EmblemHealth®
WHAT CARE FEELS LIKE.

HIP SELECT EPO-PPO MEMBER HANDBOOK

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THIS IS YOUR HIP EPO-PPO MEMBER HANDBOOK.

It explains your HIP Select EPO or PPO coverage underwritten by HIP Insurance Company of New York and how you can help make it work for you. It is not your Contract or Certificate of Coverage. Your Contract or Certificate of Coverage defines your benefits as well as the terms, conditions, limitations and exclusions applied to your coverage. Please refer to your Contract or Certificate of Coverage when you have questions about your benefits.

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If you would like to receive a printed copy of this book, please call **1-800-447-8255**, seven days a week (excluding major holidays), from 8 am to 8 pm. TTY/TDD users should call **711**.

For more information about your HIP EPO-PPO coverage, visit our Web site at **www.emblemhealth.com**.

WELCOME

THANK YOU FOR SELECTING EMBLEMHEALTH AS YOUR HEALTH INSURANCE PROGRAM.

We've designed a health insurance program that makes it easy for you to get the health coverage you and your family need, when and where you need it.

As an EmblemHealth member in the HIP EPO or PPO plan, you enjoy many special advantages. Briefly, here's how the EPO and PPO health plans work:

- If you are an Exclusive Provider Organization (EPO) member, you can choose your physicians from any in-network physician in the EPO/PPO physician directory.*
- If you are a Preferred Provider Organization (PPO) member, you may also choose any in-network EPO/PPO physician.* In addition, you may receive care from out-of-network physicians (subject to the provisions indicated in your Certificate of Coverage).
- If you are a PPO member who chooses to receive care from an out-of-network physician, your cost sharing responsibilities will increase. Your benefits will be subject to both deductible and coinsurance. You will also be responsible for payment of any charge that exceeds EmblemHealth's Usual, Customary and Reasonable (UCR) charge for the covered service. And, finally, you will need to pay the physician at the time of service and file claims to obtain reimbursement.

Please check your Certificate of Coverage to see whether your EPO or PPO plan requires payment of in-network copayment, deductible and coinsurance. You will be responsible for these out-of-pocket costs.

You can learn more about EmblemHealth by logging on to our Web site at **www.emblemhealth.com** anytime, day or night. The site provides a great deal of information about HIP EPO and PPO and allows you to conduct a number of inquiries and transactions, including finding a conveniently located in-network physician. You can also make inquiries and conduct transactions by accessing our interactive voice response (IVR) system by telephone anytime, day or night. With the IVR system, you can change your address and telephone number, check claims status, confirm your eligibility for benefits and order a Provider Directory or replacement ID card, if needed.

Of course, if you prefer, you can speak directly with a Customer Service Advocate, seven days a week (excluding major holidays), from 8 am to 8 pm, for answers to questions about your coverage. Just call **1-800-447-8255** to access our IVR system or to speak with a Customer Service Advocate.

If you use a telephone device for the hearing or speech impaired, please call **711**.

* If you need to access care in New York, New Jersey or Connecticut, you must choose a physician from the EmblemHealth Web site at **www.emblemhealth.com** or from the EmblemHealth Provider Directory.

Please remember to read your Certificate of Coverage. The Certificate of Coverage and your Member Handbook together give you information you need to completely understand how the EPO/PPO plans work, policies affecting your coverage and your plan's benefits, limitations and exclusions.

Some Important Definitions

As you read this handbook, you may find it helpful to know the definitions of the terms below.

Copayment — The fee charged to you at the time of service for certain covered services and benefits. The applicable copayment, if any, is indicated in your Schedule of Benefits.

Coinsurance — A charge, expressed as a percentage of the provider's charge for services, which you are required to pay when indicated under the group policy. You are responsible for the payment of any required coinsurance charge directly to the provider when covered services are received. Your coinsurance, if any, is indicated in your Schedule of Benefits.

Deductible — The amount you must pay for covered services before we begin to pay any costs associated with covered services. The applicable deductible, if any, is indicated in your Schedule of Benefits.

EPO Benefits — Coverage for medically necessary care that is provided by in-network EPO physicians. Depending on your coverage, you may have out-of-pocket expenses — including copayment, deductible and coinsurance responsibilities* (please refer to your Certificate of Coverage). With a few exceptions, there is no coverage for services received from out-of-network physicians.

PPO Benefits — Includes both in-network and out-of-network coverage. Depending on your coverage, when you receive care from in-network PPO physicians (in-network coverage), you may have some in-network, out-of-pocket expenses — including copayment, deductible and coinsurance responsibilities* (please refer to your Certificate of Coverage). If you receive care from out-of-network physicians (out-of-network coverage), you will have to file claims for reimbursement and we will pay after you have met your deductible and coinsurance responsibilities.

PPO Out-of-Network Reimbursement — With the PPO program, you have the choice to use out-of-network physicians for health care services whenever you choose. When you use out-of-network providers, however, please remember the following:

- Your out-of-pocket costs will be higher than when using in-network physicians.
- You will usually have to pay the physician when you receive services and then file a claim form to obtain reimbursement.

EmblemHealth will pay a percentage of the Usual, Customary and Reasonable (UCR) maximum allowances established by EmblemHealth for covered services, minus any applicable deductible and coinsurance (see your Certificate of Coverage for the percentage that applies to your benefit plan). Out-of-network physicians may bill you for the difference between the UCR and their actual charges.

To optimize your benefits, certain in-network and out-of-network services must receive prior approval from EmblemHealth's Pre-service Program before the care or services are received. Please refer to Care Management: Pre-service Program for additional information.

* Please check your Certificate of Coverage to see whether your EPO or PPO plan requires payment of in-network copayment, deductible and coinsurance. You will be responsible for these out-of-pocket costs.

GETTING STARTED

Your EmblemHealth Identification Card

Your EmblemHealth Identification Card (EmblemHealth ID card) contains important information that you will need to obtain medical care, wherever you happen to be. Keep it safe and take it with you when you travel, in case of an emergency.

Keep your EmblemHealth ID card handy, too, when calling an EmblemHealth in-network provider for an appointment or Customer Service at **1-800-447-8255** for information and advice. That way you will be ready to provide the information you'll be asked to give.

If you have family coverage, each of your covered dependents will receive his or her own EmblemHealth ID card. Be sure each covered dependent knows how important the EmblemHealth ID card is for receiving benefits.

If you or one of your covered dependents did not receive an EmblemHealth ID card, or if a card has been lost or stolen, please request a new one. Just use **www.emblemhealth.com** to request a card. Or, use the interactive voice response (IVR) system by calling **1-800-447-8255** to make an automated card request. If you prefer, you can also speak with a Customer Service Advocate by calling **1-800-447-8255**.

Please note that EmblemHealth works with several organizations affiliated with providers to perform certain administrative operations, such as claims processing or case management. In these cases, contact information may differ. **Please read the back of your ID card carefully for special mailing or telephone contacts**. These are the contacts you should use.

Scheduling Appointments

When you need to use your health care benefits, just call an in-network physician an for appointment. When you call, be ready to explain why you want to see the doctor. Being clear about the reason will help the office schedule your appointment appropriately.

If you are a PPO member and choose to receive care from an out-of-network physician, you will need to file a claim to receive reimbursement. You will also have greater cost-sharing responsibilities than you would if you had used an in-network physician and will need to pay the doctor at the time of service.

Claim Filing Procedures

The HIP EPO Plan usually does not require any claim filing. You may need to file a claim, however, if you receive emergency care when you are outside the service area used by HIP EPO.

To obtain a claim form, call EmblemHealth Customer Service at **1-877-842-3625**. Attach a paid itemized bill to the completed claim form for the services you received.

Submit the claim form to the mailing address shown on the back of your EmblemHealth ID card. This is very important since EmblemHealth works with several organizations affiliated with health care providers to handle certain operations, such as claims processing.

DENTAL COVERAGE

Dental Coverage For Group Members

- EmblemHealth offers a broad range of dental coverage through an arrangement with Careington International. To find a network dentist near you, call Careington International at **1-877-548-4447**, seven days a week (excluding major holidays), from 8 am and 8 pm.

An Explanation Of Dental Coverage For Group Members

EmblemHealth offers group members access to dental coverage through an arrangement with Careington International, a leading national dental network. (See important notes a, b and c on the next page.)

This coverage provides access to the following general dental services from network dentists:

- One examination (comprehensive or periodic) every six months at $5 per visit. (See important note b on the next page.)
- One prophylaxis (cleaning) every six months at $10 per visit. (See important note b on the next page.)
- One topical application of fluoride (for children age 16 and under) every six months at $5 per visit.
- Fluoride applications age 17 and over (one every six months) — copay determined by location of service.

Additional available services — including but not limited to X-rays, fillings, crowns or dentures — will be provided at a discounted rate subject to fee schedules that EmblemHealth has negotiated. For example, suppose a dentist's usual fee for a particular service is $125, but EmblemHealth has negotiated a discounted fee of $100 with the network dentist. As an EmblemHealth member, you would be charged the discounted fee and, therefore, need to pay the network dentist $100.*

These schedules may change from time to time. There are several fee schedules based on the location (region) of the provider's office. Therefore, members will pay different fees based on the location of the dentist's office.

Specialist dental services, such as endodontic, oral and maxillofacial surgery, as well as orthodontic, pediatric, periodontic and prosthodontic procedures are also available from network dentists. Charges for specialist services are discounted 20 percent off the dentist's usual and customary rates. No fee schedule applies to specialist dental services.

*This is only an example to illustrate how the plan works. It does not necessarily reflect a negotiated fee for any serviceBoth general and specialist dental services may be self-referred, referred by a network dentist or arranged through Careington International. You must use network dentists for all care under this benefit to take advantage of the discounted rates. You may select any network EmblemHealth/Careington dentist and may change your choice of physician at any time. For help locating a network dentist near you, answers to benefits questions, or for a fee schedule or directory, call Careington International directly at **1-877-548-4447**, Monday through Friday, between 8 am and 8 pm.

Important Notes:

a. This benefit applies only to those members enrolled through a group or organization such as an employer, labor union association or welfare fund that acts as a remitting agent and sends EmblemHealth the premium for your coverage.

b. Network dentists may recommend that members receive additional services and procedures consistent with generally accepted dental practices. For example, a recent full-mouth series of X-rays may be required at the time of examination. Frequency of X-rays depends on the practitioner's judgment of each individual case, based on a multitude of factors.

c. An examination and X-rays are required prior to cleaning.

OPTICAL COVERAGE

The EmblemHealth Optical Program

The EmblemHealth Optical Program provides coverage for eye exams, eyeglass frames and lenses, as well as contact lenses. Each of these services is covered once every 24 months.

An Explanation Of The Optical Program For Group Members

The EmblemHealth Optical Program provides a standard benefit for all members: reduced-cost prescription eyewear from a selection of frames at a participating provider once every 24 months. Our optical program is offered through the General Vision Services (GVS) network. The GVS telephone number is **1-800-847-4661**.

How The EmblemHealth Optical Program Works

Step 1: Get Your Eyes Examined And Obtain A Prescription.

To arrange for an eye exam, just call a conveniently located General Vision Services (GVS) network provider. During your visit, the network optometrist will examine your eyes and give you a prescription. The network optometrist will then provide you with a prescription for lenses and/or contact lenses as needed

Step 2: Visit A Network Provider.

You can choose to obtain your eyeglass frames, lenses or contact lenses through a GVS network optometrist. You can also visit either an Eye Care Advantage or Comprehensive Profession Systems (CPS) network optometrist to obtain your eyeglass frames, lenses or contact lenses made. Simply bring your prescription and your EmblemHealth ID card to an optometrist in one of these three networks.

Step 3: Choose Your Frames.

The EmblemHealth selection of fully covered frames is available at every network optometrist. You will find safety, oversize, single-vision, bifocal and trifocal glasses. Lenses in glass or plastic and cosmetic tinting are included. All of our network optometrists guarantee that the frames in the EmblemHealth selection conform to current standards established by the American National Standards Institute (ANSI).

If you prefer, you can choose frames that are not included in the EmblemHealth selection. If so, then you simply pay the difference in cost between the retail price of the item selected and the retail price of the item covered.

Getting A Provider Directory

You can order a free copy of the network provider directory by calling **1-800-447-8255** and using EmblemHealth's interactive voice response (IVR) system. Or, you can log on to **www.emblemhealth.com** for the most up-to-date directory listing.

PRESCRIPTION DRUG COVERAGE

Details on any prescription drug coverage you may have, including copayment, deductible and coinsurance, appear in your prescription drug rider. Your copayment information is on your EmblemHealth ID card.

The EmblemHealth Drug Formulary

EmblemHealth prescription drug coverage is usually for prescription drugs that are listed in EmblemHealth's Drug Formulary, and are filled at an EmblemHealth participating or home delivery pharmacy.

