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GHI MEMBER HANDBOOK

Community-Rated Direct Pay Members

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Federal Health Reform's Impact on Your Benefits

Thank you for your membership. We look forward to meeting your health coverage needs. This document will help you become familiar with your health plan and offer tips for maximizing your benefits.

As you may know, federal health reform was passed in March 2010. This law could mean that there will be changes to your coverage beginning on your policy renewal date. If you don't know your policy renewal date, please ask your benefits administrator or call the Customer Service number on the back of your ID card. Keep in mind that most EmblemHealth, GHI, GHI HMO and HIP members will see very little difference in their coverage over the next few years. That's because most of our combined hospital/medical plans* already meet many of the basic requirements of the federal health reform law. If the following features aren't already part of your plan, they will go into effect on the renewal date of your policy.

Federal Health Reform Law (Except where noted, these provisions become effective on your policy renewal date.) Here is a summary of the health reform law benefit changes:

1. Annual and lifetime dollar limits on essential benefits** are eliminated as of your policy renewal date.
2. Pre-existing condition limitations are eliminated for enrollees under age 19.
3. Dependent children who do not have coverage from their own employer may stay on or can be added to their parent's policy at the time of policy renewal, until age 26.*** To add such a child to your plan, please see the instructions below.
4. There will be no out-of-pocket costs for selected preventive care services obtained in network.
5. Emergency care provided by out-of-network hospitals will be subject to the same copay and/or coinsurance that applies to emergency care provided by in-network hospitals.
6. The penalty for non-medical withdrawals from health savings accounts (HSAs) will increase from 10 percent to 20 percent on January 1, 2011.

To enroll an adult child (regardless of student status) who is up to age 26 (end of birthday month) ***
If your coverage is through an employer group and you would like to add your eligible adult child as a dependent on your existing policy, see your employer during your plan's open enrollment period to complete and submit the required enrollment form.

Please keep in mind that all benefit changes mentioned above are effective on your policy start date or renewal date, on or after September 23, 2010. Please be assured that we are doing our best to make reform work for you. If you have any questions, please call the customer service number that appears on the back of your member ID card.

** Certain non-comprehensive benefit plans are exempt from the health reform law. These programs will not change and may not conform to some or all of the new requirements.*

***Essential benefits include ambulatory care; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative care; laboratory services; preventive and wellness services and chronic disease management; pediatric services including oral and vision care; and any other services described in the Patient Protection and Affordable Care Act.*

**** If your benefit plan provides dependent coverage through age 29, that coverage will remain in effect unless you or your group drop the extended dependent coverage rider upon plan renewal. Read more about this on your plan's Web site, shown on the back of your ID card.*

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This handbook is intended to provide you with general information about your GHI Health Insurance Program. In the event of any inconsistency between this handbook and your Contract of Insurance, the terms of the Contract of Insurance shall be controlling. Coverage is subject to all terms, conditions, limitations and exclusions contained in your Contract of Insurance and any riders or amendments thereto.

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WELCOME

Welcome to the GHI Health Insurance Program

Thank you for selecting GHI as your Health Insurance Carrier.

We've tried to design a direct payment health insurance policy which makes it easy for you to access the health coverage you and your family need, when and where you need it.

This handbook contains a brief description of your health insurance policy, including important coverage information, suggestions on ways to save out-of-pocket expenses, and other procedures to follow to get the most out of your GHI health insurance policy ("GHI Health Insurance Program" or "Program").

Where possible, we've defined insurance terms as they arise. However, you may occasionally find a word or term in this handbook that you don't understand. When that happens, take a look in the section of this handbook entitled **Some Important Definitions**, and you'll probably find an explanation.

Note: Throughout this handbook, you will see the terms "Network Providers" and "Non-Network Providers." These terms are synonymous with the terms "Participating Providers" and "Non-Participating Providers," respectively. Please refer to the sections of this handbook entitled **Choosing Your Health Care Providers** and **Some Important Definitions** for more information about these terms.

If you have any questions about your coverage under the GHI Health Insurance Program, please call GHI at one of these convenient numbers:

New York City: **1-212-501-4GHI** (4444)
Syracuse: **1-315-432-0826**
Outside New York City Area: **1-800-624-2414**

We look forward to serving you and your family, now and in the future.

Internet Access to GHI

Looking for the visiting hours at your neighborhood hospital? Want to find the doctor closest to your office? Need to contact GHI Customer Service? Visit **www.ghi.com**. This is our innovative Web site designed to help you get up-to-date information on GHI, our Plans, our providers and a whole lot more.

The GHI Web site provides immediate access to the same useful information available through GHI AnswerLine, 24 hours a day. Certified by Verizon Business Internet security standards, the GHI Web site offers valuable resources for subscribers, providers, brokers and group administrators. Members visiting the Web site are requested to apply online for a Personal Identification Number (PIN), which they will receive by mail. Upon receipt of the PIN, members can use the Web site to determine eligibility, access basic benefit information and check the status of their claims. The online Provider and Hospital Directories also allow users to pinpoint provider names and locations.

Who is Covered?

You, your spouse and your eligible dependent children are eligible for coverage under the GHI Health Program. Consult your Contract for detailed eligibility information regarding your policy.

When Do Benefits Begin?

Benefits under the GHI Health Program begin on the date of enrollment in the program.

Requesting a Certificate of Creditable Coverage

When your GHI coverage terminates, we will automatically issue a certificate of creditable coverage to you. The certificate is evidence of the coverage you had with GHI. Under a Federal law known as HIPAA, you may need evidence of your prior coverage to reduce a pre-existing condition exclusion period under another plan, to help you get special enrollment in another plan, or to get certain types of individual health coverage even if you have health problems. You may request a copy of your certificate of creditable coverage by writing to GHI at:

GHI
P. O. Box 1701
New York, NY 10023-9476

Or, you may call us at **1-212-501-4GHI** (4444) or, outside of the New York City area at **1-800-624-2414** to request this certificate. You may request this certificate at any time, even if your GHI coverage is still in force.

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TYPES OF PLAN

What kind of health plan are you in? This member handbook covers two Direct Pay Health Plans:

- Value
- Core*

You can see what kind of health plan you are enrolled in by looking on your GHI Member ID card and your GHI Contract of Insurance. Your Member ID card and Contract of Insurance will indicate which network of providers is available to you. For details about Network and Non-Network Providers, see **Choosing Your Health Care Providers**.

There are some important differences between these types of programs, described below. As you read through your Member Handbook, keep in mind the type of program you are enrolled in — Core or Value. Some of the information presented may not be applicable to your specific program.

Value Plan

If you are enrolled in the GHI Direct Pay Value program, you are covered for both medical and hospital services. The Value Plan includes coverage for durable medical equipment and private duty nursing. **Please note: the GHI Value Plan Program does not cover home and office visits except for preventive services and covered well-child care visits**. Please review your contract for a detailed explanation of your benefits.

Core*

If you are enrolled in the GHI Direct Pay Core program, you are covered for both medical and hospital services. The Core Plan includes coverage for home and office visits. However, this plan does not include coverage for durable medical equipment or private duty nursing. Please review your contract for a detailed explanation of your benefits.

* The GHI Direct Pay Core program is only available to existing GHI members that are terminating from a group policy.

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WHAT BENEFITS ARE INCLUDED?

The GHI Health Program offers you and your covered dependents benefits for a wide range of health care services. Your program may include some or all of the coverages described below. In order to be eligible for reimbursement, all services rendered to you must be listed as covered and must be medically necessary. Please refer to your Contract for more information about your covered benefits. And, please review the **How Utilization Management Can Affect Your Benefits** section of this handbook for further information about medical necessity.

New York State imposes a surcharge on health care rendered by certain types of providers. This surcharge applies to payments made by GHI and to the out-of-pocket expenses that you, the patient, are often responsible for. Out-of-pocket expenses include deductibles, copayments and coinsurance. GHI will pay the surcharges attributable to payments actually made by GHI and attributable to copayments. However, patients must pay the surcharge attributable to deductibles and coinsurance. Surcharges only apply to services rendered by the following types of providers: diagnostic and treatment centers (i.e. clinics) which offer comprehensive services, ambulatory surgery centers, and hospitals. The surcharge does not apply to office visits. When applicable, GHI will indicate your surcharge liability on the Explanations of Benefits we issue. Please keep in mind, coverages and out-of-pocket expenses described throughout this booklet include a surcharge when they arise from health care rendered by the types of providers mentioned in this paragraph.

Medical. Depending upon your program, GHI may provide benefits for medical services including surgery, anesthesia and other services. In-hospital surgery, anesthesia, in-hospital physician visits and other medical services are also covered.

When you visit a GHI Network Physician or other GHI Participating Provider, you simply show your GHI identification card at the time of your visit. You will incur no out-of-pocket expense for covered services except for any applicable copayments, deductibles and/or coinsurance.

You also have the option of receiving care from Non-Network Providers for most covered medical services. **However, you will maximize your benefits and limit your out-of-pocket expenses by receiving covered services from GHI Network Providers.** You'll find more details on this topic in the section entitled **Choosing Your Health Care Providers**.

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Consult your Contract for more details on the medical benefits available to you under your policy, including applicable cost-sharing provisions.

Hospital. GHI provides coverage for inpatient and outpatient hospital services at any general acute care hospital nationwide and for certain other types of facilities and services. Consult your Contract for information on your covered benefits.

