requested health service would likely not be substantially increased over the alternate in-network health service.

Your attending physician must be a licensed, board-certified or board eligible physician qualified to practice in the specialty area appropriate to treat you for the health service.

You do not have a right to an external appeal for a denial of a referral to an out-of-network provider on the basis that a health care provider is available in-network to provide the particular health service requested by you.

The External Appeal Process

If you have received a final Adverse Determination upholding an Adverse Determination of coverage on the basis that the health care service is not Medically Necessary and Appropriate, is an experimental or investigational treatment, or is an out-of-network treatment, you have four (4) months from receipt of such notice to file a written request for an external Appeal. If there is an agreement in writing to waive any internal Appeal, or you have exhausted, or are not required to complete any internal appeal, then you have four (4) months from receipt of such waiver, depletion or exemption to file a written request for an external Appeal. We will provide an external Appeal application with the final Adverse Determination issued through our internal Appeal process or our written waiver of the internal Appeal process.

You may also request an external Appeal application from New York State by contacting:

- New York State Department of Financial Services at **1-800-400-8882**, or its Web site at **www.dfs.ny.gov**.

You must submit the completed application to State of New York Department of Financial Services at the address indicated on the application. If you can satisfy the criteria for an external Appeal, the state will forward the request to a certified external Appeal agent.

Additional Documentation. You will have an opportunity to submit additional documentation with your request. The external Appeal agent must allow you at least five (5) business days to submit any additional information, and additional information you submit must be forwarded to us, within one (1) business day of the external Appeal agent's receipt of the additional information. If the external Appeal agent determines that the information you submit represents a material change from the information on which we based our denial, the external Appeal agent will share this information with us in order to exercise our right to reconsider our decision. If we choose to exercise this right, we will have three (3) business days to amend or confirm our decision. Please note that in the case of an expedited Appeal (described below), we do not have a right to reconsider its decision.

Decision Making. In general, the external Appeal agent must make a decision within forty-five (45) days of receipt of your completed application. For this you will need to provide written consent for release of your medical records. The external Appeal agent may also request additional information from you, the attending physician or us within the forty-five (45) day period. If the external Appeal agent requests additional information, it will have five (5) business days from receipt of the additional information to make its decision. The external Appeal agent must notify you in writing of its decision within two (2) business days.

Avoiding Delays. If your attending physician certifies that a delay in providing the health care service that has been denied poses an imminent or serious threat to your health, or if your attending physician certifies that the standard external Appeal time frame would seriously jeopardize your life, health or ability to regain maximum function; or if you received emergency services and have not been discharges from a facility and the denial concerns an admission, availability of care or continued stay then you may request an expedited external Appeal. In that case, the external Appeal agent must make a decision as soon as reasonably possible but not later than seventy-two (72) hours of receipt of your completed application. Immediately after reaching a decision, the external Appeal agent must try to notify you and us by telephone or facsimile of that decision. The external Appeal agent must also notify you in writing of its decision. If the external Appeal agent's decision is not in writing, the external Appeal agent must provide written confirmation of this decision within forty-eight (48) hours after the date of the notice of the decision.

Reviewing The Final Adverse Determination. If the external appeal agent overturns our decision that a service is not Medically Necessary and Appropriate or approves coverage of an experimental or investigational treatment or an out-of-network treatment. We will provide coverage subject to the other terms and conditions of the health insurance contract. Please note that if the external Appeal agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, we will only cover the costs of services required to provide treatment to you according to the design of the trial. We shall not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be covered under

your health insurance contract for nonexperimental or noninvestigational treatments provided in such clinical trial. The external Appeal agent's decision is binding on both you and us. The external Appeal agent's decision is admissible in any court proceeding.

Your Responsibilities

Except for external Appeals pertaining to end of life care, it is your RESPONSIBILITY to initiate the external Appeal process. You may initiate the external Appeal process by filing a completed application with the New York State Department of Financial Services. You may appoint a representative to assist you with your external appeal request; however, the Department of Financial Services may contact you and request that you confirm in writing that you have appointed such representative.

Under New York State law, your completed request for Appeal must be filed within four (4) months of either the date upon which you receive written notification from us that it has upheld an Adverse Determination of coverage or the date that you receive a written waiver of any internal Appeal. We are not authorized to grant an extension of this deadline.

