EmblemHealth®

WHAT CARE FEELS LIKE.

SMALL GROUP ADMINISTRATOR'S HANDBOOK

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EmblemHealth Community-Rated Groups — 2 to 50 Employees

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WELCOME TO EMBLEMHEALTH

By offering EmblemHealth to your employees, you are providing them with access to comprehensive, -effective health benefits through a network of practitioners. EmblemHealth is committed to making sure that the plan you've selected for your employees also works for your organization. This means providing you with streamlined, hassle-free administration that demonstrates our respect for the things that matter most to you: your time, your intelligence and your budget.

As your organization's benefits administrator, you are called upon to perform a variety of activities — enrolling new members, adding coverage for dependents, removing members from your plan, requesting name and address changes, reconciling invoices, notifying members about COBRA and more. This manual is designed to provide easy-to-follow instructions that will make these and all of your interactions with EmblemHealth, simple and successful.

By providing clear and direct answers to the most commonly asked questions about plan administration, we can help you and your group members make the most of your EmblemHealth coverage. For complex issues, please call EmblemHealth Account Services at **1-866-614-6040**, Monday through Friday, from 9 am to 5 pm. An Account Services Representative is standing by to answer your questions about benefit coverage, claims, membership status and virtually any other aspect of your group's contract.

We believe this manual will become an important resource for your group. We value your selection of EmblemHealth for your health insurance needs. And we look forward to serving you.

ENROLLMENT TRANSACTIONS

Many of your interactions with EmblemHealth involve adding and deleting members from your group, and updating us when member status changes. This section provides all of the information you will need to make submitting membership transactions fast and easy.

An EmblemHealth Transaction Form is used to request any coverage changes for your group. The use of this form permits accurate and timely processing of new enrollments, terminations and other status changes. Transaction Forms can be requested in two ways:

1) By calling an Account Services Representative at **1-866-614-6040**

2) By downloading the form

Completed Transaction Forms should be mailed to:

EmblemHealth Membership Department
PO Box 2820
New York, NY 10116-2820

EmblemHealth assigns a control number to each Transaction Form upon receipt. Most forms are processed within 10 business days. Your prompt use of the Transaction Form allows EmblemHealth to produce up-to-date invoices. To assist you with the process, please see the Group Billing Section of this manual for a complete description of the EmblemHealth group billing system.

Once the Transaction Form has been processed, a confirmation copy of the form, indicating the EmblemHealth control number and the date the form was received, is returned to you. The transaction and control numbers will appear on your group's next Premium Invoice. As the group administrator, it is essential that you assist EmblemHealth in keeping your group's records up to date.

Membership Changes

EmblemHealth must be notified within 10 business days of any enrollment, termination or change in status through the submission of a Transaction Form. A request for retroactive enrollment, termination or contract changes will only be accepted if the date of the requested change is not more than 30 days prior to the date the transaction is received by EmblemHealth.

This policy is designed to expedite the processing of all transactions, as well as to simplify the review of EmblemHealth Premium Invoices.

Again, please submit your Transaction Forms to EmblemHealth without delay. Don't hold them for submission with the monthly Premium Invoice.

Transaction Cut-Off Dates

Transaction Forms are generally processed within 10 business days of receipt. The month in which processed transactions will appear on your Premium Invoice is determined by the actual date the form is received at EmblemHealth. For example:

- Transaction Forms received by November 15th would appear on your January Premium Invoice.
- Transaction Forms received between November 16th and December 15th would appear on your February Premium Invoice.

Completing the Transaction Form

The Transaction Form can be used to indicate membership changes pertaining to medical, hospital and dental contracts.

Failure to complete any part of the form will delay the processing of the transaction. The subscriber must complete Sections I, II, III, IV and VI. The Group Plan Administrator must complete Section VII.

Section I. Subscriber Information

This section must be fully completed by the subscriber each time a Transaction Form is submitted to EmblemHealth.

Section II. Enrollment Information

- When enrolling or reinstating a subscriber or member, this section should list all family members to be covered under the policy.
- When enrolling or terminating a dependent, this section should list only the family members to be added or deleted.

Section III. Other Carrier Information

If the subscriber or his/her dependents has other health coverage, this entire section must be completed.

Section IV. Did You Have Prior Health Coverage?

If yes, this section must be fully completed by the subscriber. This information allows EmblemHealth to credit prior coverage toward the pre-existing condition clause.

Section V. Pre-existing Conditions

This section describes the pre-existing limitations that are applicable to this enrollment. This section is informational.

Section VI. Subscriber Authorization

The subscriber must sign and date this section. EmblemHealth cannot process a Transaction Form without the proper signature and authorization. Incomplete forms will be returned to the group administrator.

