EmblemHealth®

Enhanced Care Plus

EmblemHealth's Health and Recovery Plan (HARP) Member Handbook

EmblemHealth®

ATTENTION: Language assistance services, free of charge, are available to you. Call **1-877-411-3625** (TTY/TDD: **711**).

Español (Spanish)
ATENCIÓN: Usted tiene a su disposición, gratis, servicios de ayuda para idiomas. Llame al **1-877-411-3625** (TTY/TDD: **711**).

中文 (Chinese)
注意：我們免費提供相關的語言協助服務。請致電 **1-877-411-3625** (TTY/TDD: **711**)。

Русский (Russian)
ВНИМАНИЕ! Вам доступны бесплатные услуги переводчика. Звоните по тел. **1-877-411-3625** (служба текстового телефона TTY/TDD: **711**).

Kreyòl Ayisyen (Haitian Creole)
ATANSYON: Gen sèvis èd nan lang gratis ki disponib pou ou. Rele nimewo **1-877-411-3625** (TTY/TDD: **711**).

한국어 (Korean)
주의: 귀하에게 언어 지원 서비스가 무료로 제공됩니다. **1-877-411-3625**(TTY/TDD: **711**)번으로 전화하십시오.

Italiano (Italian)
ATTENZIONE: sono disponibili servizi gratuiti di assistenza linguistica. Chiami il numero **1-877-411-3625** (TTY/TDD: **711**).

אידיש (Yiddish)
אכטונג: שפראך הילף סערוויסעס, אהן קיין פרייז, זיינען דא צו באקומען פאר אייך. רופט **1-877-411-3625** (TTY/TDD: **711**).

বাংলা (Bengali)
মনোযোগ দিন: ভাষা সহায়তা পরিষেবাগুলি আপনার জন্য বিনামূল্যে উপলব্ধ আছে। **1-877-411-3625** (TTY/TDD: **711**) নম্বরে ফোন করুন।

Polski (Polish)
UWAGA: dostępna jest bezpłatna pomoc językowa. Prosimy zadzwonić pod numer **1-877-411-3625** (TTY/TDD: **711**).

العربية (Arabic)
يرجى الانتباه: تتوفر لك خدمات المساعدة اللغوية مجانا، اتصل على الرقم **1-877-411-3625** أو (TTY/TDD: **711**).

Français (French)
ATTENTION : une assistance d'interprétation gratuite est à votre disposition. Veuillez composer le **1-877-411-3625** (TTY/TDD : **711**).

10-9127 10/20

اردو (Urdu)
وجہ دیں: آپ کے لیے زبان سے متعلق اعانت کی خدمات، مفت دستیاب ہیں۔ **1-877- 411-3625** (TTY/TDD: **711**) پر کال کریں۔

Tagalog (Tagalog)
NANANAWAGAN NG PANSIN: Mayroon kang magagamit na mga serbisyo para sa tulong sa wika nang walang bayad. Tawagan ang **1-877-411-3625** (TTY/TDD: **711**).

Ελληνικά (Greek)
ΠΡΟΣΟΧΗ: Διατίθενται για σας υπηρεσίες γλωσσικής βοήθειας, δωρεάν. Καλέστε το **1-877-411-3625** (για άτομα με προβλήματα ακοής (TTY/TDD): **711**).

Shqip (Albanian)
VINI RE: Shërbime ndihmore për gjuhën, falas, janë në dispozicionin tuaj. Telefononi në **1-877-411-3625** (TTY/TDD: **711**).

NOTICE OF NONDISCRIMINATION POLICY

EmblemHealth complies with Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. EmblemHealth does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

EmblemHealth:

- Provides free aids and services to people with disabilities to help
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose first language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, please call member services at **1-877-411-3625** (TTY/TDD: **711**).

If you believe that EmblemHealth has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with EmblemHealth Grievance and Appeals Department, PO Box 2844, New York, NY 10116, or call member services at **1-877-411-3625**. (Dial **711** for TTY/TDD services.) You can file a grievance in person, by mail or by phone. If you need help filing a grievance, EmblemHealth's Grievance and Appeals Department is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office of Civil Rights electronically through the Office of Civil Rights Complaint Portal, available at **ocrportal.hhs.gov/ocr/portal/lobby.jsf** or by mail or phone at **U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201**; **1-800-368-1019**, (dial **1-800-537-7697** for TTY services).

Complaint forms are available at **hhs.gov/ocr/office/file/index.html**.

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Health and Recovery Plan Member Handbook

Welcome to the EmblemHealth Enhanced Care Plus Health and Recovery Plan

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

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

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

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

How Health and Recovery Plans Work

The Plan, Our Providers, and You

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

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

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

BHHCBS may help you:

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

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

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

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

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

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

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

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

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

Confidentiality

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

How to Use This Handbook

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

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

Help From Member Services

There is someone to help you at Member Services, Monday through Friday 8 a.m. to 6 p.m. Call **855-283-2146** (TTY: **711**).

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

- Call Emblem Behavioral Health Services at **888-447-2526**.

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

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

If you do not speak English, we can help. We want you to know how to use your health care plan, no matter what language you speak. Just call us and we will find a way to talk to you in

your own language. We have a group of people who can help. We will also help you find a PCP who can speak to you in your language.

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

- TTY machine (Our TTY phone number is **711**)
- Information in large print
- Case Management
- Help in making or getting to appointments
- Names and addresses of providers who specialize in your disability

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

Your Health Plan ID Card

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

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

PART I: FIRST THINGS YOU SHOULD KNOW

How to Choose Your Primary Care Provider (PCP)

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

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

You may want to find a doctor that:

- You have seen before,
- Understands your health problems,
- Is taking new patients,
- Can speak to you in your language,
- Is easy to get to,
- Is at a clinic you go to.

You can choose a PCP who works in:

- **A network medical center** — Many of our network medical centers are full-service. They have large staffs of PCPs, OB/GYNs, specialists, and support personnel. This makes it easy to get a full range of services in one place. If you need lab tests or x-rays, our network medical centers can perform most basic tests and procedures. If your PCP wants you to get a special procedure or operation that can't be done at your medical center, you'll be referred to a place that will meet your needs. Your PCP will arrange for all such services.
- **An EmblemHealth Enhanced Care Plus network doctor's office** — If you prefer, you can choose a PCP that has a private office. In this case, your PCP may have to refer you to

another network doctor or facility for care that he or she cannot provide because private PCP offices do not have all of the same services as medical centers.

- **A Community Health Center** — Community Health Centers' mission is to increase access to primary care and multi-specialty services to improve the health status of the residents in the communities they serve. Community Health Centers consist of health centers such as Diagnostic & Treatment Centers (DT&Cs), Federally Qualified Health Centers (FQHCs), and clinics. They are conveniently located in communities, offer multi-specialty services, and provide overall care in one location. Please see a list of FQHCs below. Just call Member Services at **855-283-2146** for help.

Bronx

- La Casa De Salud - 3 locations
- Morris Heights Health Center - 7 locations
- Union Community Health Center - 4 locations
- Community Healthcare Network - 4 locations
- Institute for Family Health - 9 locations

Brooklyn

- Community Healthcare Network - 3 locations
- Institute for Family Health - 2 locations
- Premium Health - 2 locations
- Damian Family Care Center
- Brownsville Multi-Service - 5 locations
- Joseph P. Addabbo Family Health Center
- Bedford Stuyvesant Family Health Center - 2 locations

Manhattan

- Betances Health Center - 2 locations
- Boriken Neighborhood Health Center (fka East Harlem Council for Human Services)
- Community Healthcare Network - 2 locations
- Damian Family Care Center - 3 locations
- William F. Ryan Community Health Center - 5 locations

Queens

- Community Healthcare Network - 4 locations
- Damian Family Care Center - 5 locations
- The Floating Hospital Health Center - 9 locations
- Joseph P. Addabbo Family Health Center - 5 locations

Staten Island

- Community Health Center of Richmond - 3 locations
- Beacon Christian Community Health Center - 2 locations

Westchester

- Open Door Family Medical Center
- Mt. Vernon Neighborhood Health Center - 4 locations

Suffolk

- LISH - 8 locations

Nassau

- Long Island FQHC - 7 locations

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

In almost all cases, your doctors will be EmblemHealth Enhanced Care Plus providers. There are four instances when you can still see another provider that you had before you joined

EmblemHealth Enhanced Care Plus. In these cases, your provider must agree to work with EmblemHealth Enhanced Care Plus. You can continue to see your provider if:

- You are more than 3 months pregnant when you join EmblemHealth Enhanced Care Plus and you are getting prenatal care. In that case, you can keep your doctor until after your delivery through post-partum care.
- At the time you join EmblemHealth Enhanced Care Plus, you have a life-threatening disease or condition that gets worse with time. In that case, you can ask to keep your provider for up to 60 days.
- At the time you join EmblemHealth Enhanced Care Plus, you are being treated for a Behavioral Health condition. In most cases, you can still go to the same provider. Some people may have to choose a provider that works with the health plan. Be sure to talk to your provider about this change. EmblemHealth Enhanced Care Plus will work with you and your provider to make sure you keep getting the care you need.
- At the time you join EmblemHealth Enhanced Care Plus, regular Medicaid paid for your home care and you need to keep getting that care for at least 120 days. In that case, you can keep your same home care agency, nurse or attendant, and the same amount of home care, for at least 90 days. EmblemHealth must tell you about any changes to your home care before the changes take effect.

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

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

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

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

Health Home Care Management

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

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

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

Your Health Home Care Manager can:

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

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

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

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

How to Get Regular Health Care

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

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

Members may call **888-447-2526** 24 hours a day, 7 days a week with behavioral health questions, concerns, and/or crises.