Prescription drug riders that cover non-formulary drugs are available to groups with retail or home delivery coverage. Check the Contract or Certificate of Coverage of this Welcome Kit for additional information about your coverage.

The EmblemHealth Drug Formulary is a continually updated list of medications that EmblemHealth network physicians, and other experts, have approved for disease treatment and preservation of our members' health. The primary purpose of the formulary is to promote the use of safe, effective and affordable drugs and treatments, while maintaining and promoting quality patient care.

Please note: Depending on your benefit, some formulary drugs may be excluded from your coverage. Please refer to your prescription drug rider and/or Contract or Certificate of Coverage to find out which drugs are excluded from your coverage.

When your doctor wants to prescribe a drug that is not on the EmblemHealth Drug Formulary, he or she must contact the Clinical Pharmacy Department to obtain prior approval. There is a phone line dedicated for this purpose: **1-877-444-3657.** Unless you have three-tiered prescription drug coverage (see Tiered Benefit Structure Chart in this section), coverage for non-formulary prescriptions will not be provided without prior approval.

EmblemHealth network physicians receive regular communications about changes tothe EmblemHealth Drug Formulary. If you have access to the Internet, you can log on to our Web site at **www.emblemhealth.com** and click on "Pharmacy Benefit Services" to check the formulary status of a drug. If you don't have access to the Internet at home, many local public libraries can provide you with free Internet access. Or, you can call EmblemHealth Customer Service at **1-800-447-8255** with questions about the drug formulary.

Brand Name Vs. Generic Drugs

Generic drugs help promote cost-effective health care. The Food and Drug Administration (FDA) requires that generic drugs meet the same quality standards as their equivalent brand name drugs. In some cases, brand medications will have more than one generic equivalent available. EmblemHealth's corporate and contracted pharmacies will dispense a covered generic equivalent when available and allowed by law.

Tiered Benefit Structure

EmblemHealth prescription drug coverage is either one-tiered, two-tiered or three-tiered.

- **One-Tiered Coverage** — If you have a one-tiered benefit, this means that you have one copay for generic prescription drugs included in the formulary.
- **Two-Tiered Coverage** — If you have two-tiered coverage, you will have one copay for brand name drugs included in the formulary. If your physician has medical justification for prescribing a non-formulary medication, your physician must obtain a Physician's Prior Approval (PPA) from EmblemHealth's Clinical Pharmacy Department. If your physician does not obtain a PPA, you will not be covered for the non-formulary medication.
- **Three-Tiered Coverage** — If you have three-tiered coverage, you will usually have one copay for generic drugs included in the formulary, a higher copay for brand name drugs included in the formulary and another higher copay for generic and brand name drugs that are not included in the formulary. Your coverage for non-preferred brand name medications means that your physician no longer has to contact EmblemHealth's Clinical Pharmacy Department for a PPA. You will be covered for non-preferred brand name drugs, but you will have a higher copay than for formulary preferred brand drugs.

The Tiered Benefit Structure Chart on the following page provides a further illustration of how the tiered benefit structure works.

Tiered Benefit Structure Chart

Please refer to your Contract or Certificate of Coverage to find out if prescriptiondrug coverage is included in your plan. If you have prescription drug coverage, yourcopayment information can also be found on your EmblemHealth ID card.

The Tiered Benefit Structure Chart on the following page provides a further illustration of how the tiered benefit structure works.

Tiered Benefit Structure Chart

Please refer to your Contract or Certificate of Coverage to find out if prescription drug coverage is included in your plan. If you have prescription drug coverage, your copayment information is also found on your EmblemHealth ID card.

The chart below illustrates the differences among one-tiered, two-tiered and three-tiered benefits

Tiered Benefit Coverage	Preferred Drugs Covered	Non-Preferred Drugs	Cost To You
One-Tiered Coverage (One copayment)	Generic drugs only.	Not Covered.	One copay for generic drugs only (Example: $5 copay – formulary generic drugs only).
Two-Tiered Coverage	Brand name drugs.	Not covered unless your physician obtains a Physician's Prior Approval (PPA) by calling EmblemHealth's Clinical Pharmacy Department at **1-877-444-3657**.	One copay for brand name drugs.
Three-Tiered Coverage	Generic and brand name drugs.	Covered. No Physician Prior Approval required for non-preferred drugs	One copay for generic drugs, a higher copay for brand name drugs and another, higher copay for non-preferred brand name drugs.

Filling Your Prescriptions At Participating Pharmacies

You can fill your prescriptions (issued by an EmblemHealth network physician) by visiting one of our more than 60,000 EmblemHealth participating pharmacies nationwide. Some physician group practices also have on-site pharmacies for your convenience.

When traveling, you may bring a prescription drug bottle from your local pharmacy to any network pharmacy nationwide. The bottle contains all the information needed by pharmacists to arrange the transfer of a prescription filled from the original pharmacy. (All state, federal and plan limitations will apply — e.g., on the number of refills allowed, and any early refill limitations.) If a refill is available, a single telephone call by the pharmacist can complete the transfer. The processing time would then be the same as with any other prescription. Always remember to present your EmblemHealth ID card when filling your prescriptions. Depending on your coverage, you may have to make a copayment when you obtain a 30-day supply (or less) of a prescription or refill. Please check the Schedule of Benefits in your Contract or Certificate of Coverage for specific details.

Filling Your Prescription Through The Home Delivery Program

EmblemHealth works with Express Scripts, Inc. (ESI) one of the leading Internet and home delivery pharmacies. You may obtain up to a 90-day supply of an EmblemHealth approved medication through ESI. Since prescription drug delivery takes 14 business days through ESI Internet/Home Delivery Pharmacy, we recommend that you have your doctor complete two prescriptions. For new prescriptions, fill the prescription right away at your local EmblemHealth participating pharmacy. Submit the second prescription to ESI in enough time to allow for processing before your initial prescription runs out.

Depending on your benefit, your copayments (if any) may be reduced by using the ESI Internet/Home Delivery Pharmacy. Plus, your medication is shipped right to your home. Reductions in copayments, however, only apply to formulary brand and generic medications. If you have the three-tier benefit and you obtain a nonpreferred brand name medication, your copayment will not be reduced.

Ordering Home Delivery Forms

You may obtain mail order forms in one of two ways:

- Call ESI Member Services toll free at **1-877-866-5798** 24 hours a day, seven days a week. If you have a hearing or speech impairment and use a TDD, call **1-800-899-2114**. You can also go to **www.StartHomeDelivery.com** to get started.
- Call EmblemHealth Customer Service at **1-800-447-8255**, seven days a week (excluding major holidays), from 8 am to 8 pm. If you have a hearing or speech impairment and use a TDD, call **711**.

Prescription Refills

Ordering prescription refills is easy and can be done by utilizing any of the three options below.

- **Online** — Log on to **www.emblemhealth.com** and click Home Delivery. Prescription refills will be displayed. Simply select the items you want to order, and follow the on-screen instructions to complete the request.
- **Telephone** — Call **1-877-866-5798** to request a refill.
- **Mail** — Use the refill order form that will accompany your prescription. Mail it with your copayment to ESI in the return envelope.

Up-To-Date Formulary Listing

To review the most up-to-date formulary listing, first register as a member at EmblemHealth's Web site, **www.emblemhealth.com**. After you have successfully registered, just click on the Pharmacy tab and follow the step-by-step instructions. Please note that the formulary is updated on a regular basis.

EmblemHealth's Specialty Pharmacy Program

Members that use a specialty drug must have their prescriptions prescribed by a network physician and get their prescriptions filled at EmblemHealth's Specialty Pharmacy, ICORE Pharmacy Services. You cannot have a specialty drug filled at a retail or mail order pharmacy.

Specialty drugs often have one or more of the following characteristics:

- Usually injected or infused
- May require special handling (e.g., refrigeration)
- Limited availability
- May require clinical monitoring

ICORE staff understands the complex needs of patients who use a specialty drug, and are available 24 hours a day/seven days a week. Additional benefits of using ICORE include:

- **Home Delivery** — ICORE will fill your prescription and deliver your drugs directly to your home.
- **Direct Pharmacist and/or Nurse Access** — You will have access to experienced pharmacists and/or nurses that ensure you get continual, prompt, personalized care while on treatments.
- **Educational Materials** — You will receive support and home instruction information.
- **Ancillary Supplies** — You will receive syringes, needles and other needed supplies at no cost.
  – You will get refill reminders and an ICORE consult with your doctor regarding your medication(s).

Specialty drugs are subject to any copayment and coinsurance described in your Contract or Certificate of Coverage. In addition, depending on your coverage, specialty drugs that are not in EmblemHealth's Drug Formulary may require that your physician obtain a Physician's Prior Approval (PPA). Please refer to the description of the EmblemHealth Drug Formulary and the PPA process described in this section.

All prescriptions must be submitted to ICORE by fax at **1-866-364-2673**, or phoned in by your physician. Any subsequent refills of an existing prescription, filled at a local pharmacy, must be transferred to ICORE. For more information, you or your network physician can call ICORE Pharmacy Services at **1-866-554-2673**.

Your network physician will know which prescriptions must be filled by ICORE. If, however, you or your network physician have any questions, please call ICORE Pharmacy Services at **1-866-554-2673**. If you have any questions regarding your benefits, please call EmblemHealth Customer Service at **1-800-447-8255**.

Clinical Pharmacy Department

- For physicians to obtain prior approval for non-formulary drugs **1-877-444-3657**
- ESI Member Services/Home Delivery **1-877-866-5798**
- TTY/TDD for hearing impaired **1-800-899-2114**

EMBLEM BEHAVIORAL HEALTH SERVICES PROGRAM

Check the schedule of Benefits included in your Contract or Certificate of Coverage for the number of visits and days of inpatient and outpatient care that your coverage may include. Be sure to check the schedule too, for any copayments you may have.

You do not need a referral to obtain covered outpatient mental health services, or alcohol or substance abuse, detoxification and rehabilitation services when received from a participating provider. You also do not need to obtain prior approval for routine outpatient mental health or alcohol/substance abuse services when received from a network provider. Routine services include, but are not limited to, initial assessment, individual, group and family treatment and medication management. Call the Emblem Behavioral Health Services Program at **1-888-447-2526** for help in selecting a provider.

For other services, including inpatient treatment and any service provided by an out-of-network provider, prior approval is required. To obtain prior approval, or to find out if a service requires prior approval, just call the Emblem Behavioral Health Services Program. When you call, you will be transferred to a trained professional who will assess your treatment and provide you with prior approval if needed. All calls will be treated as confidential.

NOTE: If you are an EPO member and receive services from an out-of-network provider, without prior approval, benefits will not be provided.

CHRONIC CONDITION DISEASE MANAGEMENT

If you or another covered member in your family has diabetes, congestive heart failure (CHF), coronary artery disease (CAD) and/or chronic obstructive pulmonary disease (COPD), the EmblemHealth PATH (**P**ositive **A**ctions **T**oward **H**ealth) Program can help you. This program is designed to work with you and your doctor to improve your care and help you better manage your health, if you qualify. This program is offered at no cost to you.

Program Benefits

- An opportunity to work one-on-one with a professional health coach by telephone.
- Free educational materials about symptom management, health risks, treatment, diet and nutrition, and more.
- Access to support services provided in your community.

Program Goals

- Help you better understand your health condition.
- Review your health information with you.
- Help you prepare questions to ask your doctor.
- Identify ways for you to stay healthy.
- Coordinate your treatment plan with your doctor.

Live a healthier, more enjoyable life by being more involved in your health care decisions.

To see if you or your covered dependent is eligible for the PATH Program, call **1-888-881-3112**, 8 am to 6 pm, Monday through Friday.

CARE MANAGEMENT

Care Management Program

- The Care Management Program (CMP) helps members to understand their treatment options and coverage
- CMP consists of the following programs:
  - **Pre-Service Reviews** — Evaluations made prior to the delivery of the services requested. Pre-service reviews may be for in-patient or out-patient services.
  - **Concurrent Reviews** — Continued or extended health care services, procedures or treatments or additional services when You are undergoing a course of continued treatment prescribed by Your Physician or home health care services following Your discharge for an inpatient Hospital admission.
  - **Case Management and Disease Management** — This component consists of nurses, behavioral health specialists, social workers, pharmacists and physicians who identify and assist members who have complex needs, serious diseases or chronic conditions and would benefit from clinical support and management. Members are regularly screened for possible candidates and may be referred directly for management.
  - **Retrospective Reviews** — Evaluations made after the requested service or procedure has already occurred and You have been discharged. Retrospective reviews may be in-patient or outpatient.
  - **Technology Evaluation** — This component consists of the continual clinical identification of new technology and updates information on non-covered experimental and investigational procedures.
- Generally, your PCP or other network physician will contact the Care Management Department when a decision has been made for you to undergo certain medical services. If you need to contact the CMP directly, just call **1-877-846-3625** or the number indicated on the back of your EmblemHealth ID card.

