EmblemHealth®
WHAT CARE FEELS LIKE.

CONSUMERDIRECT EPO MEMBER HANDBOOK

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THIS IS YOUR CONSUMERDIRECT EPO MEMBER HANDBOOK.

It explains your EmblemHealth coverage and how you can help make it work for you. It is not your Certificate of Insurance. Your Certificate of Insurance defines your benefits as well as the terms, conditions, limitations and exclusions applied to your coverage. Please refer to your Certificate of Insurance when you have questions about your benefits.

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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.

This handbook contains a description of your EmblemHealth insurance program, including important coverage information, suggestions on ways to save out-of-pocket expenses, and other procedures to follow to get the most out of your coverage.

Where possible, we've defined insurance terms as they arise. However, you may occasionally find a word or term that you don't understand. When that happens, take a look in the section of this booklet entitled **Important Definitions**, and you'll likely find an explanation.

If you have any questions about your EmblemHealth coverage, visit **www.emblemhealth.com**, or call EmblemHealth at **1-877-842-3625**, 8 am to 8 pm, seven days a week (excluding major holidays).

At EmblemHealth, we respect the fact that you live a busy life and that you don't want to spend your time navigating your health coverage system. We are committed to providing service that is respectful of your time, intelligence, and money. We look forward to serving you and your family now and in the future.

Your EmblemHealth coverage is underwritten by Group Health Incorporated ("GHI"). Both HIP Health Plan of New York and Group Health Incorporated have been operating in New York for more than 60 years. EmblemHealth, Inc. is the parent company of HIP Health Plan of New York and Group Health Incorporated.

INTERNET ACCESS TO EMBLEMHEALTH

www.emblemhealth.com
For fast, convenient service and information 24/7

Looking for the visiting hours of your neighborhood hospital? Want to find the doctor closest to your office? Need to contact EmblemHealth Member Services? Want to connect with consumer-friendly health information online?

Visit the EmblemHealth Web site at: **www.emblemhealth.com** to get up-to-date information about EmblemHealth programs, providers, and much more. The EmblemHealth site provides immediate access to the same useful information available through the EmblemHealth **AnswerLine, 1-877-842-3625, 24 hours a day. Certified by Verizon Business Internet security standards**, the EmblemHealth Web site offers valuable resources for members, providers, brokers, and group administrators.

Register for *my*EmblemHealth for personal, secure access

When you visit **www.emblemhealth.com**, take a minute to **apply online for a Personal Identification Number (PIN).** This will give you access to *my*EmblemHealth, a secure Web portal, where only members can access their personal information. You will be prompted to enter your EmblemHealth Member ID number (found on your Member ID card). Follow the on-screen prompts to register for secure access. Once registered, your PIN will be sent to you immediately by email, with a confirmation by mail. With your PIN, you will be able to quickly access your personal information, including:

- Subscriber and dependent(s) eligibility for coverage
- Basic benefit information
- Claims status and history
- Provider names and locations
- And much more

IMPORTANT CONTACT INFORMATION

Web site Address List

Member Services	**www.emblemhealth.com/members**
Provider Search	**www.emblemhealth.com/findadoctor**
Pharmacy Benefit Services (Retail and Home Delivery)	**www.emblemhealth.com/pharmacy**
Specialty Injectable Drug Services	**www.emblemhealth.com/iCORE**
Download Claim Forms	**www.emblemhealth.com/forms**
PATH Wellness Programs (Includes Healthy Beginnings and Tobacco-Free Programs)	**www.emblemhealth.com/stayhealthy**
Healthy Discounts	**www.emblemhealth.com/healthydiscounts**
PATH Programs for Chronic Conditions	**www.emblemhealth.com/livebetter**
Wellness PATH Program (Available to eligible members)	**www.emblemhealth.com/WellnessPATH**

Telephone List

Member Services TTY/TDD for hearing impaired	**1-877-842-3625** **1-866-248-0640**
Medical Services Prior Approval	**1-877-846-3625**
Mental Health and Substance Abuse Services Prior Approval	**1-866-208-1424**
Retail Prescription Drug Coverage	**1-877-793-6253**
Pharmacy Clinical Department (For physicians to obtain prior approval for non-formulary drugs)	**1-877-444-3657**

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IMPORTANT CONTACT INFORMATION

Express Scripts Inc. (ESI) Home Delivery Coverage TTY/TDD for hearing impaired	**1-877-866-5798** **1-800-899-2114**
Inquiries about specialty injectable drugs	**1-888-447-0295**
To fill specialty injectable drug prescriptions through ICORE	**1-866-554-2673**
PATH Program	**1-800-783-3655**
Healthy Beginnings PATH Program	**1-877-736-2229**
Wellness PATH Program	**1-877-330-2746**
24-Hour Nurse Line	**1-877-444-7988**
Employee Assistance Program	**1-866-208-1443**
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**
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: 1-888-300-3277)**
Hearing Care Discount Program through TruHearing	**1-866-961-3152** **(TTY: 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 & Nutrition Discounts	**1-877-327-2746**

Address List

Medical/Hospital/Misc.

To submit an address change	EmblemHealth Membership Department P.O. Box 2820 New York, NY 10116-2820
To submit a medical claim	EmblemHealth P.O. Box 3000 New York, NY 10116-3000
To submit a hospital claim (i.e., Outpatient ambulatory surgery claims). **NOTE:** In most situations the hospital/facility will submit the claim form.	EmblemHealth P.O. Box 2833 New York, NY 10116-2833
To submit a claim for Durable Medical Equipment ("DME"), Private Duty Nursing and Home Infusion	EmblemHealth P.O. Box 2874 New York, NY 10116-2874
To submit a written inquiry or request a Provider Directory	EmblemHealth P.O. Box 1701 New York, NY 10023-9476
To submit a letter regarding a Utilization Review determination	EmblemHealth Utilization Review P.O. Box 2809 New York, NY 10116-2809
To submit a written medical grievance related to a benefit determination or other determination made by EmblemHealth	EmblemHealth P.O. Box 1701 New York, NY 10023-9476
To submit a written hospital grievance related to a benefit determination or other determination made by EmblemHealth	EmblemHealth P.O. Box 2828 New York, NY 10116-2828
To return a Coordination of Benefits ("COB") questionnaire or to submit a copy of your Medicare Card to assure EmblemHealth automatically coordinates secondary Medicare claims with Medicare Part B carriers for services performed in certain geographical areas	EmblemHealth P.O. Box 2804 New York, NY 10116-2804

Behavioral Management Program (BMP) for Mental Health & Substance Abuse

To submit a claim for Outpatient Mental Health	EmblemHealth - BMP P.O. Box 2827 New York, NY 10116-2827
To submit a claim for Inpatient Mental Health and Substance Abuse (**NOTE:** Generally, it is the provider's/facility's responsibility to submit these claims.)	EmblemHealth - BMP P.O. Box 2833 New York, NY 10116-2833
For providers to submit Outpatient treatment reports	EmblemHealth - BMP P.O. Box 1884 New York, NY 10116-1884
For subscribers to submit a written inquiry regarding claims for Mental Health & Chemical Dependency	EmblemHealth - BMP P.O. Box 1701 New York, NY 10023-9476

Prescription Drug

To submit a written inquiry	EmblemHealth Pharmacy Service Program 55 Water Street New York, NY 10041-8190

EmblemHealth Headquarters and Regional Offices

New York City Headquarters	55 Water Street New York, NY 10041-8190
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 13507-1231

IMPORTANT DEFINITIONS

This handbook may contain some phrases or terms that you are not familiar with. The following definitions may assist you in understanding terms applicable to your coverage.

Allowed Charge: The amount EmblemHealth will reimburse for covered services rendered by Non-Network Providers. Allowed charges are determined differently depending upon your specific plan and the type of service rendered. For services received from a Non-Network hospital, ambulatory surgery care from a Non-Network Provider, or pre-hospital emergency medical services, the allowed charge is determined by EmblemHealth for covered services. For many medical services rendered by Non-Network Providers, allowed charges are based on a percentile of either the FAIR Health schedule, or the published rates allowed by Medicare. If a Medicare rate is not available, the Allowed Charge will be based on the same percentile of The Essential RBRVS rate ("RBRVS" is an acronym for the Resource Based Relative Value Scale). Actual reimbursement is subject to any cost-sharing (e.g., deductible, coinsurance, etc.) that applies to your plan. Please refer to your Certificate of Insurance, Certificate Attachment, and Riders for more details regarding how allowed charges are determined on your specific plan.

Annual Maximum: The maximum accumulated payments EmblemHealth will make for covered services rendered to a covered person during a policy/calendar year, or the maximum number of covered days/visits available to a covered person for a particular service or services during a policy/calendar year. Essential Benefits do not have an annual maximum accumulated payment threshold.

Adverse Determination: A determination by EmblemHealth or its agents that an admission, extension of stay, or other health care service has been reviewed and, based on the information provided, is not medically necessary, or is experimental or investigational in nature, and therefore not covered.

Balance-of-Charges: Non-Network Providers have not agreed to accept EmblemHealth's Allowed Charge as payment in full. When you receive out-of-network services, you are responsible for any provider charges that exceed EmblemHealth's allowance in addition to any cost-sharing provisions, e.g. copayment, deductible, and/or coinsurance amounts, that apply to your benefits for covered services. For example, if the provider charges $50 for a given service and EmblemHealth allows $30, then you are responsible for the $20 difference ($50 - $30 = $20). In this example, the balance-of-charges would be $20. With a ConsumerDirect EPO program, balance-of-charges may apply to services received in a network hospital or network facility performed by non-participating providers such as: an anesthesiologist, radiologist, pathologist, and/or an assistant surgeon.

Calendar Year: The twelve month period beginning January 1st and ending December 31st each year.

Certificate Attachment: The attachment is a specification page that provides important information about your EmblemHealth health insurance. It sets forth the types of services for which you are covered. It sets forth any copayments, deductibles, and other maximums that apply to your coverage.

It advises you of the Schedule(s) of Allowances and reimbursement terms that apply to covered services. It advises you whether or not you are covered for services rendered by Non-Network Providers. It also provides eligibility information about certain types of dependents.

Certificate of Insurance: Document(s) evidencing the health insurance coverage provided under the Group Contract between EmblemHealth and your group.

Coinsurance: Coinsurance is a percentage of EmblemHealth's allowance(s) payable by you for covered services. Under your plan, most covered services are subject to coinsurance. Expenses credited toward your deductible, copayments, charges for services that are not covered, and charges in excess of EmblemHealth's allowances and benefit limitations are also payable by you, but are not considered to be coinsurance.

