Our Benefits
Summary Plan Description
of Your Health and Welfare Benefits

1199SEIU Home Health Aide Benefit Fund
330 West 42nd Street
New York, NY 10036-6977
(646) 473-7470
Outside New York City area codes: (800) 575-7771
Westchester & Upstate Counties: (877) 557-1199
www.1199SEIUBenefits.org

JANUARY 2012
This booklet serves as the Summary Plan Description ("SPD") for participants in the 1199SEIU Home Health Aide Benefit Fund.

The Plan is administered by the Home Health Aide Plan Board of Trustees (the "Trustees") of the 1199SEIU Home Health Aide Benefit Fund ("NBF-Home Health Aide or Fund"), a sub-Fund of the 1199SEIU National Benefit Fund, which has established a separate Home Health Aide Trustee board. No individual or entity, other than the Trustees (including any duly authorized board, committee or designee thereof) has any authority to interpret the provisions of the Plan Document or to make any promises to you about the Plan.

Benefits under the Plan are provided by contract with the Health Insurance Company of New York ("HIP" or "HIPIC"), a New York State-licensed insurance company. These benefits are described in this SPD, and in a Certificate of Coverage issued by HIP, which has been mailed to you separately. HIP has the sole authority to interpret the Certificate of Coverage and apply its provisions. If there is any conflict between the terms of this document and the Certificate of Coverage, the Certificate of Coverage will control unless otherwise required by law.

The Home Health Aide Trustees reserve the right to amend, modify, discontinue or terminate all or part of this Plan for any reason and at any time when, in their judgment, it is appropriate to do so. These changes may be made by formal amendments to the Plan and/or any other methods allowed in the Trust Agreement for Trustee actions.

If the Plan is amended or terminated, you and other employees may not receive benefits. This may happen at any time if the Home Health Aide Plan Trustees decide to terminate the Plan or your coverage under the Plan. In no event will any employee become entitled to any vested or otherwise non-forfeitable rights under the Plan.

The Home Health Aide Trustees themselves (or through any duly authorized designee of the Trustees) reserve the complete authority and discretion to construe the terms of the Plan (and any related Plan documents) including, without limitation, the authority to determine the eligibility for, and the amount of, benefits payable under the Plan. These decisions shall be final and binding upon all parties affected by such decisions.

This booklet and any amendments are your source of information on the Plan. You cannot rely on information from coworkers, Union or Employer representatives. If you have any questions about the Plan and how its coverage works, the Fund office staff will be glad to help you. Since telephone conversations and other oral statements can easily be misunderstood, they cannot be relied upon if they are in conflict with what is stated in this Plan Document.
January 2012

Dear 1199SEIU Home Health Aide Employee:

This Summary Plan Description is a guide to your benefits package.

The biggest section in the booklet is about health benefits. This booklet will cover the procedures and policies you need to follow. Please remember: if you follow the procedures and policies for getting the most out of your benefits, you can receive comprehensive healthcare at little cost to you.

It is important that you read the entire booklet so that you know:

• What benefits you are eligible to receive;
• What policies and procedures need to be followed to get your benefits;
• How to use your benefits wisely.

It is the mission of the 1199SEIU Home Health Aide Benefit Fund to provide you with the best benefits possible. That's what 1199SEIU has been doing for 1199SEIU members for over 50 years – and what you can look forward to as an 1199SEIU member.

If you have any questions or concerns about your eligibility for benefits, call the Member Services Department at (646) 473-9200. Any questions about specific benefits should be directed to the HIP Insurance Company of New York at (800) HIP-TALK (800-447-8255).

Enjoy the benefits of your new benefit plan.

The Board of Trustees
DO YOU NEED ASSISTANCE IN USING THE SUMMARY PLAN DESCRIPTION?

This booklet is a summary of your benefits and the policies and procedures for using these benefits with the 1199SEIU Home Health Aide Benefit Fund.

If the language is not clear to you, you can get assistance by writing the Fund at:
330 West 42nd Street
New York, NY 10036

Or calling (646) 473-9200
Office hours for the Fund are 8:00 am to 6:00 pm, Monday through Friday.

HIP has a Language Line available through Customer Service at (800) HIP-TALK (800-447-8255) which provides over-the-telephone services in more than 100 languages, including Spanish.

¿NECESITA AYUDA PARA USAR LA DESCRIPCIÓN RESUMIDA DEL PLAN?

Este folleto es un resumen de sus beneficios y de las políticas y procedimientos para usar los beneficios con el 1199SEIU Home Health Aide Benefit Fund (Fondo del 1199SEIU de beneficios de asistentes de atención de salud en el hogar).

Si no entiende el idioma, puede obtener ayuda escribiéndole al fondo a:
330 West 42nd Street
New York, NY 10036

o llamando al (646) 473-9200
Los horarios de atención del fondo son de lunes a viernes de 8:00 am a 6:00 pm.

HIP dispone de una línea de ayuda de idiomas a través de su Servicio al Cliente en el número (800) HIP-TALK (800-447-8255), el cual brinda servicio a través del teléfono en más de 100 idiomas, incluyendo el español.
The Fund believes it is a “grandfathered health plan” under the Patient Protection and Affordable Care Act, which means that this plan can preserve certain basic health coverage that was already in effect when that law was enacted, and may not include certain new consumer protections that apply to other plans. However, grandfathered health plans must comply with certain other consumer protections in the Act, for example, the elimination of lifetime limits on benefits. Questions regarding the Fund’s status as a grandfathered health plan and which protections apply can be directed to the Fund at (646) 473-9200. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor, at (866) 444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.
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OVERVIEW OF YOUR BENEFITS
### IMPORTANT PHONE NUMBERS

<table>
<thead>
<tr>
<th>Home Health Aide</th>
<th>HIP</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Member Services Department</strong></td>
<td><strong>1-800-HIP-TALK ((800) 447-8255)</strong></td>
</tr>
<tr>
<td>(646) 473-9200</td>
<td><strong><a href="http://www.emblemhealth.com.com">www.emblemhealth.com.com</a></strong></td>
</tr>
</tbody>
</table>

For answers to your questions about eligibility for benefits or to be referred to another Fund Department.

For questions about your coverage and how to access the HIP system.
OVERVIEW OF YOUR BENEFITS

The following is a quick reference guide, which gives you an overview of your benefits. Do not rely on this chart alone. Please read the specific sections for a full explanation of each benefit. Benefits are provided only for members; this plan does not provide benefits for your spouse or dependents.