Remember, you are required to call GHI's Coordinated Care department to precertify your benefits prior to non-emergency inpatient stays. Precertification is described in more detail under **How Utilization Management Can Affect Your Benefits** in this booklet.

Emergency Care. You are covered for emergency care provided and billed for by a hospital, whether it is in-network or out-of-network care.

Emergency care is defined as care for a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson possessing an average knowledge of medicine and health could reasonably expect the absence of immediate medical attention to result in:

- placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy.
- Serious impairment to such person's bodily functions.
- Serious dysfunction of any bodily organ or part of such person.
- Serious disfigurement of such person.

If you require emergency care, visit the Emergency Room of any Network or Non-Network general acute care hospital. Outpatient emergency care is generally covered in full; however, some programs impose a copayment for each visit. If you are admitted to the hospital immediately from the emergency room, GHI will waive any applicable outpatient emergency care copayment. Your Contract indicates whether or not your Program requires a copayment for emergency care.

Note: When emergency care is billed and rendered not by a hospital employee but by a private provider (e.g. a physician or a laboratory or other provider that is independent of the hospital) who is not a Network GHI Provider, GHI will reimburse you, for covered services, at the applicable out-of-network allowance subject to any applicable deductibles or coinsurance. You are responsible for any difference between the Non-Network Provider's charge and the amount reimbursed to you by GHI.

Precertification is never required in connection with outpatient emergency care or emergency hospital admissions. However, you should notify GHI's Coordinated Care department of your admission within two business days following an emergency admission or as soon as reasonably possible thereafter.

Benefits under the Women's Health and Cancer Rights Act of 1998. If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA).

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For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy was preformed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses.
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under your GHI Program. Please refer to your Contract of Insurance for information about the copays, deductibles and/or coinsurance that apply to your benefits. If you would like more information on WHCRA benefits, call us at **1-212-501-4444** in New York City or **1-800-624-2414** outside New York City.

Direct Access to Obstetric and Gynecologic Care. Pursuant to the New York State Women's Health and Wellness Act of 2002, you have direct access (i.e. no referral required) to the primary and preventive obstetric and gynecologic services and pregnancy care services (including primary and preventive obstetric and gynecologic services required pursuant to such services or as a result of an acute gynecologic condition), if any, covered under your Contract of Insurance from a qualified Network Provider of your choice.

Chemical Dependency/Mental Health Treatment Benefits. Your Program provides outpatient benefits for chemical dependency. Your Program may also cover inpatient mental health care, and/or outpatient mental health care. Please consult your Contract for information on your covered chemical dependency and/or mental health benefits.

Prescription Drug. GHI offers coverage for both retail and mail order prescription drugs. Your Contract will explain if prescription drug benefits are available under your Program. These benefits may include:

- Retail prescriptions: which can be filled for acute medications — generally a short-term supply which cannot exceed a 30 consecutive day supply of the drug — at a Network Pharmacy.
- Mail order prescriptions: which can be filled for longer-term supplies of medication, generally 90 days or more.

Since some programs require you to pay the difference between brand and generic medications, you may be able to reduce your out-of-pocket costs by using generic medications. By law, generic drugs must meet the same standards for safety, purity, strength and effectiveness as brand-name drugs. Pharmacies can dispense generic drugs when authorized by your doctors and permitted by applicable law.

Please refer to your Contract for a more detailed description of any prescription drug coverage available to you under your Program.

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CHOOSING YOUR HEALTH CARE PROVIDERS

Visit our Web site at **www.ghi.com** and click on "**Find a Doctor**" to view the most up-to-date listing of GHI Network Providers. You can also call GHI at any of these convenient numbers for a listing of Network Providers:

New York City: **1-212-501-4GHI** (4444)
Syracuse: **1-315-432-0826**
Outside New York City area: **1-800-624-2414**

In general, GHI defines a provider as a medical practitioner or covered facility recognized by GHI for reimbursement purposes. The section of this booklet entitled **Some Important Definitions** explains how GHI defines a provider.

Network Providers. When you use a GHI Network Provider, you control your out-of-pocket expenses and avoid unnecessary paperwork. GHI's Network Providers have agreed to accept GHI's allowances or negotiated rates as payment in full for covered services.

You pay only the applicable copayments, deductibles and/or coinsurance for covered services, as described in your Contract and under **What You Pay** in this booklet. **You do not file any claim forms** when you use a Network Provider — that's the provider's responsibility.

Your GHI Health Program affords you direct and easy access to GHI's extensive Network of Participating Physicians and other health care providers conveniently located throughout your service area. All GHI Network Providers must pass GHI's rigorous credentialing process.

You are free to schedule an appointment with any Network Physician — including specialists — without a referral from a Primary Care Physician. Please note that the composition of GHI's Provider Network changes over time. So, when you call for an appointment, it's a good idea to confirm that the provider still participates with GHI before receiving covered services. GHI can not guarantee the continued participation of a Network Provider or your acceptance as a patient by a particular Network Provider.

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You should also be aware of these special considerations:

- You are required to precertify certain covered services prior to treatment to receive full benefits and/or payments. The precertification process is addressed in detail under the section of this booklet entitled **How Utilization Management Can Affect Your Benefits**. Please refer to your Contract to determine which covered services require precertification and what procedures you must follow for the specific benefits you are precertifying.
- Some services are covered only if you use a GHI Network Provider. These services are detailed in your Contract.
- For prescription drug benefits, many chain drug stores and independent pharmacies participate in GHI's retail Pharmacy Network. Call **1-877-444-3614** to obtain the names of Network Pharmacies.

It's Your Choice. With GHI, you have the freedom to receive most covered services from a Network or Non-Network health care provider. You are not restricted to using members of GHI's extensive Provider Network. However, certain services may be covered **only** when rendered by Network Providers. Even when out-of-network services are covered, you will maximize your benefits and limit your out-of-pocket expenses by receiving services from GHI Network Providers.

Non-Network Providers. You are eligible for benefits for most covered services even if you use providers who are not members of GHI's Provider Network. However, if you obtain covered services outside of the GHI Network of Providers, *you will be responsible for paying the provider directly and will only be reimbursed at a rate which is usually less than the provider's charge.*

If you receive care outside of GHI's Network, your out-of-pocket expenses will increase significantly. Non-Network Providers are not required to accept GHI's allowance as payment-in-full and will bill you for their charges directly. Thus, unlike when you use a Network Provider:

- You are responsible for paying any Non-Network Provider up front and for filing a claim form with GHI for reimbursement.
- Your benefits for covered services may be subject to deductibles, coinsurance, and any applicable annual and/or lifetime reimbursement provisions.
- You are responsible for the balance of any Non-Network Provider's charge over the amount GHI pays.
- Some services are covered only if you use a GHI Network Provider. Refer to your Contract for information on your covered benefits.

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WHAT GHI PAYS

Medical Services. GHI provides benefits for covered medical services rendered by Network Providers based on the GHI-CBP Schedule of Allowances or negotiated rates. GHI's Participating Network Providers have agreed to accept GHI's CBP Schedule of Allowances or negotiated rates as payment in full for covered medical services, subject to applicable cost-sharing provisions.

When you use a Non-Network Medical Provider, GHI typically reimburses you for covered services based on the GHI allowed charges as specified in your Contract, subject to applicable cost-sharing provisions. Once you have paid a maximum amount of eligible out-of-pocket expenses for covered medical services received from Non-Network Providers, GHI will reimburse you for some or all covered medical services received from Non-Network Providers up to the full amount of the applicable schedule or allowed charge.

On the Direct Pay Core and Value Programs, GHI's reimbursement for most covered medical services is based on a combination of the GHI-CBP Schedule of Allowances and the usual charge of other Providers of similar training or experience in the same or a similar geographic area for the same or similar services as reflected in the 80th percentile of the Health Insurance Association of America/Ingenix Prevailing Healthcare Charges System (HIAA/Ingenix — PHCS) in use by GHI at the time the services are rendered. Please refer to the section of your Contract entitled "**Use of Non-Participating Providers**" for more detailed information and examples of how out-of-network reimbursement works on your Program.

Certain services, including mental health treatment, durable medical equipment and others often have special reimbursement provisions, whether services are rendered in- or out-of-network. These special benefit provisions, along with the cost-sharing provisions and benefit maximums that apply to your Program, are detailed in your Contract.

GHI's fee schedules are available for review at GHI's offices and at the New York State Insurance Department.

Hospital Services. GHI's Network of Participating Hospitals and other types of Network Facilities covered under the hospital portion of your Program have agreed to accept GHI's negotiated rates as payment in full for covered services, subject to any applicable cost-sharing provisions.

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When you use a Non-Network Hospital or Non-Network Skilled Nursing Facility covered under the hospital portion of your Program, GHI reimburses you for a percentage of GHI's reasonable and customary charge as determined by GHI for that covered service, subject to any applicable cost-sharing provisions.

Prescription Drugs. GHI provides reimbursement for prescription drugs based on negotiated rates, which represent an established discount off the Average Wholesale Price of each drug.

GHI's Network Pharmacies have agreed to accept these discounted rates as payment in full for covered prescription drugs, subject to applicable cost-sharing provisions.

If your program covers drugs dispensed by Non-Network Pharmacies, GHI will reimburse you based upon the discounted in-network payment for that covered drug, subject to any applicable cost-sharing provisions.

