



MANAGED LONG TERM CARE

A Guide To Your Benefits and Services



EmblemHealth[®]
WHAT CARE FEELS LIKE.

TABLE OF CONTENTS

WELCOME TO THE EMBLEMHEALTH MANAGED LONG TERM CARE (MLTC) PROGRAM.....	1
HELP FROM MEMBER SERVICES	3
ELIGIBILITY FOR ENROLLMENT IN OUR PLAN.....	5
SERVICES COVERED BY OUR PLAN.....	9
Care Management Services	9
Covered Services	9
Limitations.....	11
Getting Care Outside the Service Area	12
Emergency Care.....	12
MEDICAID AND/OR MEDICARE SERVICES NOT COVERED BY OUR PLAN.....	13
Certain Mental Health Services	13
Certain Mental Retardation and Developmental Disabilities Services.....	14
Other Medicaid Services.....	14
Family Planning.....	14
Services Not Covered By Our Plan or Medicaid Program.....	14
SERVICE AUTHORIZATIONS.....	15
Prior Authorizations.....	15
What Happens After We Receive Your Service Authorization Request?.....	16
GRIEVANCES AND APPEALS.....	17
DISENROLLMENT FROM OUR PLAN.....	23
You Can Choose to Disenroll	23
We Can Ask You to Leave the Plan.....	23
Re-enrollment Provisions	24
OTHER INFORMATION YOU CAN REQUEST	25

TABLE OF CONTENTS

MEMBER RIGHTS AND RESPONSIBILITIES	27
NOTICE OF PRIVACY PRACTICES	29
HEALTH CARE PROXY	37

WELCOME TO THE EMBLEMHEALTH MLTC PROGRAM

Welcome to the EmblemHealth Managed Long Term Care (MLTC) program. The MLTC program is especially designed for people who have Medicaid or both Medicaid and Medicare, 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 benefits EmblemHealth covers since you are enrolled in the EmblemHealth MLTC program. It also tells you how to request a service, file a complaint or grievance or disenroll from the EmblemHealth MLTC program.

When this handbook says “we,” “us,” or “our,” it means EmblemHealth. When it says “plan” or “our plan,” it means the EmblemHealth MLTC program.

HELP FROM MEMBER SERVICES

There is someone to help you at Customer Service. You can call us at **1-855-283-2146**, seven days a week (excluding major holidays), from 8 am to 8 pm. If you have a hearing or speech impairment and use a TTY/TTD, please call **711**. At other times, you can call this number and leave a message on the answering machine. Be 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 nonbusiness hours, on weekends or holidays, call **1-888-447-4838**.

ELIGIBILITY FOR ENROLLMENT IN OUR PLAN

You are eligible to join the MLTC program if you:

- 1) Are age 18 or 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:
 - Nursing services in the home
 - Therapies in the home
 - Home health aide services
 - Personal care services in the home
 - Adult day health care
 - Private Duty Nursing
 - Consumer Directed Personal Assistance Services

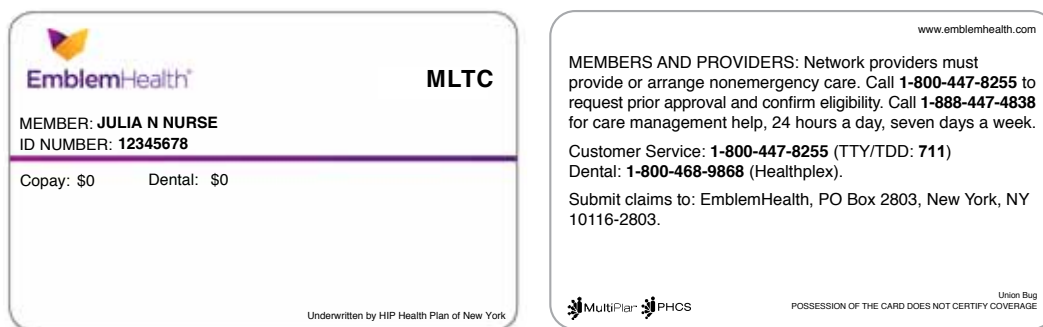
An applicant who is a hospital inpatient or is an inpatient or resident of a facility licensed by the State Office of Mental Health (OMH), the Office of Alcoholism and Substance Abuse Services (OASAS) or the State Office for People With Developmental Disabilities (OPWDD) or is enrolled in another managed care plan capitated by Medicaid, a Home and Community-Based Services Waiver program or Office of Mental Retardation and Developmental Disabilities (OMRDD) day treatment program or is receiving services from a hospice may be enrolled in our Plan 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 or OMRDD Day Treatment program.