<table>
<thead>
<tr>
<th>In-Network</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductibles</strong></td>
<td>None</td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td>None</td>
</tr>
<tr>
<td><strong>Coinsurance Maximum</strong></td>
<td>None</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Major Copayment Provisions (In-Network)</th>
<th>Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Physician (PCP) Office visits</td>
<td>$10 copay</td>
</tr>
<tr>
<td>Specialists' office visits</td>
<td>$10 copay</td>
</tr>
<tr>
<td>Hospital admission</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Emergency Room copay</td>
<td>$35 copay (waived if admitted)</td>
</tr>
<tr>
<td>Prescription drugs</td>
<td>$0 generic/$30 brand for a 90-day supply (Subject to Drug Formulary)</td>
</tr>
<tr>
<td></td>
<td>Contraceptives included (Formulary copays are reduced by 50% when using the HIP Mail Order Pharmacy Service. Up to a 90-day supply may be obtained.)</td>
</tr>
</tbody>
</table>

1 Drugs are dispensed in accordance with HIP’s Drug Formulary. Please refer to your Prescription Drug Rider for details.
<table>
<thead>
<tr>
<th>Inpatient Hospital Services</th>
<th>EPO Benefits (In-Network Benefits)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Semi-private room and board</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Operating and recovery room, intensive care, staff physician services, prescribed drugs, anesthesia, X-rays and lab tests</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Short-term speech, physical, occupational and respiratory therapy (when part of an acute admission)</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Speech, physical, occupational &amp; respiratory therapy (when part of a rehabilitation admission)</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Radiation therapy and chemotherapy</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Pre-admission testing</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Surgeon &amp; Specialist services</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Human organ transplants</td>
<td>$0 copay</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outpatient Medical Care</th>
<th>EPO Benefits (In-Network Benefits)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCP office visits</td>
<td>$10 copay</td>
</tr>
<tr>
<td>Specialists office visits</td>
<td>$10 copay</td>
</tr>
<tr>
<td>Preventive care, including physical exams, health education and counseling, immunizations and associated diagnostic services</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Well-woman care, including pap smears and mammography</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Diagnostic services including X-ray, lab tests, EKGs, MRIs and CAT scans</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Prenatal, postnatal care in physician’s office</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Outpatient hospital services and ambulatory surgery including physician and facility services</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Second medical and surgical opinions</td>
<td>$10 copay</td>
</tr>
<tr>
<td>Disposable Medical supplies</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Wheelchairs</td>
<td>Covered under DME rider</td>
</tr>
<tr>
<td>Routine Foot Care</td>
<td>Not covered</td>
</tr>
</tbody>
</table>
### Mental Health and Alcohol & Substance Abuse

#### MENTAL HEALTH CARE

<table>
<thead>
<tr>
<th>Service</th>
<th>EPO Benefits (In-Network Benefits)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td>$0 copay</td>
</tr>
<tr>
<td></td>
<td>Unlimited days</td>
</tr>
<tr>
<td>Outpatient</td>
<td>$0 copay</td>
</tr>
<tr>
<td></td>
<td>Unlimited days</td>
</tr>
</tbody>
</table>

#### ALCOHOL & SUBSTANCE ABUSE CARE

<table>
<thead>
<tr>
<th>Service</th>
<th>EPO Benefits (In-Network Benefits)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Detoxification</td>
<td>$0 copay</td>
</tr>
<tr>
<td></td>
<td>30 days</td>
</tr>
<tr>
<td>Inpatient Rehabilitation Treatment</td>
<td>Unlimited days</td>
</tr>
<tr>
<td>Outpatient Rehabilitation Treatment</td>
<td>$10 copay</td>
</tr>
<tr>
<td></td>
<td>Unlimited visits</td>
</tr>
</tbody>
</table>

#### Special Kinds of Care

<table>
<thead>
<tr>
<th>Service</th>
<th>EPO Benefits (In-Network Benefits)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency and Urgent Care</td>
<td></td>
</tr>
<tr>
<td>In hospital emergency room</td>
<td>$35 copay (waived if admitted)</td>
</tr>
<tr>
<td>In urgent care facility</td>
<td>$10 copay</td>
</tr>
<tr>
<td>In physician’s office</td>
<td>$10 copay</td>
</tr>
<tr>
<td>Ambulance service to hospital</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Home health care</td>
<td>$0 copay</td>
</tr>
<tr>
<td></td>
<td>200 visits per calendar year</td>
</tr>
<tr>
<td>Hospice care</td>
<td>$0 copay; 210 days</td>
</tr>
<tr>
<td>Skilled Nursing Facility care</td>
<td>$0 copay;</td>
</tr>
<tr>
<td></td>
<td>unlimited days per calendar year</td>
</tr>
<tr>
<td>Dialysis treatment</td>
<td>$20 copay</td>
</tr>
<tr>
<td>Diabetes equipment, supplies and</td>
<td>$10 copay</td>
</tr>
<tr>
<td>education</td>
<td></td>
</tr>
<tr>
<td>Outpatient physical, speech,</td>
<td>$10 copay; 90 visits per calendar</td>
</tr>
<tr>
<td>occupational and Respiratory therapy</td>
<td>year</td>
</tr>
<tr>
<td>Family Planning Services</td>
<td>Covered</td>
</tr>
</tbody>
</table>
Dental Care

- **General Dental Care**
  - Covered at reduced Member fee schedule

- **Preventive Dental**
  - Oral exam – One every six months
    - $5 copay per visit
  - Cleaning – One every six months
    - $10 copay per visit

**Durable Medical Equipment**

$0 annual deductible

**Private Duty Nursing**

100%

**Hearing Aids**

- Not covered
  - (Cochlear implants covered)

**Optical Care**

- **One pair of corrective glasses**
  - every twenty-four months from any Participating Provider
  - $45 copay

- **Refractive Eye Exams**
  - $0 copay

Except for emergency care, the above benefits and services are covered only when provided or referred by a HIP Primary Care Physician and/or approved in advance by the HIP Care Management Program (CMP). HIP Participating Physicians and Providers have contracted with HIP to provide care to HIP’s members; they are not employees, agents, servants or representatives of HIP. This summary is provided for information only; it does not contain complete details of the Plan, which are available only in the Contract or Certificate of Coverage and Schedule of Benefits, and it does not constitute an Agreement.
SECTION I – ELIGIBILITY

A. How You Become Eligible
B. Losing Eligibility
C. How You Regain Eligibility
D. Extending Eligibility
E. Resolving Eligibility
F. Coordinating Other Insurance Coverage
SECTION I. A
HOW YOU BECOME ELIGIBLE

To receive benefits under this Fund, you must be a participant at the time services are provided. Participation in the Fund is not the same as union membership. Your union dues do not pay for the Fund.