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

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

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

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

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

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

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

Behavioral Health Home and Community Based Services (BHHCBS)

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

If you need help to support your living in the community, EmblemHealth Enhanced Care Plus provides additional services, called Behavioral Health Home and Community Based Services (BHHCBS). These services can help you stay out of the hospital and live in the community. Some services can help you reach life goals for employment, school, or for other areas of your life you may like to work on.

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

See page 23 of this handbook for more information about these services and how to get them.

How to Get Specialty Care and Referrals

- If you need care that your PCP cannot give, they will refer you to a specialist who can. If your PCP refers you to another doctor, we will pay for your care. Most of these specialists are EmblemHealth providers. Talk with your PCP to be sure you know how referrals work.
- If you think a specialist does not meet your needs, talk to your PCP. Your PCP can help you if you need to see a different specialist.
- There are some treatments and services that your PCP must ask EmblemHealth to approve *before* you can get them. Your PCP will be able to tell you what they are.
- If you are having trouble getting a referral you think you need, contact Member Services at **855-283-2146**.
- If we do not have a specialist in our provider network who can give you the care you need, we will get you the care you need from a specialist outside our plan. This is called an **out-of-network referral**. You, your PCP, or plan provider must ask EmblemHealth for approval before you can get an out-of-network referral. If your PCP or plan provider refers you to a provider who is not in our network, you are not responsible for any of the costs except copayments as described in this handbook.
- To request services by a specialist or providers outside our provider network, contact Member Services at **855-283-2146**. We will need a written reason why you need to see a specialist or provider who is not in our network. You can ask your PCP or other provider to send us this information on your behalf. We will follow the same rules for prior authorization requests.
  - — Sometimes, we may not approve an out-of-network referral because we have a provider in EmblemHealth that can treat you. If you think our plan provider does not have the right training or experience to treat you, you can ask us to check if your out-of-network referral is medically needed. You will need to ask for a Plan Appeal. See page 35 of this handbook to find out how.

  - Sometimes, we may not approve an out-of-network referral for a specific treatment because you asked for care that is not very different from what you can get from an EmblemHealth provider. You can ask us to check if your out-of-network referral for the treatment you want is medically needed. You will need to ask for a Plan Appeal. See page 35 of this handbook to find out how.
- If you need to see a specialist for ongoing care, your PCP may be able to refer you for a specified number of visits or length of time (a standing referral). If you have a standing referral, you will not need a new referral for each time you need care.
- If you have a long-term disease or a disabling illness that gets worse over time, your PCP may be able to arrange for:
  - Your specialist to act as your PCP, or
  - A referral to a specialty care center that deals with the treatment of your illness.

You can also call Member Services for help in getting access to a specialty care center.

You Can Get These Services From Our Plan

Without a Referral

You can self-refer for the following services:

Women's Health Care

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

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

Family Planning

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

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

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

HIV and STI Screening

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

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

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

HIV Prevention Services

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

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

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

Eye Care

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

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

Behavioral Health (Mental Health and Substance Use)

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

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

Smoking Cessation

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

Maternal Depression Screening

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

Emergencies

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

- That comes on all of a sudden, and
- Has pain or other symptoms.

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

Examples of an emergency are:

- A heart attack or severe chest pain
- Bleeding that won't stop or a bad burn
- Broken bones
- Trouble breathing/convulsions/loss of consciousness
- When you feel you might hurt yourself or others
- If you are pregnant and have signs like pain, bleeding, fever, or vomiting
- Drug overdose

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

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

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

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

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

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

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

You can also contact Emblem Behavioral Health Services 24 hours a day, 7 days a week at **888-447-2526** if you are in mental health or drug use crisis. If you are out of the area when you have an emergency:

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

Remember

You do not need prior approval for emergency services. Use the emergency room **only** if you have a **TRUE EMERGENCY**.
The Emergency Room should NOT be used for problems like flu, sore throats, or ear infections. If you have questions, call your PCP or our plan at **855-283-2146**.

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

Urgent Care

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

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

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

Care Outside of the United States

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

We Want to Keep You Healthy

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

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

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

PART II: YOUR BENEFITS AND PLAN PROCEDURES

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

Benefits

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

Services Covered By Our Plan

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

Regular Medical Care

- Office visits with your PCP
- Referrals to specialists
- Eye/hearing exams
- Help staying on schedule with medicines
- Coordination of care and benefits

Preventive Care

- Regular checkups
- Access to free needles and syringes
- Smoking cessation counseling
- HIV education and risk reduction
- Referral to community-based organizations (CBOs) for supportive care
- Smoking cessation care

Maternity Care

- Pregnancy care
- Doctors/midwife and hospital services
- Screening for depression during pregnancy and up to a year after birth

Home Health Care

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

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

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

Personal Emergency Response System (PERS)

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

Adult Day Health Care

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

Therapy for Tuberculosis (TB)

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

Hospice Care

- Hospice helps patients and their families with their special needs that come during the final stages of illness and after death.
- Must be medically needed and arranged by EmblemHealth Enhanced Care Plus.

- Provides support services and some medical services to patients who are ill and expect to live for one year or less.
- You can get these services in your home or in a hospital or nursing home.

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

Dental Care

EmblemHealth Enhanced Care Plus believes that providing you with good dental care is important to your overall health care. We offer dental care through a contract with Healthplex, an expert in providing high-quality dental services. Covered services include regular and routine dental services such as preventive dental checkups, cleaning, x-rays, fillings, and other services to check for any changes or abnormalities that may require treatment and/or follow-up care for you. You do not need a referral from your PCP to see a dentist.

How to Get Dental Services

Starting Jan. 1, 2021, you must choose a dentist in the Healthplex network for preventive and restorative dental care such as routine checkups, x-rays, fillings, root canals, crowns, and more.

- If you need help finding a dentist, or you want to change your dentist, please call Healthplex at **855-910-2406**, from 8 a.m. to 6 p.m., Monday through Friday. Healthplex Customer Services representatives are available to help you. They speak many languages, but if they don't speak yours, they will connect you with a language interpretation service. Or, you can go to **emblemhealth.com** to find a dentist near you.
- Once you find a participating dentist, call the dentist right away to schedule an appointment. Then schedule regular preventive dental visits every six months to keep your teeth and gums healthy.
- Show your member ID card to access dental benefits. You will not receive a separate dental ID card. When you visit your dentist, you should show your plan ID card.

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

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

Vision Care

EmblemHealth has partnered with EyeMed Vision Care for your eye care benefits. You must choose an eye care provider in the EyeMed network. If you need help finding an eye care provider, call EyeMed Member Services at **877-324-2791**, Monday through Saturday, 7:30 a.m. to 11 p.m., and Sunday, 11 a.m. to 8 p.m. You can also call EmblemHealth Member Services at **855-283-2146**.

- Services of an ophthalmologist, ophthalmic dispenser, and optometrist.
- Coverage for contact lenses, polycarbonate lenses, artificial eyes, and/or replacement of lost or destroyed glasses, including repairs, when medically necessary. Artificial eyes are covered as ordered by a plan provider.
- Eye exams, generally every two years, unless medically needed more often.

- Glasses, with new pair of Medicaid-approved frames every two years, or more often if medically needed.
- Low vision exam and vision aids ordered by your doctor.
- Specialist referrals for eye diseases or defects.

Pharmacy

- Prescription drugs
- Over-the-counter medicines
- Insulin and diabetic supplies
- Smoking cessation agents, including OTC products
- Hearing aid batteries
- Emergency contraception (6 per calendar year)
- Medical and surgical supplies
- Medications to treat substance use disorder (SUD), including medication assisted treatment (MAT)

A pharmacy copayment may be required for some people, and for some medications and pharmacy items.

There are no copayments for the following members or services:

- Consumers who are pregnant: during pregnancy and for the two months after the month in which the pregnancy ends.
- Family planning drugs and supplies like birth control pills, male or female condoms, syringes and needles.
- Consumers in a Comprehensive Medicaid Care Management (CMCM) or Service Coordination Program.
- Consumers in an Office of Mental Health (OMH) or Office for People with Developmental Disabilities (OPWDD) Home and Community Based Services (HCBS) Waiver Program.
- Consumers in a Department of Health (DOH) HCBS Waiver Program for persons with traumatic brain injury (TBI).
- Family planning drugs and supplies like birth control pills and male or female condoms.
- Drugs to treat mental illness (psychotropic) and tuberculosis.

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

- If you have a copay, there is a copayment for each new prescription and each refill.
- If you transferred to a new plan during the calendar year, keep your receipts as proof of your copayments or you may request proof of paid copayments from your pharmacy. You will need to give a copy to your new plan.
  - Certain drugs may require that your doctor get prior authorization before writing your prescription. Your doctor can work with EmblemHealth Enhanced Care Plus to make

sure you get the medications that you need. Learn more about prior authorization later in this handbook.

- You have a choice in where you fill your prescriptions. You can go to any pharmacy that participates with our plan or you can fill your prescriptions by using a mail order pharmacy. For more information on your options, please contact Member Services at **855-283-2146**.

Your maximum pharmacy copay is $50 per quarter in a calendar year. The copay will reset each quarter (or every three months), no matter how much you paid last quarter. The quarters are:

- First quarter: January 1 – March 31
- Second quarter: April 1 – June 30
- Third quarter: July 1 – September 30
- Fourth quarter: October 1 – December 31

If you cannot pay your pharmacy copay, you should talk to your health care professional. You cannot be refused services or goods because you are unable to pay. However, you will always be responsible for unpaid copayments.