Copayment (copay charge): The fixed dollar amount members must pay for certain covered services. It is usually paid to a Network Provider at the time the service is rendered.

Cost-Sharing: A comprehensive term for the deductible, copayment, and coinsurance provisions in your program.

Deductible: A portion of eligible expenses that an individual or family must pay during a policy/calendar year before EmblemHealth will begin to pay benefits for covered services. Under the terms of your plan, you must satisfy your deductible each policy/calendar year before EmblemHealth can pay any claims (except for certain preventive care services, to which the deductible does not apply). **Note**: If you have family coverage (meaning two or more people are covered under the same plan), then the full amount of the family deductible must be satisfied before EmblemHealth can pay any benefits for any family member.

Dependent: An individual other than the subscriber who is eligible to receive health care services under the subscriber's Certificate of Insurance. Generally, dependents are limited to the subscriber's spouse and dependent children. Your group may have coverage extended to include domestic partners.

Eligible Expense: The total dollar amount allowed by EmblemHealth (i.e., EmblemHealth's allowance) for a particular service or procedure.

Emergency Care: Care for 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.

Essential Benefits: Essential Benefits include ambulatory care; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative care; laboratory services; preventive and wellness services and chronic disease management; pediatric services including oral and vision care; and any other services described as Essential Benefits pursuant to the Patient Protection and

Affordable Care Act. There are no annual or lifetime maximum payment thresholds on Essential Benefits. Your plan may or may not cover all Essential Benefits. Refer to your Certificate of Insurance for a complete description of covered services.

Exclusive Provider Option (EPO): A benefit program that utilizes a network(s) of providers and uses provider selection standards, utilization management, and quality assessment techniques to complement negotiated fee reductions as an effective strategy for long-term health care cost savings. Under an EPO benefit Program, covered individuals usually retain the freedom of choice of providers within the specified network. Services rendered by Non-Network Providers are generally not covered under an EPO benefit Program except for emergency care situations.

Group Contract: The group contract is the agreement EmblemHealth has with your group to provide health insurance.

Grievance procedure: A complaint process whereby you, your duly authorized representative, your provider, or their duly authorized representative may seek review of benefit determinations or other determinations made by EmblemHealth relating to your health insurance program. The grievance procedure does not include issues related to medical necessity and experimental/investigation decisions. Issues related to medical necessity and experimental/investigation decisions are subject to appeal, not the grievance process.

High Deductible Health Plan: A High Deductible Health Plan (HDHP) is a plan that has higher deductibles than traditional health care plans. A qualified HDHP satisfies certain requirements in terms of deductibles and out-of-pocket expenses as formulated by the IRS. The out-of-pocket maximum is based on deductibles, copayments, and coinsurance, but does not include premiums paid. Except for Essential Benefits, a qualified HDHP may not provide benefits until the deductible has been met. For family coverage, a plan is a HDHP only if, under the terms of the plan, and without regard to which family member incurs expenses, no amounts are payable until the family has incurred covered medical expenses in excess of the family deductible.

Hospital: Hospital refers to an institution that has medical and surgical facilities for the care and treatment of the sick. It must be a short-term acute care general hospital. A short-term acute care general hospital is an institution engaged primarily in providing inpatient diagnostic and therapeutic facilities for surgical and medical diagnoses, treatment, and care of sick and injured persons. The hospital must provide 24-hour nursing service by registered graduate nurses who are present and on duty. The hospital must be supervised by a staff of physicians. A hospital in not one of the following:

- An old age, rest, or nursing home
- A convalescent home or similar institution
- A sanitarium
- A camp, school, college, or university infirmary
- A facility primarily for the treatment of mental problems, tuberculosis, drug abuse, or alcoholism
- A weight loss or fitness center
- A skilled nursing center or facility
- An institution utilized primarily for custodial care or as a domicile
- A health resort or spa
- A place for hospice care treatment
- A rehabilitation facility

Lifetime Maximum: The maximum accumulated payments EmblemHealth will make for covered services rendered to a covered person per lifetime, or the maximum number of days/visits available to a covered person per lifetime for a particular service or services. Essential Benefits do not have a lifetime maximum accumulated payment threshold.

Medically Necessary: Medically necessary care is health care that is rendered by a hospital or a licensed or certified provider and is determined by EmblemHealth to meet all of the criteria listed below:

- It is provided for the diagnosis, direct care, or treatment of the condition, illness, disease, injury, or ailment.
- It is consistent with the symptoms or proper diagnosis and treatment of the medical condition, disease, injury, or ailment.
- It is in accordance with accepted standards of good medical practice in the community.
- It is furnished in a setting commensurate with the member's medical needs and condition.
- It cannot be omitted under the standards referenced above.
- It is not in excess of the care indicated by generally accepted standards of good medical practice in the community.
- It is not furnished primarily for the convenience of the member, the member's family, or the provider.
- In the case of a hospitalization, the care cannot be rendered safely or adequately on an outpatient basis and, therefore, requires that the member receive acute care as a bed patient.

The fact that a provider has prescribed a service or supplies does not automatically mean that the service or supplies will qualify for reimbursement under the EmblemHealth program. To be eligible for reimbursement by EmblemHealth, all covered services must meet the EmblemHealth medical necessity criteria described above.

Network Provider: Also known as a "Participating Provider," a Network Provider is any doctor or other provider who has agreed with us to accept our Schedule of Allowances or negotiated rate(s) as payment in full for covered services and who participates in the network that applies to your program. Visit **www.emblemhealth.com** for the names of Network Providers. You may also call or write to EmblemHealth for this information, or consult your EmblemHealth Provider Directory at **www.emblemhealth.com**.

Non-Network Provider: Also known as "Non-Participating Provider," a Non-Network Provider does not have an agreement with EmblemHealth to accept EmblemHealth's Network Rates as payment in full and/or is not a member of the EmblemHealth provider network. Services rendered by Non-Network Providers are generally not covered under a ConsumerDirect EPO benefit Program except for emergency care situations.

Network rate: The scheduled allowance(s) or negotiated rate(s) a Network Provider has agreed to accept as payment in full for covered services rendered to EmblemHealth members. Our network rate(s) usually represent a reduction to the provider's regular fee. In some cases, we will have a negotiated rate with a Network Provider. Our negotiated rates will vary, depending upon the terms agreed upon between us and the Network Provider.

Participating Provider: See **Network Provider.**

Non-Participating Provider: See **Non-Network Provider.**

Out-of-Pocket Maximum: The maximum dollar amount per policy/calendar year of coinsurance expenses payable by you for covered medical and hospital services. The specific amount may differ depending upon the features of your specific plan and whether services are rendered in network or out of network.

Precertification: Certain covered services must be precertified by contacting EmblemHealth for approval prior to treatment. Failure to obtain EmblemHealth's advance approval for these services may result in a reduction of benefits and/or payments.

Provider: A provider is a medical practitioner or covered facility recognized by EmblemHealth for reimbursement purposes. A provider may be any of the following, subject to the conditions listed in this paragraph:

- A doctor of medicine
- A doctor of osteopathy
- A dentist
- A chiropractor
- A doctor of podiatric medicine
- A physical therapist
- A nurse midwife
- A certified and registered psychologist
- A certified and qualified social worker
- An optometrist
- A nurse anesthetist
- A speech therapist
- An audiologist
- A clinical laboratory
- A screening center
- A general hospital
- Any other type of practitioner or facility specifically listed in your Certificate of Insurance as a practitioner or facility recognized by EmblemHealth for reimbursement purposes

A provider must be licensed or certified to render the covered service. The covered service must be within the scope of the provider's license or certification. Please note that not all services rendered by a specific class of providers listed above are reimbursable. In order for the treatment to be reimbursable, the service rendered to you must be covered under your EmblemHealth program and must be medically necessary. In addition, the practitioner or facility rendering the service must be listed in your Certificate of Insurance or this handbook as a provider who is recognized by EmblemHealth to render the covered service. Please refer to your Certificate of Insurance to determine if a service is covered. In any case, where the two documents conflict, the Certificate of Insurance will govern.

Rider: A document that modifies a plan's Certificate of Insurance and/or Certificate Attachment. Riders generally add or exclude coverage or amend the terms of existing coverage.

Utilization Review: A review to determine whether covered services that have been provided or are proposed to be provided to you, whether undertaken prior to, concurrent with, or subsequent to the delivery of such services, are medically necessary, experimental, or investigational in nature.

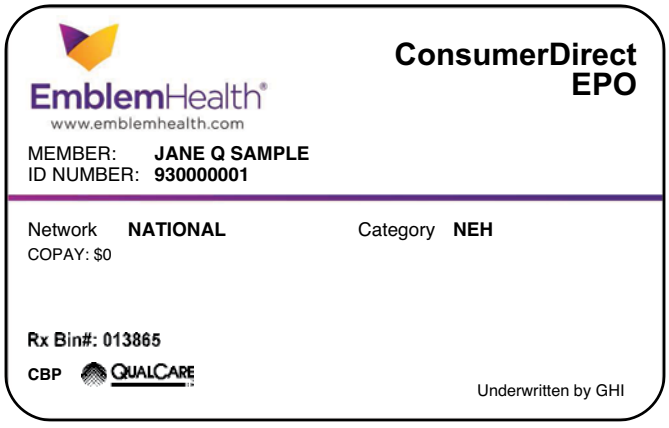
Utilization Review Agent: EmblemHealth or any other agent performing utilization review on our behalf.

Utilization Review Appeal: The process by which you or your representative may request review of a denied service(s) based upon an Adverse Determination made by EmblemHealth or a Utilization Review agent acting on our behalf. An Adverse Determination is a denial by EmblemHealth of coverage for services considered not medically necessary or experimental or investigational in nature.

YOUR EMBLEMHEALTH ID CARD

Information on your Member ID card

The sample below shows the information you will find on your Member ID card. The front of the card has the member's name and ID number. It also shows the program (ConsumerDirect EPO Plan) and network you have access to. (For more details on your provider network, see the chapter *Choosing Your Health Care Providers*.) The back of your card lists important telephone numbers and addresses.



Keep your EmblemHealth Member ID card with you at all times. Always show your Member ID card when you use health care services.

Identify yourself to providers as an EmblemHealth member.

Avoid unnecessary confusion and paperwork. Always show your EmblemHealth Member ID card to a Network Provider. Your identification as an EmblemHealth member allows the provider to submit claims directly to EmblemHealth. Make it easier on yourself. Make sure your provider knows you're an EmblemHealth member.

You will receive additional cards if you have family coverage.