YOU BECOME A PLAN PARTICIPANT BY MEETING THESE ELIGIBILITY REQUIREMENTS:

1) You work in a covered job title at a Contributing Employer.

A “covered job title” is one specified by the collective bargaining agreement among 1199SEIU and the agencies that contribute to the Fund. Since these can change from time to time, you may receive a list of Contributing Employers and/or covered titles upon written request to the Fund office.

AND

2) You have elected to enroll in the Fund and completed and submitted an 1199SEIU Home Health Aide Enrollment Form.

To be covered by the benefit plan, you must enroll in the Fund and agree to the required weekly premium contribution, which your employer will automatically deduct from your paycheck. Make sure to fill out all the information on the Enrollment Form completely and return it to the Fund office.

AND

3) You have become eligible under “120-hour” rule described below.

To become a participant, you must have 120 or more “hours worked” per month for two consecutive calendar months. This two-month period is called the “determination period.” You will then become a participant one calendar month later. This one-month period between the determination period and the date of first eligibility is called the “waiting period.”

Participation is always counted from the first day of a month. “Hours worked” includes all hours for which you were paid by your employer. This includes hours for which you received sick and vacation pay.

AND

4) You meet the eligibility criteria described in the box on page 17.
NEW ELIGIBILITY RULES AS OF JANUARY 1, 2011

A. The Member’s eligibility to participate in the HIP Plan shall be determined as follows:

(i) Open Eligibility Periods: All Members who have completed probation and have met the eligibility requirements set forth above for the two-month eligibility (look back) period and have followed the required procedures and deadlines, as determined by the Trustees and communicated to Members, potentially shall be eligible to enroll in the New HIP Plan as of the Effective Dates of Enrollment set forth below (“Potential Enrollees”).

(ii) Potential Enrollment: Potential Enrollees who newly choose to enroll in the Fund’s HIP Plan shall sign up, as required, for the following Effective Dates of Enrollment as set forth below. All eligible Members who are enrolled in the Fund’s HIP Plan shall remain in the Plan provided they continue to meet the eligibility requirements.

(iii) The following sets forth the Effective Dates of Enrollment:

<table>
<thead>
<tr>
<th>Effective Dates of Enrollment</th>
</tr>
</thead>
<tbody>
<tr>
<td>• January 1 of each year</td>
</tr>
<tr>
<td>• April 1 of each year</td>
</tr>
<tr>
<td>• July 1 of each year</td>
</tr>
<tr>
<td>• October 1 of each year</td>
</tr>
</tbody>
</table>

B. Maximum Designated Enrollees Under the Employer’s Annual Cap: The specific number of Members who can be designated to actually enroll shall be determined by the Employer and 1199SEIU, and communicated to the Fund’s Executive Director (“Designated Enrollees”):

(i) If the number of Potential Enrollees (as determined in paragraph A (ii) above) is less than or equal to the number of Designated Enrollees, then all Potential Enrollees will be permitted to actually enroll in the New HIP Plan for that open period.

(ii) If the number of Potential Enrollees (as determined in paragraph A (ii) above) is greater than the number of Designated Enrollees, then the actual enrollment will be limited to the number of Designated Enrollees, by the selection criteria set forth in the MOA.
C. Actual Enrollees Must Be Eligible for Each Eligibility Period:

Once an eligible Member actually enrolls in the Fund’s HIP Plan, the eligible Member must meet the eligibility requirements for each open period. An eligible Member actually enrolled in the Fund’s HIP Plan cannot be bumped out of the Fund’s HIP Plan by a more senior employee who subsequently becomes eligible during a subsequent open period.

In the event that eligible Members who actually enroll in the Fund’s HIP Plan do not meet the eligibility requirements for the following open period, then they will no longer be eligible to participate in the Fund’s plan. Reinstatement in the Plan is not automatic. Once an eligible Member meets the eligibility requirement for any subsequent eligibility period, the Member must re-enroll in the HIP Plan provided there is availability for Designated Enrollees.

Note: You may need to meet additional eligibility rules set forth in your Collective Bargaining Agreement.

Note: This Fund provides member-only benefits. There is no coverage provided for spouse or dependent children.
EXAMPLES OF THE 120-HOUR RULE

1) Ms. Wilson began working for Progressive as a home health aide at the end of January 2011. In January, she worked only 21 hours. In February she worked 240 hours. In March she worked 260 hours. By March 31, she had completed the “Determination Period” – two months in a row with 120 or more hours. After a one-month waiting period, she will be eligible to elect benefits during the Open Enrollment Period in May and be eligible for benefits on July 1, 2011.

2) Ms. Wilson began working for Progressive as a home health aide at the end of January 2011. In January she worked 80 hours. In February she worked 260 hours. Even though she worked a combined total of 340 hours over two calendar months, she did not complete the “Determination Period” because she only worked 80 hours in January. If she works at least 120 hours in March, she will be eligible – after a one-month waiting period – to elect benefits during the Open Enrollment Period in May and be eligible for benefits effective July 1, 2011.

LET THE FUND KNOW OF ANY CHANGES

You will receive your benefits quicker if the Fund has your up-to-date information.

You must notify the Fund when:

• You move
• You change employers

Remember to send copies of all the documents needed by the Fund, such as your birth certificate.

An English translation certified to be accurate must accompany foreign documents.

Note: The Fund does not cover retired employees.
SECTION I. B
HOW YOU LOSE ELIGIBILITY

You will no longer be eligible for Fund benefits if you do not work the required 120 hours in both months of the look back period (the last two consecutive calendar months of the prior quarter). Eligibility ends at the end of the current quarter (March 31st, June 30th, September 30th or December 31st) after the look back period. You may also lose your eligibility if you are on a leave, no longer working for your employer, if your employer is no longer required to make contributions to the Fund or you stop paying the weekly premium. You may be able to extend your coverage. (See How You Can Extend Eligibility, pages 22-26.)
SECTION I. C
HOW YOU REGAIN ELIGIBILITY

You may regain eligibility by again working the required 120 hours or more hours in both months of the look back period (the last two consecutive calendar months of the current quarter). Once an eligible member meets the eligibility requirement for any subsequent eligibility period, the member must elect during the next Open Enrollment period provided there is availability for Designated Enrollees. Your benefits will begin on the first day of the quarter (January 1st, April 1st, July 1st or October 1st), following the reinstatement of your eligibility.

