Important Member Resources

IMPORTANT EMBLEMHEALTH MEMBER RESOURCES

At EmblemHealth, we're committed to supporting the whole you.

An important part of that commitment is making sure you're informed about all the resources available to you. We have put together details on tools that can help you receive the best quality of care. This includes:

Member resources available on our website .... Page 1

Your privacy rights .... Page 1

Your rights to external appeals (independent, external review) as a commercial or Quality Health Plan member .... Page 2

Your member rights and responsibilities .... Page 2

Looking for a doctor or hospital? Provider directories are available .... Page 3

Using your preferred language .... Page 3

Doctor transitions as your child grows .... Page 3

What to do if you reach your benefit limit? .... Page 3

Learn about our Care Management services .... Page 4

Coordinate your health care .... Page 4

What is utilization management? .... Page 4

How new medical technologies may become a covered benefit .... Page 5

Care to keep you healthy .... Page 5

MEMBER RESOURCES AVAILABLE ON OUR WEBSITE

Questions about your coverage? You can find helpful information on **emblemhealth.com**, any time, any place. Some of this information may require that you sign in to your member account. You can find important information, including:

- Benefits and services included in, and excluded from, coverage in your plan.
- Procedures to follow for prescription drug coverage. You can also find your plan's covered pharmaceuticals, including your plan's restrictions and preferences, out-of-pocket expenses, exceptions, limitations, lists of covered medicines and information regarding generic substitutions, therapeutic interchanges, and step therapy protocols.
- Information on generics, substitutions, and other lower cost alternatives to certain medicines.
- Copays and other fees you may need to pay for services.
- Printing a temporary ID card and requesting a replacement permanent card.
- How to obtain the most up-to-date information about practitioners, doctors, and facilities that participate with EmblemHealth.
- How to change your primary care provider.
- How to submit claims for covered services.
- Benefit restrictions that apply to services obtained outside of the organization's system or service area.
- How to get care before or after normal business hours.
- How to get primary care services, including points of access, specialty care, hospital services, mental health care, and substance use services.
- How to get care and coverage when you're out of your plan's service area.
- How to submit a complaint or an appeal that negatively affects your coverage, benefits, or your relationship with EmblemHealth. You can do this verbally or in writing.
- How to get language assistance.
- How to obtain emergency care and when to call **911**.
- How we evaluate new medical technology to include as covered benefits.
- Creating a personal health record.
- Taking a health assessment.
- Health and wellness information and programs at EmblemHealth.

To learn more about your plan's pharmacy restrictions and preferences, please sign in to **emblemhealth.com**. Pertinent pharmacy information can also be found in both your member materials such as your Member Handbook, Evidence of Coverage, or new member Welcome Kit, and the pharmacy web page.

YOUR PRIVACY RIGHTS

EmblemHealth is committed to making sure that your health information is kept private and safe. Our Notice of Privacy Practices explains how we use information about you and when we can share it with others. This important document also informs you about your rights with respect to your health information and how you can exercise these rights. To get a copy, visit **emblemhealth.com/privacy** or call the Customer Service number on the back of your member ID card.

YOUR RIGHTS TO EXTERNAL APPEALS AS A COMMERCIAL OR QUALITY HEALTH PLAN MEMBER

If you disagree with certain coverage decisions, you can request an appeal by someone other than EmblemHealth.

You have the right to an external appeal (independent, external review) when health care services are denied as:

- Not medically necessary,
- Experimental/investigational,
- A clinical trial,
- A rare disease treatment, or
- In certain cases, out-of-network.

Providers also have their own rights to an external appeal when these health care services are denied when the services are being received (concurrently) or after they are received (retrospectively). External appeal requests must be submitted to the New York State Department of Financial Services (DFS). DFS will assign independent medical experts to review the appeal.

These medical experts may overturn your plan's decision in whole or in part. Or, they may uphold your plan's denial of coverage. Their decision is binding for both you and your plan.

To appeal to DFS, you first request your plan's internal appeal. You have 180 days to request an internal appeal from your plan after receiving your Adverse Determination (denial). If we uphold the original denial, you will receive a letter known as a Final Adverse Determination.

You have four months after you receive our final adverse decision on your appeal to ask for an external appeal. If you and your plan agree to skip our appeal process, you must ask for the external appeal within four months after the agreement with your plan is made.

When we issue a Final Adverse Determination denial, you will receive instructions on how to file an external appeal along with an external appeal application.

If you have questions or if you need help with an external appeal application, call DFS at **800-400-8882** or visit their website, **dfs.ny.gov**.

Note: *The DFS external appeal process does not apply to Medicare, federal employees, or Administrative Services Only (ASO) members. It is only for Commercial or Exchange-Marketplace (Quality Health Plan) members.*

YOUR MEMBER RIGHTS AND RESPONSIBILITIES

Understanding your member rights and responsibilities helps you make the most of your plan. That's why we ask that you go to **emblemhealth.com/resources** and read your Member Rights and Responsibilities. These outline what you can expect of us, as well as what we expect from you. When you know more about your rights and responsibilities as an EmblemHealth member, it's easier for us to give you the best health care possible. You also have the right to make recommendations regarding EmblemHealth's Member Rights and Responsibilities policy.

LOOKING FOR A DOCTOR OR HOSPITAL? PROVIDER DIRECTORIES ARE AVAILABLE

Need to find a network pharmacy, medical provider, or hospital near you?

Our online directories are updated daily. Go to **emblemhealth.com/findadoctor** and follow the links to search our most up-to-date listings for doctors, dentists, drug stores, and other health care professionals.

Should a doctor or group decide to retire or is no longer contracted with EmblemHealth, we will notify you so you can select a different doctor.

