EMBLEMHEALTH ENHANCED CARE PLUS HEALTH AND RECOVERY PLAN MEMBER HANDBOOK

2018

EmblemHealth®

"If you do not speak English, call us at **1-855-283-2146**. We have access to interpreter services and can help answer your questions in your language. We can also help you find a health care provider who can communicate with you in your language."

Spanish: Si usted no habla inglés, llámenos al **1-855-283-2146**. Ofrecemos servicios de interpretación y podemos ayudarle a responder preguntas en su idioma. También podemos ayudarle a encontrar un proveedor de salud que pueda comunicarse con usted en su idioma.

French: Si vous ne parlez pas anglais, appelez-nous au **1-855-283-2146**. Nous avons accès à des services d'interprétariat pour vous aider à répondre aux questions dans votre langue. Nous pouvons également vous aider à trouver un prestataire de soins de santé qui peut communiquer avec vous dans votre langue.

Haitian Creole: Si ou pa pale lang Anglè, rele nou nan **1-855-283-2146**. Nou ka jwenn sèvis entèprèt pou ou, epitou nou kapab ede reponn kesyon ou yo nan lang ou pale a. Nou kapab ede ou jwenn yon pwofesyonèl swen sante ki kapab kominike avèk ou nan lang ou pale a."

Italian: "Se non parli inglese chiamaci al **1-855-283-2146**. Disponiamo di servizi di interpretariato e siamo in grado di rispondere alle tue domande nella tua lingua. Possiamo anche aiutarti a trovare un fornitore di servizi sanitari che parli la tua lingua."

Russian: «Если вы не разговариваете по-английски, позвоните нам по номеру **1-855-283-2146**. У нас есть возможность воспользоваться услугами переводчика, и мы поможем вам получить ответы на вопросы на вашем родном языке. Кроме того, мы можем оказать вам помощь в поиске поставщика медицинских услуг, который может общаться с вами на вашем родном языке».

Chinese (PRC) 如果您不会讲英语，请拨打会员服务号码 **1-855-283-2146** 与我们联系。我们提供各种口译服务，可以用您的语言帮助回答您的问题。此外，我们还可以帮您寻找能够用您的语言与您交流的医疗护理提供方。

Chinese (Taiwain) 如果您無法使用英語交談，請以下列電話號碼與我們聯繫：**1-855-283-2146**。我們會使用口譯服務以您的語言來協助回答您的問題。我們也可以協助您找到能夠使用您母語溝通的健康照護提供者。

HERE'S WHERE TO FIND INFORMATION YOU WANT

HEALTH AND RECOVERY PLAN MEMBER HANDBOOK

Welcome to EmblemHealth Enhanced Care Plus Health and Recovery Plan

We are glad that you enrolled in EmblemHealth Enhanced Care Plus, a Health and Recovery Plan, or HARP, approved by New York State. HARPs are a new kind of plan that provide Medicaid members with their health care, plus care for behavioral health. In this handbook, behavioral health means mental health, substance use disorder and rehabilitation.

We are a special health care plan with providers who have a lot of experience treating persons who may need mental health and/or substance use care to stay healthy. We also provide care management services to help you and your health care team to work together to keep you as healthy as possible.

This handbook will be your guide to the full range of health care services available to you.

We want to be sure you get off to a good start as a new member of EmblemHealth Enhanced Care Plus. In order to get to know you better, we will get in touch with you in the next two weeks. You can ask us any questions you have, or get help making appointments. If you want to speak with us sooner, just call us at **1-855-283-2146**. You can also visit our website at **emblemhealth.com** to get more information about EmblemHealth Enhanced Care Plus.

How Health and Recovery Plans Work

The Plan, Our Providers, and You

You may have seen or heard about the changes in health care. Many consumers get their health benefits through managed care, which provides a central home for your care. If you were getting behavioral health services using your Medicaid card, now those services may be available through EmblemHealth Enhanced Care Plus.

As a member of EmblemHealth Enhanced Care Plus, you will have all the benefits available in regular Medicaid, plus you can also get specialty services to help you reach your health goals. We offer extended services to help you get and stay healthy, and help with your recovery.

EmblemHealth Enhanced Care Plus offers new services, called Behavioral Health Home and Community Based Services (BHHCBS), to members who qualify.

BHHCBS may help you:

- Find housing.
- Live independently.
- Return to school.
- Find a job.
- Get help from people who have been there.
- Manage stress.
- Prevent crises.

As a member of EmblemHealth Enhanced Care Plus, you will also have a Health Home Care Manager who will work with all your physical and behavioral health providers to pay special attention to your whole health care needs. The Health Home Care Manager will help make sure you get the medical, behavioral health and social services you may need, such as help to get housing and food assistance.

You may be using your Medicaid card to get a service that is now available through EmblemHealth Enhanced Care Plus. To find out if a service you already get is now provided by EmblemHealth Enhanced Care Plus, contact Member Services at **1-855-283-2146**.

You and your health care team will work together to make sure you enjoy the best physical and emotional health possible. You can get special services for healthy living, such as nutrition classes and help to stop smoking.

EmblemHealth has a contract with the New York State Department of Health to meet the health care needs of people with Medicaid. In turn, we choose a group of health care, mental health and substance use providers to help us meet your needs. These doctors and specialists, hospitals, clinics, labs, case managers, and other health care facilities make up our **provider network**. You will find a list in our provider directory. If you do not have a provider directory, call Member Services at **1-855-283-2146** to get a copy or visit our website at **emblemhealth.com**.

When you join EmblemHealth Enhanced Care Plus, one of our providers will take care of you. Most of the time that person will be your **Primary Care Provider (PCP)**. You may want to choose a PCP from your mental health or substance use clinic. If you need to have a test, see another specialist, or go into the hospital, your Primary Care Provider will arrange it.

Your Primary Care Provider is available to you every day, day and night. If you need to speak to him or her after hours or weekends, leave a message and how you can be reached. Your Primary Care Provider will get back to you as soon as possible. Even though your Primary Care Provider is your main source for health care, in some cases, you can self-refer to certain doctors for some services. See page 11 for details.

You may be restricted to certain plan providers if you are:

- getting care from several doctors for the same problem
- getting medical care more often than needed
- using prescription medicine in a way that may be dangerous to your health
- allowing someone other than yourself to use your plan ID card

Confidentiality

We respect your right to privacy. EmblemHealth Enhanced Care Plus recognizes the trust needed between you, your family, your doctors and other care providers. EmblemHealth Enhanced Care Plus will never give out your medical or behavioral health history without your written approval. The only persons that will have your clinical information will be EmblemHealth Enhanced Care Plus, your Primary Care Provider, your Health Home Care Manager and other providers who give you care and your authorized representative. Referrals to such providers will always be discussed with you in advance by your Primary Care Provider and/or Health Home Care Manager. EmblemHealth Enhanced Care Plus staff has been trained in keeping strict member confidentiality.

How To Use This Handbook

This handbook will tell you how your new health care plan will work and how you can get the most from EmblemHealth Enhanced Care Plus. This handbook is your guide to health and wellness services. It tells you the steps to take to make the plan work for you.

The first several pages will tell you what you need to know right away. The rest of the handbook can wait until you need it. Use it for reference or check it out a bit at a time. When you have a question, check this Handbook or call our Member Services unit at **1-855-283-2146**. You can also call the New York Medicaid Choice Helpline at **1- 800-505-5678**.

Help From Member Service

There is someone to help you at Member Services Monday through Friday 8 AM - 6 PM. Call **1-855-283-2146**/TTY: 711.

If you have a behavioral health (mental health or substance use) **crisis** at any time:

- Call Emblem Behavioral Health Services at **1- 888-447-2526**
- If your PCP is in the Montefiore network, call **1-800-401-4822**

You can call Member Services to get help **any time you have a question.** You may call us to choose or change your Primary Care Provider *(PCP for short),* to ask about benefits and services, to get help with referrals, to replace a lost ID card, to report that you are pregnant, the birth of a new baby or ask about any change that might affect your benefits.

We offer **free sessions** to explain our health plan and how we can best help you. It's a great time for you to ask questions and meet other members. If you'd like to come to one of the sessions, call us to find a time and place that is best for you.

If you do not speak English, we can help. We want you to know how to use your health care plan, no matter what language you speak. Just call us and we will find a way to talk to you in your own language. We have a group of people who can help. We will also help you find a PCP (Primary Care Provider) who can speak to you in your language.

For people with disabilities: If you use a wheelchair, or are blind, or have trouble hearing or understanding, call us if you need extra help. We can tell you if a particular provider's office is wheelchair accessible or is equipped with special communications devices. Also, we have services like:

- TTY/TDD machine (Our TTY phone number is 711).

- Information in large print
- Case Management
- Help in making or getting to appointments
- Names and addresses of providers who specialize in your disability

If you are getting care in your home now, your nurse or attendant may not know you have joined our plan. **Call us right away** to make sure your home care does not stop unexpectedly.

Your Health Plan ID Card

After you enroll, we will send you a **Welcome Letter**. Your EmblemHealth Enhanced Care Plus ID card should arrive within 14 days after your enrollment date. Your card has your PCP's (Primary Care Provider's) name and phone number on it. It will also have your Client Identification Number (CIN). If anything is wrong on your EmblemHealth Enhanced Care Plus ID card, call us right away. Your ID card does not show that you have Medicaid or that EmblemHealth Enhanced Care Plus is a special type of health plan.

Carry your ID card at all times and show it each time you go for care. If you need care before the card comes, your Welcome Letter is proof that you are an EmblemHealth Enhanced Care Plus member. You should also keep your Medicaid benefit card. You will need your Medicaid card to get services that EmblemHealth Enhanced Care Plus does not cover.

PART I — FIRST THINGS YOU SHOULD KNOW

How To Choose Your Primary Care Provider (PCP)

You may have already picked your PCP (Primary Care Provider). **If you have not chosen a PCP, you should do so right away.** If you do not choose a doctor within 30 days, we will choose one for you. Member Services (**1-855-283-2146**) can check to see if you already have a PCP or help you choose a PCP. **You may also be able to choose a PCP at your behavioral health clinic.**

You can call us to request a provider directory. This is a list of all the providers, clinics, hospitals, labs, and others who work with EmblemHealth Enhanced Care Plus. It lists the address, phone, and special training of the doctors. The provider directory will show which doctors and providers are taking new patients. You should call their offices to make sure that they are taking new patients at the time you choose a PCP. You can also get a list of providers on our website at **emblemhealth.com**.

You may want to find a doctor that:

- you have seen before,
- understands your health problems,
- is taking new patients,
- can speak to you in your language,
- is easy to get to,
- is at a clinic you go to.

You can choose a PCP who works in:

- **A network medical center** — Many of our network medical centers are full-service. They have large staffs of PCPs, OB/GYNs, specialists and support personnel. This makes it easy to get a full range of services in one place. If you need lab tests or X-rays, our network medical centers can perform most basic tests and procedures. If your PCP wants you to get a special procedure or operation that can't be done at your medical center, you'll be referred to a place that will meet your needs. Your PCP will arrange for all such services.
- **An EmblemHealth Enhanced Care Plus network doctor's office** — If you prefer, you can choose a PCP that has a private office. In this case, your PCP may have to refer you to another network doctor or facility for care that he or she cannot provide because private PCP offices do not have all of the same services as medical centers.
- **A Community Health Center**—Community Health Centers' mission is to increase access to primary care and multi-specialty services to improve the health status of the residents in the communities they serve. Community Health Centers consists of health centers such as Diagnostic & Treatment Centers (DT&Cs), Federally Qualified Health Centers (FQHCs), and clinics. They are conveniently located in communities, offer multi-specialty services and provide overall care in one location. Please see a list of FQHCs below. Just call Member Services **1-855-283-2146** for help.

Bronx

- Burnside Medical Center
- Institute for Family Health – 5 locations
- Jessica Guzman Medical Center
- Plaza De Castillo
- Starhill ClinicMorris Heights Health Center – 7 locations
- HHC-Segundo Ruiz Belvis Diagnostic and Treatment Center
- HHC-Morrisania Diagnostic and Treatment Center

Brooklyn

- Brooklyn Plaza Medical Center – 2 locations
- Brownsville Multi-Services – 5 locations
- Century Medical and Dental Center
- Ezra Medical Center - 38th Street
- Joseph P. Addabbo Family Health Center
- Family Health Center (Lutheran) – 10 locations
  Bedford Stuyvesant Family Health Center, Inc. – 2 locations
- First Medcare Inc.
- Lutheran – 9 locations
- HHC-Cumberland Diagnostic and Treatment Center
- HHC-East New York Diagnostic and Treatment Center

Manhattan

- Institute for Family Health – 5 locations

Queens

- Joseph P. Addabbo Family Health Center – 4 locations
- The Floating Hospital Health Center

Staten Island

- Beacon Christian Community Health Center, Inc.