Covered Services/Exclusions

In general, we do not cover experimental or investigational treatments. However, we shall cover an experimental or investigational treatment approved by an external appeal agent in accordance with this health care contract. If the external appeal agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, we will only cover the costs of services required to provide treatment to you according to the design of the trial. We shall not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be covered under this subscriber contract for nonexperimental or noninvestigational treatments provided in such clinical trial.

Hold Harmless

When the health care provider requests an external Appeal of a concurrent Adverse Determination, including when the physician requests an external Appeal as your designee, the health care provider shall not pursue any reimbursement from you for services the external Appeal agent determines not to be Medically Necessary and Appropriate, except to collect a copayment, coinsurance or deductible if required.

Time to Sue

No action at law or in equity shall be brought to recover on your Certificate of Coverage prior to the expiration of sixty (60) days after proof of loss has been submitted to us. Any lawsuit under your Certificate of Coverage must commence within two (2) years from the date of the service in question. Any legal action must be commenced in the State of New York.

RIGHTS AND RESPONSIBILITIES

Understanding your rights and responsibilities as a 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 member. If for any reason, you do not understand these rights or how to interpret them, we and our network physicians will provide you with help.

- The right to access covered services 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 receive considerate and respectful care in a clean and safe environment.
- The right to receive, upon request, a list of the physicians and other health care providers in our provider network.
- The right to change your physician.
- The right to be assured that network health care providers have the qualifications stated in our professional standards established by our credentialing committee, which are available upon request.
- The right to know the names, positions and functions of any network provider's staff and to refuse their treatment, examination or observation.
- The right to obtain from 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 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 network 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.
- 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 consult by appointment, during business hours, with responsible administrative officials at our plan and your network physician's office to make specific recommendations for the improvement of the delivery of health services.
- The right to file an appeal or external review related to a determination about care and services rendered. For additional information on filing an appeal, see *If You Disagree With A Decision* in your Member Handbook and/or call Customer Service at **1-800-447-8255**. TDD: **1-888-447-4833**.
- 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.
- 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 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 network physicians and other providers with accurate and relevant information about your medical history and health so that appropriate treatment and care can be rendered.
- 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 personnel and the personnel of any hospital or health facility to which you are referred.

- 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 options and goals, to the degree possible.
- The responsibility to be actively involved in your own health care by seeking and obtaining information, by discussing treatment options with your physician and making informed decision about your health care.
- The responsibility to understand our benefits, policies and procedures as outlined in your Contract and handbook, including policies related to prior approval for all services that require such approval.
- The responsibility to pay copayments, if applicable, at the time services are rendered.
- The responsibility to abide by the policies and procedures of your network physician's office.

YOUR CHILD'S MEMBERSHIP STATUS

Converting To A Different Contract at Age 19

Members become ineligible for Child Health Plus at age 19. At this time, you will receive notification of termination and information about how to apply for Family Health Plus. If your dependent does not meet Family Health Plus eligibility criteria, a direct payment plan is another choice to consider.

For direct payment coverage and premium information, contact Customer Service at **1-800-447-8255**.

Canceling Your Child's Membership

We hope you will never decide to cancel your child's membership. But if you do wish to cancel for any reason at all:

- Call us at **1-800-447-8255** or refer to your Subscriber Contract, or
- Send us your written request to disenroll to:

  HIP Health Plan of New York
  CHPlus Enrollment Department
  55 Water Street, 5th Floor
  New York, NY 10041-8190

Or, fax your request to: **1-212-510-5266**

Rest assured that we cannot cancel your child's membership for reasons of health, regardless of your child's medical situation. Please refer to your child's Subscriber Contract for a list of the only situations in which we can terminate your child's membership in CHPlus.

AT YOUR SERVICE

Keeping Us Informed

Please let us know if you have any change affecting your child's coverage, including a name, address or phone number change, a change in marital status or the birth or death of a covered family member. You can notify us of the change by using **www.emblemhealth.com**, or calling Customer Service.

Also, please be sure to give us your opinions and ideas. Write to the Senior Director of Customer Affairs at the Customer Service address provided in the next section, e-mail us by visiting **www.emblemhealth.com** or call us at **1-800-447-8255**. We actively seek member input through such vehicles as our active, broadly representative Member Council and periodic regional member forums. But individual input like yours is especially important in helping us continue to meet our commitment to service excellence. Individual input also allows for our members to participate in the development of our policies.