Adverse Determinations

- In some instances, it may be determined through the CMP that a particular service is not medically necessary or appropriate or is experimental or investigational. If that happens, you will be notified. We will include the reasons, including clinical rationale, for our determination, date of service, provider name, claim amount (if applicable), diagnosis code and treatment code, and corresponding meaning of these codes. The notice will also advise you of your right to appeal our determination, give instructions for requesting a standard or expedited internal appeal and initiating an external appeal. The notice will specify that you may request a copy of the clinical review criteria used to make the determination. The notice will specify additional information, if any, needed for us to review an appeal and an explanation of why the information is necessary. The notice will also refer to the Plan provision on which the denial is based. We will send notices of determination to you (or your designee) and, as appropriate, to your provider.

Introduction

Health care today is complicated. Sometimes it is difficult to understand all the treatment options available in every case. Sometimes it is difficult to be certain exactly what is covered and what is not — even though EmblemHealth provides detailed information to assure full disclosure and to facilitate understanding.

For these reasons, EmblemHealth has developed a series of special information, support and review programs, which are described in this section of your handbook. We have described them in detail, because we want you to understand exactly how we work to help you receive the most appropriate care in the most appropriate settings, and understand exactly what benefits are available to you.

We believe these programs support sound medical choices and optimal health outcomes. In the final analysis, however, it is up to you and your physician to make the final decisions about which health care choices are best for you. EmblemHealth, however, reserves the right to determine if the medical services provided are necessary and/or covered under your Contract or Certificate of Coverage.

Care Management Program (CMP)

EmblemHealth's Care Management Program (CMP) gives you important resources to help with the medical care decisions you and your physician must make. The CMP consists of these key utilization review components:

- Pre-service Review Program
- Concurrent Care Review Program
- Case Management Program
- Retrospective Review Program
- Technology Evaluation Program

Utilization review will occur whenever we make decisions about medical necessity and the delivery of services or treatments.

As a managed care organization, EmblemHealth is dedicated to providing quality care and service to each of its members. The following policy statement is distributed to all EmblemHealth network physicians and members:

Utilization Management (UM) decisions made by EmblemHealth are based solely on the appropriate level of care and proper medical setting. EmblemHealth does not reward practitioners or other individuals conducting utilization review for issuing denials of coverage for service or care. In addition, financial incentives provided to UM decision-makers do not encourage decisions that result in underutilization.

Furthermore, all EmblemHealth employees who make utilization-related decisions (and those who supervise them) are required to sign a document acknowledging that they have received the statement. This includes Medical Directors, Care Management Directors and Managers, licensed UM staff and other people and organizations who make UM decisions on behalf of EmblemHealth.

Pre-Service Review program

EmblemHealth's Pre-service Review Program assists in making decisions about care or diagnostic services that members and their physicians anticipate they will need to receive in the near future. Therefore, EmblemHealth requires members (or their physicians on their behalf) to contact Pre-service Review to assure coverage of certain services.

Prior approval must be obtained from the EmblemHealth CMP for the services indicated below:

- Inpatient nonemergency procedures that provide acute, rehabilitation and skilled nursing care.
- All outpatient invasive surgical procedures and surgical treatments in a facility or doctor's office.
- Inpatient treatment of Mental Illness and Substance Use Disorder, Detoxification treatment of Substance Use Disorder, and Rehabilitation treatment of Substance Use Disorder.
- Non-routine outpatient treatment of Mental Illness and Substance Use Disorder, which includes:– partial hospitalization;
  – intensive outpatient treatment;
  – ambulatory detoxification treatment;
  – outpatient ECT (electro-convulsive treatment);
  – neuropsychological testing; and
  – psychological testing.
- Non emergent transportation.
- Home health care.
- Hospice care.
- Services obtained by Non-Participting providers with specialty expertise.
- Pre-transplant evaluation and transplant services.
- Outpatient cardiac and pulmonary rehabilitation.
- Outpatient Diagnostic Radiology Services.
- Outpatient Physical, Occupational and Speech Therapies.
- Radiation Oncology.
- Pain management.
- Sleep studies.
- Advanced molecular diagnostics and genetic testing.
- Hyperbaric Oxygen Therapy.
- Experimental and/or Investigational Treatment Procedures.

Contacting Pre-Service Review

Should you need to contact the Pre-service Review Department, just call **1-877-846-3625**. Representatives are available Monday through Friday from 9 am to 5 pm. If you call after those hours, and your call concerns an urgent or emergency admission, you will be prompted to leave a message, and a representative from Pre-service Review will call you or your doctor back, if necessary. If the Pre-service Review Department receives sufficient information, your case will be routed to the appropriate Concurrent Reviewer. If your call concerns an elective admission, you will be advised to call back the next business day when representatives are available. Please refer to your EmblemHealth member ID card for the number to call.

The Pre-service Review Department may determine that coverage cannot be provided for a service for a number of reasons. In these instances, a determination may result in no approval being given and, instead, lead to the issuance of a denial or adverse determination. (See *Care Management: Adverse Determinations*.) Prior to an adverse determination being issued, a physician from CMP will attempt to resolve any outstanding issues with your physician.

Our Commitment To You For Timely Pre-Service Review Program Determinations And Notifications

Determinations for non-urgent claims — If we have all the information necessary to make a determination regarding a pre-service review, we will make a determination and provide notice to You (or Your designee) and Your provider, by telephone and in writing, within three business days of receipt of the request. If we need additional information, we will request it within three business days. You or Your provider will then have forty-five (45) calendar days to submit the information. We will make a determination and provide notice to you (or your designee) and your provider, by telephone and in writing, within the earlier of three business days of our receipt of the information or, if we do not receive the information, within fifteen (15) calendar days of the end of the forty-five (45) day time period.

Determinations for urgent claims — If we have all information necessary to make a determination, we will make a determination and provide notice to you (or your designee) and your provider, by telephone and in writing, within twenty-four (24) hours of receipt of the request. If we need additional information, we will request it within twenty-four (24) hours. You or your provider will then have forty-eight (48) hours to submit the information. We will make a determination and provide notice to you and your provider by telephone and in writing within forty-eight (48) hours of the earlier of our receipt of the information or the end of the forty-eight (48)-hour time period.

If we have approved a course of treatment, we will not reduce or terminate the approved services unless we have given You enough prior notice of the reduction or termination so that You can complete the appeal process before the services are reduced or terminated.

Concurrent Care Review Program

The Concurrent Care Review Program (CCP) facilitates the coordination and conti-nuity of services rendered to a member when in a hospital or other facility. You are automatically entered into the program at the time you are admitted to the hospital.

CCP support begins within 24 hours of your admission to the facility. It's important for the program to start early in the facility, since typically as much as 80 percent of all hospital services are provided within the first 48 hours. When your admission is arranged through the Pre-service Review Program, the team knows in advance that you are being admitted to a facility. When your admission is an emergency, the hospital will usually contact the CCP within 24 hours for you.

Our Commitment To You For Timely Concurrent Review Program Determinations And Notifications

Utilization Review decisions for services during the course of care (concurrent reviews) will be made, and notice provided to you (or your designee) and your provider, by telephone and in writing, within one business day of receipt of all information necessary to make a decision. If we need additional information, we will request it within one business day. You or your provider will then have forty-five (45) calendar days to submit the information. We will make a determination and provide notice to you (or your designee) and your provider, by telephone and in writing, within the earlier of one business day of our receipt of the information or, if we do not receive the information, within fifteen (15) calendar days of the end of the forty-five (45) day time period.

If we receive a request for coverage of home health care services following an inpatient hospital admission, we will notify you or your designee and Your provider of our decision by telephone and in writing within one business day of receipt of all necessary information; or, when the day subsequent to the request falls on a weekend or holiday, within 72 hours of receipt of all necessary information unless it is an urgent claim for which the urgent claim time frames are applicable.

When we receive a request for home health care services and all necessary information prior to your discharge from an inpatient hospital admission, we will not deny coverage for home health care services, either on the basis of medical necessity or for failure to obtain prior authorization, while our decision on the request is pending.

For concurrent reviews that involve urgent matters, we will make a determination and provide notice to You (or Your designee) and Your provider within twenty-four (24) hours of receipt of the request if the request for additional benefits is made at least twenty-four (24) hours prior to the end of the period to which benefits have been approved. Requests that are not made within this time period will be determined within the timeframes specified above for pre-service urgent claims.

If we have approved a course of treatment, we will not reduce or terminate the approved services unless we have given You enough prior notice of the reduction or termination so that You can complete the appeal process before the services are reduced or terminated.

Initial approvals for acute inpatient care, acute rehabilitation or skilled nursing admissions may be extended concurrently by having the utilization management team and/or your physician contact the CCP for medically necessary additional care.

Experimental/Investigational Treatment

EmblemHealth will not provide coverage for any procedure or service, which in EmblemHealth's sole judgment is experimental, investigational or for rare diseases, unless required by an external appeals agent. You may request utilization review for experimental or investigational health care services or rare disease treatment. The procedure for filing an external appeal is described in the section of this handbook entitled *If You Disagree With A Decision*.

Case Management Program

This component consists of nurses, behavioral health specialists, social workers, pharmacists and physicians who identify and assist members who have complex needs, serious diseases or chronic conditions and would benefit from clinical support and management. Members are regularly screened for possible candidates and may be referred directly for management.

Members may be in the program from weeks, to months, to years, and Case Management Program contact may be daily, weekly or monthly — it all depends on the individual condition and the circumstances. All contacts and services have one main purpose: the most optimal health care outcome for you.

Retrospective Review Program

This component is the process that provides determinations and electronic or written notification involving retrospective reviews where services have already been delivered and a claim has been submitted.

The Retrospective Review Program reviews medical and hospital records after services have been provided to determine if such services were medically necessary and appropriate. For example, a retrospective review may be triggered by a history of unusually high number of tests ordered by the physician for the service provided.

Reviews may result in a retrospective denial if, for example, the services you received:

- Were not approved prior to your receiving them.
- Were not a medical emergency as defined in Emergency And Out-Of-Area Care.
- Were not medically necessary (see definition of medical necessity under *Care Management: Adverse Determinations*) or are otherwise excluded from coverage as provided in your Contract or Certificate of Coverage.

Please remember: EmblemHealth is obligated to administer coverage to ensure that all contract provisions are honored. That means providing all benefits to which members are entitled. It also means not providing benefits that are excluded from coverage. For example, EmblemHealth members are generally not entitled to benefits for experimental or investigational procedures. Please refer to your Contract or Certificate of Coverage for more details.

Retrospective Review Program

If we have all information necessary to make a determination regarding a retrospective claim, we will make a determination and provide notice to You (or Your designee) and Your provider within thirty (30) calendar days of receipt of the claim. If we need additional information, we will request it within thirty (30) calendar days. You or Your provider will then have forty-five (45) calendar days to submit the information. We will make a determination and provide notice to You and Your provider within fifteen (15) calendar days of the earlier of our receipt of the information or the end of the forty-five (45) day time period.

If We fail to make a decision within the above-noted timeframes, then the denial of the health care service and/or treatment is considered deemed to be an Adverse Determination subject to Your Appeal rights.

Technology Evaluation Program

This component consists of the continual clinical identification of new technology and updates information on non-covered experimental and investigational procedures.

Benefits are not available for services, supplies, procedures and items considered to be investigational or experimental. A drug, device, procedure or treatment may be determined to be investigational or experimental if any of the following applies:

- There are insufficient outcomes data available from controlled clinical trials published in the peer-reviewed literature to substantiate its safety and effectiveness for the disease or injury involved.
- The FDA has not granted the required approval for general use.

- A recognized national medical or dental society, or regulatory agency, has determined, in writing, that it is experimental, investigational or for research purposes.
- The written protocols or informed consent used by the treating facility, or the protocols or informed consent of any other facility studying substantially the same drug, device, procedure or treatment, state it is experimental, investigational or for research purposes.

Also, your coverage does not include any technology or any hospitalization in connection with such technology if, in EmblemHealth's judgment, such technology is obsolete or ineffective for the diagnosis or treatment of the particular condition. Governmental approval of a technology is not necessarily sufficient to render it of proven benefit, or appropriate or effective for a diagnosis or treatment of a particular condition.

EmblemHealth provides you with the opportunity to further pursue your request for coverage of a specific treatment if we have initially denied your benefits. Please refer to *If You Disagree With A Decision* for more information.

EmblemHealth's Medical Policy Subcommittee meets a minimum of 10 times a year to decide when certain technologies previously considered experimental have come to satisfy the general medical standards in effect in our service area at the time of their evaluation.

Also, in making a coverage determination in an individual patient case, EmblemHealth's professional staff will consult with physicians involved in the care of a member.

Delegated Management Arrangements

EmblemHealth providers often prefer that prior approval, case management, care management and utilization review decisions be made by provider-affiliated organizations and/or reviewers who are independent of EmblemHealth. To that end, EmblemHealth has entered into several delegated arrangements with organizations and reviewers who are independent of EmblemHealth. Depending upon the PCP you select or have been assigned to, decisions regarding your care may be delegated by EmblemHealth to one of these fully licensed, qualified organizations or reviewers.