To learn more about these services, call Pharmacy Member Services at **888-447-7364** (TTY: **711**).

Hospital Care

- Inpatient care
- Outpatient care
- Lab, x-ray, other tests

Emergency Care

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

For more about emergency services, see page 13 of this handbook.

Specialty Care

Includes the services of other practitioners, such as:

- Physical therapy (PT), occupational therapy (OT), and speech therapy (ST). EmblemHealth will cover medically necessary PT, OT, and ST visits that are ordered by a doctor or other licensed professional.
- Audiologists.
- Durable medical equipment (DME), including hearing aids, artificial limbs, and orthotics.
- Renal and hemodialysis.
- HIV/AIDS treatment services.
- Midwifery services.

- Cardiac rehabilitation.
- Podiatrists if you are diabetic.
- Other covered services as medically needed.

Residential Health Care Facility Care (Nursing Home)

- Includes short-term, or rehab, stays and long-term care;
- Must be ordered by a physician and authorized by EmblemHealth Enhanced Care Plus;
- Covered nursing home services include medical supervision, 24-hour nursing care, assistance with daily living, PT, OT, and speech-language pathology.

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

Long term (permanent) nursing home stays are not a covered benefit in EmblemHealth Enhanced Care Plus HARP product. If you qualify for permanent long term placement, you will need to disenoll from EmblemHealth Enhanced Care Plus HARP Plan. This benefit will be covered by Medicaid fee-for-service until you are enrolled in a Medicaid managed care plan.

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

Behavioral Health Care

Behavioral health care includes mental health and substance use (alcohol and drugs) treatment and rehabilitation services. All of our members have access to services to help with emotional health, or to help with alcohol or other substance use issues. You do not need a PCP referral to access these services. These services include:

Mental Health Care

- Comprehensive Psychiatric Emergency Program (CPEP) (including Extended Observation Bed)
- Rehab services if you are in a community home or in family-based treatment
- Outpatient clinic services
- Inpatient mental health treatment
- Partial hospitalization program
- Continuing day treatment
- Personalized Recovery Oriented Services (PROS)
- Assertive Community Treatment Services (ACT)
- Individual and group counseling
- Crisis intervention services

Substance Use Disorder Services

- Crisis Services
  - Medically Managed Withdrawal Management
  - Medically Supervised Withdrawal Management (Inpatient/Outpatient*)
- Inpatient addiction treatment services (hospital or community based)
- Residential addiction treatment services
  - Stabilization in Residential Setting
  - Rehabilitation in Residential Setting

- Outpatient addiction treatment services
  - Intensive Outpatient Treatment
  - Outpatient Rehabilitation Services
  - *Outpatient Withdrawal Management
  - Medication Assisted Treatment
- *Opioid Treatment Programs (OTP)

Harm Reduction Services

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

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

To learn more about these services, call Member Services at **855-283-2146**.

Behavioral Health Home and Community Based Services (BH HCBS)

BH HCBS can help you with life goals such as employment, school, or other areas of your life you want to work on. To find out if you qualify for HCBS, a Health Home Care Manager must complete a screening with you that will show if you can benefit from these services. If the screening shows you can benefit from HCBS, the Care Manager will complete a full assessment with you to find out what your whole health needs are, including physical, behavioral, and rehabilitation services. If you are not interested in a Health Home Case Manager, Carelon HARP Care Managers and a Recovery Coordination Agency (RCA) will assist in making linkages to home and community based services.

BH HCBS includes:

- Habilitation Services – helps you learn new skills in order to live independently in the community.
- Short-term Respite – gives you a safe place to go when you need to leave a stressful situation.
- Intensive Respite – helps you stay out of the hospital when you are having a crisis by providing a safe place to stay that can offer you treatment.
- Education Support Services – helps you find ways to return to school to get education and training that will help you get a job.
- Pre-Vocational Services – helps you with skills needed to prepare for employment.

- Transitional Employment Services – gives you support for a short time while trying out different jobs. This includes on-the-job training to strengthen work skills to help keep a job at or above minimum wage.
- Intensive Supported Employment Services – helps you find a job at or above minimum wage and keep it.
- Ongoing Supported Employment Services – helps you keep your job and be successful at it.
- Non-Medical Transportation – transportation to non-medical activities related to a goal in your plan of care.

Behavioral Health Community Oriented Recovery and Empowerment (CORE) Services

EmblemHealth covers CORE services. Eligible members can get CORE services through a recommendation from a qualified provider. You can use your EmblemHealth member ID card to get these CORE services:

- **Psychosocial Rehabilitation (PSR)**
  This service helps with life skills, like making social connections, finding or keeping a job, starting or returning to school, and using community resources.
- **Community Psychiatric Supports and Treatment (CPST)**
  This service helps you manage symptoms through counseling and clinical treatment.
- **Empowerment Services – Peer Supports**
  This service connects you to peer specialists who have gone through recovery. You will get support and assistance with learning how to:
  - Live with health challenges and be independent,
  - Help you make decisions about your own recovery, and
  - Find natural supports and resources.
- **Family Support and Training (FST)**
  This service gives your family and friends the information and skills to help and support you.

What are the changes from BH HCBS to CORE services?

These CORE services are almost the same as they were in BH HCBS. There are two changes:

1. You now have more options for services to support goals related to work and school. You can work with a CORE PSR provider to help you:
   - Get a job or go to school while managing mental health or addiction struggles,
   - Live independently and manage your household, and
   - Build or strengthen healthy relationships.
2. Short-term Crisis Respite and Intensive Crisis Respite are now called Crisis Residential Services and are still available.

What's not changing?

These seven services are still available under BH HCBS:

- Habilitation
- Education Support Services
- Pre-Vocational Services
- Transitional Employment
- Intensive Supported Employment
- Ongoing Supported Employment
- Non-Medical Transportation

Will I have to change my BH HCBS provider to get CORE services?

If you were getting CPST, PSR, FST, or Peer Support as BH HCBS before Feb. 1, 2022, you can keep getting the same services from your provider under CORE. Your provider will talk to you about any changes that affect you. You can also ask your Care Manager for help.

Do I need an assessment for BH HCBS?

Yes, you need to complete the New York State Eligibility Assessment with your Care Manager or recovery coordinator to get a BH HCBS.

Do I need an assessment for CORE services?

No, you do not need the New York State Eligibility Assessment to get CORE services. You can get a CORE service if it is recommended for you by a qualified provider, like a doctor or social worker. The qualified provider may want to discuss your diagnosis and needs before making a recommendation for a CORE service.

How do I find a qualified provider to recommend me for CORE services?

Your primary care doctor or therapist may be able to make a recommendation for CORE services. If you need help finding a qualified provider, contact Member Services at the number below. You can also ask your Care Manager for help. To learn more about these services, call Member Services at **855-283-2146** (TTY: **711**).

Crisis Residence Services for Children and Adults

EmblemHealth pays for Crisis Residence services for HARP members. These overnight services help people who are having an emotional crisis.

Residential Crisis Support

This is a program for people with symptoms of emotional distress. These symptoms cannot be managed at home or in the community without help.

Intensive Crisis Residence

This is a treatment program for people who are having severe emotional distress.

Other Covered Services

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

National Diabetes Prevention Program (NDPP) Services

If you are at risk for developing type 2 diabetes, EmblemHealth covers services that may help.

EmblemHealth covers diabetes prevention services through the National Diabetes Prevention Program (NDPP). This benefit will cover 22 NDPP group training sessions over the course of 12 months.

The NDPP is an educational and support program designed to help at-risk people from developing type 2 diabetes. The program consists of group training sessions that focus on the long-term, positive effects of healthy eating and exercise. The goals for these lifestyle changes include modest weight loss and increased physical activity. NDPP sessions are taught using a trained lifestyle coach.

Eligibility

You may be eligible for diabetes prevention services if you have a recommendation by a physician or other licensed practitioner and are:

- At least 21 years old,
- Not currently pregnant,
- Overweight, and
- Have not been previously diagnosed with type 1 or type 2 diabetes.

And, you meet one of the following criteria:

- You have had a blood test result in the prediabetes range within the past year, **or**
- You have been previously diagnosed with gestational diabetes, **or**
- You score 5 or higher on the CDC/American Diabetes Association (ADA) Prediabetes Risk Test.

Talk to your doctor to see if you qualify to take part in the NDPP.

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

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

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

Family Planning

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

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

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

Infertility Services

If you are unable to get pregnant, EmblemHealth covers services that may help.

EmblemHealth covers some drugs for infertility. This benefit is limited to coverage for 3 cycles of treatment per lifetime.

EmblemHealth will also cover services related to prescribing and monitoring the use of such drugs. The infertility benefit includes:

- Office visits
- X-ray of the uterus and fallopian tubes
- Pelvic ultrasound
- Blood testing

Eligibility

You may be eligible for infertility services if you meet the following criteria:

- You are 21-34 years old and are unable to get pregnant after 12 months of regular, unprotected sex.
- You are 35-44 years old and are unable to get pregnant after 6 months of regular, unprotected sex.

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

HIV and STI Screening

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

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

TB Diagnosis and Treatment

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

Benefits Using Your Medicaid Card Only

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

Transportation

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

To get non-emergency transportation, you or your provider must call the number below that applies to you:

- Nassau and Suffolk County members: LogistiCare at **844-678-1103**
- Westchester County members: Medical Answering Services (MAS) at **866-883-7865**
- New York City Members: Medical Answering Services (MAS) at **844-666-6270**

If possible, you or your provider should call LogistiCare at least 3 days before your medical appointment and provide your Medicaid identification number (ex. AB12345C), appointment

date and time, address where you are going, and doctor you are seeing. Non-emergency medical transportation includes: personal vehicle, bus, taxi, ambulette, and public transportation.

