



MANAGED LONG TERM CARE PLUS PROGRAM

A Guide To Your Benefits and Services



EmblemHealth[®]
WHAT CARE FEELS LIKE.

TABLE OF CONTENTS

WELCOME TO THE EMBLEMHEALTH MANAGED LONG TERM CARE PLUS PROGRAM	1
HELP FROM CUSTOMER SERVICE	3
ELIGIBILITY FOR ENROLLMENT IN THE PROGRAM.....	5
SERVICES COVERED BY THE EMBLEMHEALTH MANAGED LONG TERM CARE PLUS PROGRAM	9
Care Management Services	9
Additional Covered Services	10
Limitations.....	12
Getting Care Outside the Service Area.....	12
Emergency Care.....	12
MEDICAID SERVICES NOT COVERED BY OUR PLAN	15
Certain Mental Health Services.....	15
Certain Mental Retardation and Developmental Disabilities Services	15
Other Medicaid Services	16
Family Planning.	16
Services Not Covered By Our Plan or Medicaid Program.....	16
SERVICE AUTHORIZATIONS AND ACTIONS	17
Prior Authorization.....	17
Action Appeals	20
External Appeals.....	23
What to Do If You Have a Complaint About Our Plan or Want to Appeal a Decision about Your Care.....	24
RULES FOR COMPLAINTS AND APPEALS	25
DISENROLLMENT FROM THE MANAGED LONG TERM CARE PLUS PROGRAM	29
You Can Choose to Disenroll	29
We Can Ask You to Leave the Plan.....	30
Re-enrollment Provisions	30

TABLE OF CONTENTS

OTHER INFORMATION YOU CAN REQUEST.....	31
MEMBER RIGHTS AND RESPONSIBILITIES.....	33
PRIVACY NOTICE.....	37
HEALTH CARE PROXY.....	45

WELCOME TO THE EMBLEMHEALTH MANAGED LONG TERM CARE PLUS PROGRAM

Welcome to the EmblemHealth Managed Long Term Care Plus program. The program is especially designed for people who have Medicare and Medicaid and who need health and long-term care services like home care and personal care to stay in their homes and communities as long as possible.

This handbook tells you about the added benefits the the Managed Long Term Care Plus program covers. It also tells you how to request a service, file a complaint or grievance, or disenroll from the program.

The benefits described in this handbook are in addition to the Medicare benefits described in the Medicare Evidence of Coverage. Keep this handbook with the Medicare Evidence of Coverage. You need both to learn what services are covered and how to get services.

HELP FROM CUSTOMER SERVICE

You can call Customer Service at, **1-877-344-7364**, Monday through Sunday, from 8 am to 8 pm. If you have a hearing or speech impairment and use a TTY/TDD, call **711**. After these hours, you can call this number and leave a message on the answering machine. Make sure to give enough detail for us to understand why you are calling. We will return your call within 24 hours.

If you speak another language, a customer service representative can use the Language Line service, which has more than 100 languages and dialects.

If you need care management help during non-business hours, on weekends or holidays, call **1-888-447-4838**.

ELIGIBILITY FOR ENROLLMENT IN THE PROGRAM

The EmblemHealth Managed Long Term Care Plus program is for people who have both Medicare and Medicaid. You are eligible to join the program if you are also enrolled in Dual Eligible (HMO SNP) for Medicare coverage and:

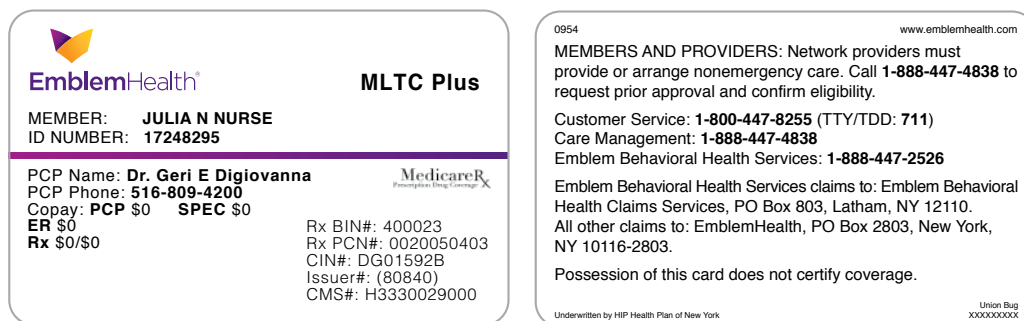
1. Are age **18** and older.
2. Reside in the plan's service area of Bronx, Kings, Nassau, New York, Queens, Richmond, Suffolk and Westchester counties.
3. Have a chronic illness or disability that makes you eligible for services usually provided in a nursing home.
4. Are able to stay safely in your home at the time you join the plan.
5. Require care management and are expected to need one or more of the following services for at least 120 days from the date that you join our plan:
 - a. Nursing services in the home
 - b. Therapies in the home
 - c. Home health aide services
 - d. Personal care services in the home
 - e. Adult day health care
 - f. Social day care if used instead of in home personal care services, **or**
 - g. Private duty nursing

An applicant who is a hospital inpatient or is an inpatient or resident of a facility licensed by the State Office of Mental Health (OMH), the Office of Alcoholism and Substance Abuse Services (OASAS) or the State Office for People With Developmental Disabilities (OPWDD), or is enrolled in another managed care plan capitated by Medicaid, a Home and Community-Based Services Waiver program, a Comprehensive Medicaid Case Management program (CMCM) or OMRDD day treatment program, or is receiving services from a hospice and may be enrolled with the contractor upon discharge or termination from the inpatient hospital, facility licensed by the OMH, OASAS or OPWDD, other managed care plan, hospice, Home and Community-Based Services Waiver program, CMCM or OMRDD day treatment program.

ELIGIBILITY FOR ENROLLMENT IN THE PROGRAM

Your network physician must agree to work with the EmblemHealth Managed Long Term Care Plus program, or you must be willing to change to a physician who will work with our Managed Long Term Care Plus plan. Your physician must express a willingness to write orders for covered services that allow you to receive care from network providers upon enrollment.

The coverage explained in this handbook becomes effective on the effective date of your enrollment in the EmblemHealth Managed Long Term Care Plus program. Once the nurse assessment has been completed, and you have reviewed your initial service plan and you have signed our enrollment application, we will begin processing your request for enrollment. If you meet the eligibility requirements for the program, we will submit your application to New York Medicaid Choice or the Local Department of Social Services (LDSS). Once you have been approved by New York Medicaid Choice or the LDSS and we have been notified about your approval, you will receive a member ID card in the mail, as well as a welcome call from your case manager.