EXAMPLE OF REGAINING ELIGIBILITY — 120-HOUR RULE

Ms. Ruiz was a participant in the Fund and enrolled in the HIP Plan, but did not work 120 hours in May or June so coverage ceased on September 30th. Beginning in August, she was once again working 120 hours per month. By counting August and September as the Determination Period, she would be eligible to re-enroll in the Plan and become eligible again as of January 1.
SECTION I. D
HOW YOU CAN EXTEND ELIGIBILITY

WHILE TAKING FAMILY AND MEDICAL LEAVE

The Family and Medical Leave Act of 1993 (FMLA) provides that the Fund – upon proper notification from your employer – will extend eligibility for you for up to 12 weeks, under certain conditions. You are entitled to an FMLA extension if you are a Member and experience an FMLA “qualifying event”:

• For the birth of your child and to care for the baby
• When you adopt a child or become a foster parent
• To care for your spouse, your child or your parent who has a serious health condition (but not your mother-in-law or father-in-law)
• When you have a serious health condition that keeps you from doing your job
• When your spouse, son, daughter or parent is a military service member and is on or has been called to active duty in support of a contingency operation in cases of “any qualifying exigency.”

FMLA defines a serious health condition to include an injury, illness, impairment, or physical or mental condition that involves inpatient hospital care or continuing treatment by a healthcare provider.

If you are eligible for FMLA leave for one of the above qualifying family and medical reasons, you may receive up to twelve (12) work weeks of unpaid leave during a twelve (12) month period. During this FMLA leave, you are entitled to receive continued health coverage under the Fund under the same terms and conditions as if you had continued to work.

If you need to care for your spouse, son, daughter, parent or “next of kin” who has a serious injury or illness incurred in the line of active duty, you are eligible for up to 26 work weeks of unpaid FMLA leave in a 12-month period. For Armed Forces members, FMLA defines a serious injury or illness as an illness or injury that may render the service member medically unfit to perform his or her military duties.

If you return to work with the required number of hours (120) or more in your first full month after your FMLA leave ends, there is no lapse in coverage.

To be eligible for continued benefit coverage during your FMLA leave, your employer must notify the Fund that you have been approved for FMLA leave.

Your employer – not the Fund – has the sole responsibility for determining whether you are granted leave under FMLA.
FMLA legislation was enacted to provide for temporary leave in situations where an employee intends to return to work when your FMLA leave ends. If you do not return to work, you may owe your employer for the costs that were paid on your behalf over any period of time where coverage was extended solely on the basis of your FMLA leave.

**WHILE TAKING A UNIFORMED SERVICES LEAVE**

Under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), if your coverage under the Fund ends because of your service in the U.S. uniformed services, your medical coverage will be reinstated for you when you return to work with your employer without any waiting periods.

If you take a leave of absence under USERRA, healthcare coverage under the Plan will be continued for up to 30 days of active duty. If you are on active duty for thirty-one (31) days or more, coverage may be continued at your election and expense for up to 24 months (or such period of time required by law). See pages 23-26 for a full explanation of the COBRA coverage provisions.

When you are discharged from service in the uniformed services (not less than honorably), your full eligibility will be reinstated on the day you return to work with a Contributing Employer, provided that you return within ninety (90) days from the date of discharge if military service was more than one-hundred eighty-one (181) days, or within fourteen (14) days from the date of discharge if service was more than thirty (30) days but less than one-hundred-eighty (180) days, or at the beginning of the first full regularly scheduled working period on the first calendar day following discharge if the period of service was less than thirty-one (31) days. If you are hospitalized or convalescing from an injury caused by active duty, these time limits are extended for up to two (2) years. Contact the Fund Office if you have any questions regarding coverage during a military leave.

The Fund may apply exclusions and/or waiting periods permitted by law, including for any disabilities that the Veterans Administration (VA) has determined to be service-related. This includes any injury or illness found by the VA to have been incurred in, or aggravated during, the performance of service in the uniformed service.

**COBRA**

This section contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).
Under this law, you, have the option of extending your healthcare coverage for a limited period of time in certain instances where coverage under the Fund would otherwise end because of a life event known as a “qualifying event.”

This coverage is available on a self-pay basis. This means that you pay monthly premiums directly to the Fund to continue your group health coverage.

**COBRA “QUALIFYING EVENTS”**

The following are “qualifying events” which would entitle you to choose COBRA coverage:

- Your hours are reduced, making you no longer eligible, or
- Your employment ends (for any reason except gross misconduct), or
- Your employer files for bankruptcy, suspending its obligation to contribute to the Fund.

Being off work on Family and Medical Leave is not a qualifying event for COBRA. If you do not go back to work, you are considered to have left your job which may lead to a qualifying event.

**LENGTH OF COBRA COVERAGE**

You may choose to continue coverage for up to 18 months for yourself.

**DISABILITY EXTENSION OF COBRA COVERAGE**

You may continue COBRA coverage for an additional 11 months if both these conditions exist:

- Social Security determines that you are disabled as of the date of the initial qualifying event (or within 60 days thereafter); and
- You notify the Fund within 60 days from the date of the Social Security disability determination and before the end of the 18-month period of COBRA continuation coverage.

Note that an increased premium may apply for the 19th through the 29th month. You must notify the Fund within 30 days of a determination by Social Security that you are no longer disabled.

**NOTIFICATION OF COBRA EVENTS**

The Plan must be notified that a qualifying event has occurred. For some COBRA qualifying events, your employer is responsible for notifying the Fund within 30 days. These qualifying events are:

- Your death (if you are employed at the time)
- Employment termination
- Reduction in hours
- Your Medicare eligibility, or
- Your employer’s bankruptcy.
For all other COBRA events, you are responsible for notifying the Fund at (646) 473-9200, or at: 1199SEIU Home Health Aide Benefit Fund, 330 West 42nd Street, New York, NY 10036, within 60 days of the event or of the date coverage would end as a result of the event. If you do not notify the Fund within this time, you forfeit COBRA rights.

Once the Fund receives notice that a qualifying event has occurred, you will be offered COBRA coverage. Regardless of who notifies the Fund of the COBRA situation, you have 60 days from the date your coverage terminates (or, if later, from the date you receive notice of your COBRA rights) to make the decision to continue coverage.

Note that the Fund reserves the right to verify eligibility and terminate COBRA retroactively if you are determined to be ineligible or if there has been a material misrepresentation of the facts.