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

Developmental Disabilities

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

Services NOT Covered

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

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

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

This includes:

- Non-covered services (listed above),
- Unauthorized services,
- Services provided by providers not part of EmblemHealth Enhanced Care Plus

If You Get a Bill

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

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

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

Service Authorization

Prior Authorization:

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

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

* Some services not listed here may require prior approval based on the circumstances. There is no prior authorization for substance use disorder (SUD) services.

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

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

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

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

What happens after we get your service authorization request:

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

We may decide to deny a service authorization request or to approve it for an amount that is less than requested. These decisions will be made by a qualified health care professional. If we decide that the requested service is not medically necessary, the decision will be made by a clinical peer reviewer, who may be a doctor or may be a health care professional who typically provides the care you requested. You can request the specific medical standards, called clinical review criteria, we use to make decisions about medical necessity.

After we get your request, we will review it under a standard or fast track process. You or your doctor can ask for a fast track review if it is believed that a delay will cause serious harm to your health. If your request for a fast track review is denied, we will tell you and your case will be handled under the standard review process.

We will fast track your review if:

- A delay will seriously risk your health, life, or ability to function;
- Your provider says the review must be faster;
- You are asking for more service than you are getting right now.

In all cases, we will review your request as fast as your medical condition requires us to do so but no later than mentioned below.

We will tell you and your provider both by phone and in writing if your request is approved or denied. We will also tell you the reason for the decision. We will explain what options for appeals or Fair Hearings you will have if you don't agree with our decision. (See also the Plan Appeals and Fair Hearings sections later in this handbook.)

Time frames for prior authorization requests:

- Standard review: We will make a decision about your request within 3 work days of when we have all the information we need, but you will hear from us no later than 14 days after we receive your request. We will tell you by the 14th day if we need more information.
- Fast track review: We will make a decision and you will hear from us within 72 hours. We will tell you within 72 hours if we need more information.

Time frames for concurrent review requests:

- Standard review: We will make a decision within 1 work day of when we have all the information we need, but you will hear from us no later than 14 days after we receive your request. We will tell you by the 14th day if we need more information.

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

Special time frames for other requests:

- If you are in the hospital or have just left the hospital and you are asking for home health care, we will make a decision within 72 hours of your request. This may be extended 14 days based on the need for more information.
- If you are asking for mental health services that may be related to a court appearance, we will make a decision within 72 hours of your request.
- If you are asking for an outpatient prescription drug, we will make a decision within 24 hours of your request.
- A step therapy protocol means we require you to try another drug first, before we will approve the drug you are requesting. If you are asking for approval to override a step therapy protocol, we will make a decision within 24 hours for outpatient prescription drugs. For other drugs, we will make a decision within 14 days of your request.

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

- Write and tell you what information is needed. If your request is in a fast track review, we will call you right away and send a written notice later.
- Tell you why the delay is in your best interest.
- Make a decision no later than 14 days from the day we asked for more information.

You, your provider, or someone you trust may also ask us to take more time to make a decision. This may be because you have more information to give the plan to help decide your case. This can be done by calling **855-283-2146** or writing to:

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

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

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

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

Other Decisions About Your Care:

Sometimes, we will do a concurrent review on the care you are receiving to see if you still need the care. We may also review other treatments and services you have already received. This is called retrospective review. We will tell you if we make these decisions.

Time frames for other decisions about your care:

- In most cases, if we make a decision to reduce, suspend, or stop a service we have already approved and you are now getting, we must tell you at least 10 days before we change the service.
- We must tell you at least 10 days before we make any decision about long-term services and supports, such as home health care, personal care, CDPAS, adult day health care, and nursing home care.
- If we are checking care that has been given in the past, we will make a decision about paying for it within 30 days of receiving all information we need for the retrospective review. If we deny payment for a service, we will send a notice to you and your provider the day the payment is denied. These notices are not bills. **You will not have to pay for any care you received that was covered by the plan or by Medicaid even if we later deny payment to the provider.**

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

Phone: **844-614-8800** (TTY Relay Service: **711**)

Web: **icannys.org** | Email: **ican@cssny.org**

How Our Providers Are Paid

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

- If our PCPs work in a clinic or health center, they probably get a salary. The number of patients they see does not affect this.
- Our PCPs who work from their own offices may get a set fee each month for each patient for whom they are the patient's PCP. The fee stays the same whether the patient needs one visit or many — or even none at all. This is called capitation.
- Sometimes, providers get a set fee for each person on their patient list, but some money (maybe 10%) can be held back for an incentive fund. At the end of the year, this fund is used to reward PCPs who have met the standards for extra pay that were set by the plan.
- Providers may also be paid by fee-for-service. This means they get a plan-agreed-upon fee for each service they provide.

You Can Help With Plan Policies

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

Information from Member Services

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

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

Keep Us Informed

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

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

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

Disenrollment and Transfers

If You Want to Leave Our Plan

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

Some examples of good cause include:

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

To change plans:

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

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

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

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

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

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

- Move out of the county or service area,
- Change to another managed care plan,
- Join an HMO or other insurance plan through work,
- Go to prison, or

- Otherwise lose eligibility.
- If you have to leave EmblemHealth Enhanced Care Plus or become ineligible for Medicaid, all of your services may stop unexpectedly, including any care you receive at home. Call New York Medicaid Choice at **800-505-5678** right away if this happens.

We Can Ask You to Leave Our Plan

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

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

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

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

Plan Appeals

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

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

Your provider can ask for reconsideration:

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

You can file a Plan Appeal:

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

- You have 60 days from the date of the Initial Adverse Determination notice to ask for a Plan Appeal.

- You can call Member Services at **855-283-2146** if you need help asking for a Plan Appeal, or following the steps of the appeal process. We can help if you have any special needs like a hearing or vision impairment, or if you need translation services.
- You can ask for a Plan Appeal, or you can have someone else like a family member, friend, doctor, or lawyer ask for you. You and that person will need to sign and date a statement saying you want that person to represent you.
- We will not treat you any differently or act badly toward you because you ask for a Plan Appeal.

Aid to continue while appealing a decision about your care:

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

- **Within 10 days from being told that your care is changing; or**
- **By the date the change in services is scheduled to occur, whichever is later.**

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

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

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

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

Phone	**855-283-2146**
Fax	**212-510-5320**
Mail	Grievance and Appeals Department EmblemHealth 55 Water Street, New York, NY 10041
In Person	Visit any of our Neighborhood Care Centers.

If you ask for a Plan Appeal by phone, unless it is fast tracked, you must also send your Plan Appeal to us in writing. After your call, we will send you a form that is a summary of your phone Plan Appeal. If you agree with our summary, you should sign and return the form to us. You can make any needed changes before sending the form back to us.

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

- If we said that the service you asked for is not very different from a service available from a participating provider, you can ask us to check if this service is medically necessary for you. You will need to ask your doctor to send this information with your Plan Appeal:

  1) A statement in writing from your doctor that the out-of-network service is very different from the service the plan can provide from a participating provider. Your doctor must be a board certified or board eligible specialist who treats people who need the service you are asking for.
  2) Two medical or scientific documents that prove the service you are asking for is more helpful to you and will not cause you more harm than the service the plan can provide from a participating provider.

- lf you think our participating provider does not have the correct training or experience to provide a service, you can ask us to check if it is medically necessary for you to be referred to an out-of-network provider. You will need to ask your doctor to send this information with your appeal:

  1) A statement in writing that says our participating provider does not have the correct training and experience to meet your needs, and
  2) That recommends an out-of-network provider with the correct training and experience who is able to provide the service.

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

What happens after we get your Plan Appeal:

- Within 15 days, we will send you a letter to let you know we are working on your Plan Appeal.
- We will send you a free copy of the medical records and any other information we will use to make the appeal decision. If your Plan Appeal is fast tracked, there may be a short time to review this information.
- You can also provide information to be used in making the decision in person or in writing. Call EmblemHealth at **855-283-2146** if you are not sure what information to give us.
- Plan Appeals of clinical matters will be decided by qualified health care professionals who did not make the first decision, at least one of whom will be a clinical peer reviewer.
- Non-clinical decisions will be handled by persons who work at a higher level than the people who worked on your first decision.

- You will be given the reasons for our decision and our clinical rationale, if they apply. The notice of the Plan Appeal decision to deny your request or to approve it for an amount that is less than requested is called a **Final Adverse Determination**.
- **If you think our Final Adverse Determination is wrong:**
  - You can ask for a Fair Hearing. See the Fair Hearings section of this handbook.
  - For some decisions, you may be able to ask for an External Appeal. See the External Appeals section of this handbook.
  - You may file a complaint with the New York State Department of Health at **800-206-8125**.

Time frames for Plan Appeals:

- **Standard Plan Appeals:** If we have all the information we need, we will tell you our decision within 30 days from when you asked for your Plan Appeal.
- **Fast track Plan Appeals:** If we have all the information we need, fast track Plan Appeal decisions will be made in 2 working days from your Plan Appeal but not more than 72 hours from when you asked for your Plan Appeal.
  - We will tell you within 72 hours if we need more information.
  - If your request was denied when you asked for more inpatient substance use disorder treatment at least 24 hours before you were to leave the hospital, we will make a decision about your appeal within 24 hours.
  - We will tell you our decision by phone and send a written notice later.