Maximum Benefits. Certain benefits have maximum limits on either the dollar amount GHI will pay or the number of services covered. Once you have reached these maximum limits, GHI will not provide additional reimbursement for these benefits. These limits may be Annual Maximums and/or Lifetime Maximums.

Your Program may also include maximums on all covered medical services received from Non-Network Providers. Once GHI's payments reach these maximum limits, GHI will not reimburse any additional covered medical services received from Non-Network Providers.

These limits may be Annual Maximums and/or Lifetime Maximums.

Your Contract lists those benefit maximums, if any, which are in effect for your coverage.

Transfers Among Providers. If, during the course of treatment, you transfer from one provider to another, GHI's allowance for the covered services may be prorated between providers. Normally, GHI will not pay more than its maximum allowance had payment been made to only one provider.

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WHAT YOU PAY

You can obtain most covered services from either Network or Non-Network Providers and still be eligible for benefits under the Program. **You will maximize your benefits and avoid out-of-pocket expenses by utilizing GHI Network Providers**.

Your financial responsibility is limited to the following categories:

Premiums. You are responsible for paying the premium established by GHI for your policy directly to GHI.

Your coverage with GHI will be terminated if you fail to pay your premium in a timely manner as provided in your Contract.

Cost-Sharing. The specific cost-sharing provisions for your policy are detailed in your Contract. The following information is included here to help you more easily understand the information in your Contract.

When you use Network Providers, many services are covered in full, but some may require a **copayment** — a predetermined dollar amount you pay for certain covered services. The copayment is usually paid to the provider at the time service is rendered. For example, you may have to pay the doctor a $10 copayment for an office visit.

Certain benefits may also require you to satisfy a deductible and/or pay coinsurance, even if you receive covered services in-network.

When you obtain covered services from Non-Network Providers, you may also be responsible for any or all of the following types of charges:

- **Deductible:** A portion of eligible expenses that an individual or family must pay during a calendar year before GHI will pay benefits for covered services.
- **Coinsurance:** A percentage of GHI's allowance(s) payable by you for covered services.
- **Copayment:** A predetermined dollar amount you pay for certain covered services.
- **Balance of Charges:** Non-Network Providers have not agreed to accept GHI's allowance or negotiated rate as payment in full. You are responsible for any provider charges that exceed GHI's allowance(s) in addition to any copayment, deductible and/or coinsurance amounts that apply to your benefits for covered services when you receive care from Non-Network Providers.

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For example, if the provider charges $50 for a given service and GHI allows $30, you are responsible for the $20 difference ($50 – $30 = $20) in addition to any cost-sharing provisions that apply to your coverage.

Your Contract details the specific cost-sharing provisions for all benefits under your Program.

Amounts Exceeding Benefit Maximum(s). Certain covered services have maximum limits on either the dollar amount GHI will pay or the number of services covered. Once you have reached these maximum limits, you must pay for any additional services. These limits may be Annual Maximums and/or Lifetime Maximums.

Your Program may also include maximum(s) on all covered medical services received from Non-Network Providers. Once GHI's reimbursement reaches these maximum limits, you pay for any additional covered medical services received from Non-Network Providers. These limits may be Annual Maximums and/or Lifetime Maximum limits.

Consult your Contract for information on maximum limits that apply under your policy.

Non-Covered Services. GHI will not pay for any service not listed as covered or any service that is specifically excluded under your policy. You will be responsible for the provider's full charges for these services.

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HOW UTILIZATION MANAGEMENT CAN AFFECT YOUR BENEFITS

All covered services are subject to Utilization Management by GHI. Utilization Management (also known as utilization review) seeks to determine whether the health care services that have been provided are being provided, or are proposed to be provided are medically necessary. An explanation of GHI's criteria for "medical necessity" appears in Some Important Definitions in this brochure.

Utilization Management also seeks to determine whether the health care services that have been provided, are being provided, or are proposed to be provided, are Experimental or Investigational in nature and, therefore, excluded from coverage.

Utilization Management at GHI is a highly specialized process. GHI's Medical Director oversees and supervises all utilization review activities, which are performed by GHI's Coordinated Care department. Any Adverse Determination by GHI is confirmed by a Clinical Peer Reviewer before it is made. An Adverse Determination is a finding by GHI or its agents that an admission, extension of stay, or other health care service has been reviewed and based on the information provided, the admission, extension or other service is not medically necessary or is experimental or investigational in nature and therefore not reimbursable by GHI.

All notices of Adverse Determination will include instructions on how to initiate standard, expedited and external Utilization Management Appeals. They will also include information about the reasons for the determination (including the clinical rationale), instructions on how to initiate an appeal, and notice of availability of the clinical review criteria or other rule, guideline or protocol relied upon by GHI to make the determination, and other rights available to you.

In the event that GHI renders an Adverse Determination without attempting to discuss the matter with the health care provider who specifically recommended the service, procedure or treatment under review, the provider may request a reconsideration of the Adverse Determination. Except in cases of retrospective reviews, reconsideration will occur within one business day of GHI's receipt of the request and shall be conducted by the provider and the GHI clinical peer reviewer who made the initial Adverse Determination (or a designated clinical peer reviewer if the original clinical peer reviewer is not available). If the Adverse Determination is upheld, GHI will provide written notice of the determination, including the reasons

for the determination, including the clinical rationale, instructions on how to initiate appeals, and notice of availability of the clinical review criteria relied upon by GHI to make the determination.

You have the right to appeal any Adverse Determination by GHI. (See **Utilization Management Appeal Procedures**.)

Utilization Management provisions, such as precertification, require that you contact GHI before receiving treatment, admission to a hospital and/or other health care services.

The remainder of this section explains when and how to contact GHI for Utilization Management services and how Utilization Management can affect your benefits. The Appeals Procedure section describes how to appeal an Adverse Determination by GHI if you are not satisfied with GHI's decision.

You can reach GHI's Utilization Management department at **1-877-842-3625**.

Precertification. Your Contract may require you or your provider to obtain precertification of certain services in order to be eligible for maximum benefits and to avoid penalties. **Precertification is the evaluation of proposed treatments or services for medical necessity before they are rendered** and includes precertification of hospital and medical services. Requests for services that require precertification are known as pre-service claims. When utilizing a Network Provider for covered services, the Network Provider will initiate the precertification process on your behalf.

The following sections outline how to obtain precertification from GHI. In general, you and/or your provider need to initiate the precertification process by calling GHI before services are rendered. GHI will notify you and your provider of its decision on a non-urgent precertification request within three business days of receipt of all necessary information. GHI will notify you in writing and by telephone.

If GHI requires more information to make a decision, GHI will request such information from you and your provider. GHI will give you at least 45 days to supply the information. If you supply all of the requested information to GHI within the time that GHI gives you to supply it, GHI will notify you of its decision within three business days. Otherwise, GHI will notify you of its decision within fifteen days of its receipt of partial information or within 15 days of the end of the time period GHI gives you to supply the information.

If you fail to follow GHI's precertification procedure(s) when required by your program, GHI will inform you of the proper precertification procedure within five days (or within 24 hours in the case of a request for approval of urgent care claim) of receipt of the request by a GHI person or unit customarily responsible for handling benefit matters.

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If your precertification request involves urgent care that has not yet been initiated, GHI will notify you and your provider of its decision on your request within 72 hours from receipt of the request. GHI will notify you in writing and by telephone. If GHI requires more information to make a decision, GHI will notify you of the required information with 24 hours after GHI's receipt of the claim. GHI will give you at least 48 hours to supply the information. GHI will notify you of its decision on your request within 48 hours of its receipt of the information or within 48 hours of the end of the time period GHI gives you to supply the information whichever is earlier. GHI may reasonably require you or your provider to explain the medical reasons that give rise to a need for urgent care.

Certain procedures, treatments and admissions require that you obtain advance approval from GHI to receive full benefits. The specific services which require you to obtain precertification under your Program are identified in your Contract.

For hospital admissions, you, a family member or your physician should contact GHI's Coordinated Care Program for precertification:

- At least 10 days prior to the date of admission for elective procedures, or as soon as reasonably possible.
- Within two business days of an emergency admission, or as soon as reasonably possible.

To precertify most care, contact GHI's Coordinated Care department at **1-212-615-4662** (area codes 212, 718, 516) or **1-800-223-9870** (all other areas).

If you fail to precertify non-emergency services that require precertification under your Contract, your benefits may be reduced and the paid-in-full feature of using a GHI Network Provider may no longer be applicable.

Note that for covered services, Network Providers will contact GHI directly for precertification.

Concurrent Review. If you or your provider request a non-urgent continuation, extension or addition to a previously approved plan of care, GHI will notify you and if appropriate, your provider of its decision within one business day of GHI's receipt of all necessary information, but not more than 15 days after GHI's receipt of the request. If GHI reduces or terminates a previously approved course of treatment (for reasons other than amendment or termination of your Program or your GHI coverage), GHI will notify you and if appropriate, your provider of its decision sufficiently in advance so that you can appeal the decision. GHI will notify you in writing and by telephone.

If care has already been initiated and you are seeking an extension of urgent care, the time in which GHI will decide your urgent care request will vary. It will depend upon when GHI receives your request. If GHI receives your request at least 24 hours before the end of the previously approved treatment plan, then GHI will notify you and your provider of its decision on your urgent care request within 24 hours after GHI's receipt of the request. If GHI receives your request less than 24 hours before the end of the previously approved treatment plan, then GHI will notify you and your provider of its decision within the earlier of 1 business day of its receipt of all necessary information or 72 hours of its receipt of the request. GHI will notify you in writing and by telephone.