Section VII. Employer Information

This section must be completed by the group administrator for every transaction. It is important to include the effective date, group number, the group's full name and the type of product for each submitted Transaction Form.

Community-rated groups must also complete the information requested under Documentation Based on Group Size.

Incomplete Transaction Forms cannot be processed and will be returned to the group with a request for the additional information. EmblemHealth must be notified of requested changes within 30 calendar days in order to honor the requested effective date.

National Medical Support Notices

The NYS Division of Child Support Enforcement has procedures to enforce a parent's responsibility to provide health coverage for a dependent child. These procedures include:

- In compliance with a court order, a local social services office must send a National Medical Support Notice to an employer group about a group member's responsibility to insure the child.
- If you receive a National Medical Support Notice for your employee or his/her dependent, please send a copy of the notice to EmblemHealth, along with a completed EmblemHealth Transaction Form, noting the child's enrollment.
- Be sure to note any change in your group member's contract type.

Please mail the completed National Medical Support Notice to your EmblemHealth Account Services Representative or to EmblemHealth's Membership Department at:

EmblemHealth Membership Department
PO Box 2820
New York, NY 10116-2820
Re: National Medical Support Notice

You may also fax the completed form to EmblemHealth at **1-212-563-8679**.

If you have any questions, please contact your EmblemHealth Account Services Representative.

GROUP BILLING SYSTEM

This section provides guidance regarding EmblemHealth's premium invoice, including an explanation of the information provided on the invoice and instructions about sending your payment in order to ensure continued coverage.

EmblemHealth's group billing system generates premium invoices between the 10th and the 15th of the prior month. For example, September invoices will be generated on August 15th.

The Premium Invoice

The monthly Premium Invoice contains:

- A coupon page
- A summary page
- A listing of all transactions affecting billing processed for the month (such as new enrollments, status changes and terminations)
- A detailed alphabetical listing of all subscribers active on EmblemHealth's membership master file, as of the date the invoice is prepared

The invoice provides you with a clear record of all subscribers for whom you are being billed and it helps you perform an accurate reconciliation of subscriber records. Including the hospital and medical premiums, the invoice indicates which subsidiary of EmblemHealth is underwriting your insurance, if applicable.

Note: Upon receipt of the Premium Invoice, the group administrator is responsible for verifying the accuracy and completeness of the information provided. Any questions may be directed to EmblemHealth.

Understanding Your Invoice

The listing below explains all the types of information included in your EmblemHealth Premium Invoice.

Coupon Page

This page contains:

- The address to which you should mail your payment
- The Billing Group (Main Group) number
- The due date of the invoice
- The grand total due as of this invoice
- Boxes for you to enter what you are paying

The coupon page must be remitted with payment, as this allows the payment to be automatically posted to the account against the correct invoice.

Summary

This section summarizes the information found in the Transactions and Detailed Monthly Premium Invoice sections of your invoice. It includes:

- The identification of each subsidiary group when multiple subgroups are billed on one Premium Invoice
- The current premium amount due
- Net back charges/credits and retroactive premium adjustment
- A "Balance Forward" that represents the group's total outstanding balance from the prior period at the time the bill was created (you may find this date in the lower left hand corner of the bill)
- Total net outstanding premium due as of the invoice date

Transactions

Also listed on the invoice are details of transactions affecting premiums and payments processed for each subscriber from the date the prior invoice was prepared.

- Group indicator is used to denote subsidiary group numbers within your enrolled membership when multiple groups are billed on one Premium Invoice.
- Contract type indicates the type of policy, such as:
  - Ind — Individual
  - Fam-D — Family, subscriber, spouse and children
  - Fam-C — Parent and children (may not be applicable to all groups)
  - Fam-E — Subscriber and spouse (may not be applicable to all groups)
- Type of transaction is used to indicate such transactions as enrollment, termination, coverage change and more. See bottom of invoice for transaction key definitions.
- Transaction Form Number should match the number on the confirmation copy of the Transaction Form EmblemHealth returned to you.
- Effective Date is the date the transaction was processed. Back Charge or Credit is the premium amount billed or credited for all transactions processed with an effective date during, or prior to, the current month.

Detailed Monthly Premium Invoice

This portion lists all active subscribers as of the date the invoice is prepared.

- Group indicator that identifies each group when multiple groups are billed on one Premium Invoice.
- Contract type (defined above).
- Type of transaction. See bottom of invoice for keys.
- Number that matches the number on the confirmation copy of the Transaction Form EmblemHealth returned to you.
- Premium amount billed for the current month.
- Back charge or credit. This is the premium amount billed or credited for all transactions processed with an effective date prior to the current month.
- Total premium amount due. This includes current premium, plus or minus any prior adjustments.