Your physician must agree to work with us or you must be willing to change to a physician who is willing to work with our managed long term care plan. Your physician must express a willingness to write orders for covered services that allow you to receive care from network providers upon enrollment.

Enrollment in a MLTC program is mandatory for most people age 21 and over who have both Medicare and Medicaid. Enrollment is voluntary if you are between 18-20 years old and have been assessed as eligible for nursing home level of care.

ELIGIBILITY FOR ENROLLMENT IN OUR PLAN

The coverage explained in this handbook becomes effective on the effective date of your enrollment in our plan. Once the nurse assessment has been completed and you have reviewed your initial service plan and you have signed our plan 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 Human Resources Administration (HRA) or the Local Department of Social Services (LDSS). Once you have been approved by HRA 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 approval from HRA 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.

Participating Providers and Covered Services

You have the freedom to choose providers for covered services paid for by Medicare or Medicaid. However, when Medicare or Medicaid stops paying for these services, you must use a network provider in order for us to cover the service. We pay the Medicare coinsurance and deductibles if Medicare is the primary payor.

We will provide you with a list of our network providers. You have the freedom to choose any provider from this list for covered services. We will help you in choosing or changing a provider for covered or non-covered services.

Network providers will be paid in full directly by us 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 us, you are not responsible for paying the bill. Please contact your case manager. You may be responsible for payment of covered services that were not authorized by us or for covered services that were received from non-network providers.

To access services that are not covered under this plan (such as doctor visits or inpatient hospital care), use your Medicare or Medicaid card.

ELIGIBILITY FOR ENROLLMENT IN OUR PLAN

Transitional Care Procedures

During the first 90 days in our Plan, your Care Manager will arrange for you to keep the same services you had before you joined the Plan

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.

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 OUR PLAN

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 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 services 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** to request other services covered by the plan.

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 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.
- **Consumer Directed Personal Assistance Services** includes the services listed under Personal Care, but self-directing members have the flexibility and freedom to choose their own caregiver. You, or a person acting on your behalf, assume full responsibility for hiring, training, supervising and — if need be — terminating the employment of persons providing the services. 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 as well as physical therapy, occupational therapy and speech pathology services in your home. 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.

SERVICES COVERED BY OUR PLAN

- **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 our 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.
- **Nonemergency 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 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** from 8 am to 8 pm, Monday through Thursday, and Friday from 8 am to 6 pm. You may also call this number with questions about your dental benefits. You can also self-refer to a dental clinic operated by an academic dental center.
- **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 that signals for help in the event of an emergency. You can request this service through your case manager. Access to this service 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**, including 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.

SERVICES COVERED BY OUR PLAN

- **Nursing Home Care Not Covered by Medicare** (see Limitations). 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.
- **Vision Services**, including routine eye exams, eyeglasses and repairs and medically necessary contact lenses. These services are covered for all MLTC 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 MLTC members. When you need these services, your provider will get approval from us.
- **Durable Medical Equipment**, including medical/surgical supplies, prosthetics, orthotics, orthopedic footwear, Enteral and Parenteral formulas (see Limitations). When you need these services, your doctor providing your care will get approval from us.
- **Outpatient Occupational, Physical and Speech Therapies**, including rehabilitation services provided by a licensed and registered therapist for the purpose of reducing physical or mental disability.
- **Respiratory Therapy**, including preventive, maintenance and rehabilitative services provided by a qualified respiratory therapy professional.
- **Podiatry Services**, including routine foot care provided by a podiatrist when your physical condition poses a hazard due to the presence of localized illness, injury or symptoms involving the foot, resulting from the diagnosis and treatment of diabetes, ulcers and infections. Routine hygienic foot care, including treatment of corns and calluses, the trimming of nails, and other hygienic care such as cleaning or soaking feet, is not covered in the absence of a pathological condition.

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 diseases of amino acid and organic acid metabolism shall include modified solid food products that are low-protein or that 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 are 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

We do not cover services provided outside the defined service area. However, 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. Note that you may be disenrolled if you leave the service area for more than 30 consecutive days. If you have an emergency (see the Emergency Care section of this handbook), go to the nearest emergency room or call **911**. Emergency coverage is covered as a part of your primary medical coverage, e.g., Medicaid or Medicare.