Please note that the standards applied by these organizations and reviewers are the same standards applied by EmblemHealth. Also note that you have the right to appeal any decisions made by a delegated agent directly to that delegated entity. Please refer to *If You Disagree With A Decision* for additional information. Please refer to your EmblemHealth ID card for the numbers to call for your PCP and to discuss your medical care. For EmblemHealth membership information, continue to telephone Customer Service and check our Web site at **www.emblemhealth.com**.

Adverse Determinations

In some instances, it may be determined through the Care Management Program that a particular service is not, or in the case of a post-service review, was not medically necessary. All determinations are conducted by qualified personnel, including clinical peer reviews.

For additional information concerning adverse determinations, please refer to *If You Disagree With A Decision*.

What Does Medically Necessary Mean?

Medically necessary health care services or supplies are those that are required to prevent, diagnose, correct or cure conditions in the member that cause acute suffering, endanger life, result in illness or infirmity, interfere substantially with the member's capacity for normal activity or threaten some significant disability. Services or supplies that are not provided in the most appropriate setting or level of care are not medically necessary.

All determinations are conducted by qualified personnel as follows:

- Licensed health care professionals who are trained in the principles and procedures of intake screening and data collection. Administrative personnel are used only to perform intake screening, data collection and nonclinical review functions. They are supervised by licensed health care professionals.
- A health care professional who is appropriately trained in the principles, procedures and standards of utilization management.
- A clinical peer reviewer when the review involves an adverse determination.

A clinical peer reviewer is a physician who possesses a current and valid nonrestricted license to practice medicine. A clinical peer reviewer may also be a health care professional other than a licensed physician who, where applicable, possesses a current and valid nonrestricted license, certification or registration.

Where no provision for a license, certification or registration exists, a clinical peer reviewer for a health care professional other than a physician must be credentialed by the national accrediting body appropriate to the profession, and in the same profession/specialty as the health care provider who typically manages the medical condition.

In some instances, an adverse determination is made without providing an opportunity for a discussion with the health care provider who specifically recommended the health care service, procedure or treatment under review. In such a case, the health care provider will have the opportunity to request a provider reconsideration.

Points to remember about a provider reconsideration include:

- Except in cases of retrospective review, such reconsideration will occur within one business day of notice of adverse determination.
- The reconsideration will be conducted by your health care provider and the original clinical peer reviewer who made the initial determination, or a designated clinical peer reviewer if the original clinical peer reviewer is not available.

Notice of Review Determination. Upon completion of our review, you, your designee and, under certain circumstances, your Physician, will receive both a verbal and written notice of the determination that has been made. The written notice will include the clinical rationale, if any, for the determination, instructions on how to initiate an Appeal and notice of the availability, upon request, of the clinical review criteria relied upon to make the determination. You or your designee have the right to an appeal of a utilization review decision by requesting an expedited, standard or external appeal processes.

Submission Of Grievances

You or your representative may submit a grievance at any time directly to EmblemHealth. To submit a grievance by phone, you may call **1-800-447-8255**. A grievance is either a complaint or a request for a Benefit Determination. If you are dissatisfied with our response to a grievance, you may appeal the response by following the appeal process for a Benefit Determination.

STAYING HEALTHY

At EmblemHealth we want you to take advantage of the covered services and benefits available to you through your plan. Based on the age and gender of you and your covered dependents, you may receive reminders to get important preventive health screenings and tests. These reminders may include information about immunizations, preventive cancer screenings and well visits. To view the recommended preventive care guidelines, visit **www.cdc.gov**.

Preventive Care

- Take advantage of the preventive health services available to you that can help reduce your risk for certain diseases and conditions.
- Be sure that your child(ren) receive(s) all necessary screenings, tests and immunizations.
- If you are a woman and believe that you are pregnant, schedule an appointment with your OB/GYN. Your OB/GYN can order the blood test necessary to confirm your pregnancy.
- If you are a smoker, consider joining the Quit Smoking Program. This self-help program provides members who want to stop smoking with a comprehensive education kit, support and pharmacotherapy to help you quit. To register, call **1-866-611-QUIT** (1-866-611-7848).
- Visit **http://www.cdc.gov/** to view other recommended preventive care guidelines.

Adult Care

Your coverage offers many preventive health services to help you reduce your risk for certain diseases and conditions. For instance, routine immunizations and screening tests are available to members. Immunizations and tests, such as a hepatitis vaccine or a diabetes test, are a simple and effective way to prevent disease. our services can also help you manage ongoing health conditions.

If you have a personal or family history for a particular disease or condition, or if you have specific questions about your health, you should sit down with your physician and review your particular needs.

Childhood And Adolescent Care

Parents will want to assure that their children receive all necessary screenings, tests and immunizations.

- Immunizations protect children from various diseases. Immunizations are key to preventive health care.
- Routine physical exams (also called well-child visits) are vital to keeping children healthy. Each visit includes many tests and exams.
- Call your child's pediatrician to schedule an appointment.
- Visit **www.cdc.gov** to view other preventive guidelines.

Prenatal Care

Prenatal care is the care an expectant mother receives during pregnancy. Good health care during pregnancy increases the chances of having a healthy baby. Therefore, women who believe they are pregnant should schedule an appointment with their OB/GYN. The OB/GYN will order a blood test to confirm pregnancy and check the woman's overall health.

Tips For Expectant Mothers

By receiving medical care early and taking certain precautions, you can make a difference in the health and life of your baby . . .

- Schedule an appointment with your OB/GYN before the 12th week of pregnancy.
- During that visit with the OB/GYN, be ready to provide the doctor with information on your family history and current lifestyle.
- Speak with the doctor about any prescribed or over-the-counter medications, as many can cause harm to a developing baby.
- Avoid smoking, drugs and alcohol, as they also harm the developing baby.
- Eat a balanced diet to be sure that you are nutritionally fit to support both yourself and your baby.

Join the free Healthy Beginnings PATH program and receive a health risk assessment, a book on pregnancy, other educational information and access to a 24-hour-a-day nurse answer line. Just call **1-877-736-2229**.

Also, after delivery of the baby . . .

- You should make an appointment to see your OB/GYN between 21 and 56 days after childbirth.
- Schedule an appointment for the baby to be seen by his or her pediatrician between two (2) and four (4) weeks of age. Please note that this pediatric visit will not be covered by your plan unless the child has been added to your plan within 30 days of the child's birth.

It is common for new mothers to feel overwhelmed by the emotional stresses and inadequate rest that accompany caring for a newborn. If feelings of sadness or hopelessness persist, it's important to speak to your doctor or mental health practitioner. Postpartum depression is an illness that can be treated by your health care team. Look forward to receiving a Welcome Home Kit after your baby's birth, which includes a self-screening postpartum test.

Learn more about this subject at **www.emblemhealth.com**.

Quit Smoking Program

The Quit Smoking Program is a self-help program that provides members who want to stop smoking with a comprehensive educational kit, support calls from a smoking cessation specialist, nicotine replacement therapy and pharmacotherapy to help you quit.

By joining this program, members are fully covered for the nicotine replacement (gum, lozenge or patch), Bupropian (generic Zyban®) or Chantix® for a total of 24 weeks of treatment, as long as you continue participating in the program.

To enroll or learn more about this free program, call **1-866-611-QUIT** (1-866-611-7848).

Special Benefits Available To You!

Depending on your coverage, you may be eligible to join any health club and receive an annual reimbursement of of up to $200. Just complete the Health Club Reimbursement form on the following page and submit the completed form along with a copy of your membership contract from the facility and proof of payment (e.g., canceled checks, receipts) to EmblemHealth.

EmblemHealth®

HEALTH CLUB REIMBURSEMENT FORM

Please complete all of the information requested below. Remember to attach a copy of your membership contract from the facility as well as your current health club facility bill showing the cost of your membership* and proof of payment (receipts, cancelled checks). Submit this form and other material to the address below:

EmblemHealth
JAF Station PO Box 2884
New York, NY 10116

MEMBER INFORMATION:

Last name	First name	Middle initial
HIPID #	Member date of birth (mm/dd/yy)	

Name and address of health club facility where you are an active member:

Name of health club		
Street address		
City	State	ZIP
Date of membership: From (mm/dd/yy) _____ To (mm/dd/yy) _____		
Total annual membership fee:	Total amount paid by member:	Date of final payment:

*Annual membership fees excludeinitiation fees paid to facility. Reimbursement by EmblemHealth will be made once the entire annual membership is paid in full. No proof of installment payments should be submitted to EmblemHealth unless the total amount of all installments paid is equal to the annual membership cost. EmblemHealth will not reimburse members on an installment basis. Annual membership is defined as a 12 consecutive month period with no interruptions. Reimbursement may need to be prorated based on the portion of the year members are enrolled in a health benefits plan with this covered benefit.

FOR INTERNAL USE ONLY:

Cptcode: GYM12	POS: 99 Provider	Lic: MEMREIMNY 001	Prov TIN: MEMREIMNY 000IC	ICD9: V690

DIAGNOSTIC SERVICES

Visiting Your In-Network Physician

If you have chosen to receive your primary care from an in-network physician, they may provide some diagnostic testing in their own office. For other services, your physician will usually refer you to another in-network physician. In rare instances where the service is not available from within the network, your physician will seek prior approval from EmblemHealth for a referral to an out-of-network physician.

Note: If you are in the PPO plan and receive diagnostic services provided or arranged by an out-of-network physician (without prior approval from EmblemHealth), you will only be eligible for out-of-network benefits.

Before You Obtain Diagnostic Services

Before obtaining diagnostic services, make sure you ask your physician the following questions:

- Where and when will the services be provided? Find out the exact time and location of your blood test or X-ray services to avoid any last-minute stress. If you have to go farther than "just down the hall," ask for directions, too.
- Are there special instructions? You may have to do something (such as drink a special liquid) or not do something (such as eat) in preparation for your X-ray, mammogram or lab services. If you follow the special instructions, you will avoid having the services postponed or repeated.
- How and when can I get my results? If you are anxious about the results, ask how and when you may get them. Your physician or the service provider should be able to tell you about how long it will take for the results to come back and how you can find out what they are.
- Do you know how to reach me? We do our best to keep our records up to date. But if you have changed your name, address or phone number recently without telling us, make sure you update your physician. Also, please advise EmblemHealth of the change by using **www.emblemhealth.com** or calling us at **1-800-447-8255**.

Please refer to the Schedule of Benefits included in your Contract or Certificate of Coverage for any copayment, deductible or coinsurance required for diagnostic services.

EMERGENCY AND OUT-OF-AREA CARE

What Constitutes An Emergency

A medical or behavioral condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

(1) Placing the health of the person afflicted with such condition (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, or, in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;
(2) Serious impairment to such person's bodily functions;
(3) Serious dysfunction of any bodily organ or part of such person; or
(4) Serious disfigurement of such person.

Coverage For Emergency Care

If you need care for an emergency condition, you do not need to get EmblemHealth's prior approval.

No claim for such emergency care will be denied because EmblemHealth's prior approval was not obtained. Also, emergency services will be covered if an authorized person, acting on behalf of EmblemHealth, has approved the service. However, all claims for coverage of emergency services are subject to EmblemHealth's retrospective review to determine if the services were medically necessary. (See *Care Management Program: Adverse Determinations.*)

Getting Help In An Emergency

In an emergency, as defined above, go to the nearest emergency room or call 911 to get immediate help.

When you get care, you or someone on your behalf must contact us at **1-877-846-3625** if you are admitted to a hospital in an emergency. This is to ensure that EmblemHealth is made aware of the admission.

Remember

- Use the Emergency Room only if you have a true emergency.
- If you have any questions, call the phone number on your EmblemHealth ID card.

Getting Non-Emergency, But Urgently Needed Care

In case of non-emergency but urgent injury or illness, contact an in-network physician (PPO members may also use out-of-network physicians). Your in-network physician can arrange for the care you need.

Care While Traveling In Other Areas Of The Country

Emergency Care

Emergency care is covered anywhere and does not require making any special arrangements in advance. (See *Emergency And Out-Of-Area Care: What Constitutes An Emergency*.)

Important Emergency And Urgent Care Tips

- Put your physician's telephone number near your telephone.
- If your call is not answered by either an operator or a recording, your call did not go through. Hang up and dial the number again.
- If you are told to expect a call back, keep your telephone line free for the call. If you are calling from a pay telephone, let the person answering your call know. If you need to, you can speak to someone right away.
- Have your EmblemHealth member ID number ready.
- Be ready to answer questions like:
  - What's wrong? What are your symptoms?
  - Do you have a fever? What's your temperature? (If you can, take your temperature before you call.)
  - Are you taking any medication? (Know the names of your medications, including any over-the-counter drugs, such as aspirin, Tylenol, cough or cold medicines.)
- Have the name and telephone number of your pharmacy in case you need a prescription.
- If your physician refers you somewhere for treatment, take your EmblemHealth ID card with you. Also take your EmblemHealth ID card in case you need to fill a prescription.
- Call your physician back if you get worse or if you have questions.