If you do not meet the eligibility requirements for the program, you will receive a notice from us informing you of the decision.

If you change your mind at any point prior to enrollment and no longer want to apply for enrollment in our plan, you can request an application for withdrawal.

Enrollment in our program is based on your meeting the eligibility criteria established by the New York State Department of Health and on approval from New York Medicaid Choice or LDSS. We will not discriminate based on health status or changes in health status. We will cover the cost of all health-related covered services.

Network Providers and Covered Services

Network providers will be paid in full directly by Managed Long Term Care Plus for each service authorized and provided to you with no copay or cost to you. If you receive a bill for covered services authorized by Managed Long Term Care Plus you are not responsible to pay the bill, please contact your care manager. You may be responsible for payment of covered services that were not authorized by Managed Long Term Care Plus, or for covered services that were received from non-network providers.

ELIGIBILITY FOR ENROLLMENT IN THE PROGRAM

Transitional Care Procedures

New enrollees may continue an ongoing course of treatment with a non-network provider for a transitional period of up to 60 days from enrollment. The provider must agree to accept payment at the plan rate, adhere to plan quality assurance and other policies, and provides medical information about the care to the plan.

When an enrollee's health care provider leaves the network, an ongoing course of treatment may be continued for a transitional period of up to 90 days. The provider must agree to accept payment at the plan rate, adhere to plan quality assurance and other policies, and provide medical information about the care to the plan.

Monthly Spend-Down

The HRA or LDSS may determine that you are required to pay a spend-down amount. HRA or LDSS will notify you in writing if you have a spend-down obligation. When you enroll in our plan, you will need to pay that amount to us. We will send you a monthly bill with instructions on how and where to send the payment.

SERVICES COVERED BY THE EMBLEMHEALTH MANAGED LONG TERM CARE PLUS PROGRAM

Deductibles and Copayments on Medicare Covered Services

Many of the services that you receive including inpatient and outpatient hospital services, doctor's visits, emergency services and laboratory tests are covered by Medicare and are described in the Medicare Evidence of Coverage. Sections 2 and 3 of the Medicare Evidence of Coverage explain the rules for using plan providers and getting care in a medical emergency or if urgent care is needed. Some services have deductibles and copayments. These amounts are shown in the Benefit Chart in Section 4 of the Medicare Evidence of Coverage under the column "What you must pay when you get these covered services." Because you have joined Managed Long Term Care Plus and you have Medicaid, our plan will pay these amounts. You do not have to pay these deductibles and copayments except for those that apply to chiropractic care unless you are a Qualified Medicare Beneficiary (QMB) and pharmacy items. If there is a monthly premium for benefits (see Section 8 of the Evidence of Coverage), you will not have to pay that premium since you have Medicaid. We will also cover many services that are not covered by Medicare but are covered by Medicaid. The sections below explain what is covered.

Care Management Services

As a member of our plan, you will get care management services. Our plan will provide you with a case manager who is a health care professional — usually a nurse or a social worker. Your case manager, along with your care management team, will work with you and your doctor to decide the services you need and to develop a care plan. Your care management team will also assist you with arranging appointments for any health care services you need and will also arrange transportation, if needed. Your care management team will monitor and reassess your health status and care needs. As your needs change, your plan of care will be changed. These changes may include increasing or decreasing services and changing the service provided to better meet your health care needs. You will be assigned a case manager when you enroll. You can call the case manager at **1-888-447-4838**.

SERVICES COVERED BY THE EMBLEMHEALTH MANAGED LONG TERM CARE PLUS PROGRAM

Additional Covered Services

Because you have Medicaid and qualify for our program, our plan will arrange and pay for the health and social services described below. You may get these services as long as they are medically necessary, that is, if the services are needed to prevent or treat your illness or disability. Your case manager will help identify the services and providers you need. In some cases, you may need a referral or an order from your doctor to get these services. You must get these services from the providers in our network. If you cannot find a provider in our plan, you must let your case manager know, and he or she will make arrangements with a non-network provider to provide the covered service. The service requested needs to be included in the benefit package and determined by the program as solely covered by Medicaid, and is not available from a network provider.

- **Personal Care**, such as assistance with bathing, eating, dressing, toileting and walking. You can request these services through your case manager. Access to these services is based on an individual's care plan and must be authorized by your case manager before you receive the service.
- **Home Health Care Services Not Covered by Medicare**, including home health aide services and nursing supervision to medically unstable individuals. These services must be ordered by a physician. Your doctor providing the care will ask our plan to approve these services when you need them.
- **Nutrition**, including nutritional assessment, evaluation and development of treatment plans. Also nutritional counseling and education. You can request these services through your case manager. Access to these services is based on an individual's care plan and must be authorized by your case manager before you receive the service.
- **Medical Social Services**, including assessment, arranging for services and assistance to address social problems that impact your ability to live at home. Most medical social services will be provided by an EmblemHealth Managed Long Term Care Plus social worker. If additional services are necessary, the services must be authorized by your case manager and included as part of your care plan.
- **Home-delivered meals and/or meals in a group setting**, including meals provided at home, or in a group setting, such as adult day care or senior centers. You can request these services through your case manager. Access to these services is based on an individual's care plan and must be authorized by your case manager before you receive the service.
- **Social Day Care** which provides socialization, supervision, personal care and nutrition in a protective setting. You can request these services through your case manager. Access to these services is based on an individual's care plan and must be authorized by your case manager before you receive the service.
- **Non-Emergency Transportation**. New York City members can use public buses and trains to and from health care appointments without prior approval. Other forms of transportation, including taxis, vans and ambulette service, can be used when it is necessary to get needed medical care and other health related services. In these cases, you

SERVICES COVERED BY THE EMBLEMHEALTH MANAGED LONG TERM CARE PLUS PROGRAM

must use network transportation providers. Access to these services is based on an individual's care plan and must be authorized by your case manager before you use the service.