Premium Payment

To maintain your group's coverage, be sure to make payment by the due date indicated on the Premium Invoice. Payment in full is required. Please remit payment to the PO Box on your invoice.

The Premium Invoice should not be used to report status changes such as new enrollments, terminations or changes in family status. During the month as such changes occur, you should report them by submitting a Transaction Form to:

EmblemHealth Membership Department
PO Box 2820
New York, NY 10116-2820

Prompt reporting of membership changes allows EmblemHealth to process your requests on a timely basis and promotes accurate invoices. If your transactions are not received by the 3rd, they will post on a subsequent bill.

For example, an invoice due January 1st is produced around December 10th. If your Transaction Form including a request for a termination is received by EmblemHealth after December 3rd, it will not be posted to your January invoice. It will be posted to your February 1st invoice with the appropriate retroactive credit or debit adjustment for the prior period.

It is important to pay the exact amount indicated on the Premium Invoice. Please do not compute the effect of any recent membership status changes on your Premium Invoice. Your next invoice will reflect any retroactive charges or credits automatically.

It is important that payment be received by the due date specified on your Premium Invoice.
Under the terms of your Group Policy with EmblemHealth, premium payments are due and payable by the first day of the month for which coverage is provided, with a 30-day grace period for payment.

Beginning with premiums due on or after September 1, 2012, if we do not receive your group's premium payment within the grace period, your coverage will be terminated retroactively to the last paid date of coverage. If your group's coverage is terminated for nonpayment of premium, your group may not be eligible for reinstatement for 12 months.

IDENTIFICATION CARDS

Refer to this section for sample ID cards as well as details about who receives an ID card and the circumstances under which new cards are issued.

Upon a subscriber's enrollment, EmblemHealth generates and mails an identification card reflecting the subscriber's medical, hospital, dental and/or vision coverages.

Who Gets an ID Card?

- A subscriber with individual coverage receives one ID card
- A subscriber with family coverage in an EPO/PPO product receives an additional ID card for each dependent over 19 years of age
- A subscriber with family coverage in the CompreHealth plan receives an ID card for each covered dependent

EmblemHealth ID cards may differ based on plan design. Additional cards may be issued only if the plan design offers them more cards. In addition, EmblemHealth ID cards are automatically generated when the following transactions are processed:

- Reinstatement
- Category change
- Name change of primary subscriber
- Contract changes (such as from individual to family plan, or from family to individual plan)
- Change in the primary subscriber of a family contract
- Request for a replacement due to loss of card
- Request for additional cards for dependent students
- Dependent reaches 19 years of age

ID cards will not be issued for address changes or when adding or terminating a dependent when the contract remains a family plan.

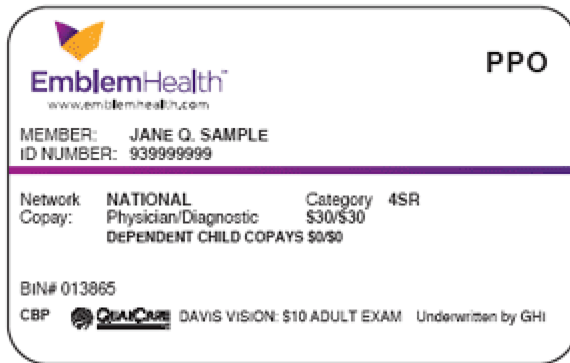
Special requests for ID cards should be directed to:

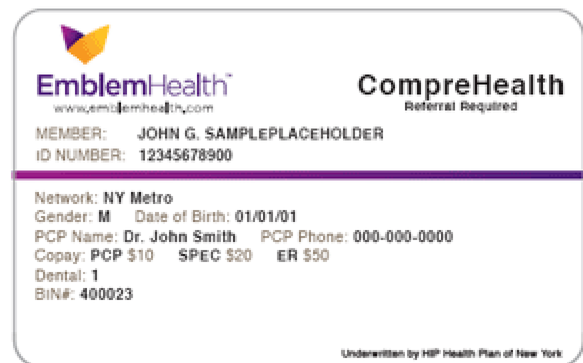
EmblemHealth Correspondence
PO Box 1701
New York, NY 10116-1701

Understanding the EmblemHealth ID Card

Sample PPO ID Card

Sample CompreHealth ID Card





The front of the EmblemHealth ID card features the covered subscriber's name and EmblemHealth ID number.

It also lists the network, group-specific copayments and Primary Care Provider (PCP), if applicable.

Subscribers with prescription drug benefits receive a combined ID and pharmacy card, which includes the Prescription BIN Number.