Never lend your EmblemHealth ID card to anyone. If your card is lost or stolen, immediately call Member Services at **1-877-842-3625 to report the loss and to receive a replacement card.** You may also order additional Member ID cards by visiting our Web site at **www.emblemhealth.com**.

TYPE OF PLAN: HIGH DEDUCTIBLE HEALTH PLAN

You are enrolled in a high deductible health plan, the EmblemHealth ConsumerDirect Exclusive Provider Option (EPO) program. Your EmblemHealth Certificate of Insurance and Certificate Attachment found in your Welcome Kit will have all of your benefit information.

Your Member ID card and your Certificate Attachment will show which network of providers is available to you. For details about Network and Non-Network Providers, see *Choosing Your Health Care Providers*.

No referral needed. With EmblemHealth's ConsumerDirect EPO program, you are free to schedule an appointment with any participating network physician --including specialists --without obtaining a referral from your primary care physician. **With limited exceptions, such as emergency care, your coverage will provide benefits *only* for covered services rendered by a Network Provider. Out-of-network benefits are generally not available.**

The EmblemHealth ConsumerDirect EPO program is underwritten by Group Health Incorporated ("GHI"), an EmblemHealth company.

Refer to your Certificate of Insurance for details.

What is a high deductible health plan?

A high deductible health plan (HDHP) is designed with a high deductible that shifts some of the day-to-day health care costs to the insured in exchange for lower premiums. HDHPs have higher deductibles than traditional health care plans, along with lower premiums.

About your deductible

Once the deductible has been satisfied, the applicable in-network coinsurance amount will apply. The deductible and coinsurance amounts that apply to your program are shown in your Certificate Attachment. Your program may use either a policy year or a calendar year basis to calculate these amounts. "Policy year" refers to the twelve month period beginning with the effective date of your Group Contract and each subsequent twelve month period that the Group Contract is renewed. If your program uses the policy year method, you will have a Rider for this amending your Certificate of Insurance.

The deductible applies to all expenses, including prescription drugs, covered by the plan. However, certain preventive care services are covered on a "first-dollar" basis, the deductible does not apply. Except for preventive care, a HDHP may not provide benefits in any given policy/calendar year until the deductible for that policy/calendar year is met. For family coverage, no amounts are payable from the HDHP until the full family deductible has been met, regardless of which family member incurs expenses.

For a detailed explanation of how the deductible, coinsurance, out-of-pocket maximums and other cost-sharing provisions affect EmblemHealth's ConsumerDirect Programs, please see the section of this handbook entitled *Claims and Reimbursement*.

Health Savings Account

EmblemHealth ConsumerDirect programs qualify for a Health Savings Account (HSA). The HSA is designed to give you an opportunity to save money for future medical expenses with tax advantages.

For more information about your ConsumerDirect program and how you have the power to manage your own health care choices and expenses, you can read or print a pdf of the brochure "You've Got the Power!". Click here.

MEMBER SERVICES

Call member services promptly if you:

- Have questions or concerns about your coverage
- Want to know more about providers
- Have service issues or need problem resolution

Most questions may be answered by visiting our Web site at **www.emblemhealth.com** or by calling Member Services at **1-877-842-3625**.

Your satisfaction is important to us.

When you contact Member Services, we will make every effort to answer your questions in a timely manner and to your satisfaction. When a non-English speaking member, or his/her representative, contacts the Member Services area, arrangements will be made to accommodate the language needs of the member. **For the hearing impaired, please call 1-866-248-0640.**

Member input into EmblemHealth's policy development

As an Article 43, not-for-profit health services corporation, Group Health Incorporated ("GHI"), the EmblemHealth company that underwrites your EPO coverage, is required by New York State Insurance Law to have a board of directors whose members are representative of EmblemHealth's Network Hospitals or medical professionals, members, and the general public.

MEMBER ELIGIBILITY

When do benefits begin?

Benefits under the EmblemHealth Health Insurance program begin on the date you are enrolled in the program as determined by your group. Please contact your group benefit administrator to find out the date of this enrollment.

Your family's eligibility

Your Certificate of Insurance and Certificate Attachment describe the specific eligibility provisions for dependent children under your group's contract.

Newborns (natural or adopted) must be enrolled within 30 days of birth in order to be covered from the moment of birth. Other new dependents, such as older adopted children, or a new spouse, must be also enrolled within 30 days of adoption or marriage to avoid a gap in coverage. Contact your employer's benefits department for details and specific guidelines for enrolling new dependents.

In the event of a change in your family status (e.g., marital status change, births, deaths), you must contact your employer's benefits department. Changes in family status could affect your coverage.

Please contact your group benefit administrator if you have any questions pertaining to eligibility. EmblemHealth can only change an enrollment status after receiving notification from your group.

Dependent coverage

Dependent children are generally eligible for coverage and this coverage extends through the end of the month that the dependent child reaches age 26. Coverage will terminate on the last day of the dependent's birthday month.

Age limitation for dependents may be extended based on your Program design. See your Certificate Attachment for details on dependent enrollment age limitations.

Dependent children incapable of self-sustaining employment

EmblemHealth will provide coverage for dependents who are incapable of self-sustaining employment due to mental illness, developmental disability, mental retardation or physical handicap beyond the usual limiting age of your program. Please note that EmblemHealth reserves the right to request proof that the child continues to qualify as a dependent incapable of self-sustaining employment. You must submit a completed questionnaire to EmblemHealth at least 31 days prior to the date that dependent coverage would otherwise terminate in order for EmblemHealth to determine whether the dependent is eligible. You may contact Member Services online at **www.emblemhealth.com** or call **1-877-842-3625** to obtain this questionnaire. EmblemHealth will notify you in writing of its determination of eligibility. Submit the questionnaire to:

EmblemHealth
Membership Department
P.O. Box 2820
New York, NY 10116-2820

What to do if you are no longer covered by your group

Changes in employment, marital status, or the age of a dependent can bring an end to coverage under your program. But you may be able to continue coverage for a limited period of time under your group's coverage and/or purchase an individual direct payment health insurance contract from us, **www.emblemhealth.com**, or from New York State of Health's marketplace, **www.nystateofhealth.ny.gov**. See your Certificate of Insurance for more details.

Requesting a certificate of creditable coverage

If your EmblemHealth coverage terminates before 2015, we will automatically issue a certificate of creditable coverage to you. The certificate is evidence of the coverage you had with EmblemHealth. Under a Federal law known as HIPAA, you may need evidence of your prior coverage to reduce a pre-existing condition exclusion period under another plan. Although you will automatically receive a certificate of coverage , you may not need to use it. Make sure you check with the plan you are considering enrolling in to see if a certificate of credible coverage is required. You may request a copy of your certificate of creditable coverage by writing to EmblemHealth at:

EmblemHealth
P. O. Box 2862
New York, NY 10116 -2862

Or, you may call us at **1-877-842-3625** to request this certificate. You may request this certificate at any time prior to 2015, even if your EmblemHealth coverage is still in force.

Address change

Address changes should be submitted to your group and EmblemHealth in a timely fashion. EmblemHealth can accept your address change either through our Web site's Member page, **www.emblemhealth.com/Members.aspx**, or you can submit your address change in writing to:

EmblemHealth
Membership Department
P.O. Box 2820
New York, NY 10116-2820

Special enrollment rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption to avoid a gap in coverage.

Also, if a court has ordered you to cover a spouse or minor children, you must add the spouse and minor children within 30 days of the court order. If any federal or state law requires coverage to be provided, you must apply for enrollment within 30 days of the occurrence of the event that triggers your right to enroll or within any time period specified in the law requiring the coverage, whichever is longer.

To request special enrollment or obtain more information, contact your group benefit administrator.

CHOOSING YOUR HEALTH CARE PROVIDERS

Great doctors. More choices.

At EmblemHealth, we know that nothing is more important than access to quality doctors and health care facilities. That's why we work hard to attract and keep the best doctors and hospitals in each network. You'll find that your network includes:

- "Top Docs" from *New York* Magazine's list, and great hospitals like Memorial Sloan-Kettering, Montefiore Medical Center, Lenox Hill Hospital, North Shore-Long Island Jewish Health System and Albany Medical Center.
- Convenient, regional access to doctors in New York, New Jersey and Connecticut, and to providers across all 50 states.

It's easy to "Find a Doctor" at www.emblemhealth.com.

To make it easy to find the right doctor near where you live and work, visit **www.emblemhealth.com** 24 hours a day, seven days a week and click on "Find a Doctor" to view the most up-to-date listing of EmblemHealth Network Providers. All EmblemHealth Network Providers are listed on our Web site.

To use the system, enter your Username and Password in the box under "Already a Member?" and click "Next." The system will then show what network you have access to. Follow the prompts to locate a provider by name or location. You can refine your search by distance, gender, language, office hours, and more. You can even get driving directions to the provider's office. Click on a particular provider's name to see all the networks that provider is affiliated with.

Scheduling an appointment with a Network Provider

Since you are enrolled in a ConsumerDirect EPO program, when you schedule an appointment, **you should always confirm that the provider participates with EmblemHealth because a ConsumerDirect EPO program generally does not cover services rendered by Non-Network Providers except for emergency care situations.**

The logos on your Member ID card may help you and your provider determine participation status. When making an appointment with a New Jersey provider, ask if the provider belongs to the QualCare network to verify that he or she is an EmblemHealth Network Provider. Similarly, when making an appointment with a Connecticut provider, ask if the provider is in the MultiPlan network. When making an appointment with a provider located outside the NY/NJ/CT area, ask if the provider is an EmblemHealth "CBP" provider or "MultiPlan" network provider.

You can also call EmblemHealth at **1-877-842-3625** for a listing of Network Providers.

In general, EmblemHealth defines a provider as a medical practitioner or facility recognized by EmblemHealth for reimbursement purposes. The section of this handbook entitled "**Important Definitions**" contains additional details on how EmblemHealth defines a provider.

Choosing Network Providers cuts expenses and paperwork

When you use an EmblemHealth Network Provider, you control your out-of-pocket expenses and avoid unnecessary paperwork. EmblemHealth's Network Providers have agreed to accept EmblemHealth's allowances or negotiated rates as payment in full for covered services.

Once you have satisfied your deductible, you pay only the applicable coinsurance or copayments, as described in your Certificate of Insurance, Certificate Attachment, and Prescription Drug Rider. Plus, you do not file any claim forms when you use a Network Provider — that's the provider's responsibility.

Your EmblemHealth health insurance program gives you direct and easy access to EmblemHealth's extensive network of participating physicians and other health care providers conveniently located where you live and work. EmblemHealth reviews and confirms the credentials of the Network Providers.