- **Private Duty Nursing** such as registered nurse or licensed practical nurse services provided either in the home or facility. These services are based on an individual's care plan developed by your case manager. Before you receive this service, your physician must determine that it is medically necessary, and your case manager must authorize the service, and include it in your care plan.
- **Dental Services** including necessary preventive, prophylactic, routine dental care and supplies as well as dental prosthetic and orthotic appliances required to improve a serious health condition. You will be assigned to a network dentist serving your area when your enrollment application is processed. However, you can change your dentist at any time by calling Healthplex, our network dental provider, at **1-800-468-9868**, Monday through Thursday, from 8 am to 8 pm, and Friday, from 8 am to 6 pm. You may also call this number with questions about your dental benefits.
- **Social/Environmental Supports** such as chore services, home modifications or respite care. You can request these services through your case manager. Access to these services is based on an individual's care plan and must be authorized by your case manager before you receive the service.
- **Personal Emergency Response Service** is a device which signals for help in the event of an emergency. You can request these services through your case manager. Access to these services is based on an individual's care plan and must be authorized by your case manager before you receive the service.
- **Adult Day Health Care** includes medical, nursing, food and nutrition, social services, rehabilitation therapy, dental, pharmaceutical, leisure time activities and other ancillary services. Services are provided in an approved, skilled nursing facility or extension site. You can request these services through your case manager. Access to these services is based on an individual's care plan and must be authorized by your case manager before you receive the service.
- **Nursing Home Care Not Covered by Medicare.** You can request these services through your case manager. Access to these services is based on an individual's care plan and must be authorized by your case manager before you receive the service (**see limitations below**).
- **Vision Services** include routine eye exams, eyeglasses and repairs and medically necessary contact lenses. These services are covered for all Managed Long Term Care Plus members. When you need these services you may go to any network optometrist, ophthalmologist or ophthalmic dispenser for exams and eyeglasses without a referral or prior approval.
- **Hearing Aid Services**, including testing and exams, hearing aid evaluations, hearing aid prescriptions and hearing aid products. These services are covered for Managed Long Term Care Plus members. When you need these services, your primary care physician will get approval from EmblemHealth.

SERVICES COVERED BY THE EMBLEMHEALTH MANAGED LONG TERM CARE PLUS PROGRAM

- **Non-Medicare Durable Medical Equipment**, including medical/surgical supplies, prosthetics, orthotics, orthopedic footwear, Enteral and Parenteral formulas (**see limitations below**). When you need these services, the doctor providing your care will get approval from EmblemHealth.
- **Outpatient Occupational, Physical and Speech Therapies**, includes rehabilitation services provided by a licensed and registered therapist for the purpose of reducing physical or mental disability.
- **Inpatient mental health care** over 190-day lifetime Medicare limits.

Limitations

- Outpatient physical, occupational and speech therapies are limited to 20 annual Medicaid visits per therapy, except for children under age 21 or if the enrollee has been assessed as developmentally disabled by the Office for People With Developmental Disabilities or if you have a traumatic brain injury.
- Enteral formula and nutritional supplements are limited to individuals who cannot obtain nutrition through any other means, and to the following conditions: 1) tube-fed individuals who cannot chew or swallow food and must obtain nutrition through formula via feeding-tube; and 2) individuals with rare inborn metabolic disorders requiring specific medical formulas to provide essential nutrients not available through any other means. Coverage of certain inherited disease of amino acid and organic acid metabolism shall include modified solid food products that are low-protein or which contain modified protein.
- Orthopedic footwear and inserts coverage is limited to individuals when used as an integral part of a lower limb orthotic appliance or as part of a diabetic treatment plan.
- Compression and support stockings is limited to treatment of venous stasis ulcers or during pregnancy.
- Nursing home care is covered for individuals who are considered a permanent placement provided you are eligible for institutional Medicaid coverage.

Getting Care Outside the Service Area

If you are planning to be out of the service area for an extended period of time, please contact your case manager, as soon as possible, so that any necessary supplies can be ordered for you to take with you. If you have an emergency (see emergency section of this handbook), go to the nearest emergency room or call **911**.

Emergency Care

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

SERVICES COVERED BY THE EMBLEMHEALTH MANAGED LONG TERM CARE PLUS PROGRAM

Examples of emergencies include:

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

Examples of **non-emergencies** are colds, sore throat, upset stomach, minor cuts and bruises or strained muscles.

How to Get Emergency Care

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

If you are not sure if you have an emergency, call your PCP at the telephone number on your EmblemHealth ID card. Your PCP or the doctor covering for your PCP will:

- Tell you what you can do at home
- Tell you to come to his/her office
- Tell you to go to the nearest urgent care center
- Tell you to go to the nearest emergency room

When you get care, you or someone on your behalf should notify your PCP within 48 hours, or as soon as possible after you get emergency care. We also suggest that you or someone on your behalf contact your care manager at **1-888-447-4838** if you are admitted to a hospital in an emergency.

MEDICAID SERVICES NOT COVERED BY OUR PLAN

There are some Medicaid services that Managed Long Term Care Plus **does not** cover. You can get these services from any provider who accepts Medicaid by using your Medicaid Benefit Card. Call Customer Service at **1-877-344-7364** if you have any questions about whether a benefit is covered by EmblemHealth or Medicaid. Some of the services covered by Medicaid using your Medicaid Benefit Card include:

Pharmacy

Most prescription drugs are covered by Medicare Part D as described in Section 6 of the Managed Long Term Care Plus Medicare EOC. Regular Medicaid will cover some drugs not covered by Medicare.

Certain mental health services, including:

- Intensive psychiatric rehabilitation treatment
- Day treatment
- Case management for the seriously and persistently mentally ill (sponsored by state or local mental health units)
- Partial hospital care not covered by Medicaid
- Rehabilitation services to those in community homes or in family-based treatment
- Continuing day treatment
- Assertive community treatment
- Personalized recovery oriented services

Certain mental retardation and developmental disabilities services, including:

- Long-term therapies
- Day treatment
- Medicaid service coordination
- Services received under the Home and Community-Based Services Waiver

MEDICAID SERVICES NOT COVERED BY OUR PLAN

Other Medicaid Services

- Methadone treatment
- Comprehensive Medicaid case management
- Directly observed therapy for TB (tuberculosis)
- Adult day treatment for persons with HIV/AIDS
- HIV COBRA case management

Family Planning

Members may go to any Medicaid doctor or clinic that provides family planning care. You do not need a referral from your primary care provider (PCP).

Services Not Covered by Our Program and Medicaid

You must pay for services that are not covered by EmblemHealth or by Medicaid. Your provider should tell you in advance that these services are not covered **AND** you must agree to pay for the services. Examples of services not covered by EmblemHealth or Medicaid are:

- Cosmetic surgery if not medically needed
- Personal and comfort items
- Infertility treatment
- Services of a non-network provider (unless Managed Long Term Care Plus sends you to that provider)

If you have any questions, call Customer Service at **1-877-344-7364**.