Please note that it is not necessary for your members to provide a group number when an out-of-network claim is submitted.

We believe that your group will benefit from the detailed plan information provided on these ID cards. If you have any questions regarding your group's ID cards, please contact EmblemHealth's Account Services Department at **1-866-614-6040**, Monday through Friday, from 9 am to 5 pm.

COBRA REQUIREMENTS

Here is a brief summary of your group's responsibilities for offering members continuation of coverage under the federal COBRA legislation and of New York State law.

Except as specifically provided otherwise by law, the employer or plan administrator is required to notify all employees, retirees and their spouses of their rights to continuation of coverage under COBRA and/or state law (hereinafter collectively "COBRA"), in accordance with applicable laws and regulations, and to notify EmblemHealth of COBRA elections (see Eligibility Guidelines section for details) and associated qualifying events and associated status changes through the enrollment transaction process in a timely manner.

Conversion to Direct Payment Coverage

A COBRA-qualified beneficiary may request enrollment in an individual direct-payment health coverage plan in lieu of COBRA at the conclusion of the period of COBRA coverage, if they elect it. A group health plan must notify a COBRA recipient of the option of enrolling in a conversion health plan within a 180-day period prior to expiration of COBRA coverage. Individuals who enroll in a direct payment plan are responsible for paying the full premium for that plan. The Direct Payment Conversion section explains this in more detail. Multi-employer plans, by their terms, can provide a longer time period for employers to notify plan administrators of qualifying events and for plan administrators to notify qualified beneficiaries of their COBRA rights.

Individuals who enroll in a direct payment plan are responsible for paying the full premium for that plan. The Direct Payment Conversion section explains this in more detail.

DIRECT-PAYMENT CONVERSION

Did you know your group members have the opportunity to purchase EmblemHealth hospital and medical coverage when they leave your group? This section provides the details on EmblemHealth's policy for offering members conversion to direct-payment coverage.

EmblemHealth provides subscribers and their dependents who reside in New York State with the opportunity to purchase hospital and medical benefits on a direct payment basis upon termination from your group plan. The level of benefits available may depend upon the benefits the subscriber received through your group plan at the time the coverage ended. Coverage under the direct-payment plan will differ from the coverage the subscriber received under your group plan.

Subscribers or covered dependents who are eligible for Medicare, and whose group coverage terminates, may convert to one of our direct payment Medicare supplement conversion plans, or our Medicare Advantage Plan.

Enrollment Procedure

EmblemHealth will send a direct-payment conversion notice to the members upon termination of their group coverage. Members must apply for conversion coverage within 45 days of receipt of the notice. If, for some reason, the member does not receive a conversion notice, the time frame for applying for conversion coverage will be extended to 90 days after the group coverage ends. Upon receipt of the completed application, EmblemHealth will process the conversion. The conversion will be retroactive effective on the date that the group coverage terminated in order to prevent a lapse in coverage.

Billing Procedure

An invoice will be sent to a conversion applicant after the application is processed. Once the initial invoice is paid, the member receives an ID card and contract. Subsequent bills are issued on a quarterly basis.

COORDINATION OF BENEFITS (COB)

Coordination of Benefits (COB) procedures are designed to ensure that when a member is covered by more than one insurer, the costs of health care are appropriately assigned to the correct insurer. This section describes EmblemHealth's COB procedures.

If the EmblemHealth plan is the primary plan, claims should be filed with EmblemHealth first. If the subscriber is covered by another insurer, this should be indicated on the claim form. If EmblemHealth is the secondary plan, claims should be filed as follows:

- For medical benefits: After filing the claim with the primary carrier and receiving an Explanation of Benefits (EOB) detailing that insurer's reimbursement, the subscriber should submit to Emblem-Health a medical claim with an itemized bill from the physician and a copy of the correlating EOB from the primary carrier.
- For hospital benefits: The subscriber should inform the hospital that EmblemHealth is the secondary plan if he or she is admitted to the hospital or receives emergency room services. For elective outpatient services, the subscriber should use the EmblemHealth hospital outpatient claim form and complete Part E on the reverse side of the form. The hospital will forward a copy of the bill to EmblemHealth for processing.

If the primary insurer rejects coverage for any services received, the subscriber should mail a copy of the rejection statement with his or her claim submission to one of the following addresses:

- For EmblemHealth EPO, EmblemHealth PPO, InBalance EPO, ConsumerDirect EPO and ConsumerDirect PPO
  PO Box 3000
  New York, NY 10116

- For EmblemHealth CompreHealth
  PO Box 2845
  New York, NY 10116

Other Health Insurance Questionnaire

In some cases, EmblemHealth may ask for information about additional coverage in the form of an Other Health Insurance Questionnaire. The questionnaire must be completed by the subscriber and returned to EmblemHealth for the claim to be considered for payment.