Westchester

- Doctors United Inc.
- Hudson River Health Care
- Monsey Family Medical Center
- Mt. Vernon Neighborhood Health Center – 4 locations

Suffolk

- Elsie Owens Health Center (Hudson River HealthCare)
- Greenport Health Center

Nassau

- Long Island FQHC (4 locations)
- Hudson River Health Care

When you call Member Service, just mention the name of the FQHC or doctor you want.

In almost all cases, your doctors will be EmblemHealth Enhanced Care Plus providers. There are four instances when you can still **see another provider that you had before you joined EmblemHealth Enhanced Care Plus**. In these cases, your provider must agree to work with EmblemHealth Enhanced Care Plus. You can continue to see your provider if:

- You are more than 3 months pregnant when you join EmblemHealth Enhanced Care Plus and you are getting prenatal care. In that case, you can keep your doctor until after your delivery through post-partum care.
- At the time you join EmblemHealth Enhanced Care Plus, you have a life threatening disease or condition that gets worse with time. In that case, you can ask to keep your provider for up to 60 days.
- At the time you join EmblemHealth Enhanced Care Plus, you are being treated for a behavioral health condition. In that case, you can ask to keep your provider through treatment for up to 2 years.
- At the time you join EmblemHealth Enhanced Care Plus, regular Medicaid paid for your home care and you need to keep getting that care for at least 120 days. In that case, you can keep your same home care agency, nurse or attendant, and the same amount of home care, for at least 90 days. EmblemHealth must tell you about any changes to your home care before the changes take effect.

If you do not choose a PCP within 30 days of your effective date of enrollment, we will choose one for you. If you are not restricted to a PCP, you have the right to change your PCP any time, for any reason. Just follow the instructions in the Getting Help from the Plan section of this handbook to select a PCP.

If you are restricted to a PCP, you may change your PCP 45 days after your initial appointment with the PCP and after that can only change your PCP every three months, unless you have good cause to change PCPs. If you are restricted to any other provider(s), you can only change the provider(s) to whom you are restricted every six months without good cause. Good cause includes:

- Your provider no longer wishes to be your provider.
- Your provider closes the office where you get care or moves to a location greater than 30 minutes or 30 miles from your home.
- Your provider leaves our network.
- You move beyond 30 minutes or 30 miles from your provider's office.
- Other circumstances exist that make it necessary to change providers.

If your **provider leaves** EmblemHealth Enhanced Care Plus, we will tell you within 5 days from when we know about this. If you wish, you may be able to see that provider ***if*** you are more than three months pregnant or if you are receiving ongoing treatment for a condition. If you are pregnant, you may continue to see your doctor through post-partum care. If you are seeing a doctor regularly for a special medical problem, you may continue your present course of treatment for up to 90 days. Your doctor must agree to work with EmblemHealth during this time. If any of these conditions apply to you, check with your PCP or call Member Services **1-855-283-2146**.

Health Home Care Management

EmblemHealth Enhanced Care Plus is responsible for providing and coordinating your physical health care and your behavioral health services. We use Health Homes to coordinate services for our members. It is your choice if you want to join a Health Home, and we encourage you to join a Health Home for your Care Management.

EmblemHealth Enhanced Care Plus can help you enroll with a Health Home that will assign your personal Health Home Care Manager. Your Health Home Care Manager can help you make appointments, help you get social services, and keep track of your progress.

Your Health Home is responsible for giving you an assessment to see what Behavioral Health Home and Community Based Services you may need. Using the assessment, you and your Health Home Care Manager will work together to make a Plan of Care that is designed especially for you.

Your Health Home Care Manager can:

- Work with your PCP and other providers to coordinate all of your physical and behavioral health care;
- Work with the people you trust, like family members or friends, to help you plan and get your care;
- Support you getting social services, like SNAP (food stamps) and other social service benefits;
- Develop a plan of care with you to help identify your needs and goals;
- Help with appointments with your PCP and other providers;
- Help managing ongoing medical issues like diabetes, asthma, and high blood pressure;
- Help you find services to help with weight loss, healthy eating, exercise and to stop smoking;
- Support you during treatment;
- Identify resources you need that are located in your community;
- Help you with finding or applying for stable housing;
- Help you safely return home after a hospital stay; and
- Make sure you get follow up care, medications and other needed services.

Your Health Home Care Manager will be in touch with you right away to find out what care you need and to help you with appointments. Your Health Home Care Manager or someone from your Health Home provider is available to you 24 hours a day, 7 days a week at **1-855-283-2146**.

If you are in a crisis and need to talk to someone right away, call **1- 888-447-2526**. If your PCP in the Montefiore network, call **1-800-401-4822**. Your Health Home Care Manager will work with you, your caregiver, your provider and an EmblemHealth Care Manager to put into place your plan of care. The EmblemHealth Care Manager may specialize in behavioral health or medical health, depending upon your needs.

The EmblemHealth Care Manager can support you when you need to move from one kind of care to another, such as inpatient to the community and will be in contact with you, your caregiver(s), your providers and the Health Home Care Manager to make sure that you get the medically necessary services and supports. The Care Manager may request information from your providers so that we can make decisions on requests for care and supports for you. We will meet with your Home Health Care manager regularly so that everyone is updated on what care and support you are receiving and if your care plan needs to be updated.

How to Get Regular Health Care

Your health care will include regular check-ups for all your health care needs. We provide referrals to hospitals or specialists. We want new members to see his or her Primary Care Provider for a first medical visit soon after enrolling in EmblemHealth Enhanced Care Plus. This will give you a chance to talk with your Primary Care Provider about your past health issues, the medicines you take, and any questions that you have.

Day or night, your PCP is only a phone call away. Be sure to call your PCP whenever you have a medical question or concern. If you call after hours or weekends, leave a message and where or how you can be reached. Your PCP will call you back as quickly as possible. Remember, your PCP knows you and knows how the health plan works.

Members may call **1- 888-447-2526** or **1-800-401-4822** twenty four (24) hours a day, seven (7) days a week with behavioral health questions, concerns and/or crises.

Your care must be **medically necessary** -- the services you get must be needed:

- to prevent, or diagnose and correct what could cause more suffering, or
- to deal with a danger to your life, or
- to deal with a problem that could cause illness, or
- to deal with something that could limit your normal activities.

Your PCP will take care of most of your health care needs. You should have an appointment to see your PCP. If ever you can't keep an appointment, call to let your PCP know.

As soon as you choose a PCP, call to make a first appointment. If you can, prepare for your first appointment. Your PCP will need to know as much about your medical history as you can tell him or her. Make a list of your medical background, any problems you have now, any medications you are taking, and the questions you want to ask your PCP. In most cases, your first visit should be within four weeks of your joining the plan. If you have the need for treatment over the coming weeks, make your first appointment in the first week of joining EmblemHealth Enhanced Care Plus. Your Health Home Care Manager can help you make and get ready for your first appointment.

If you need care before your first appointment, call your PCP's office to explain your concern. He or she will give you an earlier appointment for this concern. (You should still keep your first appointment to discuss your medical history and ask questions.)

Use the following list as a guide for the longest time you may have to wait after you ask for an appointment. Your Care Manager can also help you make or get appointments.

- urgent care: within 24 hours
- non-urgent sick visits: within 3 days
- routine, preventive care: within 4 weeks
- first pre-natal visit: within 3 weeks during 1st trimester (2 weeks during 2nd, 1 week during 3rd)
- first family planning visit: within 2 weeks
- follow-up visit after mental health/substance use ER or inpatient visit: 5 days
- non-urgent mental health or substance use specialist visit: within 2 weeks.
- adult baseline and routine physicals: within 4 weeks

Behavioral Health Care and Home And Community Based Services (BHHCBS)

Behavioral health care includes mental health and substance use treatment services. You have access to services that can help you with emotional health. You can also get help with alcohol or other substance use issues.

If you need help to support your living in the community, EmblemHealth Enhanced Care Plus provides additional services, called Behavioral Health Home and Community Based Services (BHHCBS). These

services can help you stay out of the hospital and live in the community. Some services can help you reach life goals for employment, school, or for other areas of your life you may like to work on.

To be eligible for these services, you will need to get an assessment. To find out more, call us at **1-855-283-2146** or ask your Care Manager about these services.

See page 22 of this Handbook for more information about these services and how to get them.

How To Get Specialty Care and Referrals

If you need care that your PCP cannot give, he or she will refer you to other specialists who can. If your PCP refers you to another doctor, we will pay for your care. Most of these specialists are EmblemHealth Enhanced Care Plus providers. Talk with your PCP to be sure you know how referrals work.

If you think the specialist does not meet your needs, talk to your PCP. Your PCP can help you if you need to see a different specialist.

There are some treatments and services that your PCP must ask our plan to approve *before* you can get them. Your PCP will be able to tell you what they are.

If you are having trouble getting a referral you think you need, contact Member Services at **1-855-283-2146**.

If we do not have a specialist in our provider network who can give you the care you need, we will get you the care you need from a specialist outside our plan. This is called an **out-of-network referral**. Your PCP or plan provider must ask EmblemHealth Enhanced Care Plus for approval *before* you can get an out-of-network referral. If your PCP or plan provider refers you to a provider who is not in our network, you are not responsible for any of the costs except any co-payments as described in this handbook.

To request services by a specialist or providers outside our provider network, contact Member Services at **1-855-283-2146**. We will need a written reason why you need to see a specialist or provider who is not in our network. You can ask your PCP or other provider to send us this information on your behalf. We will follow the same rules for Prior Authorization requests.

Sometimes we may not approve an out-of-network referral because we have a provider in EmblemHealth Enhanced Care Plus that can treat you. If you think our plan provider does not have the right training or experience to treat you, you can ask us to check if your out-of-network referral is medically needed. You will need to ask for an **action appeal**. See page 30 to find out how.

You will need to ask your doctor to send the following information with your action appeal:

1) a statement in writing that says EmblemHealth's provider does not have the right training and experience to meet your needs, and
2) that recommends an out-of-network provider with the right training and experience who is able to treat you.

Your doctor must be a board certified or board eligible specialist who treats people who need the treatment you are asking for.

Sometimes, we may not approve an out-of-network referral for a specific treatment because you asked for care that is not very different from what you can get from EmblemHealth's provider. You can ask us

to check if your out-of-network referral for the treatment you want is medically needed. You will need to ask for an **action appeal**. See page 30 to find out how.

You will need to ask your doctor to send the following information with your action appeal:

1) a statement in writing from your doctor that the out-of-network treatment is very different from the treatment you can get from EmblemHealth's provider. Your doctor must be a board certified or board eligible specialist who treats people who need the treatment you are asking for, and
2) two medical or scientific documents that prove the treatment you are asking for is more helpful to you and will not cause you more harm than the treatment you can get from EmblemHealth's provider.

If your doctor does not send this information, we will still review your action appeal. However, you may not be eligible for an external appeal.

You may need to see a specialist for ongoing care of a medical or behavioral health condition. Your PCP may be able to refer you for a specified number of visits or length of time (a **standing referral**). If you have a standing referral, you will not need a new referral for each time you need care.

If you have a long-term disease or a disabling illness that gets worse over time, your PCP may be able to arrange for:

- your specialist to act as your PCP;
- a referral to a care center that specializes in the treatment of your illness.

You Can Get These Services From Our Plan

Without A Referral

Women's Health Care

You do not need a referral from your PCP to see one of our providers IF

- you are pregnant, or
- you need OB/GYN services, or
- you need family planning services, or
- you want to see a mid-wife, or
- you need to have a breast or pelvic exam.

Family Planning

You can get the following family planning services: advice about birth control, birth control prescriptions, male and female condoms, pregnancy tests, sterilization, or an abortion. During your visits for these things, you can also get tests for sexually transmitted infections, a breast cancer exam or a pelvic exam.

You *do not need a referral* from your PCP to get these services. In fact, you can choose where to get these services. You can *use your EmblemHealth Enhanced Care Plus ID card* to see one of our family planning providers. Check the plan's Provider Directory or call Member Services for help in finding a provider.