**LOSS OF COBRA COVERAGE**

You will lose your COBRA coverage if:

- You do not pay monthly premiums on time,
- You become covered under another group health plan,
- The Home Health Aide Benefit Fund no longer provides benefits,
- You become entitled to Medicare benefits,
- You are determined by the Social Security Administration to be no longer disabled (if you have extended coverage due to a disability);
- Your employer stops contributing to the Fund; or
- For cause, such as fraudulent claim submission, on the same basis that coverage could terminate for similarly situated active employees.

Once your COBRA coverage has stopped for any reason, it cannot be reinstated.

Claims incurred by you will not be paid unless you have elected COBRA coverage and pay the premiums, as required by the Plan Administrator.

This description of your COBRA rights is only a general summary of the law. The law itself must be consulted to determine how the law would apply in any particular circumstance.

If you have any questions about COBRA continuation coverage, please contact the Member Services Department at (646) 473-9200.

**YOUR HIPAA RIGHTS**

When your Fund coverage ends, a federal law – the Health Insurance Portability and Accountability Act (HIPAA) – protects you if your new health plan excludes pre-existing conditions.

When your Fund coverage ends, under HIPAA you are entitled by law to, and will be provided with, a Certificate of Creditable Coverage. Certificates of Creditable Coverage indicate the
period of time you were covered under the Fund (including COBRA coverage), as well as certain additional information required by law. The Certificate of Creditable Coverage may be necessary if you become eligible for coverage under another group health plan, or if you buy a health insurance policy within 63 days after your coverage under this Fund ends (including COBRA coverage). The Certificate of Creditable Coverage is necessary because it may reduce any exclusion for preexisting coverage periods that may apply to you under the new group health plan or health insurance policy.

The Certificate of Creditable Coverage will be provided to you shortly after this Fund knows, or has reason to know, that coverage (including COBRA coverage) has ended. The Certificate of Creditable Coverage will also be provided once the Fund office receives a written request, provided that the request is received within 2 years after the later of the date your coverage under the Fund ended or the date your COBRA coverage ended.

Accordingly, the Fund will provide you with Certificates of Creditable Coverage showing when you were covered by the Fund:

- On your request, within 24 months after your Fund coverage ceases;
- When you are entitled to elect COBRA (see page 24);
- When your COBRA coverage ceases.

You should retain these Certificates of Creditable Coverage as proof of prior coverage for your new health plan. For further information, call the Member Services Department of the Fund at (646) 473-9200.

**PRIVACY OF PROTECTED HEALTH INFORMATION**

HIPAA also imposes certain confidentiality and security obligations on the Benefit Fund and HIP with respect to medical records and other individually identifiable health information used or disclosed by the Benefit Fund or HIP. HIPAA also gives you rights with respect to your health information, including certain rights to receive copies of the health information that the Benefit Fund or HIP maintains about you, and knowing how your health information may be used. A complete description of how the Benefit Fund or HIP uses your health information, and your other rights under HIPAA's privacy rules, is available in the Benefit Fund's "Notice of Privacy Practices," which is distributed to all named participants. Anyone may request an additional copy of this Notice by contacting the Benefit Fund office.
SECTION I. E
HOW TO RESOLVE QUESTIONS CONCERNING ELIGIBILITY FOR BENEFITS

Sometimes questions arise about an 1199SEIU Home Health Aide worker’s eligibility for benefits. Most eligibility disputes involve under-reporting of hours by employers or misinterpretation. Often the Fund office can make adjustments upon presentation of evidence from either an employer (agency) payroll office or upon examination of paycheck stubs presented by the member.

The Fund has no independent means of discovering agency-reporting errors. It depends upon notification from you that an error was made. If incorrect hours have affected your eligibility, an explanation with photocopies of paycheck stubs in the problem month – as well as the prior month and the subsequent month – should be sent to:

   Eligibility Department  
   1199SEIU Home Health Aide  
   Benefit Fund  
   330 West 42nd Street  
   New York, NY 10036

The Fund has sole authority and discretion to resolve all eligibility questions.
SECTION I. F
COORDINATING OTHER INSURANCE COVERAGE

You may be covered by other insurance. This insurance comes in various forms: a spouse’s insurance coverage, Medicare, an automobile insurance policy with medical coverage, Workers’ Compensation for job-related injuries or additional insurance coverage from another job.

If you have medical expenses, the Fund will determine who pays first. Then the Fund will coordinate with the other insurer so that the total payment is not more than the reasonable charges. The insurer that pays first is called the “primary” insurer. The insurer that pays second (the “secondary” insurer) will pay the remaining expenses to the extent those are covered by that insurer.

EXAMPLE OF COORDINATING BENEFITS

If you have medical expenses, the Fund will determine who pays first. Then the Fund will coordinate with the other insurer so that the total payment is not more than the reasonable charges. The insurer that pays first is called the “primary” insurer. The insurer that pays second (the “secondary” insurer) will pay the remaining expenses to the extent those are covered by that insurer.

OTHER GROUP HEALTH INSURANCE

When you are covered by more than one group health insurance plan (like family coverage through your spouse’s insurance plan), the two plans “coordinate benefits.”

Coordinating benefits helps the Fund protect itself from paying where it has no obligation to do so. The Fund’s benefit plan contains provisions to make sure that the proper insurer is held responsible for making proper payment.

If you have coverage under any other insurer, there is a method to determine who pays first and how much. This is called “Coordination of Benefits” (COB), and the rules are listed here.

COB RULES

- The other insurer is always primary if it has no “COB” provision.
- If the other insurer is non-group coverage, this plan is primary.
- If the other insurer has “COB” provisions, then the insurer that covers the patient as an employee is primary.
- If you are the patient and have coverage under two group plans, the plan you have been with longest is primary.
WHEN YOU ARE COVERED BY MEDICARE

The Fund is the primary payer for working members age 65 and over who may be covered by Medicare. You will be eligible for the same coverage as any other working member.

However, you may want to sign up for Medicare Part A and Part B as well. That way, Medicare will become your secondary payer.

This means that after the Fund pays benefits for your covered expenses, you may submit a claim for any unpaid balances to Medicare to be considered.

If you prefer, you may elect to end your coverage under the Fund and elect to have Medicare as your only insurance. However, if you elect this option, the Fund may not provide any benefits that supplement those provided under Medicare.

In the case of an individual entitled to Medicare benefits on the basis of end stage renal disease (ESRD), the Fund will be the primary payer of benefits only for the period required by law. Thereafter, the Fund will be secondary to Medicare.