The following provider types are part of EmblemHealth's provider network:

- Primary care physicians
- Specialist physicians
- Mental health and chemical dependency providers and facilities
- Hospitals
- Ancillary care providers
- Vision care providers
- Pharmacies nationwide

No referral needed

You are free to schedule an appointment with any Network Provider—including specialists—without a referral from your primary care physician. Some physicians, however, will only accept patients that have referrals from other health care providers.

Please note that the EmblemHealth provider network changes over time. Before scheduling an appointment or receiving covered services, be sure to confirm that the provider still participates in the EmblemHealth network selected for your program. EmblemHealth cannot guarantee the continued participation of a Network Provider or your acceptance as a patient by a particular Network Provider.

You should also be aware of these special conditions for payment:

Note: Your ConsumerDirect EPO program only covers services, with the exception of emergency care, if you use an EmblemHealth Network Provider.

If you decide to choose a Non-Network Provider, please note:

Non-Network Providers are not required to accept EmblemHealth's allowance as payment in full and will bill you for their charges directly. Unlike when you use a Network Provider:

- You are responsible for paying any Non-Network Provider up front except for emergency care.
- You will generally have greater cost-sharing responsibilities when you receive care from Non-Network Providers.

Refer to your Certificate of Insurance and Certificate Attachment for information on your covered benefits.

CLAIMS AND REIMBURSEMENT

How to File a Claim

Using a Network Provider makes obtaining benefits truly simple. You show your EmblemHealth ID card and your Network Provider will file the claim for you on your behalf. After the claim is processed you and the Network Provider will be sent an Explanation of Benefits, which will include information on what your responsibility is. If your deductible has not been met, it will show how much you owe towards your deductible. If your deductible has been met, it will show how much coinsurance you owe. For covered services, Network Providers may not balance bill you and charge you more than EmblemHealth's Network Rate. You should not owe more than the amount indicated on the Explanation of Benefits.

Network Providers will file claims on your behalf so EmblemHealth can track the deductible amounts you pay and properly credit your records until you have satisfied your deductible each policy/calendar year.

You must satisfy your deductible each policy/calendar year before EmblemHealth will pay any claims (except for Essential Benefits, to which the deductible does not apply).

If you use a Non-Network Provider, since you are enrolled in a ConsumerDirect EPO program you must pay the provider's full charge , except for emergency care situations. If you receive emergency care services from a Non-Network Provider promptly submit a claim form to EmblemHealth for processing.

Submit claims for medical services to:

EmblemHealth
P.O. Box 3000
New York, NY 10116-3000

Submit claims for hospital (facility) services to:

EmblemHealth
P.O. Box 2833
New York, NY 10116-2833

Most claims are processed and mailed by EmblemHealth within 10 to 15 business days from the date the claim is received from you or your provider. To save time, we suggest you request the provider complete the claim form at the time of your visit so that you can mail the claim to EmblemHealth right away.

In order to prevent a denial of coverage due to failure to file a claim in a timely fashion, you must file your claim with EmblemHealth within 18 months after the date upon which the service was provided.

The Health Insurance Claim Form is used for most services and can be found at **www.emblemhealth.com**.

How to get the fastest claim service

If you are submitting a claim form, you can help speed claim processing by making sure you fill out every section of the claim form accurately and completely.

Remember to:

- Include your Member ID number, which is shown on your EmblemHealth Member ID card. Be sure to show if you have any other coverage each time you submit a claim.
- Make sure your doctor provides a copy of a detailed, itemized bill or completely fills out the claim form. **The claim cannot be processed if it does not specify the exact services performed.**

Promptly complete and mail claims to the appropriate address indicated on the claim form.

Your EmblemHealth Explanation of Benefits ("EOB"):

You will usually receive an Explanation of Benefits ("EOB") from EmblemHealth when we process a claim submitted by you or your provider.

When you use an EmblemHealth Network Provider we will send you and the Network Provider or hospital an EOB to inform you that EmblemHealth has processed a claim on your behalf. The services you received and the dates they were performed are listed on the statement, along with EmblemHealth's network rate for each covered service and any deductible or coinsurance amounts applied by EmblemHealth. The EOB will indicate if you owe anything toward your deductible. If your deductible has been met, it will indicate the amount of coinsurance you owe, if any. A reimbursement check, if appropriate, will generally be sent to the provider.

If you use a Non-Network Provider for medical services with a ConsumerDirect EPO program, you are responsible for paying any Non-Network Provider up front except for emergency care. If you receive emergency care services, you must file a claim form with EmblemHealth to request reimbursement for these services. After EmblemHealth processes a claim you've submitted, we will send you an EOB, along with a reimbursement check, if appropriate. The statement will tell you the services you received, the dates they were performed, EmblemHealth's allowances for covered services, and any deductible or coinsurance amounts applied by EmblemHealth.

When you obtain covered services from providers, you may be responsible for any or all of the following types of charges:

- **Deductible**—A portion of eligible expenses that an individual or family must pay during a policy/calendar year before EmblemHealth will begin to pay benefits for covered services.
- **Coinsurance**—A percentage of EmblemHealth's allowance(s) payable by you for covered services. Expenses credited toward your deductible, copayments, charges for services that are not covered , and charges in excess of EmblemHealth's allowances and benefit limitations are also payable by you, but are not considered coinsurance.

- **Copayment**—The fixed dollar amount members must pay for certain covered services. It is usually paid to a Network Provider at the time the service is rendered.
- **Balance of Charges**—Non-Network Providers have not agreed to accept EmblemHealth's Allowed Charge as payment in full. Since you are enrolled in a Consumer Direct EPO program when you receive out-of-network services, usually emergency services, you are responsible for any provider charges that exceed EmblemHealth's allowance in addition to any cost-sharing provisions, e.g. copayment, deductible, and/or coinsurance amounts, that apply to your benefits, usually emergency services. For example, if the provider charges $50 for a given service and EmblemHealth allows $30, then you are responsible for the $20 difference ($50 - $30 = $20). In this example, the balance-of-charges would be $20. With a ConsumerDirect EPO program, balance-of-charges may apply to services received in a network hospital or network facilities performed by non-participating providers such as: an anesthesiologist, radiologist, pathologist, and/or an assistant surgeon.

What EmblemHealth pays

Network Providers

After you have satisfied your deductible, EmblemHealth provides benefits for covered hospital and medical services rendered by Network Providers based on our fee schedule or negotiated rates. Our Network Providers have agreed to accept our fee schedule or rates as payment-in-full for covered services, subject to other applicable cost-sharing provisions. The percentage of the Network rate or allowed charge not paid to the Network Provider by EmblemHealth is your "coinsurance expense." You are responsible for paying this portion of the rate or allowance to the Network Provider.

Non-Network Providers

An EmblemHealth ConsumerDirect EPO program does not usually, except for emergency care, offer the option of seeing a Non-Network Provider. Your coverage will provide benefits only for covered services rendered by a Network Provider.

Special services

Certain services, including mental health treatment, durable medical equipment, and others, if covered, often have special reimbursement provisions. These special benefit provisions, along with the cost-sharing provisions and benefit maximums that apply to your Program, are set forth in your Certificate of Insurance, Certificate Attachment and any applicable Riders.

Non-Covered services

EmblemHealth will not pay for any services that are not listed as covered or are specifically excluded under your program. You will be responsible for the provider's full charges for such services.

Transfers among providers

If during the course of treatment you transfer from one provider to another, EmblemHealth's allowance for the covered services may be pro-rated between the providers. Normally, EmblemHealth will not pay more than its maximum allowance had payment been made to only one provider.

Lifetime maximum

Each person is subject to the lifetime benefit maximum shown in the Certificate Attachment for covered services other than Essential Benefits. EmblemHealth will not pay more than this amount per person per lifetime for such covered services. Some covered services may also be subject to maximum limits on the number of visits, days or the dollar amount that EmblemHealth will pay per person, per lifetime. Please refer to the Certificate and Attachment for details.

What you pay

You will maximize your benefits and minimize out-of-pocket expenses by utilizing EmblemHealth Network Providers.

Your financial responsibility is limited to the following categories:

Premiums. In many cases, your health coverage will be provided as part of a group. EmblemHealth will not charge you directly for coverage as a member of an EmblemHealth-enrolled group. Your group, however, may include a periodic charge to you for your health benefits.

Your coverage with EmblemHealth may be terminated due to the failure of your group to pay its premium in a timely manner. In such cases, you will be eligible to purchase replacement coverage with EmblemHealth under a direct-payment health insurance contract. Under such a contract, you are responsible for paying your premium directly to EmblemHealth.

Cost-sharing. The specific cost-sharing provisions for your plan are detailed in your Certificate of Insurance. The following information is included here to help you more easily understand the information in your Certificate of Insurance.

When you obtain covered services from Non-Network Providers, not including emergency services, you are responsible for the following type of charge:

- **Balance of Charges**—Non-Network Providers have not agreed to accept EmblemHealth's Allowed Charge as payment in full. When you receive out-of-network services, you are responsible for any provider charges that exceed EmblemHealth's allowance in addition to any cost-sharing provisions, e.g. copayment, deductible, and/or coinsurance amounts, that apply to your benefits for covered services. For example, if the provider charges $50 for a given service and EmblemHealth allows $30, then you are responsible for the $20 difference ($50 - $30 = $20). In this example, the balance-of-charges would be $20. With a ConsumerDirect EPO program, balance-of-charges may apply to services received in a network hospital or network facility performed by non-participating providers such as: an anesthesiologist, radiologist, pathologist, and/or an assistant surgeon.

Your Certificate of Insurance details the specific cost-sharing provisions for all benefits under your plan.

Out-of-Pocket Maximum: Once you have satisfied your deductible and paid a maximum amount of eligible out-of-pocket expenses for covered services received in a policy year, EmblemHealth will reimburse for covered services up to the full amount of the applicable fee schedule, negotiated rates, or allowed charge for the balance of that policy/calendar year. This means that, once you have paid the maximum in eligible out-of-pocket expenses during a given policy/calendar year, EmblemHealth will not require any additional coinsurance or copayment from you for covered services for the rest of that

policy/calendar year. This limits the amount of coinsurance and/or copayments you must pay in a given policy year. Eligible out-of-pocket expenses include deductibles, coinsurance and copayments. The specific out-of-pocket maximum amounts that apply to your plan are set forth in your Certificate Attachment.

Eligible out-of-pocket expenses do not include premiums, financial penalties, and any amounts you must pay a Non-Network Provider that are in excess of EmblemHealth's allowed charges.