Complex Case Management. Should you or a covered family member experience a specific illness or injury with potential long-term effects, GHI's Complex Case Management program concentrates on alternatives to improve the quality and cost-effectiveness of your care. GHI's Medical Director and Case Managers assess the patient's individual needs and the full range of treatment and financial options available from the onset of a condition or illness through recovery or stabilization.

As with all concurrent review, once you have notified GHI's Coordinated Care department of your hospital admission, Complex Case Management will occur automatically, if appropriate. You do not need to take any action.

Retrospective Review. Retrospective review is the review of claims received at GHI for services already performed (i.e. post-service claims) and occurs prior to claim payment. Retrospective Review confirms medical necessity and determines the need for, or to uphold, a non-precertification penalty.

GHI will notify you, and if appropriate your provider, of its decision on a retrospective review within 30 days after its receipt of the claim. GHI will notify you in writing.

If GHI requires more information to decide your claim, GHI will request such information within 30 days after its receipt of the claim. GHI will give you at least 45 days to supply the information. If GHI requests more information, GHI will notify you of its decision on your claim within 15 days after GHI's receipt of all or part of the information or within 15 days after the end of the time period GHI gives you to supply the information.

Submission of a claim by the provider or by you automatically triggers retrospective review. No action is required by you.

How To Contact Coordinated Care. You may contact GHI's Coordinated Care Department by telephone at:

1- 212-615-4662 (area codes 212, 718, 516)
1- 800-223-9870 (all other areas)

Or, you may contact Coordinated Care in writing at:

GHI Coordinated Care
P.O. Box 2809
New York, New York 10116-2809

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HOW TO OBTAIN BENEFITS

When you use a Network Provider, obtaining benefits for covered services is truly simple. You show your GHI identification card, pay any applicable copayment, deductible or coinsurance charges, and that's it.

The hospital, doctor or other provider files the claim for you and awaits reimbursement from GHI. Generally, your only expense when you receive covered services from Network Providers are any cost-sharing required under your Program.

If you use a Non-Network Provider, you must pay the provider's charge and promptly submit a claim form to GHI to receive reimbursement for covered services. Most claims are processed and mailed by GHI within 10 to 15 business days from the date we receive them from you or your provider. To save time, we suggest you request that the provider complete the claim form at the time of your visit so you can mail the claim to GHI right away.

In order to prevent a denial of coverage due to failure to timely file a claim, you must file your claim with GHI within 18 months after the date upon which the service was rendered.

The Health Insurance Claim Form is used for most services. GHI has special claim forms for visiting nurse and out-patient hospital claims.

How to Get the Fastest Claim Service. If your provider will not be submitting a claim form on your behalf, you can help speed claim processing by completing every section of the claim form accurately.

Specifically, remember to:

- Include your certificate number in Section A. This number is indicated on your GHI ID card. If you are covered under any other plan, complete Section 3A.
- Make sure your physician provides a copy of a detailed, itemized bill or completely fills out Part D. **The claim cannot be processed and will be returned to you if it does not specify the exact services performed**.

Promptly complete and mail claims to the appropriate address indicated both on the claim form and in the back of this booklet.

Your GHI Claims Payment Statement. You will receive an Explanation of Benefits statement from GHI whenever GHI processes a claim submitted by you or your provider.

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When you use a GHI Network Provider. Once GHI processes a claim on your behalf, we will send you and your physician or hospital an Explanation of Benefits statement to inform you that GHI has processed a claim on your behalf. The statement will show the amount of GHI's payment to the provider and the date(s) service(s) was performed.

If you use a Non-Network Provider. After GHI processes a claim you have submitted, we will send you an Explanation of Benefits statement, along with a reimbursement check, if appropriate. The services received and the dates they were performed are listed on the statement along with GHI's allowances for covered services and any cost-sharing amounts applied by GHI. The statement also gives you instructions about how to file an inquiry or a grievance and other information.

Remember, you will receive a percentage of GHI's fee schedule or allowance if you obtain covered services from a Non-Network Provider. **If the Non-Network Provider charges more than GHI's fee schedule or allowance, you must pay the difference between GHI's payment and the provider's charge, in addition to any applicable cost-sharing amount(s)**.

Prescription Drug Benefits: Retail. If your policy includes prescription drug coverage, simply present your prescription drug identification card to the GHI Network Pharmacist along with the doctor's prescription. There are no claim forms to fill out when you use a GHI Network Pharmacy and present your prescription drug ID card. The pharmacist will fill your prescription and apply applicable copayments, deductibles or coinsurance.

Your Program may also provide coverage for prescriptions filled by Non-Network Pharmacies. If you use an Non-Network Pharmacy, you must pay for your medications in full at the time of purchase and submit a claim form for reimbursement. Reimbursement is limited to the amount GHI would have paid at a Network Pharmacy, less applicable cost-sharing provisions as indicated in your Contract.

Prescription Drug Benefits: Mail Order. Your Program may also provide for mail order services for long-term or ongoing prescription medications. Your prescription and the applicable copayment must be mailed to the Program's Prescription Benefits Manager (PBM). Please refer to the section of this booklet entitled "**Important Phone Numbers and Addresses**" for contact information for the PBM.

You will receive notification of the number of refills available on your prescription with your original mail-order prescription medication. Simply mail this refill notice and any applicable copayment to the PBM in the pre-addressed order envelope provided. You should order your refills at least three weeks before you need them.

Your Contract indicates what, if any, mail-order prescription drug benefits are available under your policy.

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UTILIZATION MANAGEMENT APPEAL PROCEDURES

You have the right to appeal any Adverse Determination made by GHI relative to a hospital admission, extension of stay, or other health care service that has been reviewed and determined by GHI to be medically unnecessary or experimental or investigational in nature and therefore, not covered. You have the right to designate a representative to appeal any Adverse Determination on your behalf.

A Utilization Management Appeal must be filed either by telephone or in writing within 180 days from the time you receive GHI's notification of an Adverse Determination. When filing a Utilization Management Appeal, please include your GHI identification number and all applicable claim numbers. Your request should also include any other data and comments which you believe support your appeal.

Verbal Utilization Management Appeals can be initiated by calling toll free **1-888-906-7668**.

Please submit written Utilization Management Appeals to:

GHI - Coordinated Care Appeals
P.O. Box 2809
New York, New York 10116-2809

Be sure to clearly indicate if you are requesting an expedited appeal or urgent care claim appeal, as described below.

Standard Appeals. GHI will acknowledge receipt of a non-urgent appeal within 15 days of GHI's receipt of your appeal. If GHI needs more information to decide your appeal, GHI will notify you and your provider of the needed information within 15 days of GHI's receipt of the appeal. The time within which GHI will respond to your appeal will vary depending upon the type of claim that you are appealing. If GHI fails to decide your appeal within these time periods, the service will be deemed approved.

Pre-Service Claim Appeals. In the case of a pre-service claim, GHI will decide your appeal within 30 days from GHI's receipt of the appeal. A pre-service claim is a claim or request for a service that you or your provider must precertify with GHI under the terms of your Contract.

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Post-Service Claim Appeals. In the case of a postservice claim, GHI will decide your appeal within 30 business days of GHI's receipt of all necessary information, but not more than 60 days from GHI's receipt of the appeal. A postservice claim is a claim for benefits relating to a service that has already been provided to you.

Urgent Care Claim Appeals. In the case of an urgent care claim, GHI will decide your appeal within the earlier of two business days of GHI's receipt of all necessary information or 72 hours after GHI's receipt of the appeal. An urgent care claim is a claim that, if subjected to the time periods applied to other types of claims could seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function, or subject the patient to severe pain that cannot be managed adequately.

Concurrent Care Appeals. If you are appealing GHI's denial of a non-urgent continuation, extension or addition to the care plan, GHI will decide your appeal within the earlier of two business days of GHI's receipt of all necessary information or 30 days after GHI's receipt of the appeal. If you are appealing GHI's reduction or termination of a previously approved care plan, GHI will decide your appeal within 72 hours of GHI's receipt of the appeal.

Expedited Appeals. GHI offers an expedited appeal process in certain cases. An expedited appeal may be filed only in the cases below.

- Cases that involve continued or extended health care services, procedures or treatments.
- Cases that involve requests for additional services for a person undergoing a course of continued treatment.
- Cases where the Provider believes an immediate appeal is warranted due to imminent or serious threat to the health of the person.

If GHI needs more information to decide your appeal, GHI will notify you and your Provider of the needed information within 24 hours. GHI will make a decision on your appeal within two business days of GHI's receipt of the information needed for GHI to conduct a full and fair review, but not more than 72 hours from GHI's receipt of the appeal.

To file an expedited appeal, please call GHI toll free at **1-888-906-7668**.

External Appeal (effective July 1, 1999). You may file an application for an external appeal by a New York State approved external appeal agent if you have received a denial of coverage based on medical necessity or because the service is experimental and/or investigational.

To be eligible for an external appeal, you must have received a final adverse determination as a result of GHI's Utilization Management Appeal process or both you and GHI must have jointly agreed to waive the Utilization Management appeal process.

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You may obtain an external appeal application from:

- The New York State Department of Insurance at **1-800-400-8882**, or its Web site (**www.ins.state.ny.us**).
- Our Medical/Coordination Care department at **1-888-906-7668**.