Emergency Care

In an emergency, call **911**. Follow any orders that your primary health care coverage has given you. It's also a good idea to tell your doctor and our case manager as soon as possible after you receive emergency care, so that he/she can update your medical record and arrange for any post-emergency follow-up care.

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 nonemergencies are colds, sore throat, upset stomach, minor cuts and bruises or strained muscles.

MEDICAID AND/OR MEDICARE SERVICES NOT COVERED BY OUR PLAN

There are some Medicaid and/or Medicare services that we do not cover. You can get these services from any provider who accepts Medicaid or Medicare by using your Medicaid or Medicare Benefit Card. Call Customer Service at **1-855-283-2146** if you have any questions about whether a benefit is covered by EmblemHealth, Medicaid or Medicare. Some of the services covered by Medicaid and/or Medicare include:

- Pharmacy
- Inpatient hospital services
- Outpatient hospital services
- Laboratory
- Physician
- Radiology and radioisotope services
- Emergency transportation
- Clinic visits
- Renal dialysis
- Alcohol and substance abuse services
- Assisted Living Program (Medicaid only)

Medicaid Covers Mental Health Services, including:

- Intensive psychiatric rehabilitation treatment
- Day treatment
- Case management for 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

MEDICAID AND/OR MEDICARE SERVICES NOT COVERED BY OUR PLAN

Medicaid Covers 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

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.

Services Not Covered by Our Plan, Medicare or Medicaid Programs

You must pay for services that are not covered by us or by Medicare/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 us or Medicare/Medicaid are:

- Cosmetic surgery if not medically needed
- Personal and comfort items
- Infertility treatment
- Services of a non-network provider (unless we send you to that provider)

If you have any questions, call Customer Service at **1-855-283-2146**.

SERVICE AUTHORIZATIONS

When we determine 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 our 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 arrange for prior authorization. The following treatments and services must be approved before you get them:

- Personal care.
- Consumer directed personal care services
- Home health care services including respiratory therapy.
- Nutrition services (when not provided by our staff).
- Medical social services (when not provided by our staff).
- Home delivered and/or meals in a group setting such as a day center.
- Social day care.
- Nonemergency transportation.
- Personal emergency response services.
- Social and environmental supports.
- Adult day health care.
- Nursing home care.
- Hearing services.
- Certain durable medical equipment.
- Outpatient physical therapy, occupational therapy, and speech therapy.

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

Write:

EmblemHealth
Care Management Department
441 Ninth Ave
New York, NY 10004

Fax: 1-212-510-3004

SERVICE AUTHORIZATIONS

Services will be authorized for a set period of time, and a specified quantity if applicable. This is called an **authorization period**.

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 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.

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,.

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. If we deny your request, in whole or in part, it is called an Action. See the section “Grievances and Appeals” for more information on Actions and how to Appeal an Action.

GRIEVANCES AND APPEALS

EmblemHealth will try its best to deal with your concerns or issues as quickly as possible and to your satisfaction. You may use either our grievance process or our appeal process, depending on what kind of problem you have.

There will be no change in your services or the way you are treated by EmblemHealth staff or a health care provider because you file a grievance or an appeal. We will maintain your privacy. We will give you any help you may need to file a grievance or appeal. This includes providing you with interpreter services or help if you have vision and/or hearing problems. You may choose someone (like a relative or friend or a provider) to act for you.

To file a grievance or to appeal a plan action, please contact us by telephone or in writing.

We can be reached by calling one of these three numbers:

Customer Service: **1-855-283-2146**

Care Management: **1-888-447-4838**

Expedited Appeals: **1-888-447-6855**

Or you can write to us at this address:

Emblem Health
Grievance and Appeal Department
P.O. Box 2844
New York, NY 10116-2844

When you contact us, you will need to give us your name, address, telephone number and the details of the problem.

What is a Grievance?

A grievance is any communication by you to us of dissatisfaction about the care and treatment you receive from our staff or providers of covered services. For example, if someone was rude to you or you do not like the quality of care or services you have received from us, you can file a grievance with us.

GRIEVANCES AND APPEALS

The Grievance Process

You may file a grievance orally or in writing with us. The person who receives your grievance will record it, and appropriate plan staff will oversee the review of the grievance. We will send you a letter telling you that we received your grievance and a description of our review process. We will review your grievance and give you a written answer within one of two timeframes.

1. If a delay would significantly increase the risk to your health, we will decide within 48 hours after receipt of necessary information
2. For all other types of grievances, we will notify you of our decision within 45 days of receipt of necessary information, but the process must be completed within 60 days of the receipt of the grievance. The review period can be increased up to 14 days if you request it or if we need more information and the delay is in your interest.