When you use Network Providers, Essential Benefits such as an annual adult physical exam and well-baby/well-child care, are covered in full, meaning there is no cost to you (i.e., no cost-sharing) for covered services.

New York State surcharge

New York State imposes a surcharge on health care given by certain types of providers. This surcharge applies to payments made by EmblemHealth and to the out-of-pocket expenses that you, the patient, are often responsible for. Out-of-pocket expenses include deductibles, copayments and coinsurance. EmblemHealth will pay the surcharge attributable to payments actually made by EmblemHealth, and it will pay the surcharge attributable to copayments. Patients must pay the surcharge attributable to any copayment, deductibles and coinsurance if the providers separately bill you for this amount.

At the time this booklet was revised, the surcharge only applies to services given by the following types of providers: general hospitals, hospital-based extension clinics, comprehensive diagnostic and treatment centers, diagnostic and treatment center extension clinics, diagnostic and treatment centers that provide ambulatory surgical services, and clinical laboratories.

How to be reimbursed for Medicare services

EmblemHealth automatically coordinates secondary Medicare claims with the Medicare Part B carrier if you have services performed in the following areas and states:

Queens County, New York; Florida; New Jersey; Pennsylvania; Delaware; Washington, D.C.; Prince George's and Montgomery counties in Maryland; Fairfax, Arlington and Alexandria counties in Virginia. In these areas, Medicare Part B claims are automatically sent by the primary Medicare carrier to EmblemHealth for payment of secondary claims. This means you do not have to submit a claim for payment of secondary Medicare-eligible coverage from EmblemHealth. However, to make sure this convenience is put into effect, you should submit a copy of your Medicare Card to EmblemHealth at the following address:

EmblemHealth
c/o COB Department
P.O. Box 2804
New York, NY 10116-2804

You will not be required to submit any further Medicare claims for services in these areas. EmblemHealth will automatically process your claim in coordination with Medicare.

If you have services performed outside the above areas, you must first submit your claim to Medicare. EmblemHealth will not duplicate payments made by Medicare. To receive EmblemHealth benefits for services that are partially covered by Medicare, your claim must be filed with Medicare first. Your Explanation of Medicare Benefits form must be attached to your EmblemHealth claim form.

Important note about Medicare

To maintain maximum health benefits coverage, you must join Medicare by calling your local Social Security office as soon as you are eligible. To enroll in Medicare Part A (Hospital) and Part B (Medical), contact the Social Security office three months before your 65th birthday.

YOUR BENEFITS

What benefits are included?

The EmblemHealth health insurance program offers you and your eligible dependents coverage for a wide range of health care services. In order to be eligible for reimbursement, all services rendered to you must be listed in your Certificate of Insurance as covered and must be medically necessary.

Please refer to your Certificate of Insurance, Certificate Attachment and any applicable Riders for a description of the health care services covered under your EmblemHealth health insurance program. Or, if you have any questions, please ask your group benefits administrator. You may also telephone EmblemHealth Member Services Department for help.

Please review the *Utilization Review: How It Can Affect Your Benefits* section of this handbook and your Certificate of Insurance for further information about medical necessity.

Medical. EmblemHealth provides benefits for general medical care for out-of-hospital and some in-hospital services, including, under most programs, home and office visits for the diagnosis and treatment of illness or injury, surgery, anesthesia and other medical services.

Hospital. EmblemHealth provides coverage for inpatient and outpatient general acute care hospital services, and for certain other types of facilities and services. Your Certificate of Insurance and Certificate Attachment will explain any differences in benefits between Network and Non-Network Hospitals.

Preventive Care: First Dollar Coverage

The following Preventive Care Services are covered in full under the EmblemHealth ConsumerDirect program when services are rendered by a Network Provider:

- Well baby/well child care, including immunizations up to age 19
- Adult preventive care services including an annual physical exam, mammography, pap smear, bone density screening and prostate screening.

"First dollar coverage" means that these services are NOT subject to deductible and coinsurance when you use the services of a Network Provider.

For a more detailed description of these preventive care services and what they include, please refer to your Certificate of Insurance.

A word about precertification

EmblemHealth must approve some services before you receive them—that is what "precertification" means. Since you are enrolled in an ConsumerDirect EPO program, the Network Provider will take care of this for you. For more details about precertification, see your Certificate of Insurance and Certificate Attachment, and/or the section of this handbook entitled *Utilization Review*.

Coverage for emergency care

You are covered for emergency care provided and billed for by a hospital emergency room, whether it is in-network or out-of-network.

Definition of emergency care: Care for 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:

- 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;
- Serious impairment to such person's bodily functions;
- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of such person.

If you require emergency care, as defined above, visit the Emergency Room of any general acute care hospital. Emergency care, including emergency room professional and facility charges, emergency admission professional and facility charges, and emergency ambulance (ground and air) are covered, subject to the deductible and coinsurance as set forth in your Certificate Attachment.

Precertification is never required in connection with outpatient emergency care or emergency hospital admissions. However, if your program requires precertification of hospital admissions, you should notify EmblemHealth's Utilization Review Department of your admission within two (2) business days following an emergency admission or as soon as you are reasonably able to do so.

Chemical dependency/mental health treatment (CD/MH) benefits

EmblemHealth programs offer outpatient benefits for chemical dependency, inpatient treatment for chemical dependency, inpatient mental health care, and/or outpatient mental health care. Your Certificate of Insurance and Certificate Attachment or Rider will indicate the specific services covered under your group's program.

EmblemHealth uses a benefits manager in order to administer its CD/MH benefit program. Cost-effective coverage is achieved through a special network of mental health facilities, psychiatrists, certified social workers, and other mental health professionals.

Benefits under the Women's Health and Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-

related benefits, coverage will be provided in a manner determined in consultation with the attending doctor and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses, and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under your EmblemHealth program. Please refer to your Certificate of Insurance and Certificate Attachment for information about the copays, deductibles, and/or coinsurance that apply to your benefits. If you would like more information on WHCRA benefits call us at **1-877-842-3625**.

Direct access to obstetric and gynecologic care

Pursuant to the New York State Women's Health and Wellness Act of 2002, you have direct access (i.e., no referral required) to primary and preventive obstetric and gynecologic services and pregnancy care services, including primary and preventive obstetric and gynecologic services required pursuant to such services or as a result of an acute gynecologic condition, if any, covered under your Certificate of Insurance from a qualified Network Provider of your choice.

PRESCRIPTION DRUGS

Prescription drug coverage, if it is part of your program, under the EmblemHealth ConsumerDirect Program is subject to the same overall plan deductible as other covered services; there is not a separate drug deductible. Your plan's deductible must be satisfied each policy/calendar year before EmblemHealth will pay claims for covered services, including prescription drug claims. The amount of the plan's deductible is set forth in your Certificate Attachment.

If your Program covers prescription drugs, EmblemHealth provides reimbursement based on negotiated rates, which represent an established discount of the Average Wholesale Price of each drug. Please note that your program may not provide coverage if you use an out-of-network pharmacy.

EmblemHealth's Network Pharmacies have agreed to accept these discounted rates as payment in full for covered prescription drugs, subject to applicable cost-sharing provisions.

Your Prescription Drug Rider will indicate what additional cost-sharing (copayments and/or coinsurance) may apply to your prescription drug coverage after you have satisfied your deductible.

EmblemHealth offers coverage for retail and/or home delivery prescription drugs. Check your Certificate of Insurance and Certificate Attachment and/or Riders to find out whether prescription drug benefits are available to you under your program. These benefits may include:

- **Retail prescriptions,** which can be filled for acute medications — generally a short-term supply, which cannot exceed a 30 consecutive day supply of the drug — at a Network Pharmacy.
- **Home delivery prescriptions,** which can be filled for longer-term supplies of medications, up to 90 days.

Prescription drug benefit — Retail: If your group's program includes prescription drug coverage, when you visit an EmblemHealth Network Pharmacy, simply present your EmblemHealth Member ID card to the network pharmacist along with the doctor's prescription. There are no claim forms to fill out when you use an EmblemHealth Network Pharmacy. The pharmacist will fill your prescription and will apply any applicable copays, deductibles or coinsurance.

Prescription drug benefit — Home Delivery Program: Your program may also provide for home delivery services for long-term or ongoing prescription medications. Your prescription and the applicable copay must be mailed to the designated EmblemHealth mail order pharmacy vendor for dispensing.

With your original mail-order prescription medication, you will receive a notice showing the number of times it may be refilled. Simply mail this refill notice and any applicable copay in the pre-addressed order envelope which has been provided. It's a good idea to order your refills at least three weeks before you need them.

In addition to EmblemHealth's designated mail order pharmacy vendor, you have the option to fill home delivery prescriptions at a retail pharmacy that has agreed with us, in advance, to accept our mail order program terms, conditions and rates.

The copay or coinsurance amount you must pay may vary depending upon whether you receive a generic, preferred ("formulary"), or non-preferred ("non-formulary") drug. You may be able to reduce your out-of-pocket costs by using generic medications whenever possible. By law, generic drugs must meet the same standards for safety, purity, strength and effectiveness as brand-name drugs. Pharmacies can dispense generic drugs when authorized by your doctors and permitted by applicable law.

Formulary drugs: Some programs may include a formulary, which is a list of prescription drugs that are preferred for use. The formulary is subject to periodic review and modification by EmblemHealth. Some programs have an "open" formulary, meaning members are covered for both formulary (preferred) and non-formulary (non-preferred) prescription drugs. Other programs have a "closed" formulary, meaning members are generally covered only for prescription drugs listed on the formulary.

Generic and Single Source Generic Drugs: Most programs will cover generic drugs at a lower cost than the brand name equivalent that is listed as preferred on the formulary. Some programs may include single source generic drugs with preferred drugs on the formulary. The single source generic drug would then be subject to the same cost-sharing as the formulary drugs. Single source generic drugs are defined as those drugs going off patent for which the single source generic house has exclusivity for a period of time.

If your program includes formulary drugs, you can find the formulary on our Web site, **www.emblemhealth.com**. Your Certificate of Insurance or Prescription Drug Rider will indicate whether your prescription drug benefits include formulary drugs, and whether your program has an "open" or "closed" formulary. Generally, your out-of-pocket expenses for formulary (preferred) drugs will be higher than for their generic equivalent. Your out-of-pocket expenses will usually be highest when using non-formulary (non-preferred) prescription drugs.

For more information about your prescription drug benefit, please refer to your Certificate of Insurance, Certificate Attachment and any applicable Riders for a description of the health care services covered under your EmblemHealth health insurance program. Or, if you have any questions, please ask your group benefits administrator. You may also telephone EmblemHealth Member Services Department for assistance.