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

- You or your doctor asks to have your Plan Appeal reviewed under the fast track process. Your doctor would have to explain how a delay will cause harm to your health. If your request for fast track is denied, we will tell you and your Plan Appeal will be reviewed under the standard process; **or**
- Your request was denied when you asked to continue receiving care that you are now getting or need to extend a service that has been provided; **or**
- Your request was denied when you asked for home health care after you were in the hospital; **or**
- Your request was denied when you asked for more inpatient substance use disorder treatment at least 24 hours before you were to leave the hospital.

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

- Write you and tell you what information is needed. If your request is in a fast track review, we will call you right away and send a written notice later.
- Tell you why the delay is in your best interest.
- Make a decision no later than 14 days from the day we asked for more information.

You or your representative may also ask us to take more time to make a decision. This may be because you have more information to give the plan to help decide your case. This can be done by calling **855-283-2146** or writing to:

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

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

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

If we do not decide your Plan Appeal on time, and we said the service you are asking for is:

1) Not medically necessary;
2) Experimental or investigational;
3) Not different from care you can get in the plan's network; or
4) Available from a participating provider who has correct training and experience to meet your needs, the original denial will be reversed. This means your service authorization request will be approved.

External Appeals

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

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

For these types of decisions, you can ask New York State for an independent **External Appeal**. This is called an External Appeal because it is decided by reviewers who do not work for the health plan or the state. These reviewers are qualified people approved by New York State. The service must be in the plan's benefit package or be an experimental treatment, clinical trial, or treatment for a rare disease. You do not have to pay for an External Appeal.

Before you ask for an External Appeal:

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

You have **4 months** after you receive the plan's Final Adverse Determination to ask for an External Appeal. If you and the plan agreed to skip the plan's appeals process, then you must ask for the External Appeal within 4 months of when you made that agreement.

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

Here are some ways to get an application:

- Call the Department of Financial Services at **800-400-8882**.
- Go to the Department of Financial Services' website at **dfs.ny.gov**.
- Contact the health plan at **855-283-2146**.

Your External Appeal will be decided in 30 days. More time (up to five work days) may be needed if the External Appeal reviewer asks for more information. You and the plan will be told the final decision within 2 days after the decision is made.

You can get a faster decision if:

- Your doctor says that a delay will cause serious harm to your health, or
- You are in the hospital after an emergency room visit and the hospital care is denied by the plan.

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

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

- You ask for a fast track Plan Appeal within 24 hours, **and**
- You ask for a fast track External Appeal at the same time.

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

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

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

Fair Hearings

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

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

- You are not happy with a decision we made to restrict your services. You feel the decision limits your Medicaid benefits. You have 60 days from the date of the Notice of Intent to Restrict to ask for a Fair Hearing. If you ask for a Fair Hearing within 10 days of the Notice of Intent to Restrict, or by the effective date of the restriction, whichever is later, you can continue to get your services until the Fair Hearing decision. However, if you lose your Fair Hearing, you may have to pay the cost for the services you received while waiting for the decision.
- You are not happy with a decision that your doctor would not order services you wanted. You feel the doctor's decision stops or limits your Medicaid benefits. You must file a complaint with EmblemHealth. If EmblemHealth agrees with your doctor, you may ask for a Plan Appeal. If you receive a Final Adverse Determination, you will have 120 days from the date of the Final Adverse Determination to ask for a state Fair Hearing.
- You are not happy with a decision that we made about your care. You feel the decision limits your Medicaid benefits. You are not happy we decided to:
  - Reduce, suspend, or stop care you were getting; or
  - Deny care you wanted; or
  - Deny payment for care you received; or
  - Did not let you dispute a copay amount, other amount you owe, or payment you made for your health care.

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

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

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

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

The decision you receive from the Fair Hearing officer will be final.

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

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

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

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

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

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

Complaint Process

Complaints:

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

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

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

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

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

How to File a Complaint with Our Plan:

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

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

You can write us with your complaint or call the Member Services number and request a complaint form. It should be mailed to:

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

What Happens Next:

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

- Who is working on your complaint.
- How to contact this person.
- If we need more information.

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

Your complaint will be reviewed by one or more qualified people. If your complaint involves clinical matters, your case will be reviewed by one or more qualified health care professionals.

After we review your complaint:

- We will let you know our decision in 45 days of when we have all the information we need to answer your complaint, but you will hear from us in no more than 60 days from the day we get your complaint. We will write you and will tell you the reasons for our decision.
- When a delay would risk your health, we will let you know our decision in 48 hours of when we have all the information we need to answer your complaint, but you will hear from us in no more than 7 days from the day we get your complaint. We will call you with our decision or try to reach you to tell you. You will get a letter to follow up our communication in 3 work days.
- You will be told how to appeal our decision if you are not satisfied and we will include any forms you may need.
- If we are unable to make a decision about your complaint because we don't have enough information, we will send a letter and let you know.

Complaint Appeals:

If you disagree with a decision we made about your complaint, you can file a complaint appeal with the plan.

How to make a complaint appeal:

- If you are not satisfied with what we decide, you have at least 60 work days after hearing from us to file a complaint appeal;
- You can do this yourself or ask someone you trust to file the complaint appeal for you;

- The complaint appeal must be made in writing. If you make a complaint appeal by phone, it must be followed up in writing. After your call, we will send you a form, which is a summary of your phone appeal. If you agree with our summary, you must sign and return the form to us. You can make any needed changes before sending the form back to us.

What happens after we get your complaint appeal:

After we get your complaint appeal, we will send you a letter within 15 work days. The letter will tell you:

- Who is working on your complaint appeal.
- How to contact this person.
- If we need more information.

Your complaint appeal will be reviewed by one or more qualified people at a higher level than those who made the first decision about your complaint. If your complaint appeal involves clinical matters, your case will be reviewed by one or more qualified health professionals, with at least one clinical peer reviewer, that were not involved in making the first decision about your complaint.

If we have all the information we need, you will know our decision in 30 work days. If a delay would risk your health, you will get our decision in 2 work days of when we have all the information we need to decide the appeal. You will be given the reasons for our decision and our clinical rationale, if it applies. If you are still not satisfied, you or someone on your behalf can file a complaint at any time with the New York State Department of Health at **800-206-8125**.

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

Phone: **844-614-8800** (TTY Relay Service: **711**)

Web: **icannys.org** | Email: **ican@cssny.org**

PART III: MEMBER RIGHTS AND RESPONSIBILITIES

Your Rights

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

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

Your Responsibilities

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

- Work with your care team to protect and improve your health.
- Find out how your health care system works.
- Listen to your PCP's advice and ask questions when you are in doubt.
- Call or go back to your PCP if you do not get better, or ask for a second opinion.
- Treat health care staff with the respect you expect yourself.
- Tell us if you have problems with any health care staff. Call Member Services.
- Keep your appointments. If you must cancel, call as soon as you can.
- Use the emergency room only for real emergencies.
- Call your PCP when you need medical care, even if it is after-hours.

ADVANCE DIRECTIVES

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

Health Care Proxy

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

CPR and DNR

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

Organ Donor Card

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

HEALTH CARE PROXY

Appointing Your Health Care Agent In New York State

The New York Health Care Proxy Law allows you to appoint someone you trust — for example, a family member or close friend — to make health care decisions for you if you lose the ability to make decisions yourself. By appointing a health care agent, you can make sure that health care providers follow your wishes. Your agent can also decide how your wishes apply as your medical condition changes. Hospitals, doctors, and other health care providers must follow your agent's decisions as if they were your own. You may give the person you select as your health care agent as little or as much authority as you wish. You may allow your agent to make all health care decisions or only certain ones. You may also give your agent instructions that he or she has to follow. This form can also be used to document your wishes or instructions with regard to organ and/or tissue donation.

About the Health Care Proxy Form

This is an important legal document. Before signing, you should understand the following facts:

1. This form gives the person you choose as your agent the authority to make all health care decisions for you, including the decision to remove or provide life-sustaining treatment, unless you say otherwise in this form. "Health care" means any treatment, service, or procedure to diagnose or treat your physical or mental condition.
2. Unless your agent reasonably knows your wishes about artificial nutrition and hydration (nourishment and water provided by a feeding tube or intravenous line), he or she will not be allowed to refuse or consent to those measures for you.
3. Your agent will start making decisions for you when your doctor determines that you are not able to make health care decisions for yourself.
4. You may write on this form examples of the types of treatments that you would not desire and/or those treatments that you want to make sure you receive. The instructions may be used to limit the decision-making power of the agent. Your agent must follow your instructions when making decisions for you.

5. You do not need a lawyer to fill out this form.
6. You may choose any adult (18 years of age or older), including a family member or close friend, to be your agent. If you select a doctor as your agent, he or she will have to choose between acting as your agent or as your attending doctor, because a doctor cannot do both at the same time. Also, if you are a patient or resident of a hospital, nursing home, or mental hygiene facility, there are special restrictions about naming someone who works for that facility as your agent. Ask staff at the facility to explain those restrictions.
7. Before appointing someone as your health care agent, discuss it with him or her to make sure that he or she is willing to act as your agent. Tell the person you choose that he or she will be your health care agent. Discuss your health care wishes and this form with your agent. Be sure to give him or her a signed copy. Your agent cannot be sued for health care decisions made in good faith.
8. If you have named your spouse as your health care agent and you later become divorced or legally separated, your former spouse will no longer be your agent by law, unless you state otherwise. If you would like your former spouse to remain your agent, you may note this on your current form and date it or complete a new form naming your former spouse.
9. Even though you have signed this form, you have the right to make health care decisions for yourself as long as you are able to do so, and treatment cannot be given to you or stopped if you object, nor will your agent have any power to object.
10. You may cancel the authority given to your agent by telling him or her or your health care provider orally or in writing.
11. Appointing a health care agent is voluntary. No one can require you to appoint one.
12. You may express your wishes or instructions regarding organ and/or tissue donation on the form.