Please note that the Other Health Insurance Questionnaire is not to be used as an enrollment document. All other health insurance information is requested at the time of enrollment by completing Section III of the EmblemHealth Transaction Form.

Overview of the Other Health Insurance Questionnaire

Section A of the questionnaire requests basic information about the subscriber. The questionnaire also asks for basic information about the subscriber's spouse in Section B.
If any family member has other health insurance coverage, including Medicare, the subscriber must complete sections C and D of this questionnaire. The subscriber must fill in the names and addresses of all other health insurance carriers. The effective date for all other health insurance plans must be indicated.
The subscriber's signature and date are required in Section E of the questionnaire.

Forms should be submitted to one of the following addresses:

For EmblemHealth EPO, EmblemHealth PPO, InBalance EPO, ConsumerDirect EPO, or ConsumerDirect PPO, send the form to:

EmblemHealth – COB Unit
PO Box 2804
New York, NY 10116

For CompreHealth or CompreHealth EPO, send the form to:

EmblemHealth – COB Unit
PO Box 9091
Melville, New York 11747

ACCOUNT SERVICES

As a group administrator, you have different concerns and questions from those of your group members. This section explains when you should contact an EmblemHealth Account Services Representative for assistance.

EmblemHealth Account Services is dedicated to providing you with prompt, personal service. Account Services Representatives are prepared to address your inquiries about benefit coverage, claims, membership status, reinstatements, plan changes, eligibility issues, address updates, and other aspects of your group's contract. Our representatives understand the range of issues that may arise in your daily activities as the group administrator. They will work closely with other EmblemHealth departments to resolve your questions. Where applicable, they will implement corrective measures to ensure effective resolutions of your issues and prevent reoccurrences. We also analyze trends in inquiries so that service enhancements may be considered to make your experience with us hassle-free.

Please note that for inquiries about claim issues or other topics that involve a group member's Protected Health Information (PHI), you must complete and submit to us an Authorization/Disclosure Form that includes your signature as well as that of your group member.

Telephone Inquiries

Group Plan Administrators may contact the Account Services department at **1-866-614-6040**, Monday through Friday, from 9 am to 5 pm. Subscribers may contact EmblemHealth Customer Service at **1-877-VIA-EMBLEM (1-877-842-3625)**.

Inquiry Responses

When you call an Account Services Representative about a membership change or the status of a claim, the information you provide is entered into a computerized system. After researching your inquiry, the representative issues a written explanation of the resolution, including all pertinent details.

Should you require additional information about your inquiry, you need only provide the representative with the member ID number. If the prior inquiry needs to be referenced, you can provide the Inquiry Control Number located at the bottom left portion of EmblemHealth's initial response. Our representatives will access the corresponding computer file, which will include the resolution to your inquiry.

CUSTOMER SERVICE

This section identifies the customer service assistance options available to your group members, from personalized telephone contact, to an automated phone line available 24/7, to our leading-edge member self-service option available through emblemhealth.com.

EmblemHealth is committed to making it as simple as possible for your group members to obtain important information about their coverage when they need it. The following services are designed to make interacting with EmblemHealth hassle-free and to provide members with the answers they need to get the most out of their coverage.

Personal Contact by Telephone

EmblemHealth Customer Service is staffed with representatives available to assist members, group administrators and providers, Monday through Friday, from 8 am to 5 pm. Our Customer Service Center is designed to maximize service through an advanced telephone "traffic management" system that reduces busy signals and waiting time and tracks the status of every call. EmblemHealth's claims systems provide Customer Service Representatives with all the pertinent information required to answer questions. The result is fast, responsive and accurate service.

EmblemHealth Automated Telephone AnswerLine

Answers to many of your group members' most commonly asked questions can be obtained by calling the EmblemHealth AnswerLine, an automated touch-tone telephone system. AnswerLine is available 24 hours a day, 7 days a week, at **1-877-VIA-EMBLEM (1-877-842-3625)**.

Internet Access to Information About Plans and Services

Our Web site **www.emblemhealth.com** provides immediate access to important information about EmblemHealth plans, and is available 24 hours a day, 7 days a week. Certified by Verizon Business as maintaining the highest Internet security and content integrity standards, the EmblemHealth Web site offers valuable resources for members, group administrators, providers and brokers, including the latest listings of physicians, hospitals and other EmblemHealth network practitioners, health and wellness information on a variety of topics, and much more.