Or, you can *use your Medicaid card* if you want to go to a doctor or clinic outside our plan. Ask your PCP or Member Services **1-855-283-2146** for a list of places to go to get these services. You can also call the New York State Growing Up Healthy Hotline (**1-800-522-5006**) for the names of family planning providers near you.

HIV and STI screening

Everyone should know their HIV status. HIV and sexually transmitted infection screenings are part of your regular health care.

- You can get an HIV or STI test any time you have an office or clinic visit.
- You can get an HIV or STI test any time you have family planning services. You do not need a referral from your PCP (Primary Care Provider). Just make an appointment with any family planning provider. If you want an HIV or STI test, but *not as part of a family planning service,* your PCP can provide or arrange it for you.
- Or, if you'd rather not see one of our providers, you can use your Medicaid card to see a family planning provider outside of EmblemHealth Enhanced Care Plus. For help in finding either a Plan provider or a Medicaid provider for family planning services call Member Services at **1-855-283-2146**.
- Everyone should talk to their doctor about having an HIV test. To get free HIV testing or testing where your name isn't given, call **1-800-541-AIDS** (English) or **1-800-233-SIDA** (Spanish).

Some tests are "rapid tests" and the results are ready while you wait. The provider who gives you the test will explain the results and arrange for follow up care if needed. You will also learn how to protect your partner. If your test is negative, we can help you learn to stay that way.

HIV Prevention Services

Many HIV prevention services are available to you. We will talk with you about any activities that might put you or others at risk of transmitting HIV or getting sexually transmitted diseases. We can help you learn how to protect yourself. We can also help you get free male and female condoms and clean syringes.

If you are HIV positive, we can help you talk to your partners. We can help you talk to your family and friends and help them understand HIV and AIDS and how to get treatment. If you need help talking about your HIV status with future partners EmblemHealth Enhanced Care Plus staff will assist you. We can even help you talk to your children about HIV.

- You can get HIV testing and counseling without family planning. You can visit an anonymous testing and counseling site. To get more information about anonymous sites, call the New York State HIV Counseling Hotline at **1-800-872-2777** or **1-800-541-AIDS**. Or you can use your EmblemHealth Enhanced Care Plus ID card and ask your PCP to arrange it.
- If you need HIV treatment after the testing and counseling service, your PCP will arrange it.

Eye Care

The covered service includes the needed services of an ophthalmologist, optometrist, and an ophthalmic dispenser and includes an eye exam and pair of eyeglasses, if needed. Generally, you can get these once every two years, or more often if medically needed. Enrollees diagnosed with diabetes may self-refer for a dilated eye (retinal) examination once in any 12 month period. You just choose one of our participating providers.

New eyeglasses, with Medicaid approved frames, are usually provided once every two years. New lenses may be ordered more often, if, for example, your vision changes more than one-half diopter. If you break your glasses, they can be repaired. Lost eyeglasses or broken eyeglasses that can't be fixed will be replaced with the same prescription and style of frames. If you need to see an eye specialist for care of an eye disease or defect, your PCP will refer you.

Behavioral Health (Mental Health and Substance Use)

We want to help you get the mental health and substance use services that you may need.

If at any time you think you need help with mental health or substance use, you can see any behavioral health providers in our network to see what services you may need. This includes services like clinic and detox services. **You do not need a referral from your PCP**.

Smoking Cessation

You can get medication, supplies, and counseling if you want help to quit smoking. You do not need a referral from your PCP to get these services. EmblemHealth's Tobacco Free PATH program offers unlimited counseling sessions with a quit coach until you successfully quit smoking.

Maternal Depression Screening

If you are pregnant and think you need help with depression, you can get a screening to see what services you may need. You do not need a referral from your PCP. You can get a screening during pregnancy and for up to a year after your delivery.

Emergencies

You are always covered for emergencies. In New York State, an emergency means a medical or behavioral condition:

- that comes on all of a sudden, and
- has pain or other symptoms.

An emergency would make a person with an average knowledge of health be afraid that someone will suffer serious harm to body parts or functions or serious disfigurement without care right away.

Examples of an emergency are:

- a heart attack or severe chest pain
- bleeding that won't stop or a bad burn
- broken bones
- trouble breathing / convulsions / loss of consciousness
- when you feel you might hurt yourself or others
- if you are pregnant and have signs like pain, bleeding, fever, or vomiting
- drug overdose

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

Non-emergencies may also be family issues, a break up, or wanting to use alcohol or other drugs. These may feel like an emergency, but they are not a reason to go to the emergency room.

If you have an emergency, here's what to do:

- *If you believe you have an **emergency***, call 911 or go to the emergency room. You do not need EmblemHealth's or your PCP's approval before getting emergency care, and you are not required to use our hospitals or doctors.

***If you're not sure*, call your PCP or** EmblemHealth Enhanced Care Plus**.**

Tell the person you speak with what is happening. Your PCP or EmblemHealth Enhanced Care Plus representative will:

- tell you what to do at home, or
- tell you to come to the PCP's office,
- tell you about community services you can get, like 12 step meetings or a shelter, or
- tell you to go to the nearest emergency room.

You can also contact Emblem Behavioral Health Services 24 hours a day, 7 days a week at **1- 888-447-2526** if you are in mental health or drug use crisis.

If your PCP is the Montefiore network, call **1-800-401-4822**.

If you are ***out of the area*** when you have an emergency:

- Go to the nearest emergency room or call 911.
- Call EmblemHealth Enhanced Care Plus as soon as you can (within 48 hours if you can).

Remember

You do not need prior approval for emergency services. Use the emergency room **only** if you have a **TRUE EMERGENCY**.

The Emergency Room should NOT be used for problems like flu, sore throats, or ear infections.

If you have questions, call your PCP or our plan at **1-855-283-2146**.

You can also contact Emblem Behavioral Health Services 24 hours a day, 7 days a week at **1- 888-447-2526** if you are in mental health or drug use crisis. If your PCP is the Montefiore network, call **1-800-401-4822**.

Urgent Care

You may have an injury or an illness that is not an emergency but still needs prompt care.

- This could be the flu or if you need stitches.
- It could be a sprained ankle, or a bad splinter you can't remove.

You can get an appointment for an urgent care visit for the same or next day. If you are at home or away, call your PCP any time, day or night. If you cannot reach your PCP, call us at **1-855-283-2146**. Tell the person who answers what is happening. They will tell you what to do.

Care Outside of the United States

If you travel outside of the United States, you can get urgent and emergency care only in the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands and American Samoa. If you need medical care while in any other country (including Canada and Mexico), you will have to pay for it.

We Want to Keep You Healthy

Besides the regular checkups and the shots you need, here are some other services we provide and ways to keep you in good health:

- Heart Care PATH program for Heart Failure (HF)
- Better Breathing PATH program for Chronic Obstructive Pulmonary Disease (COPD)
- Diabetes Care PATH program
- Heart Care PATH program for Coronary Artery Disease (CAD)
- Better Breathing PATH program for asthma
- Healthy Beginnings PATH
- Tobacco Free PATH
- Kidney Care PATH program.
- Healthy Living PATH program for Weight Management
- Healthy Living PATH program for the 24 Hour Health Information Line
- The Dignified Decisions PATH program
- Cancer Care PATH program
- Complex Case Management
- Special Needs Plans (SNP) Case Management
- Transitional Case Management
- Long Term Services and Support (LTSS) Case Management.
- High-risk and high-utilization - program
- Point of Care Case Management
- Neonatal/Pediatric Case Management
- HIV/AIDs Case Management
- Transplant Coordination
- Sexually Transmitted Infection (STI) Testing & Protecting Yourself from STIs
- Domestic Violence Services

Call Member Services at **1-855-283-2146** or visit our website at **emblemhealth.com** to find out more and get a list of upcoming classes.

PART 2 — YOUR BENEFITS AND PLAN PROCEDURES

The rest of this handbook is for your information when you need it. It lists the covered and the non-covered services. If you have a complaint, the handbook tells you what to do. The handbook has other information you may find useful. Keep this handbook handy for when you need it.

Benefits

Health and Recovery Plans provide a number of services you get in addition to those you get with regular Medicaid. We will provide or arrange for most services that you will need. You can get a few services, however, without going through your PCP. These include emergency care; family planning; HIV testing; mobile crisis services; and specific self-referral services, including those you can get from within EmblemHealth Enhanced Care Plus and some that you can choose to go to any Medicaid provider of the service.

Services Covered By Our Plan

You must get these services from the providers who are in our plan. All services must be medically or clinically necessary and provided or referred by your PCP (primary care provider). Please call our Member Services department at **1-855-283-2146** if you have any questions or need help with any of the services below.

Regular Medical Care

- office visits with your PCP
- referrals to specialists
- eye / hearing exams
- help staying on schedule with medicines
- coordination of care and benefits

Preventive Care

- regular check-ups
- access to free needles and syringes
- smoking cessation counseling
- HIV education and risk reduction
- referral to Community Based Organizations (CBOs) for supportive care
- smoking cessation care

Maternity Care

- pregnancy care
- doctors/mid-wife and hospital services
- screening for depression during pregnancy and up to a year after birth

Home Health Care

- Must be medically needed and arranged by EmblemHealth Enhanced Care Plus
- One medically necessary post-partum home health visit, additional visits as medically necessary for high-risk women
- Other home health care visits as needed and ordered by your PCP/specialist

Personal Care/Home Attendant/Consumer Directed Personal Assistance Services (CDPAS)

- Must be medically needed and arranged by EmblemHealth Enhanced Care Plus
- Personal Care/Home Attendant - Help with bathing, dressing and feeding, and help preparing meals and housekeeping.
- CDPAS – Help with bathing, dressing and feeding, help preparing meals and housekeeping, plus home health aide and nursing. This is provided by an aide chosen and directed by you. If you want more information contact EmblemHealth Enhanced Care Plus at **1-855-283-2146**.

Personal Emergency Response System (PERS)

This is an item you wear in case you have an emergency and need help. To qualify and get this service, you must be receiving personal care/home attendant or CDPAS services.

Adult Day Health Care

- Must be recommended by your Primary Care Provider (PCP).
- Provides health education, nutrition, nursing and social care, help with daily living, rehabilitative therapy, pharmacy services, plus referrals for dental and other specialty care.

Therapy for Tuberculosis

- This is help with taking your medication for TB and follow up care.

Hospice Care

- Hospice helps patients and their families with their special needs that come during the final stages of illness and after death.
- Must be medically needed and arranged by EmblemHealth Enhanced Care Plus.
- Provides support services and some medical services to patients who are ill and expect to live for one year or less.
- You can get these services in your home or in a hospital or nursing home.

If you have any questions about these services, you can call Member Services at **1-855-283-2146**.

Dental Care

EmblemHealth Enhanced Care Plus believes that providing you with good dental care is important to your overall health care. We offer dental care through a contract with Healthplex, an expert in providing high quality dental services. Covered services include regular and routine dental services such as preventive dental check-ups, cleaning, x-rays, fillings and other services to check for any

changes or abnormalities that may require treatment and/or follow-up care for you. *You do not need a referral from your PCP to see a dentist.*

How to Get Dental Services:

You were assigned a network primary care dentist as of your effective date of enrollment. The name, address and telephone number of your dentist was included in your New Member Welcome Kit. Call your dentist right away to schedule appointments for you and all other enrolled family members. Just show your dentist your member ID card. Then schedule regular preventive dental visits every six months to keep your teeth and gums healthy.

- If you do not know who your dentist is or you want to change your dentist, please call Healthplex, our dental provider, at **1-800-468-9868**, Monday through Friday, between 8 am and 6 pm. Healthplex Member Services representatives are available to help you. They speak many languages, but if they don't speak yours, they will connect you with a language interpretation service. Hearing impaired members can call the New York State Relay Service at **1-800-662-1220**, or dial **1-800-662-1220** to connect to the Healthplex TDD line. You can change your dentist at any time for any reason. This change will be effective immediately.
- Show your Member ID card to access dental benefits. You will not receive a separate dental ID card. When you visit your dentist, you should show your plan ID card.

You can also go to a dental clinic that is run by an academic dental center without a referral.

Call EmblemHealth Enhanced Care Plus Member Services at **1-855-283-2146** for a list of academic dental centers near you.