SERVICE AUTHORIZATIONS AND ACTIONS

When EmblemHealth Managed Long Term Care Plus determines that services are covered solely by Medicaid, we will make decisions about your care following these rules:

Prior Authorization

Some covered services require **prior authorization** (approval in advance) from the EmblemHealth Managed Long Term Care Plus Case Management department before you receive them or in order to be able to continue receiving them. You, someone you trust, or your provider can for prior authorization. The following treatments and services must be approved before you get them:

- Personal care
- Home health care services including respiratory therapy
- Nutrition services
- Medical social services (when not provided by EmblemHealth staff)
- Home-delivered meals and/or meals in a group setting such as a day center
- Social day care
- Non-emergency transportation
- Personal emergency response services
- Social and environmental support
- Adult day health care
- Nursing home care
- Private duty nursing
- Inpatient mental health care over the 190-day lifetime Medicare limit
- Hearing services
- Certain non-Medicare durable medical equipment

When you ask for approval of a treatment or service, it is called a **Service Authorization Request**. To get a service authorization request, you, someone you trust or your doctor can request a service authorization verbally or in writing:

Call: **1-888-447-4838**, or

SERVICE AUTHORIZATIONS AND ACTIONS

Write:

EmblemHealth
Care Management Department
55 Water Street
New York, NY 10041

Fax: **1-212-510-3004**

You will also need to get prior authorization if you are getting one of these services now, but need to get more of the service/care during an authorization period. This includes a request for Medicaid-covered home health care services following an inpatient hospital stay. This is called **concurrent review**.

What Happens After We Receive Your Service Authorization Request?

Your service authorization request will be reviewed by a review team, which includes doctors and nurses, who work to ensure that you get the services we promise. Their job is to be certain that the treatment or service you requested is medically needed and right for you. This process is done by checking your treatment plan against acceptable medical standards.

Any decision to deny a service authorization request or to approve it for an amount that is less than requested is called an **action**. These decisions will be made by qualified health care professionals. If we decide that the requested service is not medically necessary, the decision will be made by a clinical peer reviewer, who may be a doctor, a nurse or a health care professional who typically provides the care you requested. You can request a copy of the specific medical standards, called **clinical review criteria**, that were used to make the decision for actions related to medical necessity.

After we get your request, we will review it under a **standard** or **fast-track** process. You, someone you trust or your doctor can ask for a fast-track review if it is believed that a delay will cause serious harm to your health. If your request for a fast track review is denied, we will tell you and your request will be handled under the standard review process. In all cases, we will review your request as fast as your medical condition requires us to do so, but no later than mentioned below.

We will tell you and your provider both by phone and in writing if your request is approved or denied. We will also tell you the reason for the decision. We will explain what options for appeals or fair hearings you will have if you don't agree with our decision (see Action Appeals section).

Time Frames for Prior Authorization Requests

- **Standard review:** We will make a decision about your request within three business days of when we have all the information we need, but you will hear from us no later than 14 days after we receive your request. We will tell you within 14 days if we need more information.

SERVICE AUTHORIZATIONS AND ACTIONS

- **Fast-track review:** We will make a decision and you will hear from us within three business days. We will tell you within three business days if we need more information.

Time Frames for Concurrent Review Requests

- **Standard review:** We will make a decision within one business day of when we have all the information we need, but you will hear from us no later than 14 days after we received your request.
- **Fast-track review:** We will make a decision within one business day of when we have all the information we need, but you will hear from us no later than three business days after we received your request.

If we need more information to make either a standard or fast-track decision about your service request, the time frames above can be extended up to 14 business days. We will:

- Write and tell you what information is needed. If your request is in a fast-track review, we will call you right away and send a written notice later.
- Tell you why the delay is in your best interest.
- Make a decision as quickly as possible, after we receive the necessary information, but no later than 14 days from the end of the original timeframe.

If you are not satisfied with our answer, you have the right to file an action appeal (see the Action Appeal section of this handbook).

You, someone you trust or your provider can also ask us to take more time to make a decision. This may be because you have more information that will help decide your case. This can be done by calling **1-877-344-7364** or writing.

You or someone you trust can file a complaint with the plan if you don't agree with our decision to take more time to review your request. You or someone you trust can also file a complaint the New York State Department of Health by calling **1-866-712-7197**.

Other Decisions About Your Care

Sometimes we will do a concurrent review on the care you are receiving to see if you still need the care. We may also review other treatments and services you have already received. This is called **retrospective review**. We will tell you if we take these other actions.

Time Frames for Notice of Other Actions

- In most cases, if we make a decision to reduce, suspend or terminate a service we have already approved that you are now getting within an authorization period, we must tell you at least 10 days before we change the service.
- If we are checking care that you have received in the past, we will make a decision about paying for it within 30 days of receiving necessary information for the retrospective review. If we deny payment for a service, we will send a notice to you and your provider the day the payment is denied. **You will not have to pay for any care you received that was covered by the plan or by Medicaid even if we later deny payment to the provider.**

SERVICE AUTHORIZATIONS AND ACTIONS

Action Appeals

An *action* is when Managed Long Term Care Plus denies or limits services requested by you or your provider; denies a request for a referral; decides that a requested service is not a covered benefit; reduces, suspends or terminates services that we already authorized; denies payment for services; doesn't provide timely services; or doesn't make grievance or appeal determinations within the required time frames, those are considered plan "actions." An action is subject to appeal.

If you are not satisfied with our decisions about your Medicaid care, there are steps you can take.

You can file an action appeal:

- If you are not satisfied with an action we took or what we decide about your service authorization request, you have 45 days after hearing from us to file an appeal.
- You can do this yourself or ask someone you trust to file the appeal for you. You can call Member Services at **1-877-344-7364** if you need help filing an appeal.
- We will not treat you any differently or act badly toward you because you file an appeal.
- The appeal can be made by phone or in writing. If you make an appeal by phone it must be followed up in writing.

Your provider can ask for reconsideration:

If we make a decision about your service authorization request without talking to your doctor, your doctor may ask to speak with the plan's medical director. The medical director will talk to your doctor within one workday.

What happens after we get your appeal:

- Within 15 days, we will send you a letter to let you know we are working on your appeal. We will let you know if we need more information to make our decision.
- Action appeals of clinical matters will be decided by qualified health care professionals who did not make the first decision, at least one of whom will be a clinical peer reviewer.
- Non-clinical decisions will be handled by persons who work at a higher level than the people who worked on your first decision.
- Before and during the appeal, you or your designee can see your case file, including medical records and any other documents and records being used, to make a decision on your case.
- You can also provide information to be used in making the decision in person or in writing.
- You will be given the reasons for our decision and our clinical rationale, if it applies. If you are still not satisfied, any further appeal rights you have will be explained or you or your designee can file a complaint with the New York State Department of Health at **1-866-712-7197**.