The application will provide clear instructions for completion. To file an external appeal, you must include **$50.00** with the application. This money will be refunded if the external appeal is decided in your favor. You may obtain a waiver of this fee if you meet GHI's criteria for a hardship exemption.

The application for external appeal must be made within 45 days of your receipt of the notice of final adverse determination as a result of GHI's appeal process, or within 45 days of when you and GHI jointly agree to waive the internal appeal process. *Additional internal GHI appeals may be available to you, which are optional. However, regardless of whether you participate in additional internal GHI appeals, an application for external appeal must be filed with the New York State Department of Insurance within 45 days from your receipt of the notice of final adverse determination from a first level internal GHI appeal to be eligible to be reviewed by an external appeal agent*.

You will lose your right to an external appeal if you do not file an application for an external appeal within 45 days from your receipt of the final adverse determination from the first level internal GHI appeal.

The application will instruct you to send it to the New York State Department of Insurance. You (and your doctors) must release all pertinent medical information concerning your medical condition and request for services. An independent external appeal agent approved by the state will review your request to determine if the denied service is medically necessary and should be covered by the program. All external appeals are conducted by clinical peer reviewers. The agent's decision is final and binding on both you and GHI.

An external appeal agent must decide a standard appeal within 30 days of receiving your application for external appeal from the state, five additional business days may be added if the agent needs additional information. If the agent determines that the information submitted to it is materially different from that considered by GHI, GHI will have three additional business days to reconsider or affirm its decision. You and GHI will be notified within two business days of the agent's decision.

You may request an expedited appeal if your doctor can attest that a delay in providing the recommended treatment would pose an imminent or serious threat to your health. The external appeal agent will make a decision within three days for expedited appeals. Every reasonable effort will be made to notify you and GHI of the decision by telephone or fax immediately. This will be followed immediately by a written notice.

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GRIEVANCE PROCEDURES

If you are dissatisfied with a benefit or other written determination made by GHI relating to your health Program, other than a medical necessity decision, you have the right to file a grievance requesting that GHI reconsider or review the determination. You have the right to designate a representative to handle your grievance for you. Adverse medical necessity decisions by GHI may be appealed.

You must file the written grievance within 180 days from the date that you received notice of GHI's decision. In submitting your grievance please include your GHI identification number as well as any applicable claim number(s). Your grievance should also include any other supporting data and comments. GHI will reply to your grievance in writing. GHI will reply to your grievance within the time period(s) set forth below.

- Urgent Care Claims: 72 hours after GHI's receipt of the grievance. An urgent care claim is a claim that, if subjected to the time periods applied to other types of claims could seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function, or subject the patient to severe pain that cannot be managed adequately.
- Preservice Claims: 30 days after GHI's receipt of the grievance. A preservice claim is a claim or request for a service that you or your provider must precertify with GHI under the terms of your Contract.
- Postservice Claims and Other Grievances: 60 days after GHI's receipt of the grievance. A postservice claim is a claim for benefits relating to a service that has already been provided to you.

Grievances involving clinical decisions will be reviewed by qualified clinical personnel.

In the event that GHI has denied a claim on the basis that the services are not medically necessary or are experimental or investigational in nature and you do not agree with GHI's determination, you should file a Utilization Management Appeal. The Utilization Management Appeal process was described earlier in this booklet. All grievances related to hospital claims should be mailed to:

GHI — Hospital Grievance
P.O. Box 2828
New York, New York 10116-2828

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All other grievances should be mailed to:

GHI — Grievance Unit
P.O. Box 1701
New York, New York 10023-9476

MEMBER RIGHTS AND RESPONSIBILITIES

Rights And Responsibilities

Understanding your rights and responsibilities as a GHI member can help you and us make the most of your GHI 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 GHI member. If for any reason, you do not understand these rights or how to interpret them, GHI and its participating physicians will provide you with assistance.

- The right to treatment 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 the GHI participating provider network.
- The right to change your physician.
- The right to be assured that GHI participating health care providers have the qualifications stated in GHI Professional Standards, established by the GHI credentialing committee, which are available upon request.
- The right to know the names, positions and functions of any participating provider's staff and to refuse their treatment, examination or observation.
- The right to 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.

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- 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 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 GHI participating physician.
- The right to privacy concerning your medical care. This means, among other things, that no person who is not directly involved in your care may be present without your permission during any portion of your discussion, consultation, examination or treatment.
- 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 or permitted by law or authorized 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 GHI and your participating 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 Grievance Procedures in your Member Handbook and/or call GHI's Customer Service Department at **1-212-501-4444** in New York City, or **1-800-624-2414** in other areas.
- **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 the organization, its services, its practitioners and providers and member rights and responsibilities.
- The right to make recommendations regarding GHI's member rights and responsibilities policies.

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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 GHI and its participating physicians and other providers with accurate and relevant information about your medical history and health so that appropriate treatment and care can be rendered.
- 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 GHI 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 GHI personnel and the personnel of any hospital or health facility to which you are referred.
- The responsibility to be actively involved in your own health care by seeking and obtaining information, by discussing treatment options with your physician and by making informed decisions about your health care.
- The responsibility to follow plans and instructions for care that you have agreed to with your practitioner.
- The responsibility to understand your health problems and participate in developing mutually agreed upon treatment goals, to the degree possible.
- The responsibility to understand GHI's benefits, policies and procedures as outlined in your Contract or Certificate of Coverage and handbook, including policies related to prior approval for all services that require such approval.
- The responsibility to pay copayments, if applicable, at the time services are rendered.
- The responsibility to abide by the policies and procedures of your participating physician's office.

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MEMBER SERVICES

Call Member Services Promptly If You:

- Have questions or concerns about your coverage.
- Want to know more about providers.
- Have service issues or need problem resolution.

Most questions may be answered by visiting our Web site, **www.ghi.com**, or by calling Member Services at **1-212-501-4444** in New York City or **1-800-624-2414** outside of New York City.

Non-English Speaking Members

Your satisfaction is important to us. When a non-English speaking member or his/her representative contacts any GHI member service area, arrangements will be made to accommodate the language needs of the member. For the hearing impaired, please call **1-212-721-4962**.

Member Input into GHI Policy Development

As an Article 43, not-for-profit health services corporation, GHI is required by New York State Insurance Law to have a board of directors whose members are representative of GHI's network hospitals or medical professionals, GHI members and the general public.

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SOME IMPORTANT DEFINITIONS

This booklet may contain phrases or terms you are not familiar with. The following definitions are provided to assist you in understanding terms applicable to your coverage:

Annual Maximum: The maximum accumulated payments GHI will make for covered services rendered to a covered person during a calendar year or the maximum number of covered days/visits available to a covered person for a particular service or services during a calendar year.

Adverse Determination: A determination by GHI or its agents that an admission, extension of stay or other health care service has been reviewed and, based on the information provided, is not Medically Necessary or is Experimental or Investigational in nature, and therefore, not covered.

Contract: The GHI direct payment contract and any riders and attachments thereto which evidence the health insurance coverage you have purchased from GHI.

Coinsurance: Coinsurance is a percentage of GHI's allowance(s) payable by you for covered services. Expenses credited toward your deductible, copay charges, charges for services that are not covered, and charges in excess of GHI's allowances and benefit limitations are also payable by you, but are not considered to be coinsurance.

Copayment (Copay Charge): The fixed dollar amount members must pay to a Network Provider for certain covered services.

Cost-Sharing: A comprehensive term for the deductible, copayment and coinsurance provisions in your Program.

Deductible: A portion of eligible expenses that an individual or family must pay during a calendar year before GHI will begin to pay benefits for covered services.

Dependent: An individual other than the member who is eligible for coverage under the member's Contract. Generally, dependents are limited to the member's spouse and minor children.

Direct Pay Contract: See Contract above.

Eligible Expense: The total dollar amount allowed by GHI for a covered service.

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Emergency Care: Care for a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

(a) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy; (b) serious impairment to such person's bodily functions; (c) serious dysfunction of any bodily organ or part of such person; or (d) serious disfigurement of such person.

Grievance Procedure: A complaint process whereby you, your duly authorized representative, your provider or the provider's duly authorized representative may seek review of benefit determinations or determinations other than determinations of medical necessity and experimental/investigational nature of services made by GHI relating to your health Program.

Hospital: The term "hospital" refers to an institution that has medical and surgical facilities for the care and treatment of the sick and must be a short-term acute care general hospital. A short-term acute care general hospital is an institution engaged primarily in providing inpatient diagnostic and therapeutic facilities for surgical and medical diagnoses, treatment, and care of sick and injured persons. The hospital must provide 24 hour nursing service by registered graduate nurses who are present and on duty. The hospital must be supervised by a staff of physicians. A hospital is not one of the following:

- An old age, rest, or nursing home
- A convalescent home or similar institution
- A sanitarium
- A camp, school, college, or university infirmary
- A facility primarily for the treatment of mental problems, tuberculosis, drug abuse or alcoholism
- A weight loss or fitness center
- A skilled nursing center or facility
- An institution utilized primarily for custodial care or as a domicile
- A health resort or spa
- A place for hospice care treatment
- A rehabilitation facility

Lifetime Maximum: The maximum accumulated payments GHI will make for covered services rendered to a covered person per lifetime or the maximum number of days/visits available to a covered person per lifetime for a particular service or services.