Frequently Asked Questions

Why Should I Choose a Health Care Agent?

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

- Allowing your agent to make health care decisions on your behalf as you would want them decided.
- Choosing one person to make health care decisions because you think that person would make the best decisions.
- Choosing one person to avoid conflict or confusion among family members and/or significant others.
- Being able to appoint an alternate agent to take over if your first choice cannot make decisions for you.

Who Can Be a Health Care Agent?

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

How Do I Appoint a Health Care Agent?

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

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

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

What Decisions Can My Health Care Agent Make?

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

Why Do I Need To Appoint a Health Care Agent If I'm Young and Healthy?

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

How Will My Health Care Agent Make Decisions?

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

How Will My Health Care Agent Know My Wishes?

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

- Whether you would want life support initiated/continued or removed if you are in a permanent coma.

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

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

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

Who Will Pay Attention To My Agent?

All hospitals, nursing homes, doctors, and other health care providers are legally required to provide your health care agent with the same information that would be provided to you and to honor the decisions by your agent as if they were made by you. If a hospital or nursing home objects to some treatment options (such as removing certain treatment), they must tell you or your agent, BEFORE OR UPON admission, if reasonably possible.

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

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

What if I Change My Mind?

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

Can My Health Care Agent Be Legally Liable for Decisions Made on My Behalf?

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

Is a Health Care Proxy the Same as a Living Will?

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

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

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

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

May I Use the Health Care Proxy Form To Express My Wishes About Organ and/or Tissue Donation?

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

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

Can My Health Care Agent Make Decisions for Me About Organ and/or Tissue Donation?

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

Who Can Consent To a Donation If I Choose Not To State My Wishes at This Time?

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

Health Care Proxy Form Instructions

Item (1)

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

Item (2)

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

Item (3)

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

Item (4)

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

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

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

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

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

Item (5)

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

Item (6)

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

Item (7)

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

Health Care Proxy

(1) I, _____

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

_____

_____

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

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

_____
(name, home address, and telephone number)

_____

_____

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

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

_____

_____

_____

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

_____

_____

In order for your agent to make health care decisions for you about artificial nutrition and hydration (nourishment and water provided by feeding tube and intravenous line), your agent must reasonably know your wishes. You can either tell your agent what your wishes are or include them in this section. See instructions for sample language that you could use if you choose to include your wishes on this form, including your wishes about artificial nutrition and hydration.

(5) Your Identification (Please Print):

Your Name: _____

Your Signature: _____

Date: _____

Your Address: _____

(6) Optional: Organ and/or Tissue Donation

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

❑ Any needed organs and/or tissues

❑ The following organs and/or tissues

_____

_____

❑ Limitations

_____

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

Your Signature: _____

Date: _____

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

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

PRIVATE	
Date	Date
Name of Witness 1 (print)	Name of Witness 2 (print)
Signature	Signature
Address	Address

IMPORTANT PHONE NUMBERS AND WEBSITES

IMPORTANT PHONE NUMBERS

Your PCP .....

EmblemHealth
- Member Services ..... **855-283-2146 (TTY: 711)**
- Nurse Hotline **877-444-7988**
- Utilization Review **855-283-2146**

To speak to a HARP Care Manager call Member Services at the phone number listed above.

Your Nearest Emergency Room .....

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

OMH Complaints **800-597-8481**

OASAS Complaints **800-553-5790**

Medicaid Helpline **800-541-2831**

NYC Human Resources Administration **718-557-1399**

New York Medicaid Choice **800-505-5678**

Local Departments of Social Services (DSS)

Nassau County DSS **516-227-7474**

Suffolk County DSS:
- Eastern Suffolk County **631-852-3710**
- Western Suffolk County **631-853-8408**

Westchester County DSS **914-995-3333**

NYS HIV/AIDS Hotline ..... **800-541-AIDS (2437)**
- Spanish ..... **800-233-SIDA (7432)**
- TTY ..... **800-369-AIDS (2437)**

New York City HIV/AIDS Hotline (English & Spanish)..... **800-TALK-HIV (825-5448)**

HIV Uninsured Care Programs ..... **800-542-AIDS (2437)**
TTY Relay, then..... **518-459-0121**

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

Partner Assistance Program..... **800-541-AIDS (2437)**
In New York City (CNAP) **212-693-1419**

Social Security Administration..... **800-772-1213**

NYS Domestic Violence Hotline **800-942-6906**
Spanish **800-942-6908**
Hearing Impaired..... **800-810-7444**

Americans with Disabilities Act (ADA) Information Line..... **800-514-0301**
TTY **800-514-0383**

Local Pharmacy .....

Other Health Providers.....

Ombudsman program contact:
Community Health Access to Addiction and Mental Health Care
Project (CHAMP)..... **888-614-5400**
Mailbox ..... **Ombuds@oasas.ny.gov**

Independent Consumer Advocacy Network (ICAN): ... **844-614-8800** (TTY Relay Service: **711**)
Web..... **www.icannys.org**
Email ..... **ican@cssny.org**

IMPORTANT WEBSITES

EmblemHealth..... **emblemhealth.com**
NYS Department of Health..... **health.ny.gov**
NYS OMH ..... **omh.ny.gov**
NYS OASAS ..... **oasas.ny.gov**
NYS DOH HIV/AIDS Information ..... **health.ny.gov/diseases/aids**
NYS HIV Uninsured Care Programs ..... **health.ny.gov/diseases/aids/resources/adap/index.htm**
HIV Testing Resource Directory... **cdc.gov/actagainstaids/campaigns/hivtreatmentworks/resources/index.html**
NYC DOHMH..... **nyc.gov/site/mopd/resources/mental-health.page**
NYC DOHMH HIV/AIDS Information... **nyc.gov/site/doh/health/health-topics/aids-hiv.page**

Notes:

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

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45-8666-23PD 11/22 bug

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Enhanced Care and Enhanced Care Plus Member Handbook Update

YOUR MEMBER HANDBOOK HAS BEEN CHANGED TO UPDATE SOME SERVICES

Gambling Disorder Treatment, Provided by Office of Addiction Services and Supports (OASAS) Certified Programs.

Starting **Jan. 1, 2023**, EmblemHealth will cover Gambling Disorder Treatment provided by Office of Addiction Services and Supports (OASAS) certified programs.

You can get Gambling Disorder Treatment:

- Face-to-face; or
- Through telehealth.

If you need Gambling Disorder Treatment, you can get them from an OASAS outpatient program or, if necessary, an OASAS inpatient or residential program.

You do not need a referral from your primary care provider (PCP) to get these services. If you need help finding a provider, please call EmblemHealth member services at the number listed below.

To learn more about these services, call Member Service at **855-283-2146** (TTY: **711**). Our hours are 8 a.m. to 6 p.m., Monday through Friday (excluding major holidays).

45-11802PD 11/22

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Referrals Not Required for In-Network Specialty Care Services

Starting **Jan. 1, 2023**, you do not need a referral from your Primary Care Provider (PCP) to see an in-network specialty care provider.* If you need care that your PCP cannot give, you may self-refer to a specialty care provider who participates in your network.

Specialty Care includes the services of other practitioners, including:

- Physical therapy (PT), occupational therapy (OT), and speech therapy (ST)
- Audiologists
- Durable medical equipment (DME), including hearing aids, artificial limbs, and orthotics
- Renal and hemodialysis
- Midwifery services
- Cardiac rehabilitation
- Podiatrists
- Other covered services as medically needed.

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

If you have questions or need help finding a provider, please call EmblemHealth member services at **855-283-2146** (**TTY: 711**). Our hours are 8 a.m. to 6 p.m., Monday through Friday (excluding major holidays).

*If you need out of network specialty care, you must get prior approval from EmblemHealth.

45-11801PD 1/23

EmblemHealth®

Preauthorization Not Required for Outpatient Physical and Occupational Therapies

As of Jan. 1, 2024, outpatient physical and occupational therapies provided by an in-network provider no longer require preauthorization before you get them.*

*If you need these services from an out-of-network provider, you must get prior approval from EmblemHealth.

45-11860PD 10/23

EmblemHealth®

Enhanced Care and Enhanced Care Plus Member Handbook Update

YOUR MEMBER HANDBOOK HAS BEEN UPDATED WITH ADDITIONAL SERVICES.

Dental Services

Beginning Jan. 31, 2024, EmblemHealth will cover crowns and root canals in certain circumstances so you may keep more of your natural teeth.

In addition, replacement dentures and implants will only need a recommendation from your dentist to determine if they are necessary. This will make it easier for you to receive these dental services.

Call Customer Service at **855-283-2146** (TTY: **711**); 8 a.m. to 6 p.m., Monday through Friday.

45-11879PD 11/23

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Enhanced Care and Enhanced Care Plus Member Handbook Update

YOUR MEMBER HANDBOOK HAS BEEN CHANGED TO INCLUDE MORE SERVICES.

Mobile Crisis Telephonic Triage Response Service

Starting March 1, 2024, EmblemHealth will cover the Mobile Crisis Telephonic Triage and Response service for members under age 21. This service is already available to members age 21 and older.

Currently, members under age 21 can receive the Mobile Crisis Telephonic Triage and Response service by using their Medicaid card. Effective March 1, 2024, you can use your EmblemHealth plan card to receive this service.