SERVICE AUTHORIZATIONS AND ACTIONS

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

- If you or your doctor asks to have your appeal reviewed under the fast-track process. Your doctor would have to explain how a delay will cause harm to your health. If your request for fast track is denied, we will tell you and your appeal will be reviewed under the standard process; **or**
- If your request was denied when you asked to continue receiving care that you are now getting or need to extend a service that has been provided.
- Fast-track appeals can be requested by phone and **do not** have to be followed up in writing.

Time frames for action appeals:

- Standard appeals: If we have all the information we need, we will tell you our decision in 30 days from your appeal. A written notice of our decision will be sent within two business days from when we make the decision.
- Fast track appeals: If we have all the information we need, fast track appeal decisions will be made in two business days from your appeal. We will tell you in three business days after giving us your appeal. If we need more information, we will tell you our decision by phone and send a written notice later.

If we do not have the information we need to make either a standard or fast-track decision about your action appeal within the above time frames, we will:

- Write to let you know that we need more time to collect the information. If your request is in a fast track review, we will call you right away and send a written notice later.
- Tell you why the delay is in your best interest.
- Take no more than 14 additional days to make a decision.

You, your provider, or someone you trust may also ask us to take more time to make a decision. This may be because you have more information to give the plan to help decide your case. This can be done by calling **1-877-344-7364** or by writing.

You or someone you trust can file a complaint with the plan if you don't agree with our decision to take more time to review your action appeal. You or your designee can also file a complaint about the review time with the New York State Department of Health by calling **1-866-712-7197**.

If your original denial was because we said the service was not medically necessary, or was experimental or investigational, and we do not tell you our decision about your appeal, the original denial against you will be reversed. This means your service authorization request will be approved.

SERVICE AUTHORIZATIONS AND ACTIONS

Aid to continue while appealing a decision about your care

In some cases you may be able to continue receiving the services while you wait for your appeal to be decided. You may be able to continue the services that are scheduled to end or be reduced if you ask for an appeal:

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

If your appeal results in another denial, you may have to pay for the cost of any continued benefits that you received. If we deny your appeal and you are not satisfied, you can appeal further using the fair hearing process or external appeals described below.

Fair Hearings

In some cases you may ask for a fair hearing from New York State.

- You are not happy with a decision your local Department of Social Services or the State Department of Health made about you staying or leaving the Managed Long Term Care Plus program.
- You are not happy with a decision that we made about one of the services that you were getting. You feel the decision limits your Medicaid benefits or that the plan did not make the decision in a reasonable amount of time.
- You are not happy with a decision that we made that denied you services. You feel that the decision limits your Medicaid benefits or that we did not make the decision in a reasonable amount of time.
- You are not happy with a decision that your doctor would not order one of the services listed above that you wanted. You feel that the doctor's decision stops or limits your Medicaid benefits. You must file a complaint and an appeal with our plan. If we agree with your doctor, you may ask for a State fair hearing.
- In some cases, you may be able to keep getting care the same way while waiting for your fair hearing to be held and decided.

You can request a fair hearing in several ways. By:

- Phone: **1-800-342-3334**
- Fax: **1-518-473-6735**

Internet: **www.otda.state.ny.us/oah/forms.asp**

Mail:

Office of Administrative Hearings
Managed Care Unit
PO Box 22023
Albany, New York 12201-2023

NOTE: If you filed a complaint or appeal under Medicare rules, you may not then request a state fair hearing about the same complaint or appeal.

SERVICE AUTHORIZATIONS AND ACTIONS

Remember, you can file a complaint anytime with the New York State Department of Health by calling **1-866-712-7197**. Call Member Services at **1-877-344-7364** if you have any questions.

External Appeals

If the plan decides to deny coverage for a medical service you and your doctor asked for because it is not medically necessary, or because it is experimental or investigational, you can ask the State Department of Financial Services for an independent **external appeal**. This is called an external appeal because it is decided by reviewers who **do not** work for either the health plan or the State. These reviewers are qualified people approved by New York State. The service must be in the plan's benefit package or be an experimental treatment. You do not have to pay for an external appeal.

Before you appeal to the State:

- You must file an action appeal with the plan and get the plan's final adverse determination; **or**
- If you have not gotten the service, and you ask for a fast-track action appeal with the plan, you may ask for an expedited external appeal at the same time. Your doctor will have to say an expedited external appeal is necessary; **or**
- You can prove the plan did follow the rules correctly when reviewing your action appeal.

You have four months after you receive the plan's final adverse determination to ask for an external appeal. If you and the plan agreed to skip the plan's appeals process, then you must ask for the external appeal within four months of when you made that agreement.

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

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

To ask for an external appeal, fill out an application and send it to the State Department of Financial Services. You can call Customer Service at **1-877-344-7364** if you need help filing an appeal. You and your doctors will have to give information about your medical problem.

Here are some ways to get an application:

- Call the State Department of Financial Services at **1-800-400-8882**
- Go to the State Department of Financial Services Web site at **www.dfs.ny.gov**
- Contact the health plan at **1-877-344-7364**

SERVICE AUTHORIZATIONS AND ACTIONS

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

You can get a faster decision if your doctor says that a delay will cause serious harm to your health. This is called an **expedited external appeal**. The external appeal reviewer will decide an expedited appeal in 72 hours or less. The reviewer will tell you and the plan the decision right away by phone or fax. Later, a letter will be sent that also tells you the decision.

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

What to Do If You Have a Complaint About Our Plan or Want to Appeal a Decision about Your Care

As a dually-eligible member of our plan, the way you make complaints and appeals about your services will depend on whether Managed Long Term Care Plus determines that the services are covered by Medicare or Medicaid.

- For complaints and appeals about a service that is covered only by Medicare (e.g. chiropractic services), you will follow the rules outlined in Sections 10 and 11 of the Plans Medicare Evidence of Coverage.
- For complaints and appeals about a service that is covered only by Medicaid (e.g. personal care services, private duty nursing, non-emergency transportation, dental services, etc.), you will follow the Medicaid rules listed below.
- For complaints and appeals about all other services covered by Managed Long Term Care Plus you may choose to follow either the Medicare rules outlined in Sections 10 and 11 of the Medicare Evidence of Coverage or the Medicaid rules described below. If you choose to follow the Medicare rules, you cannot use your Medicaid complaint and appeal rights, including the right to a state Fair Hearing regarding the complaint or appeal. But if you choose to follow the Medicaid rules, you will have up to 60 days from the day of the Managed Long Term Care Plus notice of denial of coverage to use your Medicare complaint and appeal rights.

We will explain the complaints and appeals processes available to you depending on the complaint you have. Call Customer Service at **1-877-344-7364** to get more information on your rights and the options available to you.