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Medically Necessary: Medically necessary care is health care that is rendered by a Hospital or a licensed or certified provider and is determined by GHI to meet all of the criteria listed below:

- It is provided for the diagnosis or direct care or treatment of the condition, illness, disease, injury or ailment.
- It is consistent with the symptoms or proper diagnosis and treatment of the medical condition, disease, injury or ailment.
- It is in accordance with accepted standards of good medical practice in the community.
- It is furnished in a setting commensurate with the member's medical needs and condition.
- It cannot be omitted under the standards referenced above.
- It is not in excess of the care indicated by generally accepted standards of good medical practice in the community.
- It is not furnished primarily for the convenience of the member, the member's family or the provider.
- In the case of a hospitalization, the care cannot be rendered safely or adequately on an outpatient basis and requires that the member receive acute care as a bed patient.

The fact that a provider has prescribed a service or supplies care does not automatically mean that the service or supply will qualify for reimbursement under the GHI program. To be eligible for reimbursement by GHI, all covered services must meet GHI's medical necessity criteria, described above.

Network Provider: Also known as a Participating Provider, a Network Provider is any doctor or other provider who has agreed with us to accept our allowance or negotiated rates as payment in full for covered services. Visit **www.ghi.com** for the names of Network Providers. You may also call or write to GHI for this information or consult your GHI Provider Directory at www.ghi.com.

Network Rate: The scheduled allowance(s) or negotiated rate(s) a Network Provider has agreed to accept as payment in full for covered services rendered to GHI members. Our network rate(s) usually represent a reduction to the provider's regular fee. In some cases, we will have a negotiated rate with a Network Provider. Our negotiated rates will vary, depending upon the terms agreed upon between us and the Network Provider.

Participating Provider: See Network Provider.

Out-of-Pocket Maximum: The maximum dollar amount per calendar year of coinsurance expenses payable by you for covered medical services rendered by Non-Network Providers.

Precertification: Certain covered services must be precertified by contacting GHI for approval prior to treatment. Failure to obtain GHI's advance approval for these services may result in a reduction of benefits and/or payments as defined in your Contract. Precertification can include precertification of hospital admissions and medical services.

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Pre-Existing Condition: A pre-existing condition is any disease, symptom or condition that was present on the enrollment date and for which medical advice or treatment was recommended or received during the six-month period prior to the enrollment date.

Provider: A provider is a medical practitioner or covered facility recognized by GHI for reimbursement purposes. A provider may be any of the following, subject to the conditions listed in this paragraph:

- A doctor of medicine
- A doctor of osteopathy
- A dentist
- A chiropractor
- A doctor of podiatric medicine
- A physical therapist
- A nurse midwife
- A nurse practitioner
- A certified and registered psychologist
- A certified and qualified social worker
- An optometrist
- A nurse anesthetist
- A speech therapist
- An audiologist
- A clinical laboratory
- A screening center
- A general hospital
- Any other type of practitioner or facility specifically listed in your Contract or this brochure as a practitioner or facility recognized by GHI for reimbursement purposes

A provider must be licensed or certified to render the covered service. The covered service must be within the scope of the provider's license or certification. Please note that not all services rendered by a specific class of providers listed above are reimbursable. In order for the treatment to be reimbursable, the service rendered to you must be covered under your GHI Program and must be medically necessary. In addition, the practitioner or facility rendering the service must be listed in your Contract or this brochure as a provider who is recognized by GHI to render the covered service.

Please refer to your Contract to determine if a service is covered. In any case where the two documents conflict, the Contract will govern.

Utilization Management: A review to determine whether covered services that have been provided or are proposed to be provided to you, whether undertaken prior to, concurrent with or subsequent to the delivery of such services, are medically necessary and/or experimental or investigational in nature.

Utilization Management Agent: GHI or any Utilization Management review agent performing Utilization Management on our behalf.

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Utilization Management Appeal: The process by which you or your representative may request review of a denied service(s) based upon an Adverse Determination made by GHI or a Utilization Management Agent acting on our behalf. An Adverse Determination is a denial by GHI of coverage for services considered not medically necessary, or experimental or investigational in nature.

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PRINCIPAL LIMITATIONS AND EXCLUSIONS

In addition to the terms, limitations, and exclusions described elsewhere in this brochure, the following items are not covered under GHI's benefit programs:

Air Ambulance: Except as otherwise provided in your Contract, you are not covered for air ambulance.

Care Furnished Without Charge: Payment will not be made for any care if the care is furnished or would normally be furnished to you without charge. You are not covered for services rendered for which no legally enforceable charge is incurred.

Chiropractic Care: Unless your coverage specifically includes chiropractic care, you are not covered for care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for the purpose of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment, or subluxation of the vertebral column.

Convalescent or Custodial Care: You are not covered for services related to bed rest, rest cures, convalescent care or custodial care. You are not covered for sanitarium care. Custodial care refers to help in transferring, eating, dressing, bathing, toileting and other such related activities.

Cosmetic Surgery and Treatment: Payment will not be made for services in connection with elective cosmetic surgery or treatment which is primarily intended to improve your appearance unless otherwise medically necessary. However, GHI will cover breast reconstruction surgery following a mastectomy. This includes all stages of reconstruction of the breast on which the mastectomy was performed GHI will cover surgery and reconstruction of the other breast to produce a symmetrical appearance. Payment will be made for services in connection with reconstructive surgery when the service is incidental to or follows surgery resulting from trauma, infection or other diseases of the part of the body involved. Payment will also be made for reconstructive surgery performed due to congenital disease or an anomaly of a covered child which has resulted in a functional defect.

Educational or Vocational Services: You are not covered for services which are either educational or vocational in nature.

Elective Reversal of Sterilization: You are not covered for the elective reversal of sterilization.

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Excess Inpatient Hospital Charges: You are not covered for hospital charges which are not covered under your inpatient hospital benefit.

Experimental/Investigational Treatments: In general, GHI does not cover experimental or investigational treatments. You are not covered for expenses that GHI determines to be related to:

(a) experimental treatment
(b) investigational treatment
(c) clinical trials

Experimental treatment is a treatment that has not been tested in human beings; or that is being tested but has not yet been approved for general use; or that is subject to review or approval by an Institutional Review Board.

Investigational treatment includes, but is not limited to services or supplies which are under study or in a clinical trial to evaluate their toxicity, safety and efficacy for a particular diagnosis or set of indications.

Clinical trials include, but are not limited to controlled experiments having a clinical event as an outcome measurement involving persons having a specific disease or health condition; or involve the administration of different study treatments in a parallel treatment design done to evaluate the efficacy and safety of a test treatment. Clinical trails include Phase I, Phase II and Phase III Studies. Clinical trials also include randomized trials or studies.

However, GHI will cover an experimental or investigational treatment approved by an external appeal agent certified by the State of New York. If the external appeal agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, GHI will only cover the costs of services required to provide treatment to you according to the design of the trial. GHI will not be responsible for the cost of investigational drugs or devices, the cost of non-health care services or the cost of managing research. Additionally, GHI will not be responsible for costs which would not be covered under your policy for non-experimental or non-investigational treatments which are provided as part of a clinical trial.

Medical Summaries: You are not covered for medical summaries and/or medical invoice preparations.

Medicare and Other Government Programs: Payment under your Program may be reduced by the amount you are eligible to receive for the same service under Medicare or any other federal, state, or local government program.

Non-Acute Hospital Care: You are not covered for a hospital stay or a portion of a hospital stay during which you receive non-acute care. This exclusion applies to a hospital stay or a portion of a hospital stay in connection with physical check-ups, convalescent or custodial care, rest cures, or sanitarium-type care. Care is considered custodial when it is primarily for the purpose of meeting personal needs, could be provided by persons without professional skills or training. For example, custodial care includes help in walking, getting in and out of bed, bathing, dressing, eating, and orally taking medicine.

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No-Fault Automobile Insurance: Payment will not be made for any service for which mandatory automobile no-fault benefits are recovered or are recoverable.

Nutritionist and Related Services: You are not covered for the services of Nutritionist or special dietary products, except as specifically provided in your Contract. You are not covered for weight counseling or weight control programs, such as commercial weight loss plans. However, GHI will provide benefits for covered services when medically necessary and prescribed or rendered for the treatment of morbid obesity.

Pre-existing Conditions:* Any illness, injury or condition that starts after your first day of coverage is covered. However, coverage of a pre-existing illness, injury or condition is limited. A pre-existing condition is any disease, symptom or condition that was present on the enrollment date, and for which medical advice or treatment was recommended or received during the six month period prior to the enrollment date.

If you have a pre-existing condition, that condition is not covered during the first 11 months this contract is in effect.

This limitation applies to all services related to a pre-existing condition, disease, or symptom. There are several exceptions to this rule.

a) Coverage Under a Prior Health Plan: If you were previously covered under a health insurance plan and the lapse in coverage between the termination of the prior plan and your enrollment date under this program does not exceed 63 days, GHI will credit the time you were covered under the prior plan toward the 11 month pre-existing condition limitation that applies to this Program. For purposes of this paragraph, a health insurance plan includes any of the following:

- a group health plan
- health insurance coverage
- Part A or B of Title XVIII of the Social Security Act
- Title XIX of the Social Security Act (other than coverage consisting solely of benefits under Section 1928)
- Chapter 55 of Title 10 of the United States Code
- a medical care program of the Indian Health Service or of a tribal organization
- a state health benefits risk pool; of a health plan offered under Chapter 89 of Title 5 of the United States Code
- a public health plan (as defined in regulations)
- a health benefit plan under Section 5(E) of the Peace Corp Act (22 U.S.C. 2504 (e))

b) Birth Defects: Treatments of birth defects (congenital anomalies) of a covered child are not subject to the pre-existing condition limitation.

c) Pregnancy: Under direct payment health insurance contracts, pregnancy is considered to be a pre-existing condition. GHI will apply a 10 month pre-existing

condition limitation for pregnancy existing on the enrollment date, subject to any credit for coverage under a prior health plan.

d) Newborns and Adopted Children: A newborn or a child who is adopted or placed for adoption before they are 18 years old, will not be subject to a pre-existing condition limitation. This will apply if the child is enrolled under creditable coverage within 30 days after birth or adoption or placement for adoption. This provision will not apply if the child has a break in coverage exceeding 63 days.