While you find your new doctor, EmblemHealth can continue treatment with your current doctor through the current period of active treatment or for up to 90 calendar days, whichever is less, for chronic or acute medical conditions, or if pregnant through the post-partum period if you are in your second or third trimester of pregnancy.

USING YOUR PREFERRED LANGUAGE

When you contact EmblemHealth, let us know your preferred language so that we can connect you to the language line. Written information is also available in English, Spanish, Chinese, and in other languages including Braille. TTY users should call **711**.

You can also find physicians, specialists, dentists, vision doctors, and behavioral health practitioners who may be fluent in your preferred language.

If you require a printed directory, or cannot find a translation on our website, please contact the Customer Service department using the number on the back of your member ID card.

DOCTOR TRANSITIONS AS YOUR CHILD GROWS

When your child becomes an adolescent, it’s time to find the right doctor to help with the transition to adulthood. Pregnant adolescents need to transition to an OB/GYN.

We’re here to help.

Simply go to **emblemhealth.com/findadoctor** to see a list of doctors in our network suitable for your growing child’s needs. If you have questions, call the Customer Service number on the back of your child’s member ID card and a representative will be happy to help.

WHAT TO DO IF YOU REACH YOUR BENEFIT LIMIT?

Your plan may have limits for certain benefits. If you reach your benefits limit but you still need care, we’ll let you know how to access other options and resources available to continue your care, as appropriate.

Sign in to your account at **emblemhealth.com/members** to review your benefits. You can also call us at the number on the back of your member ID card. A Customer Service representative will be happy to help.

LEARN ABOUT OUR CARE MANAGEMENT SERVICES

We have resources to help you manage your health, including those that require a lot of care, such as cancer, high-risk pregnancy, diabetes, hypertension, or other complex needs.

Our social workers and registered nurses can help you sort through your options and make sure you get the right care. They are available by telephone and in AdvantageCare Physicians sites to:

- Help you understand your disease or health issue.
- Work with you and your doctors coordinating care and services.
- Provide guidance on taking care of yourself.
- Connect you with local services.

Go to **emblemhealth.com** for more information, or call **800-447-0768 (TTY: 711)** and ask for Care Management services. You may be referred to the program by your doctor or specialist, by a discharge planner, or by a caregiver/family member. EmblemHealth may also call you to see if you are interested. You can find an AdvantageCare Physicians location at **acpny.com**. You are welcome to accept or decline participation in the program.

COORDINATE YOUR HEALTH CARE

It's important for patients, doctors, and health plans to work together to share information. Sometimes, medical and behavioral health issues are linked. For example, someone with diabetes or COPD (chronic obstructive pulmonary disease) may also suffer from depression, stress, or substance abuse. For the best results, update all of your doctors about your physical and mental health.

To help manage your care:

- Make a list of medicines and supplements (for example, vitamins) you take or have taken in the past.
- Ask your doctors to share relevant medical information with each other, including behavioral/mental health practitioners. Share information about your hospital, home care, specialists, and other visits with your primary care provider.

We also remind our network doctors to talk to each other and share related medical information at your request. If you're okay with it, we can send your care plan to your doctors for you. For help, call the Customer Service number on the back of your member ID card.

WHAT IS UTILIZATION MANAGEMENT?

We want to make sure you're getting the right care at the right time in the right place. We make decisions about health care services by using the latest medical research and information. This is called utilization management (UM). We want to make sure you understand that:

- UM decision-making is based only on the appropriateness of care and services, and on your existing coverage.
- We never reward doctors or other people who do UM reviews for denying coverage for care.
- Financial incentives for UM decision-makers do not encourage decisions that result in underutilization.

If you want to discuss a UM decision, you can call us at the number on the back of your member ID card. You can also leave a voicemail after hours and someone will get back to you within 24 hours. We can also arrange for a translator to explain certain information to you in your preferred language. The representative you speak to will identify themselves so that you know who they are and can request to speak to them again.

HOW NEW MEDICAL TECHNOLOGIES MAY BECOME A COVERED BENEFIT

EmblemHealth is committed to giving members access to current, safe, appropriate, and effective medical care consistent with the professional standard of care in our service area. This includes new services and technologies in the medical field.

EmblemHealth's Technologies & Bioethics Committee is composed of medical professionals and EmblemHealth department representatives. They review and determine when previously considered experimental and investigational technologies have come to satisfy the general medical standards. This committee reviews all available resources and information on a particular developing technology, and measures it against the criteria described in EmblemHealth's contracts with our members and providers.

After the technology is approved, it may be included as a covered benefit under some of our plans. If a doctor requests a new technology or procedure be covered, we will evaluate the procedure or technology to determine if it should be covered.

CARE TO KEEP YOU HEALTHY

We give our doctors the tools and resources to deliver the best care. Our network is a group of health care professionals and facilities that contract with EmblemHealth. They provide your covered products and services.

Our Quality Improvement Program can help you:

- Learn about your health through materials with science-based health information you can trust.
- Recover quickly or live well with chronic illness through Care Management programs. These programs help you take care of conditions like cancer, depression, diabetes, high-risk pregnancy, HIV/AIDS, hypertension, and organ transplants.
- Know how EmblemHealth is addressing patient safety, your cultural and language needs, services such as behavioral health, quality and safety of clinical care, quality of service, and your experience.

Please visit **emblemhealth.com** for more information about our Quality Improvement Program and its successes.

We know this is a lot of information. If you have questions, call us at the number on the back of your member ID card. A Customer Service representative will be happy to help.

We're committed to supporting you.

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EmblemHealth Plan, Inc., EmblemHealth Insurance Company, EmblemHealth Services Company, LLC and Health Insurance Plan of Greater New York (HIP) are EmblemHealth companies. EmblemHealth Services Company, LLC provides administrative services to the EmblemHealth companies.

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