Member Self-Service Capabilities Available Online through *my*EmblemHealth

Members can visit **www.emblemhealth.com** and apply online for a Personal Identification Number (PIN) in order to access customized information about their health care transactions with EmblemHealth. The secure, password-protected self-service section of the site, called *my*EmblemHealth, enables your members to:

- Check claims status
- Sign up for e-mail alerts for new claims

- Receive electronic copies of explanations of benefits and other routine claims and membership mailings, instead of receiving these by mail
- View detailed hospital, medical and pharmacy benefits information
- Verify coverage and effective dates for dependents
- See year-to-date deductible balances
- Request replacement ID cards
- Notify us of a change of address (street or e-mail)
- Set up and maintain a Personal Health Record for tracking medical history, records of office visits, treatment plans and more
- Take a Health Risk Assessment that will generate personalized suggestions for maintaining or improving their health and warnings about potential health risks

Walk-In Center

Members are also welcome to visit EmblemHealth's two Walk-in Customer Service Centers, located at:

441 Ninth Avenue (between 34th and 35th Streets)
New York, NY 10001
Hours of operation are from 9 am to 5 pm, Monday through Friday.

55 Water Street at Old Slip
New York, NY 10041
Hours of operation are from 8:30 am to 5 pm, Monday through Friday.

ELIGIBILITY GUIDELINES

Refer to this section for details on the standards which groups and members must meet to qualify for EmblemHealth coverage, as well as the documentation you'll need to submit to verify those qualifications.

Group Qualification

A group can purchase community-rated coverage for eligible employees, if that group:

- Has its principal location **within** New York State
- Employs no fewer than 2 and no more than 50 eligible employees at a worksite(s) in New York State

Groups with more than one office/location within the State of New York must identify each location and the employees that work at that location. Employees will be charged the premium applicable for their office location.

This policy is also subject to any applicable service area restrictions.

If a group's business ceases operation, the group loses eligibility for EmblemHealth coverage.

EmblemHealth and/or the designated administrator reserves the right to conduct periodic surveys of enrolled small groups to help ensure that the group is actively operating its business, remains qualified to be enrolled in a community-rated product and has enrolled only eligible individuals in the EmblemHealth plan.

The survey can include, but is not limited to, any or all of the following to verify continued eligibility:

- The group's most recently-filed NYS-45 or NYS-45-ATT.
- Tax documentation as requested by EmblemHealth and/or EmblemHealth's designated administrators.
- Payroll information as requested by EmblemHealth and/or EmblemHealth's designated administrators.

Participation

- **PPO requirement:** If a group elects to include at least one PPO product as one of the EmblemHealth product choices offered to its group members (PPO, ConsumerDirect PPO), a minimum of 50 percent of the eligible employees in the group must be covered by an EmblemHealth plan.
- **EPO requirement:** If a group elects to limit the EmblemHealth products offered to its group members (EPO, InBalance EPO, ConsumerDirect EPO), a minimum of 50 percent of the eligible employees in a group must be covered by a health insurance policy.
- **HMO requirement:** There is no minimum participation requirement for a EmblemHealth HMO plan (i.e. CompreHealth).

For groups with an odd number of employees, the 50 percent threshold will be determined by rounding up the total number of employees to the next even number and dividing by two (e.g., a group with five eligible employees must enroll at least three, a group with seven eligible employees must enroll at least four).

Employee Qualification

Groups must demonstrate an employer/employee relationship for all eligible employees.

EmblemHealth evaluates eligibility based on the United States Internal Revenue Service's definition of an employee of an employer group or a bona fide employer member of an association group.

EmblemHealth only covers full-time employees. EmblemHealth defines full-time eligible employees as employees who work 20 or more hours per week, each week. If an employer requires a longer number of hours worked in order to meet eligibility, then EmblemHealth will use the employer's criteria to define full-time eligible employees.

The following categories of employees are **not** eligible for coverage:

- Retirees and their dependents
- Independent contractors who receive 1099 forms and their dependents
- Seasonal employees and their dependents
- Leased Employees

A group must provide proof of employment for each employee at the time of application or at the time of a periodic survey. All eligible employees must appear on an NYS-45 or NYS-45-ATT.

The NYS-45 or NYS-45-ATT must be the filed copy for the quarter preceding the desired effective date of coverage. The status of each employee must be indicated on the form as applicable: Full-time, Part-time (less than 20 hours worked per week), Permanent, Temporary, Waiving, Eligible, Not-Eligible, Enrolling, Class Distinction (if applicable).

In the absence of providing an NYS-45 or an NYS-45-ATT, the group must provide a signed copy of its full tax return, such as an 1120, 1065, 112OS Schedule K-1, or Schedule C.

If the employer has a benefit waiting period, the employer must provide documentation verifying the terms of the waiting period.