*Effective October 1, 2010, pre-existing conditions will be waived for members age 19, end of month, and younger.

Podiatric Care (Routine): Except as otherwise provided in your Contract, you are not covered for routine podiatric care. Routine podiatric care refers to the services set forth below rendered in connection with the routine care of the feet.

a) Orthopedic shoes and other supportive devices.
b) Services or supplies for the treatment of the following, unless open surgery is necessary:
Weak feet
Strained feet
Flat feet
Any instability or imbalance of the feet Metatarsalgia (pain in the sole of the foot in the region of the arch) Bunions
c) Services or supplies for the treatment of any of the following services, except when the treatment is prescribed for metabolic disease:
Corns
Calluses
Toenails

Prohibited Referrals: You are not covered for clinical laboratory services, X-ray or imaging services, pharmacy services or any other services provided pursuant to a referral prohibited by Section 238-a(1) of the New York State Public Health Law.

Services Covered by Government: Except for Medicaid, payment will not be made for services furnished, even in part, under the Law of the United States or any state or municipality. Care for non-service related injuries or illnesses rendered in a Veterans Administration hospital is covered.

Services Not Listed as Covered: Payment will not be made for services which are not listed in your Contract as being covered under your Program.

Services Rendered by Member of Immediate Family: Payment will not be made for services rendered by the member or the member's spouse or by a child, brother, sister or parent of the member or of the member's spouse.

Services Rendered in Governmental Hospitals: You are not covered for care, unless otherwise specifically provided, in any hospital or other institution which is owned, operated, or maintained by the Veterans Administration (except as noted below), the Federal government, a state government or any local government,

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unless the hospital has an agreement with GHI to provide services to GHI members. However, you are covered in such a hospital if, because of serious injury or sudden illness, you are taken to one of these hospitals for emergency care. You must be taken to this hospital because it is close to the place where you were injured or became ill. In this type of emergency situation, GHI will continue to make payment only for as long as emergency care, in GHI's sole judgment, is necessary and it is not possible for you to be transferred to another hospital.

GHI will make payments for outpatient visits for the treatment of chemical dependency even if the facility is owned, operated, or maintained by a state government or local government. However, the facility must be certified by the Office of Alcoholism and Substance Abuse Services or, if outside of New York state, accredited to provide an alcohol or substance abuse treatment program by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). GHI will make payments to these certified or accredited facilities only if the facility would have charged you if you did not have insurance. Payment will not be made for any service that is normally furnished without charge.

Care for non-service related injuries or illnesses rendered in a Veterans Administration Hospital is covered.

Services Through Your Employer, Union or Welfare Fund: You are not covered for services rendered in a hospital, department or clinic run by your employer, labor union, or welfare fund for which there is no charge.

Stand-by Services: You are not covered for stand-by services. Stand-by services are services that a provider performs in relation to being available to provide services on a contingent basis. Mere standing-by is not covered. Stand-by services may be deemed to be rendered by any provider. For example, the administration of anesthesia is not a stand-by service. It is a covered service. The services listed below when rendered by an anesthesiologist are not covered. They are deemed stand-by services:

- Preparing a contingency anesthesia plan
- Merely being in the operating area
- Merely being in the hospital
- Being available for diagnosis or treatment on a contingent basis, if needed

As another example, stand-by services may also be provided by a surgeon. Surgery or assisting at surgery are not stand-by services. They are covered services. The services listed below are not covered when performed by a surgeon; they are deemed stand-by services:

- Preparing a contingency surgery plan
- Merely reviewing a patient's chart
- Merely being in the operating area
- Merely being in the hospital
- Being available for diagnosis, treatment, or surgery on a contingent basis, if needed

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Treatment Not Conforming to Accepted Medical Standards: All services must conform to accepted standards of medical or hospital practice in order to be eligible for reimbursement by GHI. Services received that are beyond the scope of the license of the person rendering the service are not covered.

Unnecessary Care: In general, GHI will not cover any health care service that GHI, in its sole judgment, determines is not medically necessary. If an external appeal agent certified by the State of New York overturns GHI's denial, GHI shall cover the procedure, treatment, service, pharmaceutical product or durable medical equipment for which coverage had been denied, to the extent that such the procedure, treatment, service, pharmaceutical product or durable medical equipment is otherwise covered under the terms of your policy.

War: Payment will not be made for services for care of illness or injury due to war, declared or undeclared.

Workers' Compensation: Payment will not be made for care for any injury, condition or disease if payment is available to you under a Workers' Compensation Law or similar legislation. GHI will not make any payments even if you do not claim benefits you are entitled to receive under the Workers' Compensation Law. Also, payment will not be made even if you bring a lawsuit against the person who caused the injury or condition. Payment will not be made even if you receive money from that lawsuit and you have repaid the hospital or other provider.

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HEALTHFUL CHOICES

Helping You Take a Hands-On Approach to Your Health

GHI is committed to helping our members make health care and lifestyle decisions that are right for them. In addition to offering a broad choice of doctors, as well as around-the-clock health benefits information, we also provide preventive health programs, discounts on products and services that promote good health, and more. We strive to give our members a solid foundation so they can take an active role in their health.

Your Good Health Starts With Your Doctor

One of the best ways to ensure good health is to maintain a close relationship with the doctors you know and trust. That's why we give our members plenty of choice by recruiting a network of quality providers.

Encouraging Healthier Choices, Improving Quality of Life

GHI offers programs that help you live a healthier life. These programs are provided at no additional cost to you, and your participation is voluntary. You can use the listed programs whenever you wish as part of the value-added advantages of your GHI health coverage.

Supporting Smoking Cessation

GHI's Your Guide to Stop Smoking program, in partnership with the American Cancer Society, supplies tools for those of any age and lifestyle to kick the tobacco habit. Smokers can download self-help workbook from **www.ghi.com** with helpful reference pieces, including tips for dealing with the physiological changes that accompany smoking cessation, such as weight gain. For more information, please call the Quit Line at **1-866-611-QUIT** (1-866-611-7848). The TDD telephone number for the hearing impaired is **1-866-228-4327**.

HEALTHY DISCOUNTS

Offering Big Discounts on Popular Services

The Healthy Discounts program encourages a healthy lifestyle through attractive discounts on popular products and services. For details, including links to program Web sites, visit **www.ghi.com**. Click the "Health and Wellness" tab and select "Discount Programs." Your participation in the Healthy Discounts program is voluntary. **Please note**: These discount programs are subject to change, so be sure to check directly with the programs you are interested in by calling the telephone numbers or visiting the Web sites listed below for the latest details.

Among the Healthy Discounts offerings are:

Jenny Craig

Members and their eligible dependents can join Jenny Craig and receive a FREE 30-Day Program.* Call **1-800-96-JENNY** or visit **www2.jennycraig.com/CorporateChannel/ghi.aspx**.

*Plus the cost of food and shipping when applicable.

Jazzercise

Get one week free and 15% off the monthly fee for this unique dance and body-conditioning program. Call **1-800-FIT-IS-IT** or visit **http://www.jazzercise.com**.

Nutrisystem

GHI members get 12% off all Basic, Silver, Diabetic and Vegetarian program food orders. Get over 120 delicious entrees & desserts. Members who join the Auto-Delivery program may be eligible for free delivery and an additional 10% off for 28 days. Be sure to review with Nutrisystem the details of the Auto-Delivery program as minimum participation periods and/or cancellation fees may apply depending upon the food program selected. Nutrisystem generally requires no membership or enrollment fees, and may offer free weight loss counseling and more when you join. Call **1-877-690-6531** or visit **www.nutrisystem.com/health** and enter promo code "ghi08."

Weight Watchers

Call **1-800-710-4663** or visit **www.weightwatchers.com/cs/ghi** to find local meetings to help you make positive changes to lose weight and keep it off. Also available is $10 off a Weight Watchers three-month Online subscription weight-loss program.

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Vision Care

Save on examinations, eyewear and contact lenses. Call **1-877-92DAVIS** or visit **www.davisvision.com/ghi**. Go to "Members" and enter Client Control #7810.

Laser Vision Correction

Get discounts on LASIK procedures. Call **1-800-584-2866** or visit **www.davisvision.com/ghi**. Go to "Members" and enter Client Control #7940.

Hearing Care through TruHearing

Offers free hearing screening and discounts of up to 60% on various private label and brand name hearing aids. Call **1-866-961-3152** (**TDD: 1-800-975-2674**) to locate participating providers and service centers near you, or go online to view hearing aid options at **www.truhearing.com/hearing_aids/emblemhealth/**

Hearing Care through HearX, a HearUSA Company

Receive complimentary screenings and product discounts. Call **1-800-442-8231** (**TDD: 1-888-300-3277**) or visit **www.hearusa.com**.