Our answer will describe what we found when we reviewed your grievance and our decision about your grievance.

How do I Appeal a Grievance Decision?

If you are not satisfied with the decision we make concerning your grievance, you may request a second review of your issue by filing a grievance appeal. You must file a grievance appeal in writing. It must be filed within 30 calendar days of receipt of our initial decision about your grievance. Once we receive your appeal, we will send you a written acknowledgement telling you the name, address and telephone number of the individual we have designated to respond to your appeal. All grievance appeals will be conducted by appropriate professionals, including health care professionals for grievances involving clinical matters, who were not involved in the initial decision.

For standard appeals, we will make the appeal decision within 30 business days after we receive all necessary information to make our decision. If a delay in making our decision would significantly increase the risk to your health, we will use the expedited grievance appeal process. For expedited grievance appeals, we will make our appeal decision within 2 business days of receipt of necessary information. For both standard and expedited grievance appeals, we will provide you with written notice of our decision. The notice will include the detailed reasons for our decision and, in cases involving clinical matters, the clinical rationale for our decision.

What is an Action?

When EmblemHealth 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 timeframes, those are considered plan "actions." These decisions will be made by qualified health care professionals. An action is subject to appeal. (See How do I File an Appeal of an Action? below for more information.)

Timing of the Notice of Action

If we decide to deny or limit services you requested or decide not to pay for all or part of a covered service, we will send you a notice when we make our decision. If we are proposing to reduce, suspend or terminate a service that is authorized, our letter will be sent at least 10 days before we intend to change the service.

Contents of the Notice of Action

Any notice we send to you about an action will:

- Explain the action we have taken or intend to take;
- Cite the reasons for the action, including the clinical rationale, if any;
- Describe your right to file an appeal with us (including whether you may also have a right to the State's external appeal process);
- Describe how to file an internal appeal and the circumstances under which you can request that we speed up (expedite) our review of your internal appeal;
- Describe the availability of the clinical review criteria relied upon in making the decision, if the action involved issues of medical necessity or whether the treatment or service in question was experimental or investigational;
- Describe the information, if any, that must be provided by you and/or your provider in order for us to render a decision on appeal.

If we are reducing, suspending or terminating an authorized service, the notice will also tell you about your right to have services continue while we decide on your appeal; how to request that services be continued; and the circumstances under which you might have to pay for services if they are continued while we were reviewing your appeal.

How do I File an Appeal of an Action?

If you do not agree with an action that we have taken, you may appeal. When you file an appeal, it means that we must look again at the reason for our action to decide if we were correct. You can file an appeal of an action with the plan orally or in writing. When the plan sends you a letter about an action it is taking (like denying or limiting services, or not paying for services), you must file your appeal request within 45 calendar days of the date on our letter notifying you of the action. If you call us to file your request for an appeal, you must also send a written request unless you ask for an expedited review.

How do I Contact my Plan to file an Appeal?

We can be reached by calling one of these three numbers:

Customer Service: **1-855-283-2146**
Care Management: **1-888-447-4838**
Expedited Appeals: **1-888-447-6855**

Standard appeals need to be followed up by writing to:

Emblem Health
Grievance and Appeal Department
P.O. Box 2844
New York, NY 10116-2844

The person who receives your appeal will record it, and appropriate staff will oversee the review of the appeal. We will send a letter telling you that we received your appeal, and how we will handle it. Your appeal will be reviewed by knowledgeable clinical staff who were not involved in the plan's initial decision or action that you are appealing.

GRIEVANCES AND APPEALS

For Some Actions You May Request to Continue Service During the Appeal Process

If you are appealing a reduction, suspension or termination of services you are currently authorized to receive, you may request to continue to receive these services while we are deciding your appeal. We must continue your service if you make your request to **us no later than 10 days from our mailing of the notice** to you about our intent to reduce, suspend or terminate your services, or by the intended effective date of our action, and the original period covered by the service authorization has not expired. Your services will continue until you withdraw the appeal, the original authorization period for your services has been met or until 10 days after we mail your notice about our appeal decision, if our decision is not in your favor, unless you have requested a New York State Medicaid Fair Hearing with continuation of services. (See Fair Hearing Section below.)

Although you may request a continuation of services while your appeal is under review, if your appeal is not decided in your favor, we may require you to pay for these services if they were provided only because you asked to continue to receive them while your appeal was being reviewed.