UTILIZATION REVIEW: HOW IT CAN AFFECT YOUR BENEFITS

Asking a difficult question: Is a health care service medically necessary?

Utilization Review seeks to determine whether health care services that have been provided, are being provided, or are proposed to be provided, are medically necessary. An explanation of EmblemHealth's criteria for "medical necessity" appears in the "**Important Definitions**" section of this handbook. Utilization Review also seeks to determine whether the health care services under review are experimental or investigational in nature and, therefore, excluded from coverage. **All covered services are subject to Utilization Review by EmblemHealth.**

Utilization Review at EmblemHealth is a highly specialized process involving several steps. EmblemHealth's Medical Director oversees and supervises all utilization review activities, which are generally performed by EmblemHealth's Utilization Review Department. Any Adverse Determination by EmblemHealth is confirmed by a clinical peer reviewer before it is made.

An Adverse Determination

An Adverse Determination is a finding by EmblemHealth or its agents that an admission, extension of stay, or other health care service has been reviewed and, based on the information provided, is not medically necessary or is experimental or investigational and, therefore, not covered by EmblemHealth.

All notices of Adverse Determination will include instructions on how to initiate standard and expedited internal appeals and provide information about the availability of external appeals. All notices of Adverse Determination will also include information about the reasons for the determination (including the clinical rationale), and notice of availability upon request and free of charge, of the clinical review criteria or other rule, guideline, or protocol relied upon by EmblemHealth to make the determination, and other rights available to you. The specific diagnosis code, treatment code and their corresponding meanings are also available to you upon request and free of charge.

In the event that EmblemHealth renders an Adverse Determination without attempting to discuss the matter with the health care provider who specifically recommended the service, procedure, or treatment under review, the provider may request a reconsideration of the Adverse Determination. Except in cases of retrospective reviews, reconsideration will occur within one business day of EmblemHealth's receipt of the request and shall be conducted by the provider and the EmblemHealth clinical peer reviewer who made

the initial Adverse Determination (or a designated clinical peer reviewer if the original clinical peer reviewer is not available).

If the Adverse Determination is upheld, EmblemHealth will provide written notice of the determination, including the reasons for the determination, the clinical rationale, instructions on how to initiate appeals, and notice of availability of the clinical review criteria relied upon by EmblemHealth in making the determination.

You have the right to appeal any Adverse Determination by EmblemHealth. (See *Grievance and Appeals Process: Appealing an Adverse Determination*.)

The Utilization Review provisions of your program may require that you contact EmblemHealth before receiving elective, non-emergent treatment, admission to a hospital, and/or other health care services.

You can reach EmblemHealth's Utilization Review Department at **1-877-482-3625**.

Precertification. Your program may require you or your provider to get precertification of certain services to be eligible for maximum benefits and to avoid penalties. **Precertification is the evaluation of proposed treatments or services for medical necessity before they are provided** and includes precertification of hospital and medical services. Requests for services that require precertification are known as pre-service claims. When utilizing a Network Provider for covered services, the Network Provider will initiate the precertification process on your behalf.

The following sections outline how to obtain precertification from EmblemHealth. In general, you and/or your provider need to initiate the precertification process by calling EmblemHealth before services are provided. EmblemHealth will notify you and your provider of its decision on a non-urgent precertification request within three business days after EmblemHealth's receipt of the claim. EmblemHealth will notify you in writing and by telephone.

If EmblemHealth requires more information to make a decision, EmblemHealth will request such information within 15 calendar days from you and your provider. EmblemHealth will give you at least 45 calendar days to supply the information. If you supply all of the requested information to EmblemHealth within the time that EmblemHealth gives you to supply it, EmblemHealth will notify you of its decision within three business days. Otherwise, EmblemHealth will notify you of its decision within 15 calendar days of its receipt of partial information or within 15 calendar days of the end of the time period EmblemHealth gives you to supply it.

If you fail to follow EmblemHealth's precertification procedure(s) when required by your program, EmblemHealth will inform you of the proper precertification procedure within five calendar days (or within 24 hours in the case of a request for approval of urgent care claim) of receipt of the request by an EmblemHealth person or unit customarily responsible for handling benefit matters.

Certain procedures, treatments, and admissions require that you get advance approval from EmblemHealth to receive full benefits. The specific services that require precertification under your program are identified in your Certificate and Certificate Attachments.

For hospital admissions, you, a family member, or your doctor should contact EmblemHealth's Utilization Review Program for precertification:

- At least 10 days prior to the date of admission of elective procedures, or as soon as reasonably possible.
- Within two business days of an emergency admission, or as soon as reasonably possible.

To precertify most care, contact EmblemHealth's Utilization Review Department at **1-877-482-3625**.

Note that for covered services, Network Providers will contact EmblemHealth directly for precertification.

Concurrent review. If you or your provider request a non-urgent continuation, extension, or addition to a previously approved plan of care, EmblemHealth will notify you and, if applicable, your provider of its decision within one business day of EmblemHealth's receipt of all necessary information. If EmblemHealth reduces or terminates a previously approved course of treatment (for reasons other than amendment or termination of your program or your EmblemHealth coverage), EmblemHealth will notify you and, if appropriate, your provider of its decision sufficiently in advance so that you can appeal the decision. EmblemHealth will notify you in writing and by telephone.

Urgent care. If care has already been initiated and you or your provider are seeking an extension of urgent care, the time frame in which EmblemHealth will decide your urgent care request will vary. It will depend upon when EmblemHealth receives your request. If EmblemHealth receives your request at least 24 hours before the end of the previously approved treatment plan, we will notify you of our decision on your request for an extension of the care within 24 hours after our receipt of your request. If EmblemHealth receives your request less than 24 hours before the end of the previously approved treatment plan, then we will notify you and your provider of our decision within 72 hours of our receipt of your request. EmblemHealth will notify you in writing and by telephone. EmblemHealth will provide written notice of the decision within three calendar days of providing notice by telephone.

If the request involves urgent care that has not yet been initiated, EmblemHealth will notify you and your provider of its decision on your request as soon as possible but not later than 72 hours from EmblemHealth's receipt of the claim. EmblemHealth will provide written notice of the decision within three calendar days of providing notice by telephone. If EmblemHealth requires more information to make a decision, EmblemHealth will notify you of the required information within 24 hours after EmblemHealth's receipt of the claim. EmblemHealth will give you at least 48 hours to supply the information. EmblemHealth will notify you of its decision on your request within 48 hours of its receipt of the information or within 48 hours of the end of the time period EmblemHealth gives you to supply the information.

EmblemHealth may reasonably require you or your provider to explain the medical reasons that give rise to a need for urgent care.

Complex case management. Should you or a covered family member experience a specific illness or injury with potential long-term effects, EmblemHealth's Complex Case Management program concentrates on alternatives to improve the quality and cost-effectiveness of your care. EmblemHealth's Medical Director and Case Managers assess the patient's individual needs and the full range of treatment and financial options from the onset of a condition or illness through recovery or stabilization.

Once you have notified EmblemHealth's Utilization Review Department of your hospital admission, Complex Case Management will occur automatically if appropriate. You need take no other action.

Retrospective review: Retrospective review is the review of claims received at EmblemHealth for services already performed (i.e., retrospective claims), to confirm medical necessity, and to determine the need for or uphold a non-precertification penalty.

EmblemHealth will notify you, and, if appropriate, your provider of its decision on a retrospective review within 30 calendar days after its receipt of the claim. EmblemHealth will notify you in writing.

If EmblemHealth requires more information to decide your claim, EmblemHealth will request such information within 30 calendar days after receipt of the claim. EmblemHealth will give you at least 45 calendar days to supply the information. If EmblemHealth requests more information, EmblemHealth will notify you of its decision on your claim within 15 calendar days after EmblemHealth's receipt of all or part of the information or within 15 calendar days after the end of the time period EmblemHealth gives you to supply the information.

Submission of a claim by the provider or by you automatically triggers retrospective review. You do not need to take any action.

MEMBER RIGHTS AND RESPONSIBILITIES

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

Member Rights and Member Responsibilities are available for your review.

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

Your Rights

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

- The right to be treated without discrimination, including discrimination based on race, color, religion, gender, national origin, disability, sexual orientation or source of payment.
- The right to participate with physicians in making decisions about your health care.
- The right to a non-smoking environment.
- The right to be treated with fairness and respect at all times, and in a clean and safe environment.
- The right to receive, upon request, a list of the physicians and other health care providers in our participating provider network.
- The right to change your physician.
- The right to information about our plans, networks and your covered services.
- The right to be assured that our participating health care providers have the qualifications stated in our Professional Standards, established by the EmblemHealth credentialing committee, which are available upon request.
- The right to know the names, positions and functions of any participating provider's staff and to refuse their treatment, examination or observation.
- The right to timely access to your covered services and drugs.
- The right to obtain from your physician, during practice hours, comprehensive information about your diagnosis, treatment and prognosis, regardless of cost or benefit coverage, in language you can understand. When it is not medically advisable to give such information to you, or when the member is a minor or is incompetent, the information will be made available to a person who has been designated to act on that person's behalf.

- The right to receive from your physician the information necessary to allow you to give informed consent prior to the start of any procedure or treatment and to refuse to participate in, or be a patient for, medical research. In deciding whether to participate, you have the right to a full explanation.
- The right to know any risks involved in your care.
- The right to refuse treatment, to the extent permitted by law, and to be informed of the medical consequences of refusing it.
- The right to have all lab reports, X-rays, specialists' reports and other medical records completed and placed in your chart so they may be available to your physician at the time of consultation.
- The right to be informed about all medication given to you, as well as the reasons for prescribing the medication and its expected effects.
- The right to receive, from your provider, all information you need to give informed consent for an order not to resuscitate. You also have the right to designate an individual to give this consent if you are too ill to do so.
- The right to request a second opinion from a participating physician.
- The right to privacy concerning your medical care. This means, among other things, that no person who is not directly involved in your care may be present without your permission during any portion of your discussion, consultation, examination or treatment. We will give you a written notice, called a "Notice of Privacy Practice" that describes your rights.
- The right to expect that all communications, records and other information about your care or personal condition will be kept confidential, except if disclosure of that information is required by law or permitted by you.
- The right to request that copies of your complete medical records be forwarded to a physician or hospital of your choice at your expense. However, information may be withheld from you if, in the physician's judgment, release of the information could harm you or another person. Additionally, a parent or guardian may be denied access to medical records or information relating to a minor's pregnancy, abortion, birth control or sexually transmitted diseases if the minor's consent is not obtained.
- The right to have a person of your choice accompany you in any meeting or discussion with medical or administrative personnel.
- The right to give someone legal authority to make medical decisions for you.
- The right to consult by appointment, during business hours, with our responsible administrative officials and your participating physician's office to make specific recommendations for the improvement of the delivery of health services.
- The right to make a complaint or file an appeal related to the organization or a determination about seeking care or about care and services you have received.
- You have the right to receive an explanation from us if a provider has denied care that you believe you should receive. To receive this explanation, you will need to ask us for a copy of the written decision.
- We must provide information in a way that works for you, in languages other than English or other alternate formats, in accordance with company policy and regulatory rules.