Vision Care

- services of an ophthalmologist, ophthalmic dispenser and optometrist.
- coverage for contact lenses, polycarbonate lenses, artificial eyes, and/or replacement of lost or destroyed glasses, including repairs, when medically necessary. Artificial eyes are covered as ordered by a plan provider
- eye exams, generally every two years, unless medically needed more often
- glasses, with new pair of Medicaid approved frames every two years, or more often if medically needed
- low vision exam and vision aids ordered by your doctor
- specialist referrals for eye diseases or defects

Pharmacy

- Prescription drugs
- Over-the-counter medicines
- Insulin and diabetic supplies
- Smoking cessation agents, including OTC products
- Hearing aid batteries
- Emergency Contraception (6 per calendar year)
- Medical and surgical supplies

A pharmacy co-payment may be required for some people, for some medications and pharmacy items.

There are no co-payments for the following members or services:

- Consumers who are pregnant: during pregnancy and for the two months after the month in which the pregnancy ends.
- Family Planning drugs and supplies like birth control pills, male or female condoms, syringes and needles.
- Consumers in a Comprehensive Medicaid Care Management (CMCM) or Service Coordination Program.
- Consumers in an OMH or OPWDD Home and Community Based Services (HCBS) Waiver Program.
- Consumers in a DOH HCBS Waiver Program for Persons with Traumatic Brain Injury (TBI).
- Family Planning drugs and supplies like birth control pills and male or female condoms.
- Drugs to treat mental illness (psychotropic) and tuberculosis

Prescription Item	**Co-payment Amount**	**Co-payment Details**
Brand name prescription drugs	$3.00/$1.00	1 co-pay charge for each new prescription and each refill
Generic prescription drugs	$1.00	
Over the counter drugs, such as for smoking cessation and diabetes	$0.50	

- If you have a co-pay, there is a co-payment for each new prescription *and* each refill.
- If you have a co-pay, you are responsible for a maximum of $200 each calendar year.
- If you transferred to a new plan during the calendar year, keep your receipts as proof of your co-payments or you may request proof of paid co-payments from your pharmacy. You will need to give a copy to your new plan.
  - Certain drugs may require that your doctor get prior authorization before writing your prescription. Your doctor can work with EmblemHealth Enhanced Care Plus to make sure you get the medications that you need. Learn more about prior authorization later in this handbook.
- You have a choice in where you fill your prescriptions. You can go to any pharmacy that participates with our plan or you can fill your prescriptions by using a mail order pharmacy. For more information on your options, please contact Member Services at **1-855-283-2146**.

Hospital Care

- inpatient care
- outpatient care
- lab, x-ray, other tests

Emergency Care

- Emergency care services are procedures, treatments or services needed to evaluate or stabilize an emergency.
- After you have received emergency care, you may need other care to make sure you remain in stable condition. Depending on your need, you may be treated in the Emergency Room, in an inpatient hospital room, or in another setting. This is called **Post Stabilization Services.**

For more about emergency services, see page 14.

Specialty Care

Includes the services of other practitioners, including

- Occupational, physical and speech therapy — Limited to twenty (20) visits per therapy per calendar year. Members that have a developmental disability as determined by the Office for People With Developmental Disabilities and members that have a traumatic brain injury do not have a limit on the number of visits for these services.
- Audiologists
- Durable medical equipment (DME), including hearing aids, artificial limbs and orthotics.
- Renal and hemodialysis.
- HIV/AIDS treatment services.
- Midwifery services.
- Cardiac rehabilitation.
- Outpatient detoxification services.
- Podiatrists if you are diabetic
- Other covered services as medically needed.

Residential Health Care Facility Care (Nursing Home)

- includes short term, or rehab, stays and long term care;
- must be ordered by a physician and authorized by EmblemHealth Enhanced Care Plus;
- covered nursing home services include medical supervision, 24-hour nursing care, assistance with daily living, physical therapy, occupational therapy, and speech-language pathology.

If you are in need of long term placement in a nursing home, your local department of social services must determine if you meet certain Medicaid income requirements. EmblemHealth Enhanced Care Plus and the nursing home can help you apply.

You must get this care from a nursing home that is in EmblemHealth's provider network. If you choose a nursing home outside of EmblemHealth's network, you may have to transfer to another plan. Call New York Medicaid Choice at **1-800-505-5678** for help with questions about nursing home providers and plan networks.

Call **1-855-283-2146** for help finding a nursing home in our network.

Behavioral Health Care

Behavioral health care includes mental health and substance use (alcohol and drugs) treatment and rehabilitation services. All of our members have access to services to help with emotional health, or to help with alcohol or other substance use issues. These services include:

Mental Health Care

- Intensive psychiatric rehab treatment (IPRT)
- Outpatient Clinic Services
- Inpatient mental health treatment
- Partial hospitalization program
- Continuing day treatment
- Personalized Recovery Oriented Services (PROS)
- Assertive Community Treatment Services (ACT)
- Individual and group counseling
- Crisis intervention services

Substance Use Disorder Services

- Inpatient substance use disorder (alcohol and drug) treatment
- Inpatient and outpatient detoxification services
- Outpatient clinic and opioid treatment program services (OTP), including Methadone Maintenance treatment
- Residential Substance Use Disorder Treatment
- Outpatient alcohol and drug treatment services
- Detox services for residential substance use treatment supports

Behavioral Health Home and Community Based Services (BHHCBS)

BHHCBS can help you with life goals such as employment, school, or other areas of your life you want to work on. To find out if you qualify, a Health Home Care Manager must complete a brief screening with you that will show if you can benefit from these services. If the screening shows you can benefit, the Care Manager will complete a full assessment with you to find out what your whole health needs are including physical, behavioral and rehabilitation services.

BHHCBS includes:

- Psychosocial Rehabilitation (PSR) – helps you improve your skills to reach your goals.
- Community Psychiatric Support and Treatment (CPST) - is a way to get treatment services you need for a short time at a location of your choosing, such as your own home. CPST helps connect you with a licensed treatment program.
- Habilitation Services - helps you learn new skills in order to live independently in the community.
- Family Support and Training - is teach skills to help the people in your life support you in your recovery.
- Short-term Respite - gives you a safe place to go when you need to leave a stressful situation.
- Intensive Respite - helps you stay out of the hospital when you are having a crisis by providing a safe place to stay that can offer you treatment.
- Education Support Services - helps you find ways to return to school to get education and training that will help you get a job.
- Pre-Vocational Services - helps you with skills needed to prepare for employment.
- Transitional Employment Services - gives you support for a short time while trying out different jobs. This includes on-the job training to strengthen work skills to help keep a job at or above minimum wage.
- Intensive Supported Employment Services- helps you find a job at or above minimum wage and keep it.
- Ongoing Supported Employment Services- helps you keep your job and be successful at it.
- Empowerment Services-Peer Supports - people who have been there help you reach your recovery goals.
- Non-Medical Transportation – transportation to non-medical activities related to a goal in your plan of care.

Other Covered Services

- Durable Medical Equipment (DME) / Hearing Aids / Prosthetics / Orthotics
- Court Ordered Services
- Social Support Services (help in getting community services)
- FQHC or similar services

Benefits You Can Get From Our Plan OR With Your Medicaid Card

For some services, you can choose where to get your care. You can get these services by using your EmblemHealth Enhanced Care Plus membership card. You can also go to providers who will take your Medicaid Benefit card. *You do not need a referral from your PCP to get these services.* Call Member Services if you have questions at **1-855-283-2146**.

Family Planning

You can go to any doctor or clinic that takes Medicaid and offers family planning services.

Or you can visit one of our family planning providers. Either way, you do not need a referral from your PCP.

You can get birth control drugs, birth control devices (IUDs and diaphragms) that are available with a prescription, plus emergency contraception, sterilization, pregnancy testing, prenatal care, and abortion services. You can also see a family planning provider for HIV and sexually transmitted infection (STI) testing and treatment and counseling related to your test results. Screenings for cancer and other related conditions are also included in family planning visits.

HIV and STI Screening

You can get this service any time from your PCP or EmblemHealth Enhanced Care Plus doctors. When you get this service as part of a family planning visit, you can go to any doctor or clinic that takes Medicaid and offers family planning services. You do not need a referral when you get this service as part of a family planning visit.

Everyone should talk to their doctor about having an HIV test. To access free HIV testing or testing where your name isn't given, call **1-800-541-AIDS** (English) or **1-800-233-SIDA** (Spanish).

TB Diagnosis and Treatment

You can choose to go either to your PCP or to the county public health agency for diagnosis and/or treatment. You do not need a referral to go to the county public health agency.

Benefits Using Your Medicaid Card Only

There are some services EmblemHealth Enhanced Care Plus does not provide. You can get these services from any provider who takes Medicaid by using your Medicaid Benefit card.

Transportation

Emergency and non-emergency transportation are covered by regular Medicaid.

To get non-emergency transportation, you or your provider must call LogistiCare at **1-877-564-5922**. If possible, you or your provider should call LogistiCare at least 3 days before your medical appointment and provide your Medicaid identification number (ex. AB12345C), appointment date and time, address where you are going, and doctor you are seeing. Non-emergency medical transportation includes: personal vehicle, bus, taxi, ambulette and public transportation.

If you have an emergency and need an ambulance, you must call 911.

Developmental Disabilities

- Long-term therapies
- Day treatment
- Housing services
- Medicaid Service Coordination (MSC) program
- Services received under the Home and Community Based Services Waiver
- Medical Model (Care-at-Home) Waiver Services

Services NOT Covered

*These services are not available from EmblemHealth Enhanced Care Plus **or** Medicaid*. If you get any of these services, you may have to pay the bill.

- Cosmetic surgery if not medically needed
- Services of a Podiatrist (unless you are a diabetic)
- Personal and comfort items
- Infertility treatments
- Services from a provider that is not part of EmblemHealth Enhanced Care Plus, unless it is a provider you are allowed to see as described elsewhere in this handbook, or EmblemHealth Enhanced Care Plus or your PCP sends you to that provider.

You may have to pay for any service that your PCP does not approve. Or, if you agree to be a "private pay" or "self-pay" patient before you get a service, you will have to pay for the service.

This includes:

- non-covered services (listed above),
- unauthorized services,
- services provided by providers not part of EmblemHealth Enhanced Care Plus

If You Get a Bill

If you get a bill for a treatment or service you do not think you should pay for, do not ignore it. Call EmblemHealth Enhanced Care Plus at **1-855-283-2146** right away. EmblemHealth Enhanced Care Plus can help you understand why you may have gotten a bill. If you are not responsible for payment, we will contact the provider and help fix the problem for you.

You have the right to ask for fair hearing if you think you are being asked to pay for something Medicaid or EmblemHealth Enhanced Care Plus should cover. See the Fair Hearing section later in this handbook.

If you have any questions, call Member Services at 1-855-283-2146.

Service Authorization and Actions

Prior Authorization and Timeframes

There are some treatments and services that you need to get approval for before you receive them or in order to be able to continue receiving them. This is called **prior authorization.** You or someone you trust can ask for this. The following treatments and services must be approved before you get them:

- Inpatient nonemergency procedures that provide acute, rehabilitation and skilled nursing care

- All outpatient surgery for procedures and treatment in a facility or doctor's office
- All procedures that require an assistant surgeon or co-surgeon
- Inpatient treatment of mental illness and substance use disorder and dependence
- Detoxification treatment and rehabilitation of substance use disorder and dependence, including outpatient detoxification
- Home health care
- Hospice care
- Pre-transplant evaluation and transplant services
- Outpatient cardiac and pulmonary rehabilitation
- Outpatient diagnostic radiology services
- Radiation therapy
- Outpatient physical and occupational therapies
- Sleep studies
- Psychological testing services
- Neuropsychological testing services
- Covered nonemergency services rendered by nonparticipating providers
- Some types of durable medical equipment
- Dental implants and oral appliances (such as braces)
- All genetic testing
- Certain injectable drugs
- Reconstructive surgery or other procedures that may be considered cosmetic
- All procedures considered experimental and investigational
- Home infusion therapy

* Some services not listed here may require prior approval based on the circumstances.

Asking for approval of a treatment or service is called a **service authorization request.** To get approval for these treatments or services you need to:

You, your designee or your doctor should contact EmblemHealth Care Management at least 10 business days in advance by calling **1-888-447-2884**. Representatives are available Monday through Friday, from 9 am to 5 pm. At other hours:

- If the call concerns an urgent or emergency admission, the caller will be prompted to leave a message and Care Management will call you or your doctor back the following business day.
- If the call concerns an elective admission, the caller will be advised to call back the next business day when representatives are available.