RULES FOR COMPLAINTS AND APPEALS

Complaints

We hope our plan serves you well. If you have a problem with the care or treatment you receive from our staff or providers or you do not like the quality of care or services you receive from us, call Customer Service at **1-877-344-7364** or write:

EmblemHealth
Customer Service
55 Water Street
New York, NY 10041

Please remember that complaints about services that are only a benefit under Medicare should be handled through the Managed Long Term Care Plus Medicare complaint process. Complaints about services only covered by Medicaid should be handled through the Managed Long Term Care Plus Medicaid complaint process. You can choose to use either the Medicare or Medicaid complaints process for complaints about services that Managed Long Term Care Plus determines are a benefit under both Medicare and Medicaid.

Most problems can be resolved right away. Problems that are not resolved over the phone and any complaint that comes in about a Medicaid service will be handled according to the procedures described below. You can ask someone your designee to a complaint for you. If you need our help because of a hearing or vision impairment, or if you need translation services, we can help you. We will not make things hard for you or take any action against you for filing a complaint.

How to File a Complaint With the Plan

To file by phone, call Customer Service at **1-877-344-7364**, Monday through Sunday, from 8 am to 8 pm. If you call us after hours, leave a message. We will call you back the next business day. If we need more information to make a decision, we will tell you.

RULES FOR COMPLAINTS AND APPEALS

You can write us with your complaint or call Customer Service at **1-877-344-7364** and request a complaint form. Mail the completed form to:

EmblemHealth
Grievance and Appeal Department
PO Box 2844
New York, NY 10011-2844

What happens next:

If we don't resolve the problem right away over the phone or after we get your written complaint, we will send you a letter within 15 business days. The letter will tell you:

- who is working on your complaint
- how to contact this person
- if we need more information

Your complaint will be reviewed by one or more qualified people. If your complaint involves clinical matters it will be reviewed by one or more qualified health care professionals.

After we review your complaint:

- We will let you know our decision in 45 days of when we have all the information we need to answer your complaint, but you will hear from us in no more than 60 days from the day we get your complaint. We will write you and will tell you the reason(s) for our decision.
- When a delay would risk your health, we will let you know our decision in 48 hours of when we have all the information we need to answer your complaint, but you will hear from us in no more than seven days from the day we get your complaint. We will call you with our decision or try to reach you to tell you. You will get a letter to follow up our communication in three business days.
- We will tell you how to appeal our decision if you are not satisfied and we will include any forms you may need.
- If we are unable to make a decision about your complaint, because we don't have enough information, we will send a letter and let you know.

Complaint appeals:

If you disagree with a decision we made about your complaint, you, or designee can file a **complaint appeal** with the plan.

How to make a complaint appeal:

- If you are not satisfied with what we decide, you have 60 business day after hearing from us to file an appeal;

RULES FOR COMPLAINTS AND APPEALS

- You can do this yourself, or your designee can file the appeal for you;
- The appeal must be made in writing. If you make an appeal by phone it must be followed up in writing. After your call, we will send you a form which is a summary of your phone appeal. If you agree with our summary, you must sign and return the form to us. You can make any needed changes before sending the form back to us.

What happens after we get your complaint appeal:

After we get your complaint appeal we will send you a letter within 15 business days. The letter will tell you:

- who is working on your complaint appeal
- how to contact this person
- if we need more information

Your complaint appeal will be reviewed by one or more qualified people at a higher level than those who made the first decision about your complaint. If your complaint appeal involves clinical matters, your case will be reviewed by one or more qualified health professionals, with at least one clinical peer reviewer who was not involved in making the first decision about your complaint.

We will let you know our decision within 30 working days from the time we have all information needed. If a delay would risk your health, you will get our decision in two business days of when we have all the information we need to decide the appeal. You will be given the reasons for our decision and our clinical rationale, if it applies. If you are still not satisfied, you or someone on your behalf can file a complaint at any time with the New York State Department of Health at **1-866 712-7197**.

DISENROLLMENT FROM THE EMBLEMHEALTH MANAGED LONG TERM CARE PLUS PROGRAM

Enrollment in this program is voluntary and you can dis-enroll at any time. Continued eligibility into EmblemHealth Managed Long Term Care Plus is based on you continuing to meet the eligibility criteria established by the New York State Department of Health. EmblemHealth will not discriminate based on health status or changes in your health status. We will cover the cost of all health-related covered services.

You Can Choose to Disenroll

You can ask to leave the EmblemHealth Managed Long Term Care Plus program at any time for any reason.

To request disenrollment, you can call **1-877-344-7364** or your case manager at **1-888-447-4838**. It could take up to six weeks to process your dis-enrollment, depending on when your request is received.

You may disenroll and sign up for regular Medicaid or join another health plan as long as you qualify.

You Will Have to Leave the Managed Long Term Care Plus Program if You:

- Need nursing home care, but are not eligible for institutional Medicaid
- Are out of the plan's service area for more than 90 consecutive days
- Permanently move out of our service area
- No longer require a nursing home level of care
- Join a Long-Term Home Health Care program, a Home and Community-Based Services Waiver program, or are enrolled in a program or become a resident in a facility that is under the support and protection of the Offices for People With Developmental Disabilities, or Alcoholism and Substance Abuse Services.

DISENROLLMENT FROM THE EMBLEMHEALTH MANAGED LONG TERM CARE PLUS PROGRAM

We Can Ask You to Leave the Plan

We can ask that you leave EmblemHealth if:

- You or a family member or caregiver behaves in a way that prevents the plan from providing the care you need.
- You knowingly provide false information or behave in a deceptive or fraudulent way.
- You fail to complete or submit any consent form or other document that is needed to obtain services for you.
- Fail to pay or make arrangements to pay money owed to the plan (spend down/surplus/NAMI).

Re-Enrollment Provisions

If you voluntarily disenroll, you will be allowed to reenroll in the program if you meet our eligibility criteria for enrollment. If you are involuntarily disenrolled from our program, you will not be able to re-enroll in our plan.

OTHER INFORMATION YOU CAN REQUEST

You can request the following information by calling or writing to Customer Service:

- A list of names, business addresses and official positions of EmblemHealth's board of directors, officers and owners.
- A copy of EmblemHealth's most recent certified financial statements or balance sheets, as well as summaries of income and expenses.
- A copy of the most recent individual direct pay subscriber contract.
- Information about consumer complaints from the State Department of Financial Services about EmblemHealth.
- How we keep your medical records and member information private.
- Information about how our company is organized and how it works.
- A copy of the most recent Managed Long Term Care Plus Provider Directory.

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

- How we check on the quality of care to our members.
- Qualifications needed and how health care providers can apply to be part of our health plan.