Mobile Crisis teams can help you, your child, or other members of your family with mental health and addiction crisis symptoms and needs. These may include:

- Increased anxiety.
- Depression.
- Stress due to a major life event or changes.
- Needing to speak with someone to prevent relapse.

You and your family can talk to a professional about a crisis, get support, and be connected with other services when needed.

If you are experiencing a crisis, call or text **988** or chat at **988lifeline.org**, 24 hours a day, 7 days a week.

To learn more about these services, call EmblemHealth Customer Service at **855-283-2146** (TTY: **711**), 8 a.m. to 6 p.m., Monday through Friday.

45-11889PD 1/24

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Enhanced Care and Enhanced Care Plus Member Handbook Update

The pharmacy benefit section of your member handbook will no longer be valid after April 1, 2023. Instead, refer to the information below.

PHARMACY BENEFIT CHANGE:

Starting April 1, 2023, your prescriptions will not be covered by EmblemHealth. They will be covered by Medicaid NYRx, the Medicaid pharmacy program.

Most pharmacies in New York State take the Medicaid NYRx pharmacy program. If your pharmacy does not take Medicaid, you may:

- Ask your doctor to send a new prescription to a pharmacy that takes Medicaid NYRx pharmacy program, or
- Ask your pharmacist to transfer a refill to a pharmacy that takes Medicaid NYRx pharmacy program, or
- Locate a pharmacy that takes Medicaid NYRx at: **member.emedny.org**.

You will need to show the pharmacist either your Medicaid Card **or** your Health Plan Card. This will tell them your Client Identification Number (CIN).

Medicaid NYRx has a list of covered drugs. Over-the-counter drugs and most drugs are on the list. This list of covered drugs can be found at: **emedny.org/info/formfile.aspx**.

- Some drugs need prior approval before they can be filled. This list will tell you if a drug needs prior approval. Your doctor will call to get prior approval.
- If your drug is not on this list:
  - Your doctor can ask Medicaid for approval to let you get the drug, or
  - Your pharmacist can talk to your doctor about changing to a drug that is on the list.

Medicaid NYRx pharmacy plan also has a preferred drug list. This list can be found at: **newyork.fhsc.com/downloads/providers/NYRx_PDP_PDL.pdf**.

- If you need a non-preferred drug, please contact your pharmacist or doctor so that they can get approval for you to get this drug.

The Medicaid copayment structure is not changing. Your copayment might change depending on if the drug is preferred or non-preferred.

Your pharmacy benefit also covers certain supplies:

- A list of covered supplies can be found at: **member.emedny.org/**.
- A list of preferred diabetic meters and test strips can be found at: **newyork.fhsc.com/downloads/providers/NYRx_PDSP_preferred_supply_list.pdf**.
  - You will need to change to a preferred diabetic meter and test strip.

Do you have questions or need help? The Medicaid Helpline can assist you. They can talk to you in your preferred language. They can be reached at **800-541-2831** TTY **800-662-1220**.

They can answer your call:

- Monday - Friday, 8 a.m. – 8 p.m.
- Saturday, 9am – 1 p.m.

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Enhanced Care and Enhanced Care Plus Member Handbook Update

EmblemHealth and our vendors can send you notices about service authorizations, plan appeals, complaints, and complaint appeals electronically, instead of by phone or mail. We can also send you communications about your member handbook, our provider directory, and changes to Medicaid managed care benefits electronically, instead of by mail.

We can send you these notices through our member portal, **myEmblemHealth**. Some of our health care partners will send these notices to you through their portals. You will need to register for their portals separately. For a list of our health care partners who use their own portals, visit: **emblemhealth.com/plans/state-sponsored-programs**.

If you want to get these notices electronically, you must ask us. To ask for electronic notices contact us by phone, online, or mail:

Phone: **855-283-2146** (TTY: **711**)
Online: **my.emblemhealth.com**
Mail: P.O. Box 1701, NY, NY 10023-1701

When you contact us, you must:

- Tell us how you want to get notices that are normally sent by mail.
- Tell us how you want to get notices that are normally made by phone call.
- Give us your email address.

EmblemHealth will let you know by mail that you have asked to get notices electronically.

45-11934-25

EmblemHealth®

Enhanced Care and Enhanced Care Plus Member Handbook Update

Your member handbook has been changed.

Benefits you can get from EmblemHealth or with your Medicaid card

For some services, you can choose where to get care. You can get these services by using your EmblemHealth membership card or by going to a doctor who takes your Medicaid benefit card. You do not need a referral from your primary care provider (PCP) to get these services. Call us if you have questions at **855-283-2146** (TTY: **711**).

Family planning

You can go to any doctor or clinic that takes Medicaid and offers family planning services. You can visit one of our family planning health care professionals as well. Either way, you do not need a referral from your PCP. You can get birth control drugs, birth control devices (IUDs and diaphragms) that are available with a prescription, plus emergency contraception, sterilization, pregnancy testing, prenatal care, and abortion services. You can also see a family planning provider for HIV and sexually transmitted infection (STI) testing and treatment, and counseling related to your test results. Screenings for cancer and other related conditions are also included in family planning visits.

You can request that EmblemHealth send any communication regarding family planning services to a different address or by another means (email, phone, etc.). To update your family planning communication preference, please call Member Services at **855-283-2146** (TTY: **711**) from 8 a.m. to 6 p.m., Monday through Friday.

Get these services from EmblemHealth without a referral

Women's health care

You do not need a referral from your PCP to see one of our doctors if you:

- Are pregnant.
- Need OB/GYN services.
- Need family planning services.
- Want to see a midwife.
- Need to have a breast or pelvic exam.

45-11933 10/24

Family planning

- You can get the following family planning services: advice about birth control, birth control prescriptions, male and female condoms, pregnancy tests, sterilization, and an abortion. During your visits, you can also get tests for sexually transmitted infections, a breast cancer exam, or a pelvic exam.
- You do not need a referral from your PCP to get these services. In fact, you can choose where to get these services. You can use your EmblemHealth ID card to see one of our family planning providers. Check our Provider Directory or call Member Services for help finding a doctor.
- You can use your Medicaid card if you want to visit a doctor or clinic outside our plan. Ask your PCP or call Member Services at **855-283-2146** (TTY:**711**) for a list of places to get these services. You can also call the New York State Growing Up Healthy Hotline (**800-522-5006**) for the names of family planning providers near you.

You can request that EmblemHealth send any communication regarding family planning services to a different address or by a different means (email, phone, etc.). To update your family planning communication preference, please call Member Services at **855-283-2146** (TTY: **711**) from 8 a.m. to 6 p.m., Monday through Friday.

EmblemHealth®

Enhanced Care and Enhanced Care Plus Member Handbook Update

Your member handbook has been changed to include additional services.

Starting Jan. 1, 2025, you can connect to organizations in your community that provide services to help with housing, food, transportation, and care management at no cost to you, through a regional social care network (SCN).

- Through this SCN, you and your child can meet with a social care navigator who can check your eligibility for services that can help with your health and well-being. They will ask you some questions to see where you might need some extra support.
- If you or your child qualifies for services, the social care navigator can work with you to get the support you need. You may qualify for more than one service, depending on your situation. These services include:
  - **Housing and utilities support:**
    - Installing home modifications like ramps, handrails, and grab bars to make your home accessible and safe.
    - Repairing and fixing water leaks to prevent mold from growing in your home.
    - Sealing holes and cracks to prevent pests from entering your home.
    - Providing an air conditioner, heater, humidifier, or dehumidifier to help improve ventilation in your home.
    - Helping you find and apply for safe and stable housing in the community.
  - **Nutrition support:**
    - Getting help from a nutrition expert who will give you guidance and support in choosing healthy foods to meet your health needs and goals.
    - Getting prepared meals, fresh produce, or grocery items delivered to your home for up to six months. These food items will be tailored to your specific health needs.
    - Providing cooking supplies like pots, pans, microwave, refrigerator, and utensils to prepare meals.
  - **Transportation services:**
    - Helping you get public or private transportation to places approved by the SCN such as: going to a job interview, parenting classes, housing court to prevent eviction, local farmers markets, and city or state department offices to obtain important documents.
  - **Care management services:**
    - Getting help with finding a job or job training program, applying for public benefits, managing your finances, and more.
    - Getting connected to services like childcare, counseling, crisis intervention, health homes program, and more.

If you are interested, please call Member Services at **855-283-2146** (TTY: **711**) from 8 a.m. to 6 p.m., Monday through Friday, and we will connect you to an SCN in your area. The social care navigator will verify your eligibility, tell you more about these services, and help you get connected to them.

45-11924-25 10/24

Addendum to the New York State Health and Recovery Plan Member Handbook for the Integrated Benefits for Dually Eligible Enrollees (IB-Dual) Program

Introduction

This member handbook addendum provides information for members of the Integrated Benefits for Dually Eligible Enrollees (IB-Dual) Program. The IB-Dual program allows Medicare-eligible members to be enrolled in the Enhanced Care Plus health plan. Members will get their Medicare and Medicaid benefits through EmblemHealth VIP Dual Enhanced HMO D-SNP.

How to Use This Handbook Addendum

This addendum will tell you how your new integrated health care program works and how you can get the most from EmblemHealth VIP Dual Enhanced HMO D-SNP. It provides you with information that applies to an IB-Dual member (i.e., a member who has both Medicare and Medicaid coverage with the same health plan).

This includes information about enrollment, disenrollment, access to services, and how to file a complaint or appeal that may be different from what is included in your Enhanced Care Plus member handbook.

When you have a question, check your handbook or call EmblemHealth Customer Service.