Another way to express your views is to attend one of the annual Member Forums held at various locations within our service area. These meetings are a great way to share your experiences and ask questions of our management and Member Council representatives. The dates and locations of these forums will be included in the member newsletter you receive and will also be posted in advance at all physician group practice offices.

Contacting Customer Service

You can access a great deal of Customer Service information and make a number of transactions and inquiries by visiting our Web site at **www.emblemhealth.com**. Our Web site allows you to access benefit descriptions, make claim inquiries, send e-mails to Customer Service, fill prescriptions online and view our formulary. In addition, logging on to **www.emblemhealth.com** gives you the opportunity to view our annual report and read about some important health education information.

You can also find answers to your questions by calling **1-800-447-8255**. You can speak with a customer service representative Monday through Friday, 8 am to 6 pm. At all times, you can verify information and make requests through the Interactive Voice Response (IVR) system. You should be ready to enter your child's ID number when asked. Then just follow the easy instructions.

A helpful hint: Phone volume is heaviest on Mondays and between 11 am and 3 pm on other days. So, if you need to speak with a customer service representative, you may minimize delay by calling at other times.

You may also write us at:

HIP Health Plan of New York
Customer Service Department
55 Water Street
New York, NY 10041-8190

Or visit our walk-in unit in the 55 Water Street lobby, New York, NY, Monday through Friday, 8:30 am to 5 pm.

If You Need Help In A Language Other Than English

We have a long-standing commitment to full services for our ethnically diverse membership. Accordingly, you can receive assistance through:

- The Language Line available through Customer Service at **1-800-447-8255**. The Language Line provides over-the-telephone interpretation services in more than 100 languages, including Spanish, Russian, Chinese, French, Japanese and Korean.
- Bilingual and multilingual staff and providers working in private offices and medical group offices. When the needed language is not available at the office or medical group offices, you can use the Language Line. This line can be connected to an examination room with a two-way speaker system.
- You can also request translations of this Member Handbook in Spanish. Call **1-800-447-8255** to request this translation.

If You Have A Hearing Or Speech Impairment

We maintain a special telephone message relay system that helps us communicate with hearing- or speech-impaired members. An operator using a special telephone device for those who are hearing or speech-impaired (TDD) is available with benefits information Monday through Friday, between 8:30 am and 5 pm. After hours and on weekends, TDD communications are reserved for medical emergencies.

You can also arrange with us to have a sign language interpreter present when you visit your child's PCP or for any regularly scheduled medical visit.

To communicate via TDD or arrange for a sign language interpreter, call **1-888-447-4833**, from Monday through Friday, 8:30 am to 5 pm.

HOW WE COMPENSATE NETWORK PROVIDERS

You have a right to information about how we compensate network health care providers. The most important point to understand is that we do not compensate health care providers in general or make specific payments intended to limit or reduce the quality or scope of medical care your child receives.

The physicians and health care providers that treat your child are not our agents or employees. They alone are responsible for the medical care they provide. We do not provide medical care. Nor are we responsible for any acts or omissions of any physician or other health care provider. Rather, our obligation to you and your child is to provide access to and pay for covered services in accordance with the terms of your child's Subscriber Contract. You and your child's doctor are responsible for decisions about your child's medical care.

If you have questions about payment arrangements, we encourage you to discuss them with your child's primary care physician as well as with other network providers, such as hospitals and other inpatient facilities. To assist you in these discussions, we have provided some important definitions below. These are terms commonly used by health care providers and health plans such as us when discussing compensation. Following the definitions, we have provided some general descriptions of the various methods we use to compensate network health care providers.

Definitions Of Common Compensation Terms

Fee-For-Service means payment to a provider for each covered service delivered. Payments are based upon an agreed fee schedule. The provider or the member must submit a claim to us for the payment to be processed.

Capitation or Pre-Payment means payment to a provider (such as a hospital or a large group of physicians practicing together as a professional corporation) of a fixed amount of money each month per member. This amount covers provisions of specific services to those members who have selected that provider. The provider paid through the Capitation method receives payment without submitting claims. Some providers are capitated just for the services they provide. Others are capitated to provide a broader array of services, which may include hospitalization, diagnostic services or prescription drugs.