How Long Will it Take the Plan to Decide My Appeal of an Action?

Unless you ask for an expedited review, we will review your appeal of the action taken by us as a standard appeal and send you a written decision as quickly as your health condition requires, but no later than 30 calendar days from the day we receive an appeal. (The review period can be increased up to 14 days if you request an extension or we need more information and the delay is in your interest.) During our review you will have a chance to present your case in person and in writing. You will also have the chance to look at any of your records that are part of the appeal review.

We will send you a notice about the decision we made about your appeal that will identify the decision we made and the date we reached that decision.

If we reverse our decision to deny or limit requested services, or reduce, suspend or terminate services, and services were not furnished while your appeal was pending, we will provide you with the disputed services as quickly as your health condition requires

In some cases you may request an “expedited” appeal. (See Expedited Appeal Process Section below.)

Expedited Appeal Process

If you or your provider feels that taking the time for a standard appeal could result in a serious problem to your health or life, you may ask for an expedited review of your appeal of the action. We will respond to you with our decision within 2 business days after we receive all necessary information. In no event will the time for issuing our decision be more than 3 business days after we receive your appeal. (The review period can be increased up to 14 days if you request an extension or we need more information and the delay is in your interest.)

If we do not agree with your request to expedite your appeal, we will make our best efforts to contact you in person to let you know that we have denied your request for an expedited appeal and will handle it as a standard appeal. Also, we will send you a written notice of our decision to deny your request for an expedited appeal within 2 days of receiving your request.

If the Plan Denies My Appeal, What Can I Do?

If our decision about your appeal is not totally in your favor, the notice you receive will explain your right to request a Medicaid Fair Hearing from New York State and how to obtain a Fair Hearing, who can appear at the Fair Hearing on your behalf, and for some appeals, your right to request to receive services while the Hearing is pending and how to make the request. If we deny your appeal because of issues of medical necessity or because the service in question was experimental or investigational, the notice will also explain how to ask New York State for an “external appeal” of our decision.

State Fair Hearings

If we did not decide the appeal totally in your favor, you may request a Medicaid Fair Hearing from New York State within 60 days of the date we sent you the notice about our decision on your appeal.

If your appeal involved the reduction, suspension or termination of authorized services you are currently receiving, and you have requested a Fair Hearing, you may also request to continue to receive these services while you are waiting for the Fair Hearing decision. You must check the box on the form you submit to request a Fair Hearing to indicate that you want the services at issue to continue. Your request to continue the services must be made within 10 days of the date the appeal decision was sent by us or by the intended effective date of our action to reduce, suspend or terminate your services, whichever occurs later. Your benefits will continue until you withdraw the appeal; the original authorization period for your services ends; or the State Fair Hearing Officer issues a hearing decision that is not in your favor, whichever occurs first.

If the State Fair Hearing Officer reverses our decision, we must make sure that you receive the disputed services promptly, and as soon as your health condition requires. If you received the disputed services while your appeal was pending, we will be responsible for payment for the covered services ordered by the Fair Hearing Officer.

Although you may request to continue services while you are waiting for your Fair Hearing decision, if your Fair Hearing is not decided in your favor, you may be responsible for paying for the services that were the subject of the Fair Hearing.

State External Appeals

If we deny your appeal because we determine the service is not medically necessary or is experimental or investigational, you may ask for an external appeal from New York State. The external appeal is decided by reviewers who do not work for us or New York State. These reviewers are qualified people approved by New York State. You do not have to pay for an external appeal.

When we make a decision to deny an appeal for lack of medical necessity or on the basis that the service is experimental or investigational, we will provide you with information about how to file an external appeal, including a form on which to file the external appeal along with our decision to deny an appeal. If you want an external appeal, you must file the form with the New York State Department of Financial Services within four months from the date we denied your appeal.

Your external appeal will be decided within 30 days. More time (up to 5 business days) may be needed if the external appeal reviewer asks for more information. The reviewer will tell you and us of the final decision within two business days after the decision is made.

GRIEVANCES AND APPEALS

You can get a faster decision if your doctor can say 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 3 days or less. The reviewer will tell you and us the decision right away by phone or fax. Later, a letter will be sent that tells you the decision.

You may ask for both a Fair Hearing and 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.”

DIENROLLMENT FROM OUR PLAN

Continued eligibility for our program is based on you continuing to meet the eligibility criteria established by the New York State Department of Health. We 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 our program at any time for any reason.