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

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

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

Your Responsibilities

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

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

COORDINATION OF BENEFITS ("COB")

If you have other group health insurance coverage...

If you or your dependent(s) are covered by two or more group benefit plans that provide health coverage, Coordination of Benefits (COB) rules determine which plan will pay its benefits first. Through COB, the duplication of benefits and the payment of more than the provider's charge is avoided.

The primary plan is the plan that pays its full benefits first. The other plan pays secondary benefits. When the EmblemHealth health insurance program is secondary, it will pay the lesser of its eligible expense for the covered service or an amount, when added to the amount paid by the primary plan, that will not exceed the provider's charge.

How do we determine which health plan pays the primary benefits? EmblemHealth will determine which group health plan is primary and which is secondary based on regulations issued by the New York State Department of Financial Services.

If you are eligible for Medicare...

Your group must inform EmblemHealth if you or a covered family member are eligible for Medicare. If you or any of your covered dependents are eligible for Medicare, you must enroll in Medicare (both Part A and Part B) to avoid a reduction in your benefits. If you or a covered dependent are enrolled in the EmblemHealth program and are also enrolled in Part A, Part B, or Parts A and B of Medicare, benefits are generally coordinated with EmblemHealth in the following ways:

If you are an active employee of an employer group consisting of 20 employees or more, or the spouse of such an active employee, regardless of age, EmblemHealth is the primary program for yourself and your dependents, and Medicare is the secondary program. You do have the option to elect Medicare as primary coverage; however, in this case, the EmblemHealth program by law cannot provide any benefits.

If you are an active employee of an employer group consisting of fewer than 20 employees or the spouse of such an active employee, and you are eligible and enrolled in Medicare Part A and Part B, Medicare is your primary program. EmblemHealth will provide secondary benefits.

Retired members

If you are a retiree, you and your dependents are not eligible for coverage under the EmblemHealth program unless your Certificate of Insurance, or Certificate Attachment or Rider states that retirees are eligible for coverage. If retirees are eligible for coverage, covered retirees are entitled to the benefits described in the Certificate of Insurance. EmblemHealth will coordinate benefits with Medicare. To receive EmblemHealth benefits for services which are partially covered by Medicare as the primary payor, your claim must be filed with Medicare first. You must attach a copy of your Explanation of Medicare Benefits form to your EmblemHealth claim form.

FILING A GRIEVANCE OR APPEAL

Filing a written grievance—it's your right

If you are dissatisfied with a benefit determination or other determination made by EmblemHealth relating to your health insurance program other than a medical necessity decision or decision regarding the experimental or investigational nature of the services, you have the right to file a written grievance requesting that EmblemHealth reconsider or review the determination. You have the right to designate a representative to handle your grievance for you. Adverse medical necessity decisions made by EmblemHealth and decisions regarding the experimental or investigational nature of services, may be appealed.

You must file the written grievance within 180 calendar days from the date that you received notice of EmblemHealth decision. EmblemHealth will acknowledge receipt of your grievance in writing within fifteen calendar days. In submitting your grievance, please include your EmblemHealth identification number as well as any applicable claim number(s). Your grievance should also include any other supporting data and comments. EmblemHealth will reply to your grievance in writing.

EmblemHealth will reply to your grievance within the time period(s) set forth below.

- **Urgent Care Claims: 72 hours after EmblemHealth's receipt of the grievance.**
  An urgent care claim is a claim that, if subjected to the time periods applied to other types of claims, could seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function, or subject the patient to severe pain that cannot be managed adequately.
- **Pre-Service Claims: 15 calendar days after EmblemHealth's receipt of the grievance.**
  A pre-service claim is a claim or request for a service that you or your provider must precertify with EmblemHealth under the terms of your program.
- **Post-Service Claims and other Grievances:**
  –- Within 30 calendar days after receipt of the request for disputes involving your benefits
  –- Within 45 calendar days after the receipt of all necessary information in all other grievances.

Grievances involving clinical decisions will be reviewed by qualified clinical personnel.

In the event that EmblemHealth has denied a claim on the basis that the services are not medically necessary or are experimental or investigational in nature and you do not agree with EmblemHealth's determination, you should file a Utilization Review Appeal, not a grievance.

All hospital grievances should be mailed to:

EmblemHealth-Hospital Grievance
P.O. Box 2828
New York, New York 10116-2828

All other grievances should be mailed to:

EmblemHealth-Grievance Unit
P.O. Box 1701
New York, New York 10023-9476

Appealing an adverse determination

You have the right to appeal any Adverse Determination made by EmblemHealth relative to a hospital admission, extension of stay, or other health care service that has been reviewed and determined by EmblemHealth to be medically unnecessary or experimental or investigational in nature and, therefore, not covered. You have the right to designate a representative to appeal any such Adverse Determination on your behalf.

A **Utilization Review Appeal** must be filed via telephone, or in writing within 180 calendar days from the time you receive EmblemHealth's notification of an Adverse Determination. Please include your EmblemHealth identification number, applicable claim number(s), and basis for your appeal. Your appeal should also include any other data and comments that you believe support your appeal.

Oral Utilization Review Appeals can be initiated by calling toll free 888-906-7668.

Or you may submit a written appeal to:

EmblemHealth Utilization Review Appeals
P.O. Box 2809
New York, NY 10116-2809

Please refer to the back of this handbook for the address to file your appeal.

Be sure to clearly indicate if you are requesting an expedited appeal or urgent care claim appeal, as described on the following page.

Types of appeals you can request

- **Standard appeals.** EmblemHealth will acknowledge receipt of a non-urgent appeal within 15 calendar days of EmblemHealth's receipt of your appeal. If EmblemHealth needs more information to decide your appeal, EmblemHealth will also notify you and your provider of the needed information within 15 calendar days of EmblemHealth's receipt of the appeal. The time within which EmblemHealth will respond to your appeal will vary depending upon the type of claim that you are appealing. If EmblemHealth fails to decide your appeal within 60 calendar days of receipt of all necessary information, the service will be deemed approved.
- **Pre-service claim appeals.** In the case of a pre-service claim, EmblemHealth will decide your appeal within 30 calendar days from EmblemHealth's receipt of the appeal. A pre-service claim is a

claim or request for a service that you or your provider must precertify with EmblemHealth under the terms of your program.

- **Retrospective claim appeals.** In the case of a retrospective claim, EmblemHealth will decide your appeal within 30 business days of EmblemHealth's receipt of all necessary information, but not more than 60 calendar days from EmblemHealth's receipt of the appeal. A retrospective claim is a claim for benefits relating to a service that has already been provided to you.
- **Urgent care claim appeals.** In the case of an urgent care claim, EmblemHealth will decide your appeal within the earlier of two business days of EmblemHealth's receipt of all necessary information or 72 hours after EmblemHealth's receipt of the appeal. An urgent care claim is a claim that, if subjected to the time periods applied to other types of claims, could seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function, or subject the patient to severe pain that cannot be managed adequately.
- **Concurrent care appeals.** If you are appealing EmblemHealth's denial of a non-urgent continuation, extension or addition to the care plan, EmblemHealth will decide your appeal within the earlier of two business days of EmblemHealth's receipt of all necessary information or 30 calendar days after EmblemHealth's receipt of the appeal. If you are appealing EmblemHealth's reduction or termination of a previously approved care plan, EmblemHealth will decide your appeal within 72 hours of EmblemHealth's receipt of the appeal.
- **Expedited appeals.** EmblemHealth offers an expedited appeal process in certain cases. An expedited appeal may be filed only in the cases below:
  - Cases that involve continued or extended health care services, procedures, or treatments.
  - Cases that involve requests for additional services for a person undergoing a course of continued treatment.
  - Cases where the provider believes an immediate appeal is warranted due to imminent or serious threat to the health of the person.

If EmblemHealth needs more information to decide your appeal, EmblemHealth will notify you and your provider of the needed information within 24 hours. EmblemHealth will make a decision on your appeal within two business days of EmblemHealth's receipt of the information needed for EmblemHealth to conduct a full and fair review, but not more than 72 hours from EmblemHealth's receipt of the appeal. If EmblemHealth fails to decide your expedited appeal within these time periods, the requested service will be deemed approved. To file an expedited appeal, please call EmblemHealth toll free at **1-888-906-7668**.

- **External appeal.** You or your representative may file an application for an external appeal by a New York State approved external appeal agent if, through EmblemHealth's Utilization Review process, you have received a final adverse determination upholding a denial of coverage on the basis that the service is not medically necessary or is an experimental or investigational treatment (including clinical trials and treatments for rare diseases). You have four months from receipt of the adverse determination to file a written request for an external appeal. If you and EmblemHealth have agreed in writing to waive any internal appeal, you have four months from receipt of such waiver to file a written request for an external appeal.

  EmblemHealth will charge a fee for external appeals (i.e., $25 per external appeal, not to exceed $75 per person in a calendar year). EmblemHealth will waive this fee if it presents a financial hardship.

EmblemHealth will provide an external appeal application with the final adverse determination issued through EmblemHealth's Utilization Review process or its written waiver of an internal appeal. You may also obtain an external appeal application from:

The New York State Department of Financial Services at 1-800-400-8882, or its Web site (www.dfs.ny.gov/), or The EmblemHealth Medical/Utilization Review Department at 1-877-482-3625.

The application will provide clear instructions for completion. It is your responsibility to initiate the external appeal process. Under New York State law, your completed request for appeal must be filed within four months of either the date upon which you receive written notification from EmblemHealth that it has upheld a denial of coverage or the date upon which you receive a written waiver of any internal appeal. EmblemHealth has no authority to grant an extension of this deadline.

An external appeal agent must decide a standard appeal within 30 calendar days of receipt of your completed application. If the agent requests additional information from you, your physician or EmblemHealth, the agent will have five additional business days to make a decision. The agent will notify you in writing of a decision within two business days.