You will also need to get prior authorization if you are getting one of these services now, but need to continue or get more care. This includes a request for home health care while you are in the hospital or after you have just left the hospital. This is called **concurrent review.**

What happens after we get your service authorization request:

The health plan has a review team to be sure you get the services we promise. Doctors and nurses are on the review team. Their job is to be sure the treatment or service you asked for is medically needed and right for you. They do this by checking your treatment plan against medically acceptable 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 a qualified health care professional. 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 or may be a health care professional who typically provides the care you requested. You can request the specific medical standards, called **clinical review criteria**, used to make the decision for actions related to medical necessity.

After we get your request, we will review it under either a **standard** or a **fast track** process. You 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 case will be handled under the standard review process. If you are in the hospital or have just left the hospital and we receive a request for home health care, we will handle the request as a fast track review. 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.

Timeframes for prior authorization requests:

- **Standard review**: We will make a decision about your request within 3 work 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 by the 14th day if we need more information.
- **Fast track review**: We will make a decision and you will hear from us within 3 work days. We will tell you by the third work day if we need more information.

Timeframes for concurrent review requests

- **Standard review**: We will make a decision within 1 work 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. We will tell you by the 14th day if we need more information.
- **Fast track review**: We will make a decision within 1 work day of when we have all the information we need, except:
  - If you are in the hospital or have just left the hospital, and you ask for home health care on a Friday or day before a holiday, we will make a decision no later than 72 hours of when we have all the information we need.
  - If you are getting inpatient substance use disorder treatment, and you ask for more services at least 24 hours before you are to be discharged, we will make a decision no later than 24 hours.

In all cases, you will hear from us no later than 3 work days after we received your request. We will tell you by the third work day if we need more information.

If we need more information to make either a standard or fast track decision about your service request, we will:

- Write and tell you what information is needed. If your request is 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 no later than 14 days from the day we asked for more information.

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 **1-888-447-2884** or writing to:

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

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 the request. You or someone you trust can also file a complaint about the review time with the New York State Department of Health by calling **1-800-206-8125**.

We will notify you by the date our time for review has expired. But if for some reason you do not hear from us by that date, it is the same as if we denied your service authorization request. If you are not satisfied with this answer, you have the right to file an action appeal with us. See the **Action Appeal** section later in this handbook.

Other Decisions About Your Care:

Sometimes we will do a concurrent review of 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.

Timeframes for notice of other actions

- In most cases, if we make a decision to reduce, suspend or terminate a service we have already approved and you are now getting, we must tell you at least 10 days before we change the service.
- We must tell you at least 10 days before we make any decision about long term services and supports, such as home health care, personal care, CDPAS, adult day health care, and permanent nursing home care.
- If we are checking care that has been given 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. These notices are not bills. **You will not have to pay for any care you received that was covered by the plan or Medicaid even if we later deny payment to the provider.**

How Our Providers Are Paid

You have the right to ask us whether we have any special financial arrangement with our physicians that might affect your use of health care services. You can call Member Services at **1-855-283-2146** if you have specific concerns. We also want you to know that most of our providers are paid in one or more of the following ways.

- If our PCPs work in a clinic or health center, they probably get a **salary.** The number of patients they see does not affect this.
- Our PCPs who work from their own offices may get a set fee each month for each patient for whom they are the patient's PCP. The fee stays the same whether the patient needs one visit or many -- or even none at all. This is called **capitation**.

- Sometimes providers get a set fee for each person on their patient list, but some money (maybe 10%) can be held back for an **incentive** fund. At the end of the year, this fund is used to reward PCPs who have met the standards for extra pay that were set by the Plan.
- Providers may also be paid by **fee-for-service.** This means they get a Plan-agreed-upon fee for each service they provide.

You Can Help With Plan Policies

We value your ideas. You can help us develop policies that best serve our members. If you have ideas tell us about them. Maybe you'd like to work with one of our member advisory boards or committees, or attend one of our Member Forums held each year. Call Member Services at **1-855-283-2146** to find out how you can help.

Information from Member Service

Here is information you can get by calling Member Services at **1-855-283-2146**.

- A list of names, addresses, and titles of EmblemHealth's Board of Directors, Officers, Controlling Parties, Owners and Partners.
- A copy of the most recent financial statements/balance sheets, summaries of income and expenses.
- A copy of the most recent individual direct pay subscriber contract.
- Information from the Department of Financial Services about consumer complaints about EmblemHealth Enhanced Care Plus.
- How we keep your medical records and member information private.
- In writing, we will tell you how our plan checks on the quality of care to our members
- We will tell you which hospitals our health providers work with.
- If you ask us in writing, we will tell you the guidelines we use to review conditions or diseases that are covered by EmblemHealth Enhanced Care Plus.
- If you ask us in writing, we will tell you the qualifications needed and how health care providers can apply to be part of our network.
- If you ask, we will tell you 1) if our contracts or subcontracts include physician incentive arrangements that affect the use of referral services; and, if so, 2) the types of arrangements we use; and 3) if stop loss protection is provided for physicians and physician groups.
- Information about how our company is organized and how it works.

Keep Us Informed

Call Member Services at **1-855-283-2146** whenever these changes happen in your life:

- You change your name, address or telephone number
- You have a change in Medicaid eligibility
- You are pregnant
- You give birth
- There is a change in insurance for you
- When you enroll in a new case management program or receive case management services in another community based organization

If you no longer get Medicaid, check with your local Department of Social Services. You ***may*** be able to enroll in another program.

Disenrollment and Transfers

If You Want to Leave Our Plan

You can try us out for 90 days. You may leave EmblemHealth Enhanced Care Plus and join another health plan at any time during that time. If you do not leave in the first 90 days, however, you must stay in EmblemHealth Enhanced Care Plus for nine more months, *unless* you have a good reason (good cause).

Some examples of good cause include:

- Our health plan does not meet New York State requirements and members are harmed because of it.
- You move out of our service area.
- You, the plan, and the LDSS all agree that disenrollment is best for you.
- You are or become exempt or excluded from managed care.
- We do not offer a Medicaid managed care service that you can get from another health plan in your area.
- You need a service that is related to a benefit we have chosen not to cover and getting the service separately would put your health at risk.
- We have not been able to provide services to you as we are required to under our contract with the State.

To change plans:

- Call the Managed Care staff at your local Department of Social Services.
- Call New York Medicaid Choice at **1-800-505-5678**. The New York Medicaid Choice counselors can help you change health plans.

You may be able to disenroll or transfer to another plan over the phone. If you have to be in managed care, you will have to choose another health plan.

It may take between two and six weeks to process, depending on when your request is received. You will get a notice that the change will take place by a certain date. EmblemHealth Enhanced Care Plus will provide the care you need until then.

You can ask for faster action if you believe the timing of the regular process will cause added damage to your health. You can also ask for faster action if you have complained because you did not agree to the enrollment. Just call your local Department of Social Services or New York Medicaid Choice.

You Could Become Ineligible for Medicaid Managed Care and Health and Recovery Plans

You may have to leave EmblemHealth Enhanced Care Plus if you:

- move out of the County or service area,
- change to another managed care plan,
- join an HMO or other insurance plan through work,
- go to prison, or
- otherwise lose eligibility.
- **If you have to leave EmblemHealth Enhanced Care Plus or become ineligible for Medicaid, all of your services may stop unexpectedly, including any care you receive at home.** Call New York Medicaid Choice at **1-800-505-5678** right away if this happens.

We Can Ask You to Leave Our Plan

You can also lose your EmblemHealth Enhanced Care Plus membership, if you often:

- Refuse to work with your PCP in regard to your care,
- Don't keep appointments,
- Go to the emergency room for non-emergency care,
- Don't follow EmblemHealth's rules,
- Do not fill out forms honestly or do not give true information (commit fraud),
- Act in ways that make it hard for us to do our best for you and other members even after we have tried to fix the problems

You can also lose your EmblemHealth Enhanced Care Plus, if you cause abuse or harm to plan members, providers or staff.

No matter what reason you disenroll, we will prepare a discharge plan for you to help you get services you need.

Action Appeals

There are some treatments and services that you need to get approval for before you receive them or in order to be able to continue receiving them. This is called **prior authorization**. Asking for approval of a treatment or service is called a **service authorization request**. This process is described earlier in this handbook. Any decision to deny a service authorization request or to approve it for an amount that is less than requested is called an **action**.

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

Your provider can ask for reconsideration:

- If we made a decision that your service authorization request was not medically necessary or was experimental or investigational; and we did not talk to your doctor about it, your doctor may ask to speak with the plan's Medical Director. The Medical Director will talk to your doctor within one workday.

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 60 business days after hearing from us to file an action appeal.
- You can do this yourself or ask someone you trust to file the action appeal for you. You can call Member Services **1-855-283-2146** if you need help filing an action appeal.
- We will not treat you any differently or act badly toward you if you file an action appeal.
- The action appeal can be made by phone or in writing. If you make an action 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 should sign and return the form to us. You can make any necessary changes before sending the form back to us.

To file an action appeal, write to:

EmblemHealth
Grievance and Appeal Department PO Box 2844
New York, New York 10116-2844

To file an action appeal by phone, call: **1-855-283-2146**

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

- If you or your doctor asks to have your action 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; **or**
- If your request was denied when you asked for home health care after you were in the hospital; **or**
- If your request was denied when you asked for more inpatient substance use disorder treatment at least 24 hours before you were to leave the hospital.
- Fast track action appeals can be made by phone and do not have to be followed up in writing.

What happens after we get your action appeal:

- Within 15 days, we will send you a letter to let you know we are working on your appeal.
- 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. Call EmblemHealth Enhanced Care Plus at **1-855-283-2146** if you are not sure what information to give us.
- 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 to you. You or someone you trust can file a complaint with the New York State Department of Health at **1-800-206-8125**.

Timeframes for Action Appeals:

- **Standard appeals**: If we have all the information we need we will tell you our decision **within thirty days** from your appeal. A written notice of our decision will be sent within 2 working 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 2 working days from your appeal, but no later than 3 working days after we receive your appeal.
  - We will tell you in 3 working days after giving us your appeal if we need more information.
  - If your request was denied when you asked for more inpatient substance use disorder treatment at least 24 hours before you were to leave the hospital, we will make a decision about your appeal within 24 hours.
  - We will tell you our decision by phone and send a written notice later.

If we need more information for either a standard or fast track decision about your action appeal we will:

- Write to you and tell you what information is needed. If your request is 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 no later than 14 days from the day we asked for more information.

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 you decide your case. This can be done by calling our Care Management department at**1-888-447-2884** 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 action appeal. You or someone you trust can also file a complaint about the review time with the New York State Department of Health by calling **1-800-206-8125**.

If your original denial was because we said:

- the service was not medically necessary; or
- the service was experimental or investigational; or
- the out-of-network service was not different from a service that is available in our network; or
- the out-of- network service was available from a plan provider who have the training and experience to meet your needs, or
- we do not tell you our decision about your action appeal on time, the original denial against you will be reversed. This means your service authorization request will be approved.

Aid to Continue while appealing a decision about your care:

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

- 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 fair hearing results in another denial, you may have to pay for the cost of any continued benefits that you received. The decision you receive from the fair hearing officer will be final.

External Appeals

If the plan decides to deny coverage for a medical service you and your doctor asked for because:

- the service was not medically necessary; or
- the service was experimental or investigational ; or
- the out-of-network service was not different from a service that is available in our network; or
- the out-of-network service was available from a plan provider who have the training and experience to meet your needs, you can ask New York State for an independent **external appeal**. This is called an external appeal because it is decided by reviewers who do not work for 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, clinical trial or treatment for a rare disease. You do not have to pay for an external appeal.

Before you ask for an external appeal:

- 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 and the plan may agree to skip the plan's appeals process and go directly to external appeal; **or**.
- You can prove the plan did not follow the rules correctly when processing your action appeal.

You have 4 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 within4 months of when you made that agreement.

If you had a fast track action appeal and are not satisfied with the plan's decision you can choose to file a standard action appeal with the plan **or** ask for an external appeal. If you choose to file a standard action appeal with the plan, and the plan upholds its decision, you will receive a new final adverse determination and have another chance to ask for an external appeal.

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 New York State Department of Financial Services within 4 months from the time the plan gives you the notice of final adverse determination or when you and the plan agreed to waive the appeal process.