IF YOU DISAGREE WITH A DECISION

Introduction

Appeals

This section describes the appeals processes available to you if you disagree with a Benefit Determination or Clinical Determination. It begins with some important definitions you will want to refer to as you read on.

If you have questions about how or whether you should appeal our determination, start by calling **1-800-447-8255**, seven days a week (excluding major holidays), from 8 am to 8 pm.

Definitions

Adverse Determination — A determination by a utilization review agent that an admission extension of stay, or other health care service, upon review has been denied, reduced, terminated, or a failure to provide or make payment in whole or in part for a benefit based on a determination that a benefit is experimental, investigational or not medically necessary and appropriate.

Appeal — A request that You, Your designee, and under certain circumstances Your Physician makes for Us to reverse a Benefit Determination or a Clinical Determination.

Benefit Determination — A decision we make about benefits, eligibility and claims payments, as well as issues of dissatisfaction with services received under your coverage, including denials or referrals. A Benefit Determination does not include decisions as to whether a service is medically necessary and appropriate, or experimental and/or investigational.

Clinical Determination — A determination of whether a service is medically necessary and appropriate, experimental or investigational in nature.

Complaint — Any issue of dissatisfaction with Our operations other than a Benefit Determination.

External Appeal — You may also request that an independent New York State licensed External Review Agent review our internal clinical appeal decision. Please see External Appeals for additional information.

Grievance — A request for Us to reverse a previous plan determination other than an Adverse Determination (see definition of Appeal above).

Out of Network Denials — A denial of a request for prior approval of an out-of-network health service on the basis that the service is not materially different than the health service available in-network.

Rare Disease — A life threatening or disabling condition or disease that (1)(a) is currently or has been subject to a research study by the National Institutes of Health Rare Disease Clinical Research Network; or (b) affects fewer than two hundred thousand (200,000) United States residents annually; and (2), for which there does not exist a standard health service or procedure covered by the health care plan that is more clinically beneficial than the requested health service or treatment. A Physician, other than Your attending Physician shall certify in writing that the condition is a Rare Disease.

Internal Appeals

You (or Your designee) have up to one-hundred eighty (180) calendar days after You receive notice of the adverse determination to file an appeal.

We will decide internal appeals related to pre-service reviews within fifteen (15) calendar days of receipt of the appeal request. Written notice of the determination will be provided to You or Your designee (and, where appropriate, Your health care provider) within two business days after the determination is made, but no later than fifteen (15) calendar days after receipt of the appeal request.

We will decide internal appeals related to retrospective reviews within thirty (30) calendar days of receipt of the appeal request. Written notice of the determination will be provided to You or Your designee (and, where appropriate, Your health care provider) within two business days after the determination is made, but no later than thirty (30) calendar days after receipt of the appeal request.

Reviews of continued or extended health care services, additional services rendered in the course of continued treatment, services in which a provider requests an immediate review, home health care services following an inpatient hospital admission, or any other urgent matter, will be handled on an expedited basis. Expedited appeals are not available for retrospective reviews.

In the case of out-of network treatment, Your attending Physician, who must be a licensed, board certified or board eligible Physician, must submit a written statement that the requested out-of-network health service is materially different from the health service that We approve to treat Your health care needs; and two (2) documents from the available medical and scientific evidence, that the out-of-network health service is likely to be more clinically beneficial to You than the alternative recommended in-network health service, and for which the adverse risk of the requested health service would likely not be substantially increased over the in-network health service.

For Expedited Appeals, Your provider will have reasonable access to the clinical peer reviewer assigned to the Appeal within twenty-four (24) hours of receipt of the request for an appeal. Your provider and a clinical peer reviewer may exchange information by telephone or fax. Expedited Appeals will be determined within the lesser of seventy-two (72) hours of receipt of the Appeal request or forty-eight (48) hours of receipt of the necessary information. Written notice will follow within twenty-four (24) hours of the determination but no later than seventy-two (72) hours of receipt of the appeal request.

To file a standard or expedited Appeal, please contact EmblemHealth:

By phone: **1-800-447-8255**.

Customer Service Advocates are available to assist you seven days a week (excluding major holidays), from 8 am to 8 pm.

In writing:
EmblemHealth
Grievance and Appeals Department
JAF Station
P.O. Box 2844
New York, NY 10116-2844

In person:
EmblemHealth
55 Water Street, Lobby
New York, NY 10041-8190
Hours of operation 8:30 am – 5:00 pm

If You are not satisfied with the resolution of Your expedited appeal, You may file an internal appeal or an external appeal.

Our failure to render a determination of your internal appeal within sixty (60) calendar days of receipt of the necessary information for a standard appeal or two business days of receipt of the necessary information for an Expedited Appeal shall be deemed a reversal of the initial adverse determination.

Your Right to an Immediate External Appeal. If we fail to adhere to the Grievance requirements described below, You will be deemed to have exhausted the internal claims and Appeals process and may initiate an external appeal.

Grievances

You have the right to file a Complaint or a Grievance in regard to any dispute You may have with Us provided that such dispute does not involve a denial of coverage or services on the basis that such service is not Medically Necessary and Appropriate, or is an experimental or investigational treatment. You have up to one-hundred eighty (180) days to file a first level Grievance.

1. **Acknowledgement of Your Complaint or first-level Grievance.** We will send You a written acknowledgement within five (5) business days but no later than fifteen (15) calendar days of Our receipt of Your Complaint or grievance. This letter will include a notice specifying what information must be provided to Us in order for Us to make a decision on Your Complaint or grievance.

2. **Review of Your Complaint or first-level Grievance.** Any Complaint or Grievance concerning a medical issue will be reviewed and decided by personnel qualified including licensed, certified or registered health care professionals. Once We have received all the information necessary to review Your Complaint or grievance, Our review must be completed and a decision must be made within the following time limit:

   - Within forty eight (48) hours of Our receipt of all necessary information when a delay would significantly increase the risk to Your health or within seventy two (72) hours of Our receipt of Your grievance.

- Within fifteen (15) calendar days of Our receipt of all necessary information in the case of pre-service grievances.
- Within thirty (30) calendar days of Our receipt of all necessary information in the case of post-service grievances.
- Within forty-five (45) calendar days of Our receipt of all necessary information in the case of all other grievances.

3. **Decision on Your Complaint or first-level grievance.** You or Your designee will receive a written decision regarding Your Complaint or grievance. Complaint decisions that do not include a plan determination that You disagree with are final and may not be pursued any further through Our internal review processes. Complaints that deal with allegations concerning quality of care are referred to Our quality risk management department and are subject to peer review and quality improvement initiatives. Grievance decisions will include a description, when appropriate, of how You may request to grieve the determination further, including the form to file a second-level grievance.

If You disagree with the outcome of the first-level review of a grievance, We provide the following second-level Grievance process. You or Your designee may file a second-level Grievance by contacting a Customer Service representative seven days a week (excluding major holidays), from 8 am to 8 pm, at **1-800-447-8255**. You have at least sixty (60) business days from receipt of Our written first-level Grievance decision to file a second level grievance.

1. **Acknowledgement of Your Complaint or second-level grievance.** We will send You a written acknowledgement within five (5) business days but no later than fifteen (15) calendar days of Our receipt of Your Complaint or grievance. This letter will include a notice specifying what information must be provided to Us in order for Us to make a decision on Your Complaint or second-level grievance.

2. **Review of Your Complaint or second-level grievance.** Second level grievances of an Appeal on a clinical matter must be made by personnel qualified to review the Appeal, including licensed, certified or registered health professionals who did not make the initial determination, at least one of whom must be a clinical peer reviewer. The determination of an Appeal on a matter which is not clinical shall be made by qualified personnel at a higher level than those who made the initial determination.

3. **Decision on Your Complaint or second-level grievance.** Any Complaint or second level Grievance concerning a medical issue will be reviewed and decided by personnel qualified including licensed, certified or registered health care professionals. Once We have received all the information necessary to review Your Complaint or second level grievance, Our review must be completed and a decision must be made within the following time limit:

   - Within forty eight (48) hours of Our receipt of all necessary information when a delay would significantly increase the risk to Your health or within seventy two (72) hours of Our receipt of Your grievance.
   - Within fifteen (15) calendar days of Our receipt of all necessary information in the case of pre-service grievances.
   - Within thirty (30) calendar days of Our receipt of all necessary information in the case of post-service grievances.
   - Within forty-five (45) calendar days of Our receipt of all necessary information in the case of all other grievances.

You also have the right to contact the New York State Department of Health at any time. If necessary, please contact:

New York State Department of Health
Division of Managed Care
Bureau of Managed Care Certification & Surveillance
Empire State Plaza
Corning Tower, Room 1911
Albany, New York 12237-0062
Complaint Hotline: 1-800-206-8125

Choice of Law. Your Certificate of Coverage has been issued in the State of New York. In any dispute with Us, the law of the State of New York or federal law, as appropriate, shall be applied to determine the rights of all parties hereunder.

External Appeal

Under certain circumstances, You have a right to an external appeal of a denial of coverage. Specifically, if We have denied coverage on the basis that the service is not Medically Necessary and Appropriate, or is an experimental or investigational treatment (including clinical trials and treatments for rare diseases), or You have been denied coverage for a requested pre-authorization of an out-of-network treatment, You or Your representative may appeal that decision to an external appeal agent, an independent entity certified by the State to conduct such appeals.

Your Right To Appeal A Determination That A Service Is Not Medically Necessary And Appropriate

If We have denied coverage on the basis that the service is not Medically Necessary and Appropriate, You may appeal to an external appeal agent if You satisfy the following two (2) criteria:

- The service, procedure, or treatment must otherwise be a Covered Service under the Subscriber Contract; and
- You must have received a final adverse determination through the first level of Our internal appeal process and We must have upheld the denial or both We and You have jointly agreed to waive any internal appeal.

Your Right To Appeal A Determination That A Service Is Experimental Or Investigational

If We have denied coverage on the basis that the service is an experimental or investigational treatment, You must satisfy the following two (2) criteria:

- The service must otherwise be a Covered Service under this Subscriber Contract; and
- You must have received a final adverse determination through the first level of Our internal appeal process and We must have upheld the denial or both We and You have jointly agreed to waive any internal appeal.

Your attending Physician, or the certifying Physician in the case of a Rare Disease, must certify that You have a life threatening or disabling condition or disease. A "life-threatening condition or disease" is one

which, according to the current diagnosis of Your attending physician, has a high probability of death. A "disabling condition or disease" is any medically determinable physical or mental impairment that can be expected to result in death, or that has lasted or can be expected to last for a continuous period of not less than twelve (12) months, which renders You unable to engage in any substantial gainful activities. In the case of a child under the age of eighteen, a "disabling condition or disease" is any medically determinable physical or mental impairment of comparable severity.

Your attending Physician, or the certifying Physician in the case of a Rare Disease, must also certify that Your life threatening or disabling condition or disease is one for which standard health services are ineffective or medically inappropriate or one for which there does not exist a more beneficial standard service or procedure covered by Us or one for which there exists a clinical trial, or Rare Disease treatment (as defined by law).

In addition, Your attending Physician must be a licensed, board certified or board eligible Physician qualified to practice in the area appropriate to treat Your life-threatening or disabling condition or disease, and must have recommended one of the following:

- A health service or procedure (including a pharmaceutical product) that, based on two documents from the available medical and scientific evidence, is likely to be more beneficial to You than any covered standard health service or procedure (only certain documents will be considered in support of this recommendation – Your attending Physician should contact the State in order to obtain current information as to what documents will be considered or acceptable); or
- A clinical trial for which You are eligible, is likely to benefit You in the treatment of the condition or disease (only certain clinical trials can be considered).

Your Right To Appeal A Determination That A Service Is Out-Of-Network

If We have denied coverage of an out-of-network treatment because it is not materially different than the health service available in-network, You may appeal to an external appeal agent if You satisfy the following three (3) criteria:

- The service must otherwise be a Covered Service under this Subscriber Contract;
- You must have requested pre-authorization for the out-of-network treatment; and
- You must have received a final adverse determination through the first level of Our internal appeal process and We must have upheld the denial or both We and You have jointly agreed to waive any internal appeal.

In addition, Your attending Physician must certify that the out-of-network service is materially different from the alternate recommended in-network health service, and based on two (2) documents from available medical and scientific evidence, is likely to be more clinically beneficial than the alternate in-network treatment and that the adverse risk of the requested health service would likely not be substantially increased over the alternate in-network health service.

Your attending physician must be a licensed, board-certified or board eligible physician qualified to practice in the specialty area appropriate to treat You for the health service.

You do not have a right to an external appeal for a denial of a referral to an out-of-network provider on the basis that a health care provider is available in-network to provide the particular health service requested by You.