WORKERS’ COMPENSATION

If you are injured at work or suffer from a work-related illness, you are covered by Workers’ Compensation (which is provided by your employer) or other applicable programs established by state or federal government. Injuries and diseases covered under any Workers’ Compensation program are excluded from coverage under this Plan.

You must file a Workers’ Compensation claim with your employer. Otherwise, you will jeopardize your rights to Workers’ Compensation and your benefits from the Fund for yourself and your family. Compensation can include coverage for healthcare and loss of wages. If you need help or advice concerning your Workers’ Compensation claim, call the Fund at (646) 473-9200.

AUTO INSURANCE

Benefits are not available for any service that is covered by mandatory automobile no-fault benefits, even if you do not claim benefits you are eligible to receive under the no-fault automobile insurance.
WHEN OTHERS ARE RESPONSIBLE FOR YOUR ILLNESS OR INJURY

Immediately upon paying or providing any benefit here under, HIP shall be subrogated to all rights of recovery a covered person has against any third party, to the full extent of benefits provided by HIP. In addition, if you receive any payment from any third party as a result of an injury, HIP has the right to recover from, and be fully reimbursed for, all amounts paid hereunder and will pay as a result of any illness or injury, up to the amount the covered person has received from all third parties, provided that the settlement or judgment the covered person receives specifically identifies or allocates monetary sums directly attributable to expenses for which HIP provided as benefits.

As used throughout this provision, the term “third party” means any party possibly responsible for making any payment to the covered person for any injuries or any insurance coverage, including but not limited to, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, Workers’ Compensation coverage or no-fault automobile insurance coverage. As used throughout this provision, the term “you” means the injured person or any of your agents, representatives, assignees, guardians, heirs or beneficiaries.

You shall do nothing to prejudice HIP’s subrogation and reimbursement rights and shall, when requested, cooperate with HIP’s efforts to recover its benefits paid. It is your duty to notify HIP within 45 days of the date when any notice is given to any other party, including an attorney, of the intention to pursue or investigate a claim to recover damages due to injuries sustained by the covered person.

The penalty for failing to cooperate as indicated above is that you will be responsible to repay to HIP the cost of the benefits and services provided.
SECTION II – YOUR HEALTH BENEFITS

A. How Your Health Plan Works
B. Filing Claims and Prior Notification
C. Your PCP and HIP Identification Card
D. Seeing a Specialist
E. Special Kinds of Coverage
F. Hospital Benefits
G. Diagnostic Services
H. Emergency and Out-of-Area Care
I. Staying Healthy
J. The Quality of Your Care
K. If You Disagree with a Coverage Decision or Service
L. If Your HIP Membership Ends
M. HIP at Your Service
N. Member Rights and Responsibilities
O. Understanding How HIP Participating Providers Are Compensated for Their Services
P. What Is Not Covered
SECTION II. A
HOW YOUR HEALTH PLAN WORKS

SECTION HIGHLIGHTS

The Fund has chosen Health Insurance Plan of New York (“HIP”) to provide your health benefits through their Exclusive Provider Organization (“EPO”) Plan. As a member of this Plan, PCP relationships are suggested but not required. You may choose your own personal physician from the Plan’s network of participating providers. That physician is called your Primary Care Physician, or PCP. You can choose a PCP who practices independently in a private office or a PCP in group practice at a conveniently located medical center.

Other than services for Emergency Care, you must use HIP providers to receive benefits under this Plan.

BENEFITS SUMMARY

<table>
<thead>
<tr>
<th>Benefit</th>
<th>EPO Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>None</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>Coinsurance Maximum</td>
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</table>
The Fund has chosen Health Insurance Plan of New York (“HIP”) to provide your health benefits through their Exclusive Provider Organization (“EPO”) Plan. As a member of this Plan, you may choose your own personal physician from the Plan’s network of participating providers. That physician is called your Primary Care Physician, or PCP. You can choose a PCP who practices independently in a private office or a PCP in group practice at a conveniently located medical center.

**COVERAGE**

As a member of an EPO Plan, members have the freedom to obtain most Covered Services from HIP Participating Providers. Prior approval is required from HIP for certain services listed on pages 35-36. (Prior Notification and Approval Requirements) of this SPD. Just call **(800) HIP-TALK (800-447-8255)** Monday through Friday from 8:00 am to 6:00 pm. If you use a telephone device for the hearing- or speech-impaired, please call (888) 447-4TDD (888-447-4833) Monday through Friday, 8:30 am to 5:00 pm.

**DEFINITIONS**

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

**Copayment.** An amount you pay a provider for a certain service, such as an office visit.

**EPO benefits.** Coverage for care that is given by your HIP participating provider. When you receive EPO benefits, you have no out-of-pocket expenses except any copayment that may apply.
SECTION II. B
FILING CLAIMS AND PRIOR NOTIFICATION REQUIREMENTS

- Filing a Claim
- Prior Notification Requirements

SECTION HIGHLIGHTS

- With EPO benefits, you will usually not be required to file a claim. You may need to file a claim, however, if you receive emergency care when you are outside of HIP’s service area.
- To obtain a claim form, ask your PCP or call HIP Customer Service at (800) HIP-TALK (800-447-8255). Attach a paid itemized bill for the services you received to the completed claim form.
- Submit the claim form to the mailing address indicated on the back of your HIP ID Card. This is very important since HIP works with several organizations affiliated with healthcare providers to handle certain operations, such as claims processing.

FILING CLAIMS

With EPO benefits, you rarely need to file claims. But sometimes you may need to pay a provider’s bill, and then submit a claim for reimbursement. This might occur, for example, if you receive emergency care when you are outside of HIP’s service area.

You must file a claim for reimbursement within 90 days of receiving the bill from the Provider. The address for filing claims will appear on the back of the HIP ID Card. Prompt filing of a completed claim form will result in faster payment of the claim. You may call (800) HIP-TALK (900-447-8255) to request claims forms. HIP will provide the claims forms within 15 days of such a request. If said forms are not provided within the indicated timeframe, you will be deemed to have complied with the timeframes required by HIP to file said claim. Claim forms contain the instructions necessary to complete and send them. Proof of loss must be submitted with the completed form. Unanswered sections may delay processing of the claim.

A Physician or healthcare provider will normally show his or her charges in the provider section of the claim form. If there are additional charges that are not shown on that section, you must attach
the original bill as proof of loss. These bills must show your name, the date(s) of service, provider’s name and service rendered, diagnosis or condition treated and the amount charged. If care and treatment continue over a period of time, you should submit bills periodically. Cancelled checks, cash register or credit card receipts, or self-compiled lists are not acceptable as proof of loss.