Enrollment

To be a member of the IB-Dual Program offered by EmblemHealth, you must:

- Have both Medicare Part A and Medicare Part B and be enrolled in EmblemHealth VIP Dual Enhanced HMO Medicare Advantage Dual Special Needs Plan (D-SNP) Part C.
- Live in the plan's service area which includes New York, Queens, Kings, The Bronx, Richmond, Nassau, Suffolk, and Westchester counties.
- Be a United States citizen or be lawfully present in the United States.
- Be enrolled in EmblemHealth Medicaid managed care or Health and Recovery Plan (HARP).
- Not be in receipt of community based long-term care services (CBLTSS) for more than 120 days.

Your Health Plan Identification (ID) Card

After you enroll, you will be sent a welcome letter. Your new EmblemHealth VIP Dual Enhanced HMO D-SNP IB-Dual ID card should arrive within 14 days after your enrollment date. Your card has your primary care provider's (PCP) name and phone

number on it. It will also have your Client Identification Number. If anything is wrong on your EmblemHealth VIP Dual Enhanced HMO D-SNP IB-Dual ID card, call us right away. Your IB-Dual ID card does not show that you have Medicaid or that EmblemHealth VIP Dual Enhanced HMO D-SNP is a special type of health plan.

Always carry your IB-Dual ID card and show it each time you go for care. If you need care before the card comes, your welcome letter is proof that you are a member. You should keep your Medicaid benefit card. You will need this card to get services that EmblemHealth VIP Dual Enhanced HMO D-SNP does not cover.

Disenrollment

You may disenroll from the IB-Dual program at any time. If you voluntarily disenroll from either the Medicare or Medicaid coverage with us, your coverage under this program will end.

You may be involuntarily disenrolled from your IB-Dual program if any of the following apply. You:

- Permanently move out of our service area for the IB-Dual program.
- Lose your Medicaid coverage and don't regain it within 90 days (see below under "Loss of Medicaid Eligibility" for more information).
- Are in receipt of long-term care services for more than 120 days (if EmblemHealth VIP Dual Enhanced HMO DSNP finds that you require long-term care services for more than 120 days, you will be offered the option to enroll in a Managed Long-Term Care (MLTC) plan.
- Become eligible for a long-term nursing home stay.

Medicare Coverage

If you disenroll from the EmblemHealth VIP Dual Enhanced HMO DSNP IB-Dual program, you can enroll in a Medicare Advantage plan. If you do not enroll in a Medicare Advantage plan, the federal government will enroll you in Original Medicare for your medical care and in a Prescription Drug Plan (PDP) for your prescription drug coverage.

Medicaid Coverage

If you disenroll from the EmblemHealth VIP Dual Enhanced HMO D-SNP IB-Dual program, New York Medicaid Choice will enroll you in regular Medicaid.

Note: If you disenroll from the IB-Dual program in error, please contact the plan as soon as possible.

Loss of Medicaid Eligibility

If you lose Medicaid eligibility, your coverage in the IB-Dual program will end. However, you will have a 90-day grace period when your Medicare coverage will continue with the EmblemHealth VIP Dual Enhanced HMO D-SNP. If you regain Medicaid eligibility during the 90-day grace period, your coverage in the IB-Dual program will be reinstated. If you do not regain Medicaid eligibility during the 90-day grace period, you will be responsible for any copayments, coinsurance, premiums, and/or deductibles for which Medicaid would otherwise cover had you not lost your Medicaid eligibility.

Coordinating your Benefits

EmblemHealth VIP Dual Enhanced HMO D-SNP will coordinate both your Medicare and Medicaid benefits through the IB-Dual program. Your cost-sharing for Medicare-covered services will be $0 because Medicaid will cover your Medicare cost-sharing amounts.

Some services not covered by EmblemHealth VIP Dual Enhanced HMO D-SNP are available through regular Medicaid or Original Medicare (for example, nonemergency transportation and hospice services). Additionally, the Medicaid Pharmacy Program (NYRx) will cover select over-the-counter drugs, prescription vitamins, and cough suppressants that are not covered by Medicare Part D. You will continue to have access to regular Medicaid services during your enrollment in the IB-Dual plan.

Service Authorization, Appeals, and Complaints

Service Authorization

For services that are covered by Medicare or by both Medicare and Medicaid, EmblemHealth VIP Dual Enhanced HMO D-SNP will make decisions about your care as described in Chapter 9 of your Medicare Advantage D-SNP Evidence of Coverage (EOC). These are also known as Coverage Decisions.

For services covered only by Medicaid, EmblemHealth VIP Dual Enhanced HMO D-SNP will make decisions about your care following our Service Authorization rules described in Part II of your member handbook.

Appeals

If you are unhappy with a decision EmblemHealth VIP Dual Enhanced HMO D-SNP makes, you can file an appeal. This is called a Level 1 appeal.

Chapter 9 of your Medicare Advantage D-SNP EOC tells you how to file a Level 1 appeal on any decision EmblemHealth VIP Dual Enhanced HMO D-SNP makes.

Aid to continue while appealing a decision about your care

If EmblemHealth VIP Dual Enhanced HMO D-SNP reduces, suspends, or stops a service you are getting now, you may be able to continue the service while you wait for a Level 1 appeal determination.

You must ask for a Level 1 appeal **within 10 days from being told that your care is changing, or by the date the change in service is scheduled to occur, whichever is later.**

If your Level 1 appeal results in another denial, you will not have to pay for the cost of any continued benefits that you receive.

If you are unhappy with your Level 1 appeal decision, you can appeal again. This is called a Level 2 appeal. Chapter 9 of your Medicare Advantage D-SNP EOC tells you how to file a Level 2 appeal on any decision EmblemHealth VIP Dual Enhanced HMO D-SNP makes.

Aid to continue while waiting for a Fair Hearing decision

You may be able to continue your services while you wait for a Fair Hearing decision. Continuation of benefits is only available if EmblemHealth VIP Dual Enhanced HMO D-SNP reduces, suspends, or stops a service, and the service is covered by Medicaid.

You must ask for a Fair Hearing **within 10 days from the date of the Final Adverse Determination, or by the date the change in services is scheduled to occur, whichever is later.**

If your Fair Hearing results in another denial, you may have to pay for the cost of any continued benefits that you received.

If you are unhappy with the Level 2 appeal decision for a service covered by Medicare, you may have other appeal rights options. For more information about additional appeals rights options, see Chapter 9 of your Medicare Advantage D-SNP EOC or call Customer Service.

Complaint

If you have a problem with your care or services, you can contact Customer Service at **877-344-7364.** From Oct. 1 through March 31, you can call us seven days a week from 8 a.m. to 8 p.m. From April 1 to Sept. 30, you can call us Monday through Saturday from 8 a.m. to 8 p.m.

If you send a complaint in writing, EmblemHealth VIP Dual Enhanced HMO D-SNP will respond to you in writing. Your complaint will be answered as quickly as your case requires based on your health status, either in writing, by telephone, or both, within 30 calendar days from the day your complaint is received.

See Chapter 9 of your Medicare Advantage D-SNP EOC for more information on complaints.

Benefits and Services

As an IB-Dual enrollee, you receive both your Medicare benefits and Medicaid benefits from the same health plan. Most of your health benefits and services are covered through your Medicare Advantage D-SNP. The HARP part of your plan provides a number of Medicaid services in addition to those you get with regular Medicaid.

See your Medicare Advantage D-SNP EOC for details on your Medicare benefits and services. For additional benefits and services covered through Medicaid managed care, see Part II of your Enhanced Care Plus member handbook.

EmblemHealth VIP Dual Enhanced HMO D-SNP will arrange for most services that you will need. You can get some services without going through your PCP. Please call Customer Service at **877-344-7364** if you have any questions or need help with any of these services.

Enhanced Care and Enhanced Care Plus Member Handbook Update

Your member handbook has been changed to include more services.

Doula Services

This is an important notice about your Medicaid Managed Care plan benefits. Please read it carefully. If you have any questions, please call us at **855-283-2146** (TTY: **711**).

Starting **April 1, 2025**, EmblemHealth will cover doula services during pregnancy and up to 12 months after the end of pregnancy, no matter how the pregnancy ends. Currently, members can access doula services by using their Medicaid card. Beginning **April 1, 2025**, you must use your EmblemHealth plan card to receive doula services.

What is a doula?

Doulas provide physical, emotional, educational, and non-medical support for pregnant and postpartum persons before, during, and after childbirth or end of pregnancy.

What doula services are available?

Doula services can include up to eight (8) visits with a doula during and after pregnancy and continuous support while in labor and during childbirth. If you become pregnant within the 12 months following a prior pregnancy, your eligibility for doula services will start over with the new pregnancy. Any unused doula services from a prior pregnancy will not carry over.

Doula services may include:

- The development of a birth plan.
- Ongoing support throughout the pregnancy.
- Continuous support during labor and childbirth.
- Education and information on pregnancy, childbirth, and early parenting.
- Assistance with communication between you and your doctors.
- Connections with community-based childbirth and parenting resources.

Eligibility

If you are pregnant or have been pregnant within the last 12 months, you are eligible for doula services. You are eligible for these services with each pregnancy.

If you started to receive doula services with a Medicaid-enrolled doula before April 1, 2025, your doula services will continue to be covered until 12 months after the end of your pregnancy. If you start to receive doula services on or after April 1, 2025, your doula needs to participate with EmblemHealth.

To learn more about these services, call Customer Service at **855-283-2146** (TTY: **711**) from 8 a.m. to 6 p.m., Monday through Friday.