The External Appeal Process

If You have received a final Adverse Determination upholding an Adverse Determination of coverage on the basis that the health care service is not Medically Necessary and Appropriate, is an experimental or investigational treatment, or is an out-of-network treatment, You have four (4) months from receipt of such notice to file a written request for an external Appeal. If there is an agreement in writing to waive any internal Appeal, then You have four (4) months from receipt of such waiver to file a written request for an external Appeal. We will provide an external Appeal application with the final Adverse Determination issued through Our internal Appeal process or our written waiver of the internal Appeal process.

You may also request an external Appeal application from New York State by contacting:

New York State Department of Financial Services at **1-800-400-8882**, or its website at (**www.dfs.ny.gov**)

You must submit the completed application to State of New York Department of Financial Services at the address indicated on the application. If You can satisfy the criteria for an external Appeal, the state will forward the request to a certified external Appeal agent.

Additional Documentation. You will have an opportunity to submit additional documentation with Your request. The external Appeal agent must allow you at least five (5) business days to submit any additional information, and additional information you submit must be forwarded to us, within one (1) business day of the external Appeal agent's receipt of the additional information. If the external Appeal agent determines that the information you submit represents. If the external Appeal agent determines that the information You submit represents a material change from the information on which We based our denial, the external Appeal agent will share this information with us in order to exercise our right to reconsider our decision. If we choose to exercise this right, we will have three (3) business days to amend or confirm our decision. Please note that in the case of an expedited Appeal (described below), we do not have a right to reconsider its decision.

Decision Making. In general, the external Appeal agent must make a decision within forty-five (45) days of receipt of Your completed application. For this You will need to provide written consent for release of Your medical records. The external Appeal agent may also request additional information from You, the attending Physician or Us within the forty-five (45) day period. If the external Appeal agent requests additional information, it will have five (5) business days from receipt of the additional information to make its decision. The external Appeal agent must notify You in writing of its decision within two (2) business days.

Avoiding Delays. If your attending physician certifies that a delay in providing the health care service that has been denied poses an imminent or serious threat to your health, then you may request an expedited external Appeal. In that case, the external Appeal agent must make a decision as soon as reasonably possible but not later than seventy-two (72) hours of receipt of your completed application. If the external Appeal agent's decision is not in writing, the external Appeal agent must provide written confirmation of this decision within forty-eight (48) hours after the date of the notice of the decision.

Reviewing The Final Adverse Determination. If the external appeal agent overturns Our decision that a service is not Medically Necessary and Appropriate or approves coverage of an experimental or investigational treatment or an out-of-network treatment. We will provide coverage subject to the other terms and conditions of the health insurance contract. Please note that if the external Appeal agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, We will only cover the costs of services required to provide treatment to you according to the design of the trial. We shall not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be covered under your health insurance contract for non–experimental or non-investigational treatments provided in such clinical trial. The external Appeal agent's decision is binding on both you and Us. The external Appeal agent's decision is admissible in any court proceeding.

Your Responsibilities

Except for external Appeals pertaining to end of life care, it is Your RESPONSIBILITY to initiate the external Appeal process. You may initiate the external Appeal process by filing a completed application with the New York State Department of Financial Services. You may appoint a representative to assist You with Your external appeal request; however, the New York State Department of Financial Services may contact You and request that You confirm in writing that You have appointed such representative.

Under New York State law, Your completed request for Appeal must be filed within four (4) months of either the date upon which You receive written notification from Us that it has upheld an Adverse Determination of coverage or the date that You receive a written waiver of any internal Appeal. We are not authorized to grant an extension of this deadline.

Covered Services/Exclusions

In general, We do not cover experimental or investigational treatments. However, We shall cover an experimental or investigational treatment approved by an external appeal agent in accordance with this health care contract. If the external appeal agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, We will only cover the costs of services required to provide treatment to You according to the design of the trial. We shall not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be covered under this subscriber contract for non-experimental or non-investigational treatments provided in such clinical trial.

Hold Harmless

When the health care provider requests an external Appeal of a concurrent Adverse Determination, including when the Physician requests an external Appeal as Your designee, the health care provider shall not pursue any reimbursement from You for services the external Appeal agent determines not to be Medically Necessary and Appropriate, except to collect a copayment, coinsurance or deductible if required.

Time to Sue

No action at law or in equity shall be brought to recover on your Certificate of Coverage prior to the expiration of sixty (60) days after proof of loss has been submitted to Us. Any lawsuit under your Certificate of Coverage must commence within two (2) years from the date of the service in question. Any legal action must be commenced in the State of New York.

YOUR EMBLEMHEALTH MEMBERSHIP STATUS

Continuation Of Benefits

If you had EmblemHealth coverage through your employer, you may be eligible to continue that coverage after you leave your job. You may remain on the group's coverage for up to 18 months by paying the premiums yourself. This option is available if you are unemployed, self-employed or working in a job that doesn't offer medical coverage. This option is also available if you take a new job offering medical coverage that excludes pre-existing conditions.

In addition, your spouse or dependent children may be eligible for up to 36 months of continued benefits. For information about eligibility, check with your employer. **Your employer may be obligated under a federal law known as COBRA to provide this information and cover you if you elect to pay the appropriate premium.**

Continuation Of Coverage For Disabled Persons

If you are disabled (as defined by the Social Security Administration) when your employment terminates or you become disabled within 60 days of COBRA coverage, continuation will be extended from 18 months to 29 months. Premiums from the 19th to the 29th month will be 150% of the group rate.

To benefit from this extension, you must notify the employer of the Social Security Administration's determination of disability within 60 days of such determination and before the end of the 18-month period of continuation coverage. You must also notify the employer within 31 days of the date of any final determination by the Social Security Administration that you are no longer disabled.

Converting To A Direct Payment Contract

At the end of the 18, 29 or 36 months of continuation coverage, you must be allowed to enroll in an individual conversion health plan if such a plan is otherwise generally available under the Plan.

As an EmblemHealth member, you and your dependents are eligible for conversion to a direct payment EmblemHealth plan when your group contract or your benefits under COBRA expire. (The direct payment EmblemHealth plan available to you, however, may not be the same as your previous group contract or provide the same benefits you received under COBRA.) This option may have particular value for dependent children who marry, who reach the coverage age limit or who are no longer full-time students.

For direct payment coverage and premium information, contact EmblemHealth Customer Service at **1-800-447-8255**.

Cancelling Your Membership

We hope you will never decide to cancel your membership. But if you do wish to cancel for any reason at all, contact the health benefits administrator at your company or the union welfare fund.

- If you are a direct payment member, call us at **1-800-447-8255**; or
- Write to us at:

EmblemHealth
Enrollment Department
55 Water Street
New York, NY 10041-8190

Rest assured that EmblemHealth cannot cancel your membership for reasons of health, regardless of your medical situation. Only in the following situations can EmblemHealth cancel your membership:

- If you or your group fails to pay your premiums.
- If you move outside the service area used by HIP EPO-PPO.
- If you fail to follow recommended treatments or if your behavior is such that it disrupts the operation of your health care provider(s), despite their reasonable efforts to help you follow treatments or alter behavior.
- If you engage in fraud in applying for your Contract, in seeking any benefits under your Contract or if you misuse your EmblemHealth ID Card.
- If there is any other reason approved by the Superintendent of Insurance, including filing false or improper claims.

EMBLEMHEALTH AT YOUR SERVICE

Keeping Us Informed

Please let us know if you have any change affecting your coverage, including a name, address or phone number change, a change in marital status or the birth or death of a covered family member. You can notify us of the change by using **www.emblemhealth.com**, or contacting Customer Service.

Note: If you are a state or federal employee, you must contact your Benefits Administrator to make any change to your personal data.

Also, please be sure to give us your opinions and ideas. Write to the Senior Director of Customer Affairs at the Customer Service address provided in the next section, e-mail us by visiting **www.emblemhealth.com** or call us at **1-800-447-8255**. EmblemHealth actively seeks member input through such vehicles as our active, broadly representative Member Council and periodic regional member forums. But individual input like yours is especially important in helping us continue to meet our commitment to service excellence. Individual input also allows for our members to participate in the development of HIP policies.

Another way to express your views is to attend one of the annual Member Forums held at various locations. These meetings are a great way to share your experiences and ask questions of EmblemHealth management and Member Council representatives. The dates and locations of these forums will be included in the member newsletter you receive and will also be posted in advance at all Physician Group Practices.

Contacting Customer Service

You can access a great deal of Customer Service information and make a number of transactions and inquiries by visiting our Web site at **www.emblemhealth.com**. Our Web site allows you to access benefit descriptions, make claim inquiries, send e-mails to Customer Service, fill prescriptions online and view our drug formulary. In addition, logging on to **www.emblemhealth.com** gives you the opportunity to view EmblemHealth's annual report and read about some important health education information.

You can also find answers to your questions by calling **1-800-447-8255.** You can speak with a Customer Service Advocate seven days a week (excluding major holidays), from 8 am to 8 pm. At all times, you can verify information and make requests through the interactive voice response (IVR) system. You should be ready to enter your EmblemHealth ID number when asked, then just follow the easy instructions.

A helpful hint: Phone volume is heaviest on Mondays and between 11 am and 3 pm on other days. So, if you need to speak with a Customer Service Advocate, you may minimize delay by calling at other times.

You may also write us at:

EmblemHealth
Customer Service Department
55 Water Street
New York, NY 10041-8190

Or visit our walk-in unit in the 55 Water Street lobby, New York, NY, Monday through Friday, 8:30 am to 5 pm.

If You Need Help In A Language Other Than English

We have a long-standing commitment to full services for our ethnically diverse membership. Accordingly, you can receive assistance through:

- Our langauge translation service by calling **1-800-447-8255**.
- Bilingual and multilingual staff and providers working in private offices and medical group offices. When the needed language is not available at the office or medical group offices, you can use the translation service. This service can be connected to an examination room with a two-way speaker system.

If You Have A Hearing Or Speech Impairment

EmblemHealth maintains a special telephone message relay system that helps us communicate with hearing- or speech-impaired members. An operator using a special telephone device for those who are hearing- or speech-impaired (TDD) is available with benefits information seven days a week (excluding major holidays), from 8 am and 8 pm. After hours and on weekends, TDD communications are reserved for medical emergencies.

You can also arrange with EmblemHealth to have a sign language interpreter present when you have any regularly scheduled medical visit.

To communicate via TTY/TDD or arrange for a sign language interpreter, call **711**, seven days a week (excluding major holidays), from 8 am to 8 pm.

Confidentiality Of Medical Records And Identifiable Information

Medical records are documents with information about your medical treatment. EmblemHealth understands that it is important to protect the privacy of these records.

To ensure confidentiality, EmblemHealth has instituted strict policies. For example, we regularly instruct in-network facilities, health care professionals and their medical records departments on keeping medical records confidential. In addition, all EmblemHealth employees sign a confidentiality statement and adhere to Standards of Conduct that prohibit the unauthorized release of medical records. In some cases, group customers ask EmblemHealth for reports about our service performance or the use of medical care by members of their group. When we provide this information, we are careful to assure that it is aggregated. That is, the information provided is a summary of all group member medical care utilization — no individual is identified.

Identifiable information is data in the medical record that could allow the patient to be recognized. Examples include name, address, date of birth and Social Security number.

When members enroll, they give us their consent to use this kind of information only for certain specific reasons. These reasons, which appear on the enrollment form, include general treatment, payment/billing, coordination of care, quality assessment, utilization review, fraud detection or accreditation. Identifiable information cannot be used for any other purpose or shared with any other organization without your clear and specific consent**. The only exception is in the unusual case that such release is legally required.**

We have developed a **Special Consent Form** that we send to a member if we are seeking to release identifiable information in some way other than what was agreed to at the time of enrollment. The form specifies information, including: the purpose for which it will be used; the right to inspect or copy information; the option to revoke consent; a statement regarding disclosure of information made to an entity other than a health plan; and the time period the member authorizes for release. It requires the signature of the member or a qualified person on the member's behalf.

Here is a summary of your confidentiality rights.

As an EmblemHealth member, you have the right to:

- Review and copy your health information.
- Review which departments or agencies have access to your identifiable health information.
- Protection against unauthorized disclosure of identifiable health information.
- Refuse consent to release identifiable information.
- Protection against release of any identifiable health information for the collection, use or sharing of data.
- Expect that all the information used for research or performance measurement will be limited – that is, all data will be de-identified or aggregated before release.
- File a complaint or appeal if you feel that your health information was used without proper consent.

Other Information You May Request

In accordance with New York State law, all enrollees or prospective enrollees of an EmblemHealth Plan are entitled to receive the following information upon request:

- A list of the names, business addresses and official positions of the membership of the board of directors, officers, controlling persons, owners or partners of the organization.
- A copy of the most recent annual certified financial statement of the organization, including a balance sheet and summary, or receipts and disbursements, prepared by a certified public accountant.
- A copy of the most recent individual, direct pay subscriber contract.
- Information relating to consumer complaints compiled pursuant to Section 210 of the insurance law.
- EmblemHealth's Drug Formulary, as well as information about whether individual drugs are included or excluded from coverage.