To submit a claim, ask your PCP or call HIP Customer Service at (800) HIP-TALK (800-447-8255) for a HIP claim form. Submit a paid itemized bill for the services you received along with the completed claim form to the address on the back of your HIP ID Card.

HIP works with several organizations affiliated with healthcare providers to handle certain operations, such as claims processing. Please read the back of your HIP ID Card carefully for special mailing or telephone contacts for your claims processing. These are the contacts you should use to mail your claim form and bill.

You’ll be reimbursed as long as the service for which you are submitting a claim meets the terms of this Plan.

PRIOR NOTIFICATION AND APPROVAL REQUIREMENTS

**EPO Benefits**
When you receive care provided or referred by your PCP, you will receive EPO benefits. Your PCP will handle the necessary administrative responsibilities with HIP to assure that you maximize your benefits.

When you receive certain kinds of services without receiving prior approval from HIP, you must handle some of the administrative responsibilities that your PCP would normally perform on your behalf. You will need to handle these responsibilities in order to maximize your benefits.

These services are:
- All non-emergency inpatient admissions, including hospital and nursing home care, rehabilitation, mental and behavioral health treatment, or skilled nursing facility care
- Ambulatory surgery, except termination of pregnancy (in a hospital or freestanding surgical center)
- Air ambulance
- Non-emergency land ambulances
- Home health care (nursing, physical therapy, occupational therapy, speech therapy and infusion therapy)
- Durable medical equipment (DME)
- Transplant evaluation and services
- Hospice care
The Care Management Program (CMP)\(^1\) may, in some cases, help you find more suitable care in a more suitable environment. For example, many inpatient admissions can be avoided by using the services of home health care services. And, for many people, avoiding the experience of going to the hospital and having the option to recuperate at home is preferable. That’s why it’s important to contact CMP before you go forward with any of the above treatments.

When you are planning to receive any of these services, be sure to call Prior Approval at least 10 business days in advance. Representatives are available Monday through Friday, 8:00 am to 5:00 pm, by calling (888) 447-2884.

At other hours:
- If your call concerns an urgent or emergency admission, you will be prompted to leave a message. The next business day, the message will be routed to the appropriate Concurrent Reviewer.

\(^1\) Please note that HIP works with a number of organizations affiliated with providers to handle certain administrative functions such as care management. In these cases, contact information may differ. Please read the back of your HIP Member ID Card to see if you have a special number to call for prior approvals.

- If your call concerns an elective admission, you will be advised to call back the next business day when representatives are available.

A trained representative will take the necessary information that will allow CMP to determine whether the requested services are medically appropriate for the level of care requested. (See pages 60-71 for more information.) Be sure you obtain written verification of prior approval from CMP before receiving any of these services.

- If you do not provide notification before receiving these services, HIP may pay only 50% of EPO benefits otherwise payable.

- If HIP does not grant prior approval of coverage in these cases, HIP may not provide any benefits for these services.

**Examinations**

HIP reserves the right to have a Physician of its choice examine a member who has made a claim for benefits under the Plan. HIP may do this at reasonable intervals.
SECTION II. C
YOUR HIP IDENTIFICATION CARD

• Your HIP Identification Card
• Transitional Care

SECTION HIGHLIGHTS

Your HIP Identification Card

• Your HIP ID Card is your passport to accessing medical services – keep it handy. The back of your HIP ID Card includes important information, including the specific mailing addresses and telephone numbers you need to use as a member.

• Your HIP ID Card is easy to replace if lost. You can request a new one by logging on to www.emblemhealth.com, using HIP’s Interactive Voice Response (IVR) system or speaking with a Customer Service Advocate.

• To use HIP’s IVR system or to speak with a Customer Service Advocate, call (800) HIP-TALK (800-447-8255). If you use a telephone device for the hearing- or speech-impaired, please call (888) 447-4TDD (888-447-4833).

YOUR HIP IDENTIFICATION CARD

Your HIP Identification Card (HIP ID Card) is your passport to healthcare services. It contains important information that you will need to obtain medical care, wherever you happen to be. Keep it safe and take it with you when you travel, in case of an emergency.

Keep your HIP ID Card handy, too, when calling a HIP participating provider for an appointment or HIP Customer Service at (800) HIP-TALK (800-447-8255) for information and advice. That way you will be ready to provide the information you’ll be asked to give.

• Please note that HIP works with several organizations affiliated with healthcare providers to perform certain administrative operations, such as claims processing or case management. In these cases, contact information may differ. Please read the back of your ID card carefully for special mailing or telephone contacts. These are the contacts you should use.
Notice and Transitional Care If a Physician Is No Longer in the HIP Network of Participating Providers

HIP will provide you with written notice within 15 days of learning that your PCP will no longer be a HIP participating provider. You will then need to select a new PCP. In some instances, however, you may be able to receive transitional care from your current PCP until you have selected a new PCP.

To receive transitional care, you must notify the Customer Service Department at (800) HIP-TALK (800-447-8255) prior to continuing care with the provider. Such care shall be approved by HIP only if the health provider:

- Continues to accept HIP’s rates of reimbursement for your care.
- Adheres to HIP’s quality assurance requirements and provides HIP with all necessary information related to your care.
- Adheres to all other HIP administrative policies and procedures, including those regarding prior approval requirements.

Transitional Care for New Members Receiving Ongoing Treatment

If you are a newly enrolled HIP member whose healthcare provider is not in the HIP network of participating providers, HIP will permit you to continue an ongoing course of treatment with your current provider under certain circumstances and for a limited period of time. HIP will allow a transitional period of up to 60 days from your effective date of enrollment as an aid towards transitioning care to a new HIP participating provider. This transitional care will be covered only if you have a life-threatening or degenerative and disabling disease or condition. If you are in your second trimester of pregnancy, the transitional period will include postpartum care directly related to your child’s delivery.

If you choose to continue to receive care from your current provider during this transitional period, you must notify the Customer Service Department at (800) HIP-TALK (800-447-8255) prior to continuing care with the provider. Such care shall be approved by HIP only if the health provider:

- Accepts HIP’s reimbursement rates as payment in full for the services provided to you.
- Adheres to HIP’s quality assurance requirements and provides HIP with all necessary information related to your care.
- Adheres to all other HIP administrative policies and procedures, including those regarding prior approval requirements.