To request disenrollment, you can call **1-855-283-2146** or call your case manager at **1-888-447-4838**. It could take up to six weeks to process your disenrollment, 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 our 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 30 consecutive days.
- Permanently move out of our service area.
- No longer require a nursing home level of care (for members with Medicaid only)
- You are assessed as no longer needing community-based long term care services (for members with both Medicare and Medicaid)
- 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.
- You are no longer eligible to receive Medicaid benefits.
- You are incarcerated.

We Can Ask You to Leave the Plan

We can ask that you leave our plan 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.

DISENROLLMENT FROM OUR PLAN

- Fail to pay or make arrangements to pay money owed to the plan (spend-down/surplus/National Alliance on Mental Illness (NAMI)).

Re-Enrollment Provisions

If you voluntarily disenroll, you will be allowed to re-enroll 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/balance sheets/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 MLTC 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 or call us at:

EmblemHealth
Customer Service Department
55 Water Street
New York, NY 10041-8190
Call: **1-855-283-2146**

ADULT PROTECTIVE SERVICES

Adult Protective Services (APS) is a state-mandated program available to persons 18 years of age and older, without regard to income, who:

1. Are mentally and/or physically impaired, and
2. Due to these impairments, are unable to manage their own resources, carry out the activities of daily living, or protect themselves from abuse, neglect, exploitation or other hazardous situations without assistance from others; and
3. Have no one available who is willing and able to assist them responsibly.

OTHER INFORMATION YOU CAN REQUEST

APS can help resolve the risks faced by eligible clients by arranging for services and support that will enable them to live independently and safely within their homes and communities. APS clients typically lack the ability to meet their essential needs for food, shelter, clothing or health care, due to self-neglect or because they are neglected, abused or financially exploited by others. Some of the services offered by APS include:

1. Applications for payment of rental and utility arrears
2. Identification of alternative living arrangements
3. Petitioning the Courts for guardians to assist with eviction prevention or to manage financial affairs.
4. Referrals to the proper authorities to address allegations of exploitation and abuse.

If you think you meet the criteria and could benefit from APS, call your case manager. He/she will first see if any of the help you need is covered by our Plan and, if not, will call APS and refer you for services. Or, you can self refer to APS in your area by calling the following number:

- Westchester: Adult Protective Intake (914) 995-2259
- Suffolk: Adult Protective Intake (631) 854-3195, (631) 854-3196, (631) 854-3197
- Nassau: Adult Protective Services 516-227-8083
- NYC: APS Central Intake (212) 630-1853, or call 311

MEMBER RIGHTS AND RESPONSIBILITIES

Member Rights and Responsibilities

As a member you have the right to appropriate treatment in a proper setting. You also have the right to know what to expect from us and what we expect from you. And it's important that providers have the same information about your rights and responsibilities in order to ensure that you, their patient, get the care and services your plan entitles you to.

Understanding your rights and responsibilities as a plan member can help both you and us make the most of your membership. Below we have listed what you can expect of EmblemHealth and what we expect from you. If for any reason you do not understand these rights or how to interpret them, EmblemHealth and its participating physicians will provide you with assistance.

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.

- You have the Right to receive medically necessary care.
- You have the Right to timely access to care and services.
- You have the Right to privacy about your medical record and when you get treatment.
- You have the Right to obtain information on available treatment options presented in a manner you understand.
- You have the Right to get information in a language you understand. Oral translation services are provided free of charge.
- You have the Right to get the information necessary to give informed consent before the start of treatment.
- You have the Right to be treated with respect and dignity.
- You have the Right to get a copy of your medical records and ask that the records be changed or corrected.
- You have the Right to take part in decisions about your health care, including the right to refuse treatment.
- You have the Right to be free from any form of restraint or seclusion used as a means of force, discipline, convenience or retaliation.
- You have the Right to get care without regard to sex, race, health status, color, age, national origin, sexual orientation, marital status or religion.
- You have the Right to be told where, when and how to get the services you need from your managed long term care plan, including how you can get covered benefits from out-of-network providers if they are not available in the plan network.

MEMBER RIGHTS AND RESPONSIBILITIES

- You have the Right to complain to the New York State Department of Health or your Local Department of Social Services; and, the Right to use the New York State Fair Hearing System and/or a New York State External Appeal, where appropriate.
- You have the Right to appoint someone to speak for you about your care and treatment.

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.

As a member you also have certain responsibilities. It is important that you become familiar with this section, as it will make it easier for us to provide you with access to the best health care possible.