Health Care Products and Services

Get significant discounts on medical and dental supplies and on home nursing care. Call **1-866-635-9532** or visit **www.carexpresshealth.com/ghi**.

Vitamins and Herbal Supplements

Get discounts on brand name skin care, nutrition products and more. Free shipping. Call **1-877-335-2746** or visit **www.choosehealthy.com/ghi**.

Acupuncture, Massage Therapy and Nutrition Counseling Services

Get discounts on these services through a network of providers designated by us. Call **1-877-327-2746** or visit **www.choosehealthy.com/ghi**.

Fitness Club Memberships

Get lowest posted pricing or at least a 10% discount on enrollment fees and/or monthly membership fees at participating facilities. Choose from hundreds of locations, including independent gyms, yoga and Pilates centers and fitness chains such as Bally's, Curves, Gold's Gym, Snap Fitness and more. To locate a participating club visit **www.choosehealthy.com/?hp=GHIOR** or call **1-877-327-2746**, Monday through Friday, 8:00 am to 9:00 pm. TDD users may call **1-877-710-2746**.

Note: GHI does not insure or underwrite the above "Healthy Discounts" programs and cannot guarantee continued participation of a particular vendor.

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IMPORTANT PHONE NUMBERS AND ADDRESSES

GHI Medical Program

Customer Service and General Information about your medical plan. This includes high-tech radiology, laboratory services, and chiropractic care: • Claims information • Benefits and eligibility information • To request a claim form • To obtain names/numbers of Network Providers	New York City: **1-212-501-4GHI (4444)** Syracuse: **1-315-432-0826** Outside New York City area: **1-800-624-2414**
Touch-tone telephone service for the hearing impaired	**1-212-721-4962**
To submit a medical claim	Group Health Incorporated P.O. Box 3000 New York, New York 10116-3000
To submit a letter regarding a Utilization Management determination	GHI Coordinated Care Appeals P.O. Box 2809 New York, New York 10116-2809
To request a Provider Directory in writing – or simply call GHI as indicated above	GHI Provider Directory P.O. Box 1701 New York, New York 10023-9476
To submit a claim for Durable Medical Equipment (DME) services	GHI P.O. Box 2874 New York, New York 10116-2874
To submit a claim for psychiatric services	GHI P.O. Box 2827 New York, New York 10116-2827
To submit a written medical grievance related to a benefit determination or other determination made by GHI	GHI – Grievance Unit P.O. Box 1701 New York, New York 10023-9476

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GHI Miscellaneous

To submit an address change	GHI – Membership Department P.O. Box 2820 New York, New York 10116-2820

GHI Hospital Program

Customer Service and General Information • Claims information • Benefits and Eligibility Information • To request a claim form • To obtain names/numbers of GHI Network Providers	Call the GHI Automated Hospital line at: **1-212-615-0500** in New York City **1-800-624-2414** outside New York City
Touch-tone telephone service for the hearing impaired	**1-212-721-4962**
For patient eligibility information concerning your GHI hospital plan. Information from your GHI Identification Card will be requested during this call	Patient Eligibility Profile (PEP): **1-800-548-2089**
To submit a hospital claim (i.e., out-patient ambulatory surgery claims). NOTE: In most situations the hospital/facility will submit the claim form	GHI P.O. Box 2833 New York, New York 10116-2833
To request a letter regarding a hospital Utilization Management determination	GHI – Coordinated Care Appeals P.O. Box 2809 New York, New York 10116-2809
To submit a written hospital grievance related to a benefit determination or other determination made by GHI	GHI – Hospital Grievance P.O. Box 2828 New York, New York 10116-2828

Care Requiring Precertification or Other Coordination

To precertify or arrange for the coordination of care for: • In-patient Services • Home Care Services • Home Infusion Services • Private Duty Nursing • Centers of Specialized Care • Durable Medical Equipment (DME) - precertification is cost-dependent, refer to your Contract • Complex Case Management • Any other Coordinated Care benefits To obtain an out-of-network referral	**1-212-615-4662** in New York City **1-800-223-9870** in all other areas
To submit a letter to Coordinated Care	GHI Coordinated Care P.O. Box 2809 New York, New York 10116-2809
Mental Health Services Prior Approval	**1-800-692-7311**

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GHI Prescription Drug Program

Customer Service, General Prescription Information And Drug Interaction Information • Claims information • Benefits and eligibility information • To request a claim form • To request a formulary • To request medication refills • To obtain the names/numbers of Network retail Pharmacies	For Retail Prescription Drug coverage: GHI Pharmacy Services Program **1-877-444-3614** For Home Delivery Prescription Drug coverage (also known as "Maintenance Drugs" or "Mail Order Service"): Medco Health Solutions, Inc. **1-877-204-8150**
Touch-tone telephone service for the hearing impaired	**1-800-759-1089**
To request medication refills	Medco Refill Services **1-800-473-3455**
Inquires about specialty injectable drugs	GHI Specialty Pharmacy Services **1-888-447-0295**
To fill specialty injectable drug prescriptions through ICORE (GHI's specialty pharmacy)	ICORE **1-866-554-2673**
To mail in prescription drug claims when utilizing the prescription drug home delivery program	Medco Health Solutions, Inc. P.O. Box 747000 Cincinnati, Ohio 45273-8152
To send a written inquiry	GHI Pharmacy Services Program 55 Water Street New York, New York 10041

Behavioral Management Program (BMP) for Mental Health & Chemical Dependency

To submit a claim for Outpatient Mental Health	GHI-BMP P.O. Box 2827 New York, New York 10116-2827
To submit a claim for Inpatient Mental Health and Chemical Dependency Note: Generally, it is the provider's/facility's responsibility to submit these claims.	GHI-BMP P.O. Box 2833 New York, New York 10116-2833
For providers to submit Outpatient treatment reports	GHI-BMP P.O. Box 1884 New York, New York 10116-1884
For subscribers to submit a written inquiry regarding claims for Mental Health & Chemical Dependency	GHI-BMP P.O. Box 1701 New York, New York 10116-9476

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GHI Headquarters and Regional Offices

NYC Headquarters	55 Water Street New York, New York 10041-8190 **1-800-444-2333**
Albany	80 Wolf Road Albany, New York 12205-3828 **1-800-624-2414**
Buffalo	77 Broadway Buffalo, New York 14203-1688 **1-800-624-2414**
Syracuse	5015 Campuswood Drive Pioneer Business Park East Syracuse, New York 13507-1231 **1-315-432-0826**

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NOTICE OF PRIVACY PRACTICES

IMPORTANT INFORMATION ABOUT YOUR PRIVACY RIGHTS

Effective February 1, 2013

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

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

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

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

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

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

How We Use or Share Information

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

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

Other Ways We Use or Share Information

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

- We may use or share your information with the employer or other health-plan sponsor through which you receive your health benefits. We will not share individually identifiable health information with your benefits plan unless they promise to keep it protected and use it only for purposes relating to the administration of your health benefits.

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- We may share your information with a health plan, provider, or health care clearinghouse that participates with us in an organized health care arrangement. We will only share your information for health care operations activities associated with that arrangement.
- We may share your information with another health plan that provides or has provided coverage to you for payment purposes. We may also share your information with another health plan, provider or health care clearinghouse that has or had a relationship with you for the purpose of quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, or detecting or preventing health care fraud and abuse.
- We may share your information with a family member, friend, or other person who is assisting you with your health care or payment for your health care. We may also share information about your location, general condition, or death to notify or help notify (including identifying and locating) a person involved with your care or to help with disaster-relief efforts. Before we share this information, we will provide you with an opportunity to object. If you are not present, or in the event of your incapacity or an emergency, we will share your information based on our professional judgment of whether the disclosure would be in your best interest.

State and Federal Laws Allow Us to Share Information

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

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

- We may report information on job-related injuries because of requirements of your state worker compensation laws.
- Under certain circumstances, we may share information for purposes of research.

Sensitive Information

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

Your Authorization

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

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

Your Rights

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

Restricting Your Information

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

Confidential Communications for Your Information

- **You have the right to ask to receive confidential communications** of information if you believe that you would be endangered if we send your information to your current mailing address (for example, in situations involving domestic disputes

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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.

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– 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.

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- **If you have any question**s or would like further information about this notice or about how we use or share information, you may write to the Corporate Compliance Department or call Customer Service. Please see the contact information on this page.
- **If you believe that we may have violated your privacy rights, you may file a complaint.**

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

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

Contact Information

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

Write to: Corporate Compliance Dept. P.O. Box 2878 New York, NY 10116-2878
Call: **EmblemHealth program members:** M-F, 8 am-6 pm, **1-877-842-3625**, TTY: **1-866-248-0640**
EmblemHealth Medicare members: M-Sun., 8 am-8 pm PPO: **1-866-557-7300**, TTY: **1-866-248-0640** HMO: **1-877-344-7364**, TTY: **1-866-248-0460** PDP (City of NY Retirees): **1-800-624-2414**, TTY: **1-866-248-0640** PDP (non-City of NY Retirees): **1-877-444-7241**, TTY: **1-866-248-0640**
GHI members: M-F, 8 am-6 pm, **1-800-624-2414**, TTY: **1-866-248-0640**
GHI HMO members: M-F, 8 am-6 pm, **1-877-244-4466**, TTY: **1-877-208-7920**
HIP/HIPIC members: M-F, 8 am-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.**