You will lose you 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 Department of Financial Services. You can call Member Services at **1-855-283-2146** if you need help filing an appeal. You and your doctors will have to give information about your medical problem. The external appeal application says what information will be needed.

Here are some ways to get an application:

- Call the Department of Financial Services, **1-800-400-8882**
- Go to the Department of Financial Services' web site www.dfa.ny.gov.
- Contact the health plan at **1-855-283-2146**.

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: or
- you are in the hospital after an emergency room visit and the hospital care is denied by the plan.

This is called an **expedited external appeal**. The external appeal reviewer will decide an expedited appeal in 72 hours or less.

If you asked for inpatient substance use disorder treatment at least 24 hours before you were to leave the hospital, the plan will continue to pay for your stay if:

- you ask for a fast track Internal Appeal within 24 hours, AND
- you ask for a fast track External Appeal at the same time.

The plan will continue to pay for your stay until there is a decision made on your appeals. Your plan will make a decision about your fast track Internal Appeal in 24 hours. The fast track External Appeal will be decided in 72 hours

The reviewer will tell you and the plan the decision right away by phone or fax. Later, a letter will be sent that tells you the decision.

You may also ask for a fair hearing if the plan decided 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.

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 your staying or leaving EmblemHealth Enhanced Care Plus.
- You are not happy with a decision that we made about care you were getting. You feel the decision limits your Medicaid benefits or that we did not make the decision in a reasonable amount of time.
- You are not happy about a decision we made that denied care you wanted.
- You feel the decision limits your Medicaid benefits.
- You are not happy about a decision we made to deny payment for care you received. You feel the decision limits your Medicaid benefits.
- You are not happy about your screening, assessment, or re-assessment for Behavioral Health Home and Community Based Services.
- You are not happy with a decision that your doctor would not order services you wanted.
- You feel the doctor's decision stops or limits your Medicaid benefits. You must file a complaint with EmblemHealth Enhanced Care Plus. If EmblemHealth Enhanced Care Plus agrees with your doctor, you may ask for a State fair hearing.
- The decision you receive from the fair hearing officer will be final.

If the services you are now getting are going to be reduced, stopped or restricted, you can choose to ask to continue the services your doctor ordered while you wait for your case to be decided. You must ask for a fair hearing **within 10 days** from the date of the notice that says your care will change or by the time the action takes effect. However, if you choose to ask for services to be continued and the fair hearing is decided against you, you may have to pay the cost for the services you received while waiting for a decision.

You can use one of the following ways to request a Fair Hearing:

1. By phone, call toll-free **800-342-3334**
2. By fax, **518-473-6735**
3. By internet, www.otda.state.ny.us/oah/forms.asp
4. By mail:

   Fair Hearings, NYS Office of Temporary and Disability Assistance
   Office of Administrative Hearings
   Manage Care Unit
   P.O. Box 22023
   Albany, New York 12201-2023

When you ask for a fair hearing about a decision EmblemHealth Enhanced Care Plus made, we must send you a copy of the **evidence packet.** This is information we used to make our decision about your care. The plan will give this information to the hearing officer to explain our action. If there is not time enough to mail it to you, we will bring a copy of the evidence packet to the hearing for you. If you do not get your evidence packet by the week before your hearing, you can call **1-855-283-2146** to ask for it.

Remember, you can complain anytime to the New York State Department of Health by calling **1-800-206-8125**. In some cases, you may be able to keep getting your care the same way while you wait for your Fair Hearing. Call Member Services at **1-855-283-2146** if you have questions.

Complaint Process

Complaints:

We hope our health plan serves you well. If you have a problem, talk with your PCP, or call or write Member Service. Most problems can be solved right away. If you have a problem or dispute with your care or services you can file a complaint with the plan. Problems that are not solved right away over the phone and any complaint that comes in the mail will be handled according to our complaint procedure described below.

You can ask someone you trust (such as a legal representative, a family member, or friend) to file the complaint for you. If you need our help because of a hearing or vision impairment, or if you need translation services or help filing the forms, we can help you. We will not make things hard for you or take any action against you for filing a complaint.

You also have the right to contact the New York State Department of Health about your complaint at **1-800-206-8125** or write to: NYS Department of Health, Division of Health Plan Contracting and Oversight, Bureau of Consumer Services ESP Corning Tower Room 2019, Albany, NY 12237. You may also contact your local Department of Social Services with your complaint at any time. You may also call the New York State Department of Financial Services at **1-800-342-3736** if your complaint involves a billing problem.

How to File a Complaint with Our Plan

You may contact us about a complaint in one of three ways: by phone, in writing or in person.

By phone: **1-855-283-2146**; TDD: 711

Member Services staff are available to help you seven days a week, from 8 am to 8 pm. All other times, leave information on the answering machine. Be sure to give enough detail for us to understand your problem. We will return your call the next working day.

In writing:

You can write us a letter and mail it to:
EmblemHealth Grievance and Appeal Department
PO Box 2844
New York, NY 10116-2844

In person:

EmblemHealth
Customer Service Member Access Unit
55 Water Street
New York, NY 10041-8190

What Happens Next

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

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

Your complaint will be reviewed by one or more qualified people. If your complaint involves clinical matters your case 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 reasons for our decision.
- When a delay would risk your health, we will call you with our decision in 24 hours of when we have all the information we need to answer complaint, but you will hear from us in no more than 7 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 3 working days.
- You will be told 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 you a letter and let you know.

Complaint Appeals

If you disagree with a decision we made about your complaint, you or someone you trust 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 at least 60 business 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;
- The appeal must be in writing. If you make an appeal by phone, it must be followed up in writing. 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 working days. The letter will tell you:

- who is working on your complaint appeal,
- how to contact that person, and
- 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, that were not involved in making the first decision about your complaint.

After we get all the information we need you will know our decision in 30 working days. If a delay would risk your health you will get our decision in 2 working days of when we have all the information we need to decide the appeal.

We will give you 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 **1-800-206-8125**.

PART 3 — MEMBER RIGHTS AND RESPONSIBILITIES

Your Rights

As a member of EmblemHealth Enhanced Care Plus, you have a right to:

- Be cared for with respect, without regard for health status, sex, race, color, religion, national origin, age, marital status or sexual orientation.
- Be told where, when and how to get the services you need from EmblemHealth Enhanced Care Plus.
- Be told by your PCP what is wrong, what can be done for you, and what will likely be the result in language you understand.
- Get a second opinion about your care.
- Give your OK to any treatment or plan for your care after that plan has been fully explained to you.
- Refuse care and be told what you may risk if you do.
- Refuse enrollment into a Health Home and be told how to receive your physical and behavioral health care needs without having an assigned Health Home Care Manager.
- Get a copy of your medical record, and talk about it with your PCP, and to ask, if needed, that your medical record be amended or corrected.
- Be sure that your medical record is private and will not be shared with anyone except as required by law, contract, or with your approval.
- Use EmblemHealth complaint system to settle any complaints, or you can complain to the New York State Department of Health or the local Department of Social Services any time you feel you were not fairly treated.
- Use the State Fair Hearing system.
- Appoint someone (relative, friend, lawyer, etc.) to speak for you if you are unable to speak for yourself about your care and treatment.
- Receive considerate and respectful care in a clean and safe environment free of unnecessary restraints.

Your Responsibilities

As a member of EmblemHealth Enhanced Care Plus, you agree to:

- Work with your care team to protect and improve your health.
- Find out how your health care system works.
- Listen to your PCP's advice and ask questions when you are in doubt.
- Call or go back to your PCP if you do not get better, or ask for a second opinion.
- Treat health care staff with the respect you expect yourself.
- Tell us if you have problems with any health care staff. Call Member Service.

- Keep your appointments. If you must cancel, call as soon as you can.
- Use the emergency room only for real emergencies.
- Call your PCP when you need medical care, even if it is after-hours.

ADVANCE DIRECTIVES

There may come a time when you can't decide about your own health care. By planning in advance, you can arrange now for your wishes to be carried out. First, let family, friends and your doctor know what kinds of treatment you do or don't want. Second, you can appoint an adult you trust to make decisions for you. Be sure to talk with your PCP, your family or others close to you so they will know what you want. Third, it is best if you put your thoughts in writing. The documents listed below can help. You do not have to use a lawyer, but you may wish to speak with one about this. You can change your mind and change these documents at any time. We can help you understand or get these documents. They do not change your right to quality health care benefits. The only purpose is to let others know what you want if you can't speak for yourself.

Health Care Proxy

With this document, you name another adult that you trust (usually a friend or family member) to decide about medical care for you if you are not able to do so. If you do this, you should talk with the person so they know what you want.

CPR and DNR

You have the right to decide if you want any special or emergency treatment to restart your heart or lungs if your breathing or circulation stops. If you do not want special treatment, including cardiopulmonary resuscitation (CPR), you should make your wishes known in writing. Your PCP will provide a DNR (Do Not Resuscitate) order for your medical records. You can also get a DNR form to carry with you and/or a bracelet to wear that will let any emergency medical provider know about your wishes.

Organ Donor Card

This wallet sized card says that you are willing to donate parts of your body to help others when you die. Also, check the back of your driver's license to let others know if and how you want to donate your organs.

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

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

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

What If I Change My Mind?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Health Care Proxy Form Instructions

Item (1)

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

Item (2)

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

Item (3)

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

Item (4)

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

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

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

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

- Artificial respiration.
- Artificial nutrition and hydration (nourishment and water provided by feeding tube).
- Cardiopulmonary resuscitation (CPR).
- Antipsychotic medication.
- Electric shock therapy.

- Antibiotics.
- Surgical procedures.
- Dialysis.
- Transplantation.
- Blood transfusions.
- Abortion.
- Sterilization.

Item (5)

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

Item (6)

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

Item (7)

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

Health Care Proxy

(1) I, _____

hereby appoint _____

(name, home address and telephone number)

_____

_____

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

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

_____

(name, home address and telephone number)

_____

_____

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

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

_____

_____

_____

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

_____

_____

(5) Your Identification (Please Print):

Your Name: _____

Your Signature: _____

Date: _____

Your Address: _____

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

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

❑ Any needed organs and/or tissues

❑ The following organs and/or tissues

_____

_____

❑ Limitations

_____

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

Your Signature: _____

Date: _____

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

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

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

IMPORTANT PHONE NUMBERS

Your PCP .....

EmblemHealth

Member Service 1-855-283-2146/TTY: 711
Nurse Hotline 1-877-444-7988
Utilization Review 1-855-283-2146

Your Nearest Emergency Room .....

New York State Department of Health (Complaints) 1-800-206-8125

OMH Complaints 1-800-597-8481

OASAS Complaints 1-800-553-5790

Medicaid Helpline 1-800-541-2831

NYC Human Resources Administration 1-718-557-1399

New York Medicaid Choice ..... 1-800-505-5678]

Local Departments of Social Services (DSS)

Nassau County DSS 1-516-227-7474
Suffolk County DSS:
Eastern Suffolk County 1-631-852-3710
Western Suffolk County 1-631-853-8408
Westchester County DSS 1-914-995-3333

NYS HIV/AIDS Hotline 1-800-541-AIDS (2437)
Spanish 1-800-233-SIDA (7432)
TDD 1-800-369-AIDS (2437)

New York City HIV/AIDS Hotline (English & Spanish) 1-800-TALK-HIV (8255-448)

HIV Uninsured Care Programs 1-800-542-AIDS (2437)
TDD Relay, then 1-518-459-0121

Child Health Plus (Free or low cost health insurance for children) 1-855-693-6765

PartNer Assistance Program 1-800-541-AIDS (2437)
In New York City (CNAP) 1-212-693-1419

Social Security Administration 1-800-772-1213

(Continued)

NYS Domestic Violence Hotline.....1-800-942-6906
Spanish 1-800-942-6908
Hearing Impaired.....1-800-810-7444
Americans with Disabilities Act (ADA) Information Line. 1-800-514-0301
TDD 1-800-514-0383
Local Pharmacy: .....
Other Health Providers: .....