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 providers with accurate information about your medical history and health so that we can help you get the care you need. Tell your providers you are enrolled in our plan and show them your membership card.
- The responsibility to keep your appointments or cancel them as soon as possible.
- The responsibility to help us update our records by giving us accurate personal information, including changes in name, address and phone number within 30 days of the change.
- The responsibility to be courteous and considerate with our staff and the staff of any providers.
- The responsibility to be actively involved in your own health care by discussing treatment options with your providers and making informed decisions about your health care.
- The responsibility to participate in the development of your plan of care.
- The responsibility to follow all plans and instructions for care that you have agreed to with your provider.
- 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 handbook, including the section related to prior approval for all services that require such approval.
- The responsibility to pay any spend-down amounts that may be owed.
- The responsibility to cooperate with any of your treating providers' procedures.
- The responsibility to notify us if you have any other health insurance in addition to our plan.
- The responsibility to be considerate and respect the rights of other patients in providers' offices.
- The responsibility to maintain your Medicaid and Medicare coverage. If you need help recertifying for Medicaid, call us.

NOTICE OF PRIVACY PRACTICES

IMPORTANT INFORMATION ABOUT YOUR PRIVACY RIGHTS

Effective September 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) and HIP Insurance Company of New York, Inc. (HIPIC). 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, HIP and HIPIC (collectively “the Plan”).

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

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

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

How We Use or Share Information

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

- **Payment:** We may use your information to process and pay claims submitted to us by you or your doctors, hospitals and other health care providers in connection with medical services provided to you.
- **Treatment:** We may share your information with your doctors, hospitals, or other providers to help them provide medical care to you. For example, if you are in the hospital, we may give the hospital access to any medical records sent to us by your doctor.

NOTICE OF PRIVACY PRACTICES

- **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 or disclose any of your genetic information for underwriting purposes.
 - Reviewing the competence, qualifications, or performance of our network providers, and conducting training programs, accreditation, certification, licensing, credentialing and other quality assessment and improvement activities.

Business Associates: We may share your information with others who help us conduct our business operations, provided they agree to keep your information confidential.

Other Ways We Use or Share Information

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

- We may use or share your information with the employer or other health-plan sponsor through which you receive your health benefits. We will not share individually identifiable health information with your benefits plan unless they promise to keep it protected and use it only for purposes relating to the administration of your health benefits.
- We may share your information with a health plan, provider, or health care clearinghouse that participates with us in an organized health care arrangement. We will only share your information for health care operations activities associated with that arrangement.
- We may share your information with another health plan that provides or has provided coverage to you for payment purposes. We may also share your information with another health plan, provider or health care clearinghouse that has or had a relationship with you for the purpose of quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, or detecting or preventing health care fraud and abuse.

We may share your information with a family member, friend, or other person who is assisting you with your health care or payment for your health care. We may also share information about your location, general condition, or death to notify or help notify (including identifying and locating) a person involved with your care or to help with disaster-relief efforts. Before we share this information, we will provide you with an opportunity to object. If you are not present, or in the event of your incapacity or an emergency, we will share your information based on our professional judgment of whether the disclosure would be in your best interest.

State and Federal Laws Allow Us to Share Information

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

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

Under certain circumstances, we may share information for purposes of research.

Sensitive Information

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

Your Authorization

Except as described in this Notice of Privacy Practices, and as permitted by applicable state or federal law, we will not use or disclose your personal information without your prior written authorization. We will also not disclose your personal information for the purposes described below without your specific prior written authorization:

- Your signed authorization is required for the use or disclosure of your protected health information for marketing purposes, except when there is a face-to-face marketing communication or when we use your protected health information to provide you with a promotional gift of nominal value.
- Your signed authorization is required for the use or disclosure of your personal information in the event that we receive remuneration for such use or disclosure, except under certain circumstances as allowed by applicable federal or state law.

NOTICE OF PRIVACY PRACTICES

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

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

Your Rights

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

Restricting Your Information

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

Confidential Communications for Your Information

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

Inspecting Your Information

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

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:

- Information disclosed or used for treatment, payment and health care operations purposes.
- Information disclosed to you or following your authorization.
- Information that is incidental to a use or disclosure otherwise permitted.
- Information disclosed to persons involved in your care or other notification purposes.
- Information disclosed for national security or intelligence purposes.
- Information disclosed to correctional institutions or law enforcement officials.
- Information that was disclosed or used as part of a limited data set for research, public health or health care operations purposes.