Per-Diem Payment means a payment based on a flat amount per day for hospital services or other inpatient facility care such as nursing home services. Unlike Fee-For-Service arrangements, hospitals or other facilities on a Per-Diem system will receive the same flat rate per day regardless of the services provided each day.

Diagnostic Related Group or DRG, or Case Rate, means a hospital payment based primarily on the diagnosis and medical condition of the patient. Hospitals or other inpatient facilities paid on a DRG or Case Rate will receive that payment regardless of the actual services delivered or how long the patient remains hospitalized. The DRG reimbursement payment system is a standard methodology used by Medicare to pay hospitals for services provided to Medicare beneficiaries. This methodology may be used by us to reimburse hospitals when they treat members in other lines of business.

Risk means the responsibility the provider assumes to deliver covered health care services under a Capitation arrangement. When a provider accepts Capitation for a member for a particular month, that provider has been paid in full for the covered service the member requires. That payment is made based on services the provider has agreed to deliver or arrange regardless of whether the member actually uses any services. In any given month, Capitation payment is received by the provider whether or not the member receives any services in that month or if the costs of services provided to the member exceed the Capitation payment for that month. Providers that are contracted with us through an IPA may deliver services to our members at physician group practices.

Independent Practice Association or IPA means an organization of health care providers authorized by New York State to contract with health plans such as our plan and to negotiate fee schedules or other compensation arrangements on behalf of its member physicians, hospitals and other providers.

Physician Medical Group means, for purposes of this section of the handbook, the professional corporations organized by the physicians that operate an affiliated physician group practices in Queens, Brooklyn, Staten Island and Long Island. These professional corporations negotiate compensation arrangements and contract with our plan to provide services to members. The Medical Groups employ physicians, health care professionals and other staff.

Common Reimbursement Arrangements Currently Used By Us

Physician Medical Group Compensation

To compensate primary care physicians practicing at a medical center, we contract with Medical Groups which employ these physicians. We pay the Medical Groups a Capitation for medical services these physicians provide at the physician group practice.

Under this method, the Medical Group as a whole is at risk for the services it provides. It is also at risk for the cost of certain specialty care services that are not provided at the physician group practice. The group is typically not at risk for certain other services for which they provide referrals to patients. Examples of such other services, for which the Medical Groups are not at financial risk, include pharmacy, inpatient hospital care and mental health services.

In addition, each of the Medical Groups as a whole has the opportunity to receive additional compensation in the form of quality incentive bonuses. Such bonuses may be available for achieving certain performance goals in the areas of quality improvement, quality of care, customer satisfaction and certain operational areas. For example, member satisfaction with access to care as well as decrease in hospital length of stay are some of the quality of care goals we measure and use to determine if any additional compensation is paid to each of the Medical Groups. This reinforces physicians' professional commitment to achieving member satisfaction and better health outcomes through the appropriate and timely delivery of services, at the right setting, by the right provider. Quality incentive bonuses are paid when the Medical

Group achieves overall performance goals for all our members that use the Medical Group. The bonuses are not connected to the care provided to any single member.

IPA Compensation

We may pay network physicians through an IPA in one of two ways:

- We may pay the IPA on behalf of the physician by Capitation or Fee-For-Service, or
- We may pay the physician directly on a Fee-For-Service basis.

If we pay the IPA by Capitation, the IPA is likely to be at risk for medical services it directly provides as well as for a broader array of services. This broader array of services may include specialty care, laboratory and inpatient hospital care. The IPA may, in turn, pay the primary care physicians and specialists either by Fee-For-Service or by Capitation. In so doing, the IPA will put the physicians at risk only for the services they directly provide.

Some IPA provider agreements with us may include bonus compensation. Such compensation is available as an incentive for achieving high performance measures in certain specific areas such as quality improvement, quality of care, customer satisfaction and operational cooperation. We regularly measure the performance of its entire network against such standards. Bonus compensation is paid when the IPA achieves overall performance goals for all our members that use IPA physicians. The bonuses are not connected to the care provided to any single member.

In addition, our plan and the IPA may agree to certain cost goals for particular services. After an agreed upon time period, our plan and the IPA calculate the actual costs for providing these services on a Fee-For-Service basis to the members that have selected IPA primary care physicians. The IPA and our plan then share the risk related to providing those services. Therefore, if the services actually cost less than the target, the IPA receives additional compensation. If the actual cost exceeds the target, the IPA pays a portion or all of the excess cost.