To request any of the items listed, write us at:

EmblemHealth Customer Service Department
55 Water Street
New York, NY 10041
Or call us at: **1-877-344-7364**

Enrollment Next Steps: Signing Up for Managed Long Term Care Plus **Here's What Happens Next**

If you filled out an application to join the Managed Long Term Care Plus program and have received your initial service plan, here are the next steps:

- EmblemHealth will send your application to the New York City Human Resource Administration (HRA) or Local Department of Social Services (LDSS).
- The HRA or LDSS will decide if you are approved for the Managed Long Term Care Plus plan.

OTHER INFORMATION YOU CAN REQUEST

- Once we get approval from the HRA or LDSS, we will enroll you in the plan.
- If the date your coverage begins is different from the date on your application, EmblemHealth will send you a letter with the new date.
- Once you are enrolled, you will get a call from an EmblemHealth nurse care manager, who will work with you, your family and your health care practitioners to develop a comprehensive care plan for you.
- You will also get a letter confirming your enrollment and a new member ID card.

If you have any questions during the enrollment process, please call us at **1-646-447-7383**, Monday to Friday, from 9 am and 5 pm. If you have a hearing or speech impairment and use a TTY/TDD, you can call **1-877-444-2786**, Monday to Friday, from 9 am and 5 pm.

MEMBER RIGHTS AND RESPONSIBILITIES

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

Member Rights and Member Responsibilities are available for your review.

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

Your Rights

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

- The right to be treated without discrimination, including discrimination based on race, color, religion, gender, national origin, disability, sexual orientation or source of payment.
- The right to participate with physicians in making decisions about your health care.
- The right to a non-smoking environment.
- The right to be treated with fairness and respect at all times, and in a clean and safe environment.
- The right to receive, upon request, a list of the physicians and other health care providers in our participating provider network.
- The right to change your physician.
- The right to information about our plans, networks and your covered services.
- The right to be assured that our participating health care providers have the qualifications stated in our Professional Standards, established by the EmblemHealth credentialing committee, which are available upon request.

MEMBER RIGHTS AND RESPONSIBILITIES

- The right to know the names, positions and functions of any participating provider's staff and to refuse their treatment, examination or observation.
- The right to timely access to your covered services and drugs.
- The right to obtain from and discuss with your physician, during practice hours, comprehensive information about your diagnosis, treatment and prognosis, regardless of cost or benefit coverage, in language you can understand. When it is not medically advisable to give such information to you, or when the member is a minor or is incompetent, the information will be made available to a person who has been designated to act on that person's behalf.
- The right to receive from your physician the information necessary to allow you to give informed consent prior to the start of any procedure or treatment and to refuse to participate in, or be a patient for, medical research. In deciding whether to participate, you have the right to a full explanation.
- The right to know any risks involved in your care.
- The right to refuse treatment, to the extent permitted by law, and to be informed of the medical consequences of refusing it.
- The right to have all lab reports, X-rays, specialists' reports and other medical records completed and placed in your chart so they may be available to your physician at the time of consultation.
- The right to be informed about all medication given to you, as well as the reasons for prescribing the medication and its expected effects.
- The right to receive, from your provider, all information you need to give informed consent for an order not to resuscitate. You also have the right to designate an individual to give this consent if you are too ill to do so.
- The right to request a second opinion from a participating physician.
- The right to privacy concerning your medical care. This means, among other things, that no person who is not directly involved in your care may be present without your permission during any portion of your discussion, consultation, examination or treatment. We will give you a written notice, called a "Notice of Privacy Practice" that describes your rights.
- The right to expect that all communications, records and other information about your care or personal condition will be kept confidential, except if disclosure of that information is required by law or permitted by you.
- The right to request that copies of your complete medical records be forwarded to a physician or hospital of your choice at your expense. However, information may be withheld from you if, in the physician's judgment, release of the information could harm you or another person. Additionally, a parent or guardian may be denied access to medical records or information relating to a minor's pregnancy, abortion, birth control or sexually transmitted diseases if the minor's consent is not obtained.
- The right to have a person of your choice accompany you in any meeting or discussion with medical or administrative personnel.
- The right to give someone legal authority to make medical decisions for you.

MEMBER RIGHTS AND RESPONSIBILITIES

- The right to consult by appointment, during business hours, with our responsible administrative officials and your participating physician's office to make specific recommendations for the improvement of the delivery of health services.
- The right to make a complaint or file an appeal related to the organization or a determination about seeking care or about care and services you have received.
- For more information on filing an appeal, please call Customer Service:
1-800-447-8255; TTY/TDD: **711**, Monday through Friday, from 8 am to 8 pm.
- You have the right to receive an explanation from us if a provider has denied care that you believe you should receive. To receive this explanation, you will need to ask us for a copy of the written decision.
- We must provide information in a way that works for you, in languages other than English or other alternate formats, in accordance with company policy and regulatory rules.

For additional information on filing an appeal, please call Customer Service:
1-800-447-8255; TTY/TDD: **711**, Monday through Friday, from 8 am to 8 pm

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

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

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

Your Responsibilities

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

- The responsibility to provide us and our participating physicians and other providers with accurate and relevant information about your medical history and health so that appropriate treatment and care can be rendered. Tell your doctors you are enrolled in our plan and show them your membership card.
- The responsibility to keep scheduled appointments or cancel them, giving as much notice as possible in accordance with the provider's guidelines for cancellation notification.

MEMBER RIGHTS AND RESPONSIBILITIES

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

NOTICE OF PRIVACY PRACTICES

IMPORTANT INFORMATION ABOUT YOUR PRIVACY RIGHTS 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.

NOTICE OF PRIVACY PRACTICES

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

Other Ways We Use or Share Information

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

- We may use or share your information with the employer or other health-plan sponsor through which you receive your health benefits. We will not share individually identifiable health information with your benefits plan unless they promise to keep it protected and use it only for purposes relating to the administration of your health benefits.
- We may share your information with a health plan, provider, or health care clearinghouse that participates with us in an organized health care arrangement. We will only share your information for health care operations activities associated with that arrangement.

NOTICE OF PRIVACY PRACTICES

- 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.

NOTICE OF PRIVACY PRACTICES

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

Sensitive Information

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

Your Authorization

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

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

Your Rights

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

Restricting Your Information

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

Confidential Communications for Your Information

- You have the right to ask to receive confidential communications of information if you believe that you would be endangered if we send your information to your current mailing address (for example, in situations involving domestic disputes or violence). If you are a minor and have received health care services based on your own

NOTICE OF PRIVACY PRACTICES

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.