- A written description of the organizational arrangements and ongoing procedures of the organization's quality assurance program.
- A description of the procedures followed by the organization in making decisions about the experimental or investigational nature of individual drugs, medical devices or treatments in clinical trials.
- Individual health practitioner affiliations with in-network hospitals, if any.
- Upon written request, specific written clinical review criteria relating to a particular condition or disease and, when appropriate, other clinical information that the organization might consider in its utilization review. The organization may include with the information a description of how it will be used in the utilization review.
- The written application procedures and minimum qualification requirements for health care professionals to be considered by the organization.
- Other information as required by the Commissioner of Health, provided that such requirements are put forth pursuant to the State Administrative Procedure Act.

To request any of these items, call us at: **1-800-447-8255**.

Or, you may write us at:

EmblemHealth
Customer Service Department
55 Water Street
New York, NY 10041-8190

MEMBER RIGHTS AND RESPONSIBILITIES

Your Rights As A Member

- Some of your rights are:
  - The right to understand your rights. If for any reason you do not understand these rights or how to interpret them, EmblemHealth and its network physicians will provide you with assistance.
  - The right to change physicians, in accordance with the provision of your policy.
  - The right to receive from your physicians information necessary to allow you to give informed consent prior to the start of any procedure or treatment.

Your Responsibilities As A Member

- Some of your responsibilities are:
  - The responsibility to provide EmblemHealth and its network physicians and other providers with accurate and relevant information about your medical history and health so that appropriate treatment and care can be rendered.
  - The responsibility to keep pre-scheduled appointments or to cancel appointments, giving as much notice as possible.
  - The responsibility to update your record with accurate personal data including changes in name, address, phone number, e-mail address, additional health insurance carriers and number of dependents within 30 days of the event causing the change(s).

Rights And Responsibilities

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

Your Rights

The right to understand your rights and receive information about EmblemHealth, its services, its practitioners and providers. If for any reason, you do not understand these rights or how to interpret them, EmblemHealth and its network physicians will provide you with assistance. Let's examine what the rest of your rights include:

- The right to treatment without discrimination, including discrimination based on race, color, religion, gender, national origin, disability, sexual orientation or source of payment.
- The right to participate with physicians in making decisions about your health care.
- The right to a non-smoking environment.
- The right to receive considerate and respectful care in a clean and safe environment.
- The right to receive, upon request, a list of the physicians and other health care providers in the provider network.
- The right to change your physician.
- The right to be assured that network health care providers have the qualifications stated in Emblem-Health Professional Standards, established by the EmblemHealth credentialing committee, which are available upon request.
- The right to know the names, positions and functions of any network provider's staff and to refuse their treatment, examination or observation.
- The right to obtain from your physician, during practice hours, comprehensive information about your diagnosis, treatment and prognosis, regardless of cost or benefit coverage, in language you can understand. When it is not medically advisable to give such information to you, or when the member is a minor or is incompetent, the information will be made available to a person who has been designated to act on that person's behalf.
- The right to receive from your physician the information necessary to allow you to give informed consent prior to the start of any procedure or treatment and to refuse to participate in, or be a patient for, medical research. In deciding whether to participate, you have the right to a full explanation.
- The right to refuse treatment, to the extent permitted by law, and to be informed of the medical consequences of refusing it.
- The right to have all lab reports, X-rays, specialists' reports and other medical records completed and placed in your chart, so they may be available to your physician at the time of consultation.
- The right to be informed about all medication given to you, as well as the reasons for prescribing the medication and its expected effects.
- The right to receive all information you need to give informed consent for an order not to resuscitate. You also have the right to designate an individual to give this consent if you are too ill to do so.
- The right to request a second opinion from a network physician.
- The right to privacy concerning your medical care. This means, among other things, that no person who is not directly involved in your care may be present without your permission during any portion of your discussion, consultation, examination or treatment.
- The right to expect that all communications, records and other information about your care or personal condition will be kept confidential, except if disclosure of that information is required or permitted by law or authorized by you.

- The right to request that copies of your complete medical records be forwarded to a physician or hospital of your choice at your expense. However, information may be withheld from you if, in the physician's judgment, release of the information could harm you or another person. Additionally, a parent or guardian may be denied access to medical records or information relating to a minor's pregnancy, abortion, birth control or sexually transmitted diseases if the minor's consent is not obtained.
- The right to have a person of your choice accompany you in any meeting or discussion with medical or administrative personnel.
- The right to consult by appointment, during business hours, with responsible administrative officials at EmblemHealth and your network physician's office to make specific recommendations for the improvement of the delivery of health services.
- The right to file an appeal or external review related to a determination about care and services rendered. For additional information on filing an appeal, see *If You Disagree With A Decision* in your Member Handbook, and/or call EmblemHealth's Customer Service Department at **1-800-447-8255**.
- **IMPORTANT:** State and federal laws give adults in New York State the right to accept or refuse medical treatment, including life-sustaining treatment, in the event of catastrophic illness or injury. Your membership kit includes a health care proxy form that you can use to express your wishes relating to health care if you become incapacitated. Please read this material, and Advance Directives information on the following page, carefully. To request replacement copies of the health care proxy form, please call **1-800-447-8255**.
- The right to receive information about the organization, its services, its practitioners and providers, and member rights and responsibilities.
- The right to make recommendations regarding EmblemHealth's member rights and responsibilities policies.

Advance Directives

Your membership kit contains materials on advance directives with written instructions, such as a living will or health care proxy containing your wishes relating to health care if you become incapacitated.

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. The Health Care Proxy form can also be used to document your wishes or instructions with regard to organ and/or tissue donation.

Some examples of medical treatments about which you may wish to give your agent special instructions are listed below:

- 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

Living Will

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. 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.

Your Responsibilities

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

- The responsibility to provide EmblemHealth and network physicians and other providers with accurate and relevant information about your medical history and health so that appropriate treatment and care can be rendered.
- The responsibility to keep scheduled appointments or cancel them, giving as much notice as possible in accordance with the provider's guidelines for cancellation notification.
- The responsibility to update your EmblemHealth record with accurate personal data, including changes in name, address, phone number, additional health insurance carriers and an increase or decrease in dependents within 30 days of the change.
- The responsibility to treat with consideration and courtesy all EmblemHealth personnel and the personnel of any hospital or health facility to which you are referred.
- The responsibility to be actively involved in your own health care by seeking and obtaining information, by discussing treatment options with your physician and by making informed decisions about your health care.
- The responsibility to follow plans and instructions for care that you have agreed to with your practitioner.
- The responsibility to understand your health problems and participate in developing mutually agreed upon treatment goals, to the degree possible.
- The responsibility to understand your plan's benefits, policies and procedures as outlined in your Contract or Certificate of Coverage and handbook, including policies related to prior approval for all services that require such approval.
- The responsibility to pay copayments, if applicable, at the time services are rendered.
- The responsibility to abide by the policies and procedures of your network physician's office.

HOW EMBLEMHEALTH COMPENSATES PARTICIPATING PROVIDERS

How We Compensate Participating Providers.

EmblemHealth provides access to care and coverage for services. We contract with providers or groups of providers to provide care to members. These "participating providers" are not EmblemHealth agents or employees.

EmblemHealth's provider compensation is not intended to limit or reduce the quality or scope of medical care you receive. Participating providers are compensated in a variety of ways.

For example:

- Medical groups are compensated by capitation or pre-payment arrangement.
- IPA (Independent Practice Association) physicians are compensated either through capitation or fee-for-service through the IPA, or through direct fee-for-service.
- Physicians contracting directly with EmblemHealth are compensated on a discounted fee-for-service basis.
- Facilities, such as hospitals, are compensated on a per diem (per day) or DRG (Diagnosis Related Groupings) basis.

You have a right to information about how EmblemHealth compensates participating health care providers. The most important point to understand is that EmblemHealth does not compensate health care providers in general or make specific payments intended to limit or reduce the quality or scope of medical care you receive.

The physicians and health care providers that treat you are not EmblemHealth agents or employees. They alone are responsible for the medical care they provide. EmblemHealth does not provide medical care. Nor is EmblemHealth responsible for any acts or omissions of any physician or other health care provider. Rather, our obligation to you is to provide access to and pay for covered services in accordance with the terms of your Contract or Certificate of Coverage. You and your doctor are responsible for decisions about your medical care.

If you have questions about payment arrangements, we encourage you to discuss them with your primary care physician as well as with other participating providers, such as hospitals and other inpatient facilities. To assist you in these discussions, we have provided some important definitions below. These are terms commonly used by health care providers and health plans such as EmblemHealth when discussing compensation.

Following the definitions, we have provided some general descriptions of the various methods EmblemHealth uses to compensate participating health care providers.

Definitions Of Common Compensation Terms

Fee-For-Service means payment to a provider for each covered service delivered. Payments are based upon an agreed fee schedule. The provider or the member must submit a claim to EmblemHealth for the payment to be processed.

Capitation or **Pre-Payment** means payment to a provider (such as a hospital or a large group of physicians practicing together as a professional corporation) of a fixed amount of money each month per member. This amount covers provisions of specific services to those members who have selected that provider. The provider paid through the Capitation method receives payment without submitting claims. Some providers are Capitated just for the services they provide. Others are Capitated to provide a broader array of services, which may include hospitalization, diagnostic services or prescription drugs.

Per Diem Payment means a payment based on a flat amount per day for hospital services or other inpatient facility care such as nursing home services. Unlike Fee-For-Service arrangements, hospitals or other facilities on a Per Diem system will receive the same flat rate per day regardless of the services provided each day.

Diagnostic Related Group, DRG or **Case Rate** means a hospital payment based primarily on the diagnosis and medical condition of the patient. Hospitals or other inpatient facilities paid on a DRG or Case Rate will receive that payment regardless of the actual services delivered or how long the patient remains hospitalized. The DRG reimbursement payment system is a standard methodology used by Medicare to pay hospitals for services provided to Medicare beneficiaries. This methodology may be used by EmblemHealth to reimburse hospitals when they treat members in other lines of business.

Risk means the responsibility the provider assumes to deliver covered health care services under a Capitation arrangement. When a provider accepts Capitation for a member for a particular month, that provider has been paid in full for the covered service the member requires. That payment is made based on services the provider has agreed to deliver or arrange regardless of whether the member actually uses any services. In any given month, Capitation payment is received by the provider whether or not the member receives any services in that month, or if the costs of services provided to the member exceed the Capitation payment for that month. Providers that are contracted with EmblemHealth through an IPA may deliver services to EmblemHealth members at physician group practices.

Independent Practice Association or **IPA** means an organization of health care providers authorized by New York State to contract with health plans such as EmblemHealth, and to negotiate fee schedules or other compensation arrangements on behalf of its member physicians, hospitals and other providers.

Medical Group means, for purposes of this section of the handbook, the professional corporations organized by the physicians that operate the EmblemHealth affiliated physician group practices in Queens, Brooklyn, Staten Island and Long Island. These professional corporations negotiate compensation arrangements and contract with EmblemHealth to provide services to members. The Medical Groups employ physicians, health care professionals and other staff.

Common Reimbursement Arrangements Currently Used By EmblemHealth

Medical Group Compensation

To compensate primary care physicians practicing at a medical center, EmblemHealth contracts with Medical Groups which employ these physicians. EmblemHealth pays the Medical Groups a Capitation for medical services these physicians provide at the physician group practice

Under this method, the Medical Group as a whole is at risk for the services it provides. It is also at risk for the cost of certain specialty care services that are not provided at the physician group practice. The group is typically not at risk for certain other services for which they provide referrals to patients. Examples of such other services, for which the Medical Groups are not at financial risk, include pharmacy, inpatient hospital care and mental health services.

In addition, each of the Medical Groups as a whole has the opportunity to receive additional compensation in the form of quality incentive bonuses. Such bonuses may be available for achieving certain performance goals in the areas of quality improvement, quality of care, customer satisfaction and certain operational areas. For example, member satisfaction with access to care as well as decrease in hospital length of stay are some of the quality of care goals EmblemHealth measures and uses to determine if any additional compensation is paid to each of the Medical Groups. This reinforces physicians' professional commitment to achieving member satisfaction and better health outcomes through the appropriate and timely delivery of services, at the right setting, by the right provider. Quality incentive bonuses are paid when the Medical Group achieves overall performance goals for all EmblemHealth members that use the Medical Group. The bonuses are not connected to the care provided to any single member.

IPA Compensation

EmblemHealth may pay physicians participating through an IPA in one of two ways:

- EmblemHealth may pay the IPA on behalf of the physician by Capitation or Fee-For-Service.
- EmblemHealth may pay the physician directly on a Fee-For-Service basis.