Recent Hires

- In the event that a newly hired employee is not yet listed on filed tax documentation, then a copy of the employee's W-4 or recent payroll check stub must be supplied. If a payroll check stub is supplied, it must include the company name, employee name, number of hours worked and payroll dates. The payroll dates cannot be more than 30 days prior to the date of application.
- The group must produce tax documents within 90 days after the effective date of coverage to substantiate a recent hire's eligibility. If acceptable documentation is not provided to EmblemHealth, then coverage will be terminated.

COBRA Members

COBRA enrollees must supply a letter of election and a copy of their last payroll report.

Enrollment Policycs:

- New enrollees must enroll as of their date of hire.
- If the employer has a benefit waiting period, the employee must enroll on the first day of benefit eligibility.
- New groups enrolling with EmblemHealth may waive the waiting period for all employees at the time of initial enrollment.

Eligible employees and/or dependents that do not enroll on the first day of benefit eligibility will not be eligible to enroll until the employer's next annual enrollment period, except in the circumstances below. The enrollment period commences on the anniversary date of coverage and ends after 30 days.

Exceptions that will allow the employee to enroll after the first day of benefit eligibility or after the annual enrollment period, provided the request for enrollment is made within 30 days of termination of coverage (unless provided otherwise):

- The individual was covered under another plan or policy at the time the individual was initially eligible to enroll and has lost coverage under the other plan or policy as a result of exhaustion of the period of continuation under state or federal law.
- The loss of eligibility was related to one or more of the following reasons:
  - Termination of employment
  - Termination of the other plan or contract
  - Death of spouse
  - Legal separation, divorce or annulment
  - Reduction in the number of hours of employment
  - Contract holder contributions toward the payment of premium for the other plan or contract

Additional exceptions include:

- A court has ordered coverage be provided for a spouse or minor children under a covered employee or member's health benefit plan and the request for enrollment is made within 30 days after issuance of the court order.
- Loss of eligibility for Medicaid or Child Health Insurance Program (e.g. Child Health Plus) coverage provided the request for enrollment is made within 60 days after the termination of coverage.
- Eligibility for group health plan premium assistance under Medicaid or a Child Health Insurance Program provided the request for enrollment is made within 60 days after the individual is determined to be eligible for premium assistance.

Domestic Partners and Same-Sex Spouses

Domestic partner coverage is available through EmblemHealth. A domestic partner will be treated as a dependent. Eligible dependents of the domestic partner may be added as well. Domestic partners are not recognized by the IRS and may not receive tax benefits afforded to non-domestic partners (e.g., Health Savings Accounts). Domestic partners must submit the following form to EmblemHealth, which must be notarized:

- EmblemHealth's Declaration of Cohabitation & Financial Interdependence Form (DCFIF). In addition, the partners must also provide three documents showing a similar residence and financial interdependence. The specific list of acceptable documents is shown on the Declaration of Cohabitation & Financial Interdependence Form.

Same-sex spouses are eligible for coverage to the same extent as opposite-sex spouses, provided the same-sex marriage was legally performed. EmblemHealth may request a marriage license and other documentation to verify the date, jurisdiction and other information, in order to substantiate eligibility.

These guidelines do not encompass government sponsored programs that EmblemHealth companies may offer for sale (e.g., Medicare, Healthy New York, etc.). The underwriting company should be consulted for policies and procedures that are applicable to their products. Additionally, these guidelines do not apply to legacy GHI or HIP products, as defined by EmblemHealth. The respective legacy product organization's guidelines apply.

EmblemHealth provides health benefit coverage and services through its subsidiary companies in New York State: Group Health Incorporated, HIP Health Plan of New York, HIP Insurance Company of New York, GHI HMO Select Inc., The PerfectHealth Insurance Company, ConnectiCare and EmblemHealth Services Company, LLC.

NOTICE OF PRIVACY PRACTICES

This section offers a link to EmblemHealth's up-to-date policy for safeguarding your group members' Protected Health Information (PHI).

IMPORTANT INFORMATION ABOUT YOUR PRIVACY RIGHTS

Effective February 1, 2012

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

EmblemHealth, Inc. is the parent organization of the following companies that provide health benefit plans: Group Health Incorporated (GHI), HIP Health Plan of New York (HIP), HIP Insurance Company of New York, Inc. (HIPIC) and GHI HMO Select Inc. (d/b/a GHI HMO). All of these entities receive administrative and other services from EmblemHealth Services Company LLC which is also an EmblemHealth, Inc. company.

This notice describes the privacy practices of EmblemHealth companies, including GHI, GHI HMO, HIP and HIPIC (collectively "the Plan").