IMPORTANT WEB SITES

EmblemHealth
www.emblemhealth.com

NYS Department of Health
www.health.ny.gov

NYS OMH
www.omh.ny.gov

NYS OASAS
www.oasas.ny.gov

NYS DOH HIV/AIDS Information
www.health.ny.gov/diseases/aids

NYS HIV Uninsured Care Programs
www.health.state.ny.us/diseases/aids/resources/adap/index.htm

HIV Testing Resource Directory
www.cdc.gov/actagainstaids/campaigns/hivtreatmentworks/resources/index.html

NYC DOHMH
www.nyc.gov/html/doh/html/home/home.shtml

NYC DOHMH HIV/AIDS Information
www.nyc.gov/html/doh/html/living/std-hiv.shtml

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

45-8666PD 10/17

THE BELOW SECTIONS OF YOUR MEMBER HANDBOOK HAVE BEEN REVISED TO READ AS FOLLOWS

HOW TO GET SPECIALTY CARE AND REFERRALS

- If you need care that your PCP cannot give, he or she will refer you to a specialist who can. If your PCP refers you to another doctor, we will pay for your care. Most of these specialists are EmblemHealth providers. Talk with your PCP to be sure you know how referrals work.

- If you think a specialist does not meet your needs, talk to your PCP. Your PCP can help you if you need to see a different specialist.

- There are some treatments and services that your PCP must ask EmblemHealth to approve *before* you can get them. Your PCP will be able to tell you what they are.

- If you are having trouble getting a referral you think you need, contact Member Services at 855-283-2146.

- If we do not have a specialist in our provider network who can give you the care you need, we will get you the care you need from a specialist outside our plan. This is called an **out-of-network referral**. You, your PCP or plan provider must ask EmblemHealth for approval *before* you can get an out-of-network referral. If your PCP or plan provider refers you to a provider who is not in our network, you are not responsible for any of the costs except co-payments as described in this handbook.

- To request services by a specialist or providers outside our provider network, contact Member Services at 1-855-283-2146. We will need a written reason why you need to see a specialist or provider who is not in our network. You can ask your PCP or other provider to send us this information on your behalf. We will follow the same rules for Prior Authorization requests.

    - Sometimes we may not approve an out-of-network referral because we have a provider in EmblemHealth that can treat you. If you think our plan provider does not have the right training or experience to treat you, you can ask us to check if your out-of-network referral is medically needed. You will need to ask for a **Plan Appeal.** See page 30 to find out how.

    - Sometimes, we may not approve an out-of-network referral for a specific treatment because you asked for care that is not very different from what you can get from EmblemHealth's provider. You can ask us to check if your out-of-network referral for the treatment you want is medically needed. You will need to ask for a Plan Appeal. See page 30 to find out how.

- If you need to see a specialist for ongoing care, your PCP may be able to refer you for a specified number of visits or length of time (a **standing referral**). If you have a standing referral, you will not need a new referral for each time you need care.

- *If you have a long-term disease or a disabling illness that gets worse over time*, your PCP may be able to arrange for:
  - your specialist to act as your PCP; or
  - a referral to a specialty care center that deals with the treatment of your illness. You can also call Member Services for help in getting access to a specialty care center.

Service Authorization

Prior Authorization:

There are some treatments and services that you need to get approval for before you receive them or in order to be able to continue receiving them. This is called **prior authorization**. You or someone you trust can ask for this. The following treatments and services must be approved before you get them:

There are some treatments and services that you need to get approval for before you receive them or in order to be able to continue receiving them. This is called prior authorization. You or someone you trust can ask for this. The following treatments and services must be approved before you get them:

- Inpatient nonemergency procedures that provide acute, rehabilitation and skilled nursing care
- All outpatient surgery for procedures and treatment in a facility or doctor's office
- All procedures that require an assistant surgeon or co-surgeon
- Inpatient treatment of mental illness and substance use disorder and dependence
- Detoxification treatment and rehabilitation of substance use disorder and dependence, including outpatient detoxification
- Home health care
- Hospice care
- Pre-transplant evaluation and transplant services
- Outpatient cardiac and pulmonary rehabilitation
- Outpatient diagnostic radiology services
- Radiation therapy
- Outpatient physical and occupational therapies
- Sleep studies
- Psychological testing services
- Neuropsychological testing services
- Covered nonemergency services rendered by nonparticipating providers
- Some types of durable medical equipment
- Dental implants and oral appliances (such as braces)
- All genetic testing

- Certain injectable drugs
- Reconstructive surgery or other procedures that may be considered cosmetic
- All procedures considered experimental and investigational
- Home infusion therapy

* Some services not listed here may require prior approval based on the circumstances.

Asking for approval of a treatment or service is called a **service authorization request**. To get approval for these treatments or services you need to:

You, your designee or your doctor should contact EmblemHealth Care Management at least 10 business days in advance by calling 1-888-447-2884. Representatives are available Monday through Friday, from 9 am to 5 pm. At other hours:

- If the call concerns an urgent or emergency admission, the caller will be prompted to leave a message and Care Management will call you or your doctor back the following business day.
- If the call concerns an elective admission, the caller will be advised to call back the next business day when representatives are available.

You will also need to get prior authorization if you are getting one of these services now, but need to continue or get more of the care. This is called **concurrent review**.

What happens after we get your service authorization request:

The health plan has a review team to be sure you get the services we promise. We check that the service you are asking for is covered under your health plan. Doctors and nurses are on the review team. Their job is to be sure the treatment or service you asked for is medically needed and right for you. They do this by checking your treatment plan against medically acceptable standards.

We may decide to deny a service authorization request or to approve it for an amount that is less than requested. These decisions will be made by a qualified health care professional. 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 or may be a health care professional who typically provides the care you requested. You can request the specific medical standards, called **clinical review criteria**, we use to make decisions about medical necessity.

After we get your request we will review it under a **standard** or **fast track** process. You 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 case will be handled under the standard review process.

We will fast track your review if:

- A delay will seriously risk your health, life, or ability to function;
- Your provider says the review must be faster:

- You are asking for more a service you are getting right now;

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 also the Plan Appeals and Fair Hearing sections later in this handbook.)

Timeframes for prior authorization requests:

- **Standard review**: We will make a decision about your request within 3 work 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 by the 14th day if we need more information.

- **Fast track review**: We will make a decision and you will hear from us within 72 hours. We will tell you within 72 hours if we need more information.

Timeframes for concurrent review requests:

- **Standard review**: We will make a decision within 1 work 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. We will tell you by the 14th day if we need more information.

- **Fast track review**: We will make a decision within 1 work day of when we have all the information we need. You will hear from us no later than 72 hours after we received your request. We will tell you within 1 work day if we need more information.

Special timeframes for other requests:

- If you are in the hospital or have just left the hospital and you are asking for home health care we will make a decision within 72 hours of your request.
- If you are getting inpatient substance use disorder treatment, and you ask for more services at least 24 hours before you are to be discharged, we will make a decision within 24 hours of your request.
- If you are asking for mental health or substance use disorder services that may be related to a court appearance, we will make a decision within 72 hours of your request.
- If you are asking for an outpatient prescription drug we will make a decision within 24 hours of your request.
- A step therapy protocol means we require you to try another drug first, before we will approve the drug you are requesting. If you are asking for approval to override a step therapy protocol, we will make a decision with 24 hours for outpatient prescription drugs. For other drugs, we will make a decision within 14 days of your request.

If we need more information to make either a standard or fast track decision about your service request 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 no later than 14 days from the day we asked for more information.

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 855-283-2146 or writing to:

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

You or your representative 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 about the review time with the New York State Department of Health by calling 1-800-206-8125.

We will notify you by the date our time for review has expired. But if for some reason you do not hear from us by that date, it is the same as if we denied your service authorization request. If we do not respond to a request to override a step therapy protocol on time, your request will be approved.

If you think our decision to deny your service authorization request is wrong, you have the right to file a Plan Appeal with us. See the Plan Appeal section later in this handbook.

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 make these decisions...

Timeframes for other decisions about your care:

- In most cases, if we make a decision to reduce, suspend or stop a service we have already approved and you are now getting, we must tell you at least 10 days before we change the service.
- We must tell you at least 10 days before we make any decision about long term services and supports, such as home health care, personal care, CDPAS, adult day health care, and nursing home care.

- If we are checking care that has been given in the past, we will make a decision about paying for it within 30 days of receiving all information we need 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. These notices are not bills. **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.**

You can also call the Independent Consumer Advocacy Network (ICAN) to get free, independent advice about your coverage, complaints, and appeals' options. They can help you manage the appeal process. Contact ICAN to learn more about their services:

Phone: 1-844-614-8800 (**TTY Relay Service**: 711)
Web: www.icannys.org | **Email**: ican@cssny.org]

Plan Appeals

There are some treatments and services that you need to get approval for before you receive them or in order to be able to continue receiving them. This is called **prior authorization**. Asking for approval of a treatment or service is called a **service authorization request**. This process is described earlier in this handbook. The notice of our decision to deny a service authorization request or to approve it for an amount that is less than requested is called an **Initial Adverse Determination**.

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

Your provider can ask for reconsideration:

If we made a decision that your service authorization request was not medically necessary or was experimental or investigational; and we did not talk to your doctor about it, your doctor may ask to speak with the plan's Medical Director. The Medical Director will talk to your doctor within one work day.

You can file a Plan Appeal:

If you think our decision about your service authorization request is wrong, you can ask us to look at your case again. This is called a **Plan Appeal**.

- You have **60 calendar days** from the date of the Initial Adverse Determination notice to ask for a Plan Appeal.
- You can call Member Services 855-283-2146 if you need help asking for a Plan Appeal, or following the steps of the appeal process. We can help if you have any special needs like a hearing or vision impairment, or if you need translation services.
- You can ask for a Plan Appeal, or you can have someone else, like a family member, friend, doctor or lawyer, ask for you. You and that person will need to sign and date a statement saying you want that person to represent you.

- We will not treat you any differently or act badly toward you because you ask for a Plan Appeal.

Aid to Continue while appealing a decision about your care:

If we decided to reduce, suspend or stop services you are getting now, you may be able to continue the services while you wait for your Plan Appeal to be decided. **You must ask for your Plan Appeal:**

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

If your Plan Appeal is results in another denial you may have to pay for the cost of any continued benefits that you received.

You can call, write, or visit us to ask for a Plan Appeal. When you ask for a Plan Appeal, or soon after, you will need to give us:

- Your name and address
- Enrollee number
- Service you asked for and reason(s) for appealing
- Any information that you want us to review, such as medical records, doctors' letters or other information that explains why you need the service.
- Any specific information we said we needed in the Initial Adverse Determination notice.
- To help you prepare for your Plan Appeal, you can ask to see the guidelines, medical records and other documents we used to make the Initial Adverse Determination. If your Plan Appeal is fast tracked, there may be a short time to give us information you want us to review. You can ask to see these documents or ask for a free copy by calling 1-855-283-2146...

Give us your information and materials by phone, fax, mail, or in person**:**

Phone…….	1-855-283-2146
Fax…….	1-212-510-5320
Mail……..……..	Grievance and Appeal Department EmblemHealth 55 Water Street, New York, NY 10041
In Person……...…	EmblemHealth, 55 Water Street, New York, NY 10041

If you ask for a Plan Appeal by phone, unless it is fast tracked, you must also send your Plan Appeal to us in writing. After your call, we will send you a form which is a summary of your

phone Plan Appeal. If you agree with our summary, you should sign and return the form to us. You can make any needed changes before sending the form back to us.

If you are asking for out of network service or provider:

- If we said that the service you asked for is not very different from a service available from a participating provider, you can ask us to check if this service is medically necessary for you. You will need to ask your doctor to send this information with your Plan Appeal:
  1) a statement in writing from your doctor that the out of network service is very different from the service the plan can provide from a participating provider. Your doctor must be a board certified or board eligible specialist who treats people who need the service you are asking for.
  2) two medical or scientific documents that prove the service you are asking for is more helpful to you and will not cause you more harm than the service the plan can provide from a participating provider.

- lf you think our participating provider does not have the correct training or experience to provide a service, you can ask us to check if it is medically necessary for you to be referred to an out of network provider. You will need to ask your doctor to send this information with your appeal:
  1) a statement in writing that says our participating provider does not have the correct training and experience to meet your needs, and
  2) that recommends an out of network provider with the correct training and experience who is able to provide the service.

  Your doctor must be a board certified or board eligible specialist who treats people who need the service you are asking for. If your doctor does not send this information, we will still review your Plan Appeal. However, you may not be eligible for an External Appeal. See the External Appeal section later in this handbook.