If EmblemHealth pays the IPA by Capitation, the IPA is likely to be at risk for medical services it directly provides as well as for a broader array of services. This broader array of services may include specialty care, laboratory and inpatient hospital care. The IPA may, in turn, pay the primary care physicians and specialists either by Fee-For-Service or by Capitation. In so doing, the IPA will put the physicians at risk only for the services they directly provide.

Some IPA provider agreements with EmblemHealth may include bonus compensation. Such compensation is available as an incentive for achieving high performance measures in certain specific areas such as quality improvement, quality of care, customer satisfaction and operational cooperation. EmblemHealth regularly measures the performance of its entire network against such standards. Bonus compensation is paid when the IPA achieves overall performance goals for all EmblemHealth members that use IPA physicians. The bonuses are not connected to the care provided to any single member.

In addition, EmblemHealth and the IPA may agree to certain cost goals for particular services. After an agreed upon time period, EmblemHealth and the IPA calculate the actual costs for providing these services on a Fee-For-Service basis to the members that have selected IPA primary care physicians. The IPA and EmblemHealth then share the risk related to providing those services. Therefore, if the services actually cost less than the target, the IPA receives additional compensation. If the actual cost exceeds the target, the IPA pays a portion or all of the excess cost.

Compensation For Participating Physicians Directly Contracting With EmblemHealth

Providers contracting directly with EmblemHealth are paid on a discounted Fee-For-Service basis, with no risk transferred to them.

Facility Compensation

EmblemHealth pays participating hospitals or other inpatient care facilities on a Per Diem or DRG basis. With certain high-volume hospitals, the Per Diem fee may be subject to adjustments if certain volume utilization levels are achieved over time.

IMPORTANT CONTACT INFORMATION

Telephone List

Member Services TTY/TDD for hearing impaired	**1-800-447-8255** **711**
Medical Services Prior Approval	**1-877-846-3625**
Emblem Behavioral Health Services	**1-888-447-2526**
Retail Prescription Drug Coverage	**1-877-793-6253**
Clinical Pharmacy Department (For physicians to obtain prior approval for non-formulary drugs)	**1-877-444-3657**
ESI Member Services/Home Delivery TTY/TDD for hearing impaired	**1-877-866-5798** **1-800-899-2114**
PATH Program	**1-888-881-3112**
Healthy Beginnings PATH Program	**1-877-736-2229**
Dental Coverage (Careington Dental)	**1-877-548-4447**
24-Hour Nurse Line	**1-877-444-7988**
Quit Smoking Program TTY/TDD for hearing impaired	**1-866-611-QUIT** **(1-866-611-7848)** **1-866-228-4327**
Jenny Craig	**1-800-96JENNY** **(1-800-965-3669)**
Jazzercise	**1-800-FIT-IS-IT** **(1-800-348-4748)**
NutriSystem	**1-877-690-6534**
Optical Program -- General Vision Services	**1-800-847-4661**
Vision Care Discount Program	**1-877-92DAVIS** **(1-877-923-2847)**
Laser Vision Correction Discount Program	**1-800-584-2866**
Hearing Care Discount Program through HearX, a HearUSA company	**1-800-442-8231** **(TTY/TDD: 1-888-300-3277)**

Hearing Care Discount Program through TruHearing	**1-866-961-3152 (TTY/TDD: 1-800-975-2674)**
Health Care Products & Services Discount Program	**1-866-635-9532**
Vitamins and Herbal Supplements Discounts	**1-877-335-2746**
Acupuncture, Massage Therapy, Fitness Club Membership & Nutrition Discounts	**1-877-327-2746**

HEALTHFUL CHOICES

Helping You Take A Hands-On Approach To Your Health

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

Your Good Health Starts With Your Doctor

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

Encouraging Healthier Choices, Improving Quality Of Life

EmblemHealth offers a broad range of programs that help you live a healthier life or cope with common chronic medical conditions. These programs are provided at no additional cost to you, and your participation is voluntary. You can use the listed programs whenever you wish as part of the value-added advantages of your EmblemHealth health coverage.

AccordantCare™

This program provides specialized services to members with any of 16 rare chronic conditions ranging from cystic fibrosis to Parkinson's disease, in partnership with their providers. Participants have access to specialized nursing support and education, available by phone 24 hours a day/seven days a week.

Promoting Maternity Care

If you are expecting a baby, you will receive support from the Healthy Beginnings PATH program. You can call any time day or night to consult with a registered nurse about pregnancy-related questions. You'll find helpful information at our Web site and can request a special maternity book, "Your Journey Through Pregnancy."

HEALTHY DISCOUNTS

Offering big discounts on popular services

The Healthy Discounts program encourages a healthy lifestyle through attractive discounts on popular products and services. For details, including links to program Web sites, visit **www.emblemhealth.com**, click "Health & Wellness" and select "Healthy Discounts". Your participation in the Healthy Discounts program is voluntary. Among the Health Discounts offerings are:

Jenny Craig

Members and their eligible dependents can join Jenny Craig and receive a FREE 30-Day Program (costs for food and drink not included). Call **1-800-96-JENNY**, or visit **www.jennycraig.com/corporatechannel/emblem.aspx**

Jazzercise

Get one week free and 15% off the monthly fee for this unique dance and body-conditioning program. EmblemHealth members can call **1-800-FIT-IS-IT**, or visit **www.jazzercise.com**

NutriSystem

EmblemHealth members get 12% off all Select, Basic, Silver, Diabetic and Vegetarian program orders plus all benefits found at the NutriSystem Web site. Get over 120 delicious entrees & desserts, no membership or enrollment fees, free exercise DVD, free weight loss counseling and more. EmblemHealth members can call **1-877-690-6534** or visit **www.nutrisystem.com/emblem**

Vision Care

Save on examinations, eyewear, and contact lenses. Call **1-877-92-DAVIS**, or visit **www.davisvision.com**. Click on "Members" and enter client control # 7810.

Laser Vision Correction

Get discounts on LASIK procedures. Call **1-800-584-2866**, or visit **www.davisvision.com**. Click on "Members" and enter client control # 7940.

Hearing Care through TruHearing

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

Hearing Care through HearX, a HearUSA company

Receive complimentary screenings and product discounts. Call **1-800-323-3277** or **1-800-442-8231 (TDD: 1-888-300-3277)** or visit **www.hearusa.com/centers/search_criteria.asp**

Health Care Products and Services

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

Vitamins and Herbal Supplements

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

Acupuncture, Massage Therapy, and Nutrition Counseling Services

Get discounts on these services through a network of providers designated by us. Call **1-877-327-2746**, or visit **www.choosehealthy.com/default.aspx?hp=emblem**

Fitness Club Memberships

Get lowest posted pricing or at least a 10% discount on enrollment fees and/or monthly membership fees at participating facilities. Choose from hundreds of locations, including independent gyms, yoga and Pilates centers, and fitness chains such as Bally's, Curves, Gold's Gym, Snap Fitness and more. Locate a participating club online at **http://www.choosehealthy.com/ChooseHealthy/?hp=Emblem** or call **1-877-327-2746 (TDD: 1-877-710-2746)**.

Note: EmblemHealth which offers plans underwritten by Group Health Incorporated (GHI), GHI PPO, HIP Health Plan of New York and HIP Insurance Company of New York (HIPIC), does not insure or underwrite the above "Healthy Discounts" programs.

HEALTH MANAGER

Your Personal "Health Manager" Is At Your Fingertips.

EmblemHealth's easy-to-use Web site has the information you need to make the most of your health benefits coverage. Click **here** to see how you can register for your PIN and go to the secure members section, which offers confidential access around-the-clock to your personal data.

Once you register and receive your PIN, you'll not only have direct access to your personal data, but also to a valuable service called Health Manager, which consists of a Health Risk Assessment (HRA) and a Personal Health Record (PHR).

Use The Health Risk Assessment (HRA) To Get A Picture Of Your Current Health

The HRA is a confidential, online survey that provides a "picture" of your current health with personalized feedback based on your survey responses. You'll find suggestions for lifestyle changes that can help maintain and improve your health status, including if you are at risk for more significant medical conditions and recommendations for preventive actions.

Create Your Personal Health Record (PHR)

The PHR enables you to create, organize, store, and view personal health information in one secure central location on EmblemHealth's Web site. You can print out copies to share with your doctor(s) and to keep on hand in case of emergencies.

THE HEALTHY BEGINNINGS PATH PROGRAM

Supporting a healthy pregnancy and the birth of a healthy baby

Through the Healthy Beginnings PATH program you will receive guidance about nutrition, immunizations, and general health and wellness during your pregnancy. The Healthy Beginnings PATH program offers eligible, expectant moms prenatal risk assessments, a special prenatal care book and educational materials and access to a 24/7 nurse answer line. Members identified as high risk are referred to the plan's maternal child health nurse case managers for evaluation, support and intervention.

For more information, please call **1-877-736-2229**, or visit us at **www.maternalink.com/emblemhealth**.

24-HOUR NURSE ADVICE LINE

You can speak with a registered nurse 24/7

Call toll-free **1-877-444-7988**.

Whether it's 3 pm or 3 am, you can speak to an experienced, licensed nurse about your health questions or issues. With **Healthy Returns™ 24-Hour Nurse** Advice Line, just call the toll-free number to speak to a registered nurse 24 hours day/365 days a year. Through confidential, one-on-one health counseling with a registered nurse, you'll get the accurate information you need to make more informed health care decisions.

Talk with nurses about hundreds of health issues, such as:

• Coughs	• Colds	• Fever
• Headache	• Abdominal Pain	• Smoking
• Weight Loss	• Children's Health	• Sexually Transmitted Diseases
• Food and Diet	• Women's Health	• and many more

Here's How It Works:

Dial the toll-free number: **1-877-444-7988.**

Bilingual nurses, the Language Line and TTY/TDD relay services for the hearing impaired are available.

Call the 24-Hour Nurse Advice Line 1-877-444-7988. Answers to your health questions are just a phone call away.

NOTICE OF PRIVACY PRACTICES

IMPORTANT INFORMATION ABOUT YOUR PRIVACY RIGHTS

Effective September 1, 2013

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

EmblemHealth, Inc. is the parent organization of the following companies that provide health benefit plans: Group Health Incorporated (GHI), HIP Health Plan of New York (HIP) and HIP Insurance Company of New York, Inc. (HIPIC). All of these entities receive administrative and other services from EmblemHealth Services Company LLC which is also an EmblemHealth, Inc. company. This notice describes the privacy practices of EmblemHealth companies, including GHI, HIP and HIPIC (**collectively "the Plan"**).

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

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

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

How We Use or Share Information

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

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

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

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

Other Ways We Use or Share Information

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

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

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

Sensitive Information

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

Your Authorization

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

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

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

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

Your Rights

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

Restricting Your Information

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

Confidential Communications for Your Information

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

Inspecting Your Information

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

Amending Your Information

- **You have the right to ask us to amend** information we maintain about you in your designated record set. We may require that your request be in writing and that you provide a reason for your request. We may deny your request for an amendment if we did not create the information that you want amended and the originator remains available or for certain other reasons. If we deny your request, you may file a written statement of disagreement.

Accounting of Disclosures

- **You have the right to receive an accounting** of certain disclosures of your information made by us for purposes other than treatment, payment or health care operations during the six years prior to your request. We may require that your request be in writing. If you request such an accounting more than once in a 12-month period, we may charge a reasonable fee.

Please note that we are not required to provide an accounting of the following:

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

Collecting, Sharing and Safeguarding Your Financial Information

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

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

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

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

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

Exercising Your Rights, Complaints and Questions

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

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

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

Contact Information

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

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

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

EmblemHealth Medicare members: 7 days a week (excluding major holidays), 8 am-8 pm
PPO: **1-866-557-7300**, TTY: **711**
HMO: **1-877-344-7364**, TTY: **711**
PDP (City of NY Retirees): **1-800-624-2414**, TTY: **711**
PDP (non-City of NY Retirees): **1-877-444-7241**, TTY: **711**

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

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

HIP/HIPIC members: 7 days a week (excluding major holidays), 8 am-8 pm, **1-800-447-8255**, TTY: **711**

Medicaid, Family Health Plus and Child Health Plus members: 7 days a week (excluding major holidays), 8 am - 8 pm, **1-855-283-2146**,TTY: **711**

Personal Information After You Are No Longer Enrolled

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

Changes to this Notice

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

HEALTH CARE PROXY

Planning In Advance For Your Medical Treatment

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 can 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 this form.

Frequently Asked Questions

Why Should I Choose A Health Care Agent?

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

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

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

Who Can Be A Health Care Agent?

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

How Do I Appoint A Health Care Agent?

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

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

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

What Decisions Can My Health Care Agent Make?

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

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

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

How Will My Health Care Agent Make Decisions?

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

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

(print out this page and the following pages to complete)

(1)(2)(3)(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

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 2 (print)
Signature	Signature
Address	Address

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

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