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

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

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

How We Use or Share Information

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

- **Payment**: We may use your information to process and pay claims submitted to us by you or your doctors, hospitals and other health care providers in connection with medical services provided to you.

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

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

Other Ways We Use or Share Information

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

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

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

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

Amending Your Information

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

Accounting of Disclosures

- **You have the right to receive an accounting** of certain disclosures of your information made by us for purposes other than treatment, payment or health care operations during the six years prior to your request. We may require that your request be in writing. If you request such an accounting more than once in a 12-month period, we may charge a reasonable fee.
- Please note that we are not required to provide an accounting of the following:
  - Any information collected prior to April 14, 2003.
  - Information disclosed or used for treatment, payment and health care operations purposes.

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

Collecting, Sharing and Safeguarding Your Financial Information

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

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

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

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

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

Exercising Your Rights, Complaints and Questions

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

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

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

Contact Information

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

Write to:
For all HIP, HIPIC, GHI members (except GHI HMO and GHI FHP) and EmblemHealth program members:

Corporate Compliance Dept.
P.O. Box 2878
New York, NY 10116-2878
For all GHI HMO and GHI FHP members:

Corporate Compliance Dept.
P.O. Box 4443
Kingston, NY 12402-4443

Call:
For all GHI members:**1-800-624-2414, TTY-1-866-248-0640**, M-F, 8 am-5 pm

For all GHI, Medicare Part D (NYC employee retirees) members:
1-800-624-2414, **TTY-1-866-248-0640**, M-F, 8 am-8 pm

For GHI Medicare Advantage and Medicaid Advantage members:
1-866-557-7300, **TTY-1-866-248-0640**, M-F, 8 am-8 pm

For all GHI Medicare Part D (non-NYC employee retirees) members:
1-877-444-7241, **TTY-1-888-447-4833**, M-F, 8 am-8 pm

For all GHI HMO and GHI FHP PPO members:
1-877-244-4466, **TTY-1-877-208-7920**, M-F, 8 am-6 pm

For all HIP and HIPIC members:
1-800-447-8255, **TTY-1-888-447-4833**, M-F, 8 am-6 pm

For all HIP Medicare Advantage, Medicare Part D and Medicaid Advantage members:
1-800-447-8255, **TTY-1-888-447-4833**, M-F, 8 am-8 pm

For all EmblemHealth program members:
1-877-842-3625, **TTY-1-866-248-0640**, M-F, 8 am-5 pm

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**

CONTACT INFORMATION

While **www.emblemhealth.com** is your first and easiest-to-use source for information about your group's coverage, we have assembled the following convenient, functional directory of the phone numbers of specific EmblemHealth departments.

CONTACT INFORMATION

Group/Broker Account Services

Enrollments/terminations, reinstatements, claims status, accounting	**1-866-614-6040**

Customer Service

Eligibility, claims status, benefit information, provider listings	**1-877-VIA-EMBLEM (1-877-842-3625)**
TDD/TTY (for hearing impaired)	**1-866-248-0640**

Pharmacy

Customer Service (all Rx inquires, retail and mail order)	**1-877-793-6253**
For physicians, to obtain prior approvals for non-formulary drugs	**1-877-444-3657**
Specialty Injectable Drugs – PA (Specialty Pharmacy Program)	**1-888-447-0295**

Home delivery – through Express Scripts (ESI)

Customer Service	**1-877-866-5798**
Web site	**www.express-scripts.com**

Medical Prior Approval/Precertification

CompreHealth/CompreHealth EPO	**1-877-846-3625**
InBalance EPO, ConsumerDirect EPO/PPO	**1-877-482-3625**

Mental Health Prior Approval/Precertification

CompreHealth/CompreHealth EPO	**1-877-347-2552**
InBalance EPO, ConsumerDirect EPO/PPO	**1-866-208-1424**

CONTACT INFORMATION

Health & Wellness

Employee Assistance Program (EAP)	**1-866-208-1443**
24-Hour Nurse Line	**1-877-444-7988**
Quit Smoking Program	**1-866-611-QUIT**
WellQuest Fitness Clubs	**1-800-595-8448**
Healthy Returns™ (Condition Management)	**1-866-612-0284**

OFFICE LOCATIONS

New York City
55 Water Street
New York, NY 10041-8190

New York City
441 Ninth Avenue
New York, NY 10001-1681

Albany
80 Wolf Road
Albany, NY 12205-3828

Buffalo
77 Broadway
Buffalo, NY 14203-1688

Syracuse
5015 Campuswood Drive
Pioneer Business Park
East Syracuse, NY 13057-1231

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

EmblemHealth®

WHAT CARE FEELS LIKE.

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

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