NOTICE OF PRIVACY PRACTICES

- Information disclosed to correctional institutions or law enforcement officials.
- Information that was disclosed or used as part of a limited data set for research, public health or health care operations purposes.

Collecting, Sharing and Safeguarding Your Financial Information

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

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

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

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

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

Exercising Your Rights, Complaints and Questions

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

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

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

Contact Information

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

Write to:

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

Call:

EmblemHealth program members: M-F, 8 am-8 pm, **1-877-842-3625**,
TTY/TDD: 711

EmblemHealth Medicare members: M-Sun., 8 am-8 pm

PPO: **1-866-557-7300**, TTY/TDD: 711

HMO: **1-877-344-7364**, TTY/TDD: 711

PDP (City of NY Retirees): **1-800-624-2414**, TTY/TDD: 711

PDP (non-City of NY Retirees): **1-877-444-7241**, TTY/TDD: 711

GHI members: M-F, 8 am-8 pm, **1-800-624-2414**, TTY/TDD: 711

GHI HMO members: M-F, 8 am-8 pm, **1-877-244-4466**, TTY/TDD: 711

HIP/HIPIC members: M-F, 8 am-8 pm, **1-800-447-8255**, TTY/TDD: 711

NOTICE OF PRIVACY PRACTICES

Personal Information After You Are No Longer Enrolled

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

Changes to this Notice

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

HEALTH CARE PROXY

Appointing Your Health Care Agent In New York State

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

About The Health Care Proxy Form

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

1. This form gives the person you choose as your agent the authority to make all health care decisions for you, including the decision to remove or provide life-sustaining treatment, unless you say otherwise in this form. “Health care” means any treatment, service or procedure to diagnose or treat your physical or mental condition.
2. Unless your agent reasonably knows your wishes about artificial nutrition and hydration (nourishment and water provided by a feeding tube or intravenous line), he or she will not be allowed to refuse or consent to those measures for you.
3. Your agent will start making decisions for you when your doctor determines that you are not able to make health care decisions for yourself.
4. You may write on this form examples of the types of treatments that you would not desire and/or those treatments that you want to make sure you receive. The instructions may be used to limit the decision-making power of the agent. Your agent must follow your instructions when making decisions for you.
5. You do not need a lawyer to fill out this form.
6. You may choose any adult (18 years of age or older), including a family member or close friend, to be your agent. If you select a doctor as your agent, he or she will have to choose between acting as your agent or as your attending doctor, because a doctor cannot do both at the same time. Also, if you are a patient or resident of a hospital,

HEALTH CARE PROXY

nursing home or mental hygiene facility, there are special restrictions about naming someone who works for that facility as your agent. Ask staff at the facility to explain those restrictions.

7. Before appointing someone as your health care agent, discuss it with him or her to make sure that he or she is willing to act as your agent. Tell the person you choose that he or she will be your health care agent. Discuss your health care wishes and this form with your agent. Be sure to give him or her a signed copy. Your agent cannot be sued for health care decisions made in good faith.
8. If you have named your spouse as your health care agent and you later become divorced or legally separated, your former spouse will no longer be your agent by law, unless you state otherwise. If you would like your former spouse to remain your agent, you may note this on your current form and date it or complete a new form naming your former spouse.
9. Even though you have signed this form, you have the right to make health care decisions for yourself as long as you are able to do so, and treatment cannot be given to you or stopped if you object, nor will your agent have any power to object.
10. You may cancel the authority given to your agent by telling him or her or your health care provider orally or in writing.
11. Appointing a health care agent is voluntary. No one can require you to appoint one.
12. You may express your wishes or instructions regarding organ and/or tissue donation on the form.

Frequently Asked Questions

Why Should I Choose a Health Care Agent?

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

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

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

Who Can Be A Health Care Agent?

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

How Do I Appoint A Health Care Agent?

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

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

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

What Decisions Can My Health Care Agent Make?

Unless you limit your health care agent's authority, your agent will be able to make any health care decision that you could have made if you were able to decide for yourself. Your agent can agree that you should receive treatment, choose among different treatments and decide that treatments should not be provided, in accordance with your wishes and interests. However, your agent can only make decisions about artificial nutrition and hydration (nourishment and water provided by feeding tube or intravenous line) if he or she knows your wishes from what you have said or what you have written. The Health Care Proxy form does not give your agent the power to make non-health care decisions for you, such as financial decisions.

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

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

How Will My Health Care Agent Make Decisions?

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

HEALTH CARE PROXY

How Will My Health Care Agent Know My Wishes?

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

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

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

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

Who Will Pay Attention To my Agent?

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

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

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

What If I Change My Mind?

It is easy to cancel your Health Care Proxy, to change the person you have chosen as your health care agent or to change any instructions or limitations you have included on the form. Simply fill out a new form. In addition, you may indicate that your Health Care Proxy expires on a specified date or if certain events occur. Otherwise, the Health Care Proxy will be valid indefinitely. If you choose your spouse as your health care agent or as your alternate, and you

get divorced or legally separated, the appointment is automatically cancelled. However, if you would like your former spouse to remain your agent, you may note this on your current form and date it or complete a new form naming your former spouse.

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

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

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

No. A living will is a document that provides specific instructions about health care decisions. You may put such instructions on your Health Care Proxy form. The Health Care Proxy allows you to choose someone you trust to make health care decisions on your behalf. Unlike a living will, a Health Care Proxy does not require that you know in advance all the decisions that may arise. Instead, your health care agent can interpret your wishes as medical circumstances change and can make decisions you could not have known would have to be made.

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

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

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

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

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

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

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

HEALTH CARE PROXY

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

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

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

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

Health Care Proxy Form Instructions

Item (1)

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

Item (2)

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

Item (3)

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

Item (4)

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

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

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

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

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

Item (5)

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

Item (6)

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

Item (7)

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

Health Care Proxy

(print out page to complete)

(1) I, _____

hereby appoint _____
(name, home address and telephone number)

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

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

(name, home address and telephone number)

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

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

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

HEALTH CARE PROXY

(print out page to complete)

(5) Your Identification (Please Print):

Your Name: _____

Your Signature: _____

Date: _____

Your Address: _____

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

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

Any needed organs and/or tissues

The following organs and/or tissues

Limitations

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

Your Signature: _____

Date: _____

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

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

PRIVATE	Date _____
Date _____	Name of Witness 2 (print) _____
Name of Witness 1 (print) _____	Signature _____
Signature _____	Address _____
Address _____	

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



EmblemHealth[®]
WHAT CARE FEELS LIKE.

EmblemHealth insurance plans are underwritten by Group Health Incorporated (GHI), HIP Health Plan of New York (HIP) and HIP Insurance Company of New York.

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