Collecting, Sharing and Safeguarding Your Financial Information

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

- Name, address, telephone number and/or email address;
- Names, addresses, telephone numbers and/or email addresses of your spouse and dependents;
- Your social security number, age, gender and marital status;
- Social security numbers, age, gender and marital status of your spouse and dependents;
- Any information that we receive about you and your family from your applications or when we administer your policy, claim or account;
- If you purchase a group policy for your business, information to verify the existence, nature, location and size of your business.

We also collect income and asset information from Medicaid, Child Health Plus, Family Health Plus and Healthy New York subscribers. We may also collect this information from Medicare subscribers to determine eligibility for government subsidized programs.

We may share this information with our affiliates and with business associates that perform services on our behalf. For example, we may share such information with vendors that print and mail member materials to you on our behalf and with entities that perform claims processing, medical review and other services on our behalf. These business associates must maintain the confidentiality of the

NOTICE OF PRIVACY PRACTICES

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.

We will notify you in the event of a breach of your unsecured protected health information. We will provide this notice as soon as reasonably possible, but no later than 60 days after our discovery of the breach, or as otherwise required by applicable laws, regulations or contract.

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: 7 days a week (excluding major holidays), 8 am-8 pm,
1-877-842-3625, TTY: 711

EmblemHealth Medicare members: 7 days a week (excluding major holidays), 8 am-8 pm
PPO: **1-866-557-7300**, TTY: 711

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

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

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

GHI members: 7 days a week (excluding major holidays), 8 am-8 pm, **1-800-624-2414**,
TTY: 711

HIP “GHI HMO” plan members: 7 days a week (excluding major holidays), 8 am-8 pm,
1-877-244-4466, TTY: 711

HIP/HIPIC members: 7 days a week (excluding major holidays), 8 am-8 pm, **1-855-283-2146**,
TTY: 711

Medicaid, Family Health Plus and Child Health Plus members:

7 days a week (excluding major holidays), 8 am - 8 pm, **1-855-283-2146**, TTY: 711

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, 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.

HEALTH CARE PROXY

8. If you have named your spouse as your health care agent and you later become divorced or legally separated, your former spouse will no longer be your agent by law, unless you state otherwise. If you would like your former spouse to remain your agent, you may note this on your current form and date it or complete a new form naming your former spouse.
9. Even though you have signed this form, you have the right to make health care decisions for yourself as long as you are able to do so, and treatment cannot be given to you or stopped if you object, nor will your agent have any power to object.
10. You may cancel the authority given to your agent by telling him or her or your health care provider orally or in writing.
11. Appointing a health care agent is voluntary. No one can require you to appoint one.
12. You may express your wishes or instructions regarding organ and/or tissue donation on the form, Why Should I Choose a Health Care Agent?

Frequently Asked Questions

Why Should I Choose a Health Care Agent?

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

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

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

Who Can Be A Health Care Agent?

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

How Do I Appoint A Health Care Agent?

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

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

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

What Decisions Can My Health Care Agent Make?

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

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

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

How Will My Health Care Agent Make Decisions?

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

How Will My Health Care Agent Know My Wishes?

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

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

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

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

Who Will Pay Attention To My Agent?

All hospitals, nursing homes, doctors and other health care providers are legally required to provide your health care agent with the same information that would be provided to you and to honor the

HEALTH CARE PROXY

decisions by your agent as if they were made by you. If a hospital or nursing home objects to some treatment options (such as removing certain treatment), they must tell you or your agent, **BEFORE OR UPON** admission, if reasonably possible.

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

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

What If I Change My Mind?

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

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

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

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

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

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

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

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

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

Yes. Use the optional organ and tissue donation section on the Health Care Proxy form and be sure to have the section witnessed by two people. You may specify that your organs and/or tissues be used for

transplantation, research or educational purposes. Any limitation(s) associated with your wishes should be noted in this section of the proxy.

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

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

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

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

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

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

HEALTH CARE PROXY

state any limitations, your agent will be allowed to make all health care decisions that you could have made, including the decision to consent to or refuse life-sustaining treatment.

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

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

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

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

Item (5)

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

Item (6)

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

Item (7)

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

HEALTH CARE PROXY

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

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

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

(name, home address and telephone number)

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

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

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

(5) Your Identification (Please Print):

Your Name:

Your Signature:

Date:

Your Address:

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

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

- Any needed organs and/or tissues
- The following organs and/or tissues

Limitations

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

Your Signature:

Date:

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

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

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



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WHAT CARE FEELS LIKE.