Compensation For Our Network Physicians Directly Contracting With Us

Providers contracting directly with us are paid on a discounted Fee-For-Service basis, with no risk transferred to them.

Facility Compensation

We pay network hospitals or other inpatient care facilities on a Per-Diem or DRG basis. With certain high-volume hospitals, the Per-Diem fee may be subject to adjustments if certain volume utilization levels are achieved over time.

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, summaries of income and expenses.
- A copy of the most recent individual direct pay subscriber contract.
- Information from the New York State Department of Financial Services about consumer complaints about us.
- How we keep your medical records and member information private.
- A copy of the drug formulary for use by your plan
- Information about how our company is organized and how it works.
- We will tell you with which hospitals our network providers work.
  - A written description of the organizational arrangements and ongoing procedures of the organization's quality assurance program

  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 us.
- Qualifications needed and how health care providers can apply to be part of us.
- 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:

HIP Health Plan of New York
Customer Service Department
55 Water Street
New York, NY 10041-8190

IMPORTANT CONTACT INFORMATION

Customer Service **1 800-447-8255**
(including all requests for appeals) .... **1-888-447-4833 TTY/TDD**

Medical Services
Prior Approval .... **1-866-447-9717**; Option 4

Emblem Behavioral Health Services Program
Prior Approval **1-888-447-2526**

Pharmacy Clinical Department
(for physicians to obtain prior approval
for non-preferred drugs) **1-646-447- 3146**

Express Scripts Member Services **1-877-866-5798**
.... **1-800-899-2114** TTY/TDD

Express Scripts (Prescription Refills) **1-877-866-5798**

Dental Coverage (Healthplex) **1-800-468-9868**

Smoking Cessation **1-866-697-8487**

Insurance Fraud & Abuse **1-877-835-5447**
(for confidential reporting of suspected insurance fraud)

COMPLEMENTARY HEALTH CARE DISCOUNT PROGRAM

The integration of Complementary and Alternative Medicine (CAM) into conventional western medicine is quickly revolutionizing the landscape of the American health care system. Patients and providers are increasingly using alternative methods of care to complement traditional western medicine. In response to our members' request for these services, we have teamed up with American Specialty Health to offer the ChooseHealthy™ affinity discount program.

Who Are CAM Providers?

CAM services are provided by massage therapists, acupuncturists and registered dietitians.

How Does the Program Work?

The program is simple. You schedule an appointment with a provider who participates with our program, receive treatment or service, pay for that service at the time of your appointment and the provider discounts their standard fee. There are no claim forms to complete, no pre-authorization process, no medical necessity criteria and no physician referrals are required to receive up to 25 percent discounts.

What Else Is Available?

You also have access to an online store for brand name vitamins, natural supplements, skin care and nutrition products, mental imagery and relaxation modules, and other health products. Save up to 40 percent off manufacturers' suggested retail prices and receive free shipping on most items. To take advantage of discounted rates and free shipping, go to the Health and Wellness section of our Web site, **www.emblemhealth.com**, select Stay Healthy, then under Healthy Discounts select Vitamins and Natural Supplements.

How To Locate A CAM Network Provider

To locate a CAM network provider in your area, go to the Health and Wellness section of our Web site, **www.emblemhealth.com**, select Stay Healthy, then under Healthy Discounts select acupuncture therapy, registered dietitians or massage therapy to locate a provider. You may also call Choose Healthy Customer Service at **1-877-327-2746**.

NOTICE OF PRIVACY PRACTICES

IMPORTANT INFORMATION ABOUT YOUR PRIVACY RIGHTS

Effective February 1, 2012

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 appointment 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 Insurance Department 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 phone number on the back of your ID card.

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 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 US 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 and regulations. 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 or mailing address.

Write to: Corporate Compliance Dept. P.O. Box 2878 New York, NY 10116-2878
Call: **EmblemHealth program members:** M-F, 8 am-5 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: **1-800-447-8255**, TTY: **1-888-447-4833** 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-5 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-6 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

Planning In Advance For Your Medical Treatment
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 can 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 this form.

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 EmblemHealth.*

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):

____

____

(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

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.

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