What happens after we get your Plan Appeal:

- Within 15 days, we will send you a letter to let you know we are working on your Plan Appeal.
- We will send you a free copy of the medical records and any other information we will use to make the appeal decision. If your Plan Appeal is fast tracked, there may be a short time to review this information.
- You can also provide information to be used in making the decision in person or in writing. Call EmblemHealth at 1-855-283-2146 if you are not sure what information to give us.
- Plan 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.
- You will be given the reasons for our decision and our clinical rationale, if it applies. The notice of the Plan Appeal decision to deny your request or to approve it for an amount that is less than requested is called a **Final Adverse Determination**.

- **If you think our Final Adverse Determination is wrong**:
    - you can ask for a Fair Hearing. See the Fair Hearing section of this handbook.
    - for some decisions, you may be able to ask for an External Appeal. See the External Appeal section of this handbook.
    - you may file a complaint with the New York State Department of Health at 1-800-206-8125.

Timeframes for Plan Appeals:

- **Standard Plan Appeals**: If we have all the information we need we will tell you our decision within 30 calendar days from when you asked for your Plan Appeal.

- **Fast track Plan Appeals**: If we have all the information we need, fast track Plan Appeal decisions will be made in 2 working days from your Plan Appeal but not more than 72 hours from when you asked for your Plan Appeal.
    - We will tell you within in 72 hours if we need more information.
    - If your request was denied when you asked for more inpatient substance use disorder treatment at least 24 hours before you were to leave the hospital, we will make a decision about your appeal within 24 hours.
    - We will tell you our decision by phone and send a written notice later.

Your Plan Appeal will be reviewed under the fast track process if:

- If you or your doctor asks to have your Plan 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 Plan 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; **or**
- If your request was denied when you asked for home health care after you were in the hospital; or
- If your request was denied when you asked for more inpatient substance use disorder treatment at least 24 hours before you were to leave the hospital.

If we need more information to make either a standard or fast track decision about your Plan Appeal we will:

- Write you 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 no later than 14 days from the day we asked for more information.

You or your representative 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 1-855-283-2146 or writing to:

Grievance and Appeal Department
EmblemHealth
55 Water Street, New York, NY 10041

You or your representative can file a complaint with the plan if you don't agree with our decision to take more time to review your Plan Appeal. You or someone you trust can also file a complaint about the review time with the New York State Department of Health by calling 1-800-206-8125.

If you do not receive a response to your Plan Appeal or we do not decide in time, including extensions, you can ask for a Fair Hearing. See the Fair Hearing section of this handbook.

If we do not decide your Plan Appeal on time, and we said the service you are asking for is: 1) not medically necessary; 2) experimental or investigational; 3) not different from care you can get in the plan's network; or 4) available from a participating provider who has correct training and experience to meet your needs, the original denial will be reversed. This means your service authorization request will be approved.

External Appeals

You have other appeal rights if we said the service you are asking for was:

1) not medically necessary;
2) experimental or investigational;
3) not different from care you can get in the plan's network; or
4) available from a participating provider who has correct training and experience to meet your needs.

For these types of decisions, you can ask New York State for an independent **External Appeal**. This is called an External Appeal because it is decided by reviewers who do not work for 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, clinical trial, or treatment for a rare disease. You do not have to pay for an External Appeal.

Before you ask for an External Appeal:

- You must file a Plan Appeal and get the plan's Final Adverse Determination; **or**
- If you have not gotten the service, and you ask for a fast track Plan Appeal, 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 and the plan may agree to skip the plan's appeals process and go directly to External Appeal; **or**
- You can prove the plan did not follow the rules correctly when processing your Plan Appeal.

You have **4 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 4 months of when you made that agreement.

To ask for an External Appeal, fill out an application and send it to the Department of Financial Services. You can call Member Services at 1-855-283-2146 if you need help filing an appeal. You and your doctors will have to give information about your medical problem. The External Appeal application says what information will be needed.

Here are some ways to get an application:

- Call the Department of Financial Services, 1-800-400-8882
- Go to the Department of Financial Services' web site at www.dfs.ny.gov.
- Contact the health plan at 1-855-283-2146

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: or
- You are in the hospital after an emergency room visit and the hospital care is denied by the plan.

This is called an **expedited External Appeal**. The External Appeal reviewer will decide an expedited appeal in 72 hours or less.

If you asked for inpatient substance use disorder treatment at least 24 hours before you were to leave the hospital, we will continue to pay for your stay if:

- you ask for a fast track Plan Appeal within 24 hours, AND
- you ask for a fast track External Appeal at the same time.

We will continue to pay for your stay until there is a decision made on your appeals. We will make a decision about your fast track Plan Appeal in 24 hours. The fast track External Appeal will be decided in 72 hours.

The External Appeal reviewer will tell you and the plan the decision right away by phone or fax. Later, a letter will be sent that tells you the decision.

If you ask for a Plan Appeal, and you receive a Final Adverse Determination that denies, reduces, suspends or stops your service, you can ask for a Fair Hearing. You may ask for a Fair Hearing or ask for an External Appeal, or both. If you ask for both a Fair Hearing and an External Appeal, the decision of the fair hearing officer will be the one that counts.

Fair Hearings

You may ask for a Fair Hearing from New York State if:

- You are not happy with a decision your local Department of Social Services or the State Department of Health made about your staying or leaving EmblemHealth.

- You are not happy with a decision we made to restrict your services. You feel the decision limits your Medicaid benefits. You have 60 calendar days from the date of the Notice of Intent to Restrict to ask for a Fair Hearing. If you ask for a Fair Hearing within 10 days of the Notice of Intent to Restrict, or by the effective date of the restriction, whichever is later, you can continue to get your services until the Fair Hearing decision. However, if you lose your Fair Hearing, you may have to pay the cost for the services you received while waiting for the decision.

- You are not happy with a decision that your doctor would not order services you wanted. You feel the doctor's decision stops or limits your Medicaid benefits. You must file a complaint with EmblemHealth. If EmblemHealth agrees with your doctor, you may ask for a Plan Appeal. If you receive a Final Adverse Determination, you will have 120 calendar days from the date of the Final Adverse Determination to ask for a state Fair Hearing.

- You are not happy with a decision that we made about your care. You feel the decision limits your Medicaid benefits. You are not happy we decided to:
  - reduce, suspend or stop care you were getting; or
  - deny care you wanted;
  - deny payment for care you received; or
  - did not let you dispute a co-pay amount, other amount you owe or payment you made for your health care.

  You must first ask for a Plan Appeal and receive a Final Adverse Determination. You will have 120 calendar days from the date of the Final Adverse Determination to ask for a Fair Hearing.

  If you asked for a Plan Appeal, and receive a Final Adverse Determination that reduces, suspends, or stops care you getting now, you can continue to get the services your doctor ordered while you wait for your Fair Hearing to be decided. You must ask for a fair hearing within 10 days from the date of the Final Adverse Determination or by the time the action takes effect, whichever is later.

  However, if you choose to ask for services to be continued, and you lose your Fair Hearing, you may have to pay the cost for the services you received while waiting for a decision.

- You asked for a Plan Appeal, and the time for us to decide your Plan Appeal has expired, including any extensions. If you do not receive a response to your Plan Appeal or we do not decide in time, you can ask for a Fair Hearing.

The decision you receive from the fair hearing officer will be final.

You can use one of the following ways to request a Fair Hearing:

1. By phone – call toll-free 1-800-342-3334
2. By fax – 518-473-6735
3. By internet – www.otda.state.ny.us/oah/forms.asp
4. By mail – NYS Office of Temporary and Disability Assistance
   Office of Administrative Hearings
   Managed Care Hearing Unit
   P.O. Box 22023
   Albany, New York 12201-2023

When you ask for a Fair Hearing about a decision EmblemHealth made, we must send you a copy of the **evidence packet.** This is information we used to make our decision about your care. The plan will give this information to the hearing officer to explain our action. If there is not time enough to mail it to you, we will bring a copy of the evidence packet to the hearing for you. If you do not get your evidence packet by the week before your hearing, you can call 1-855-283-2146to ask for it.

Remember, you may complain anytime to the New York State Department of Health by calling 1-800-206-8125.

You can also call the Independent Consumer Advocacy Network (ICAN) to get free, independent advice about your coverage, complaints, and appeals' options. They can help you manage the appeal process. Contact ICAN to learn more about their services:

Phone: 1-844-614-8800 (**TTY Relay Service**: 711)
Web: www.icannys.org | **Email**: ican@cssny.org]

Complaint Process

Complaints:

We hope our health plan serves you well. If you have a problem, talk with your PCP, or call or write Member Services. Most problems can be solved right away. If you have a problem or dispute with your care or services you can file a complaint with the plan. Problems that are not solved right away over the phone and any complaint that comes in the mail will be handled according to our complaint procedure described below.

You can call Member 1-855-283-2146, Monday through Friday, from 8 am to 6 pm if you need help filing a complaint, or following the steps of the complaint process. We can help if you have any special needs like a hearing or vision impairment, or if you need translation services.

We will not make things hard for you or take any action against you for filing a complaint.

You also have the right to contact the New York State Department of Health about your complaint at 1-800-206-8125 or write to: Complaint Unit, Bureau of Consumer Services, OHIP DHPCO 1CP-1609, New York State Department of Health, Albany, New York 12237

You may also contact your local Department of Social Services with your complaint at any time. You may call the New York State Department of Financial Services at (1-800-342-3736) if your complaint involves a billing problem.

How to File a Complaint with Our Plan:

You can file a complaint, or you can have someone else, like a family member, friend, doctor or lawyer, file the complaint for you. You and that person will need to sign and date a statement saying you want that person to represent you.

To file by phone, call Member Services at 1-855-283-2146, Monday through Friday, from 8 am to 6 pm. If you call us after hours, leave a message. We will call you back the next work day. If we need more information to make a decision, we will tell you.

You can write us with your complaint or call the Member Services number and request a complaint form. It should be mailed to:
Grievance and Appeal Department
EmblemHealth
55 Water Street, New York, NY 10041

What happens next:

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

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

You can also provide information to be used reviewing your complaint in person or in writing. Call EmblemHealth at 1-855-283-2146 if you are not sure what information to give us.

Your complaint will be reviewed by one or more qualified people. If your complaint involves clinical matters your case 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 reasons 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 7 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 3 work days.
- You will be told 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 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 at least 60 work days after hearing from us to file a complaint appeal;
- You can do this yourself or ask someone you trust to file the complaint appeal for you;
- The complaint appeal must be made in writing. If you make a complaint 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 work 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, that were not involved in making the first decision about your complaint.

If we have all the information we need you will know our decision in 30 work days. If a delay would risk your health you will get our decision in 2 work 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 1-800-206-8125.

You can also call the Independent Consumer Advocacy Network (ICAN) to get free, independent advice about your coverage, complaints, and appeals' options. They can help you manage the appeal process. Contact ICAN to learn more about their services:

Phone: 1-844-614-8800 (**TTY Relay Service**: 711)
Web: www.icannys.org | **Email**: ican@cssny.org]

Enhanced Care and Enhanced Care Plus
Handbook Insert

Harm Reduction Services

If you are in need of help related to substance use disorder, members in the Medicaid Managed Care benefit package will be able to get Harm Reduction Services. These services offer a patient-oriented approach to the health and wellness of substance users. Harm Reduction Services provide individuals with resources and programs to help deal with substance use. EmblemHealth will cover harm reduction services that are recommended by a doctor or other licensed professional. These include:

- A plan of care developed by a person experienced in working with substance users.
- Individual supportive counseling that assists in achieving your goals.
- Group supportive counseling in a safe space to talk with others about issues that affect your health and well-being.
- Counseling to help you with taking your prescribed medication and continuing treatment.
- Support groups to help you better understand substance use and identify coping techniques and skills that will work for you.

To learn more about these services, call Customer Service at **855-283-2146**.

Enhanced Care and Enhanced Care Plus Handbook Insert

Specialty Care

Includes the services of other practitioners, including:

- physical therapist - Limited to 40 visits per calendar year
- occupational and speech therapists – Limited to 20 visits each per calendar year
- audiologist
- midwives
- cardiac rehabilitation
- Durable medical equipment (DME), including hearing aids, artificial limbs and orthotics.
- renal and hemodialysis.
- HIV/AIDS treatment services.
- outpatient detoxification services.
- podiatrist
- other covered services as medically needed.

Limits for physical, occupational and speech therapists do not apply if you are under age 21, you have been determined to be developmentally disabled by the Office for People with Developmental Disabilities, or if you have a traumatic brain injury.

To learn more about these services, call Member Services at **855-283-2146 (TTY: 711)**.