You may request an expedited appeal if your doctor can attest that a delay in providing the recommended treatment service that has been denied would pose an imminent or serious threat to your health. The external appeal agent will make a decision within 72 hours of receipt of your completed application for expedited appeals. Every reasonable effort will be made to notify you and EmblemHealth of the decision by telephone or fax immediately. This will be followed immediately by a written notice.

Please refer to your Certificate of Insurance and applicable riders for more information.

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), from 8 am to 8 pm, **1-877-842-3625**, TTY: **711**

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

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

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

Medicaid, Family Health Plus and Child Health Plus members: 7 days a week (excluding major holidays), from 8 am to 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**.

HEALTHFUL CHOICES

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. Helping you take a hands-on approach to your health

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.

Health Manager

Your personal "Health manager" is at your fingertips at myemblemHealth. 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, myEmblemHealth, 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 resource called Health Manager, which consists of a Health risk Assessment (HRA), a Personal Health record (PHR), and a range of action plans.

Use the Health Risk Assessment (HRA) to get a picture of your current health.

The HRA is a voluntary and confidential online survey that provides a "picture" of your current health with person¬alized 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 gives you the opportunity 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.

Let us support your desire to change with action plans to suit your needs.

Action Plans are 8-week online modules to help you set goals and stay on track to address problems including weight loss, exercise, smoking, healthy eating, heart disease, diabetes and stress. Each Action Plan can be started when you want and taken on your own schedule. Mini-assessments help you identify problems, and you can track your progress towards a healthier lifestyle!

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/healthydiscounts**. Your participation in the Healthy Discounts program is voluntary and you are not required to meet any standards related to a health factor in order to access or retain these discounts. Among the Healthy 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 **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 **jazzercise.com**

NutriSystem

EmblemHealth members get 12% off all *Select, Basic, Silver, Diabetic* and *Vegetarian* program orders plus all benefits found at the NutriSystem website. Get over 120 delicious entrees & desserts, no membership or enrollment fees, free exercise DVD, free weigh loss counseling and more. EmblemHealth members can call **1-877-690-6534** or visit **nutrisystem.com/health** and enter promo code emblem8

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 participating providers and service centers near you, or go online to view hearing aid options at **truhearing.com/hearing_aids/emblemhealth/**

Hearing Care through HearX, a HearUSA company

Receive complimentary screenings and product discounts. Call **1-800-442-8231 (TDD: 1-888-300-3277)** or visit **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/choosehealthy/?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/choosehealthy/?hp=emblem**

Fitness Club Membership

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, exercise centers for yoga, Pilates, 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)**.

PATH Program

Chronic Conditions

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 (Positive Actions Toward Health) Program can help you. Managing a condition can be overwhelming and we are here to assist by offering eligible members access to education and support through our PATH health management programs. These programs will complement the care provided by your doctor by helping you better understand and manage your condition and meet your health goals. This chronic condition disease management program is designed to work with you and your doctor to improve your care and help to better manage your health, if you qualify. This program is offered at no cost to you. For more information, please call **1-800-783-3655** or visit **www.emblemhealth.com/livebetter**.

We offer our Condition Care PATH program for rare chronic conditions in partnership with AccordantCare™. This program is designed to help members with rare chronic conditions find the answers and support they need to manage their health. Members in the program can contact specialized nurses by telephone 24 hours a day, seven days a week. This specialized program is offered to members with the following conditions:

- Seizure Disorder
- Sickle Cell Disease
- Cystic Fibrosis
- Hemophilia
- Rheumatoid Arthritis
- Multiple Sclerosis
- Crohn's Disease
- Parkinson's Disease
- Myasthenia Gravis
- Scleroderma Polymyositis

- Chronic Inflammatory Demyelinating Polyradiculoneuropathy (CIDP)
- Amyotrophic Lateral Sclerosis (ALS)
- Systemic Lupus Erythematosus (SLE)
- Dermatomyositis
- Gaucher's Disease

For more information or to enroll, please call **1-866-360-5659**.

Healthy Beginnings PATH Program

Prenatal Care

Whether you are pregnant now or just thinking about it, there are many things you can do to have a healthy baby. EmblemHealth can help, which is why we developed the EmblemHealth **Healthy Beginnings PATH Program**. The program provides prenatal and parenting information that will help your baby get the best possible chance for a healthy start in life. Through the **Healthy Beginnings PATH Program** you receive guidance about nutrition, immunizations, and general health and wellness during your pregnancy.

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 EmblemHealth's 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 EmblemHealth's Welcome Home Kit after your baby's birth, which includes a self-screening postpartum test.

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

Supporting a healthy pregnancy and the birth of a healthy baby

If you are already pregnant, you may be eligible to join the Healthy Beginnings PATH program to receive guidance throughout your pregnancy and after delivery. Healthy Beginnings PATH is available at no cost and offers:

- Health assessments to help your doctor or midwife make sure you stay healthy.
- Access to a maternity nurse 24 hours a day, seven days a week, through a toll-free telephone line.
- *Your Journey Through Pregnancy book* and other educational materials sent to your home.
- An electronic newsletter about pregnancy that will be e-mailed to you every few weeks.
- A dedicated maternity nurse case manager to work with you and your doctor if your pregnancy is high risk.

As soon as you know you are pregnant, call the Healthy Beginnings PATH program at **1-877-736-BABY** (1-877-736-2229) or visit **www.emblemhealth.com/stayhealthy**. Eligible members will complete their first assessment right over the phone and receive a pregnancy book and other educational materials, access to our 24/7 phone line and a password to view all of our online pregnancy information. You can also visit the **Healthy Beginnings PATH program online** to learn more.

Tobacco-Free PATH Smoking Cessation Program

Our Tobacco-Free PATH program offers the Quit For Life® program brought to you by the American Cancer Society and Alere Wellbeing. This program provides adult members 18 years of age and older who join the program with the following services:

- Help in developing a quit plan by phone from trained quit-smoking experts.
- 24/7 phone support.
- Educational materials by mail.
- Access to the Quit for Life® Web site at www.quitnow.net.
- Full coverage for smoking cessation medications including the nicotine patch, gum and lozenge, bupropion (generic Zyban®) and Chantix®. **Make sure to talk to your doctor about which medication is right for you.**

As part of our program, we encourage our network doctors to help our members stop smoking. This way, your health care team is also on your side as you try to break the habit.

To join our program, call **1-866-611-QUIT** (1-866-611-7848), 24 hours a day, seven days a week. TDD users should call **1-877-777-6534** or visit **www.emblemhealth.com/stayhealthy**.

Wellness PATH Program

What is Wellness PATH? For eligible members, Wellness PATH is available as part of your health benefits at no additional cost to you. The program includes wellness coaching by telephone or online. Think of it as having your own personal trainer - someone who can help you live a healthier life. Coaching is proven to increase the odds that you will set and achieve your goals to better living.

The Wellness PATH program combines coaching with a health assessment tool that provides a snapshot of your health status and your health risks. It includes tools that can help you stay on track and measure your progress on the path to a healthier lifestyle. Your employer also has access to other Wellness PATH support tools.

Am I eligible for Wellness PATH? You have access to the Wellness PATH program if you are an EmblemHealth subscriber (you receive your health benefits directly from your employer and not as a dependent on someone else's policy) and if your employer is experience-rated (it has more than 50 employees).

When you log in, our system will automatically recognize whether you are eligible for Wellness PATH. If you are, you will see information on "Health Risk Assessment and Coaching" and "Health Trackers." There you will also find links to the online resources portion of Wellness PATH.

The Wellness PATH program should not be confused with EmblemHealth's Health Manager.

For more information, please call **1-877-330-2746**, or visit **www.emblemhealth.com/WellnessPATH**

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 p.m. or 3 a.m., you can speak to an experienced, licensed nurse about your health questions or issues. With **EmblemHealth's 24-Hour Nurse Advice Line**, you 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
- Headache
- Weight Loss
- Food and Diet
- Colds
- Abdominal Pain
- Children's Health
- Women's Health
- Fever
- Smoking
- Sexually Transmitted Diseases
- 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.

Answers to your health questions are just a phone call away.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Good Life Directions

The EmblemHealth EAP Program

- Offers you assistance for a range of emotional, work and family concerns.
- Guarantees confidentiality.
- Is available to you at no additional charge.

Everyone needs a little help now and then. Seek the services of your EAP—they're there for you at 1-866-208-1443.

In today's fast-paced world, juggling work and family—and all the associated demands and pressures—can get overwhelming. It can happen to anyone. Circumstances at home can spill over into your work life, just as stresses encountered on the job can affect relationships at home. If left unattended, issues that were once minor can become serious.

When times get tough, most of us can benefit from talking through our problems with someone who's objective and experienced—who can help sort things out. The EmblemHealth Employee Assistance Program (EAP) offers professional counselors who'll listen in confidence and help put you on the road to a good solution.

Help is just a phone call away.

Thanks to the EmblemHealth EAP, our members have easy access to professional counseling and referrals on a variety of issues.

What is an Employee Assistance Program?

The EmblemHealth EAP is a confidential, professional counseling service available to help employees and their families resolve personal issues and problems before they affect health, family relationships, or job performance.

You can call the EmblemHealth EAP at **1-866-208-1443**, 24 hours a day, 365 days a year.

You can talk to an EmblemHealth EAP counselor about:

- Marital problems
- Financial concerns
- Child or elder care issues
- Problems with co-workers

- Balancing work and family responsibilities
- Alcohol or drug abuse
- Dealing with the stresses in your life that are preventing you from being—and doing—your best.

Remember, no problem is too small or too serious for you to seek assistance.

How does the EAP work?

When you call, you'll speak with a counselor who's trained in assisting you with a wide range of life issues. Depending on your situation, the counselor may suggest a few more consultations. If the counselor believes you need more specialized or longer-term counseling, additional services may be available through your behavioral health benefit.

Is the EmblemHealth EAP confidential?

Absolutely! Confidentiality is a vital part of the program's success. Your participation in the program will be treated confidentially in accordance with all state and federal guidelines.

Does the EAP cost anything?

Sessions with EmblemHealth EAP counselors are free. Sometimes, additional counseling or treatment can require payment. Your EmblemHealth EAP counselor can help determine if extended services are covered under your plan and help you determine what the approximate cost would be.

Experienced professionals who work for you.

The EmblemHealth EAP is staffed by a national organization of highly qualified professionals with many years of experience in providing these types of counseling services. The EAP professionals are there to help you.

We encourage plan members to use the valuable services of the EmblemHealth EAP by calling **1-866-208-1443**. They will assist you in getting the help you need, when you need it.

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

EmblemHealth®
WHAT CARE FEELS LIKE.