The above procedures shall not require HIP to provide coverage for care that is otherwise excluded due to a preexisting condition limitation, is not medically necessary or is covered by any other exclusion or limitation.
SECTION II. D
SEEING A SPECIALIST

SECTION HIGHLIGHTS

While not required under your Plan, your PCP may arrange specialist referrals.

While your PCP will provide you with much of the care you need, there may be times when he or she will refer you to a specialist if your PCP believes your medical problem requires the attention of a physician who is specially trained in that area.

You can expect that your PCP will refer you to specialists he or she knows and trusts. Usually that means other physicians within the same medical center or medical group the PCP belongs to. For example,

- A PCP participating independently with HIP will also tend to refer you to specialists with whom he or she works regularly.

In the unusual situation where the kind of care you need is not available from within the HIP participating network, your PCP may request that you to see a non-participating provider.

Second Opinions

As a HIP member you are entitled to two kinds of second opinions:

- A second opinion related to the diagnosis and treatment of cancer from an appropriate specialist who may or may not be a HIP participating physician.
- A second medical opinion from a HIP participating provider at anytime, for any reason.

Keep in mind that a second opinion consists only of a consultation. Any subsequent required treatment must be provided or arranged through a HIP participating provider in order to obtain EPO benefits.
SECTION II. E
SPECIAL KINDS OF COVERAGE

- Prescription Drug Coverage
- Mental Health Care and Alcohol/Drug Treatment
- Dental Coverage

SECTION HIGHLIGHTS

Prescription Drug Coverage
- The HIP Drug Formulary is a continually updated list of medications approved for disease treatment and the preservation of members’ health. HIP usually covers only those drugs listed in the formulary.
- Copayment $0/Generic and /$30 Brand (subject to Drug Formulary) for a 30-day supply. Formulary copays are reduced by 50% when utilizing the HIP Mail Order Pharmacy Service. Up to a 90-day supply may be obtained.
- Prescription coverage includes coverage for contraceptive drugs and devices as mandated under New York State law.
- You will have no co-payments for certain preventive prescriptions in accordance with PPACA.
- You must fill your prescription (issued by a participating or non-participating HIP doctor) at one of HIP’s participating pharmacies.

Filling Prescriptions through the Internet or by Mail Order
- You may receive a 90-day supply of HIP-approved maintenance medications in the mail through Express Scripts. Fill the prescription right away at your local HIP participating pharmacy, and then submit a second prescription to Express Scripts, allowing 10 to 14 business days for delivery.
- You can also fill prescriptions through the Express Scripts Internet Service through www.emblemhealth.com.
- Depending on your coverage, your copayment may be reduced if you use the Express Scripts Internet/Mail Order Service.
- You can also order prescription refills through Express Scripts by calling (800) 224-5502 Monday through Friday, between 6:00 am and 10:00 pm.

Mental Health and Alcohol/Drug Treatment
- Please call (888) 447-2526 for help in selecting a provider. Or, turn to the listing of Participating Mental Health Centers in this section and contact a center convenient to you.
# BENEFITS SUMMARY

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<td>Inpatient Rehabilitation Treatment</td>
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<td>Covered at reduced Member fee schedule</td>
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<tr>
<td>Cleaning</td>
<td>1 every 6 months, $10 copay</td>
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</table>
Prescription Drug Coverage

The HIP Drug Formulary

HIP prescription drug coverage is usually for prescription drugs that are listed in HIP’s Drug Formulary and are filled at a HIP participating pharmacy.

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

When your doctor wants to prescribe a drug that is not in the HIP Drug Formulary, he or she must contact Pharmacy Services to obtain prior approval. There is a phone line dedicated for this purpose.

HIP participating providers receive regular communications about changes to the HIP Drug Formulary. If you have access to the Internet, you can log on to HIP’s Website at www.emblemhealth.com and click on Pharmacy Services to check the formulary status of a drug. If you don’t have access to the Internet at home, many local public libraries can provide you with free Internet access. Or, you can call HIP Customer Service at (800) HIP-TALK (800-447-8255) to request a copy of the HIP Drug Formulary.

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

Two-Tiered Benefit Structure

You have a two-tiered coverage, which means you will have no copay for generic drugs included in the formulary and a $30 copay for brand-name drugs included in the formulary for a 30-day supply. If your physician has medical justification for prescribing a non-formulary medication, your physician must obtain a Physician’s Prior Approval (PPA) from HIP Pharmacy Services Clinical Department. If your physician does not obtain a PPA, you will not be covered for the non-formulary medication.

- Prescription coverage includes coverage for contraceptive drugs and devices as mandated under New York State law.

Note: You will have no copay for certain preventive prescriptions in accordance with PPACA.
Filling Your Prescriptions at Participating Pharmacies

You can fill your prescriptions (issued by a non-participating or participating HIP physician) by visiting one of HIP’s participating pharmacies. Some health centers also have on-site pharmacies, for your convenience.

When traveling, you may bring a prescription drug bottle from your local pharmacy to any participating pharmacy. The bottle contains all the information needed by pharmacists to arrange the transfer of a prescription filled from the original pharmacy. (All State, Federal and plan limitations will apply – e.g., on the number of refills allowed and any early refill limitations.) If a refill is available, a single telephone call by the pharmacist can complete the transfer. The processing time would then be the same as with any other prescription.

Always remember to present your HIP ID Card when filling your prescriptions. Depending on your coverage, you may have to make a copayment when you obtain a 30-day supply (or less) of a prescription or refill.

Filling Your Prescription through the Internet and Mail Order Program

HIP works with Express Scripts, an Internet and Mail Order pharmacy. You may obtain up to a 90-day supply of a HIP-approved maintenance medication through Express Scripts. Since prescription drug delivery takes 10-14 business days through Express Scripts Internet/Mail Order Pharmacy, HIP recommends that you have your doctor complete two prescriptions. For new prescriptions, fill the prescription right away at your local HIP participating pharmacy. Submit the second prescription to Express Scripts in enough time to allow for processing before your initial prescription runs out.

Your copayments may be reduced by using the Express Scripts Internet/Mail Order Pharmacy. Plus, your medication is shipped right to your home. Reductions in copayments, however, only apply to formulary brand-name and formulary generic medications.

You can also order prescriptions through Express Scripts without using the Internet. To request a Mail Order Pharmacy application, please call HIP Customer Service at (800) HIP-TALK (800-447-8255), Monday through Friday between 8:00 am and 6:00 pm. If you are hearing- or speech-impaired, you may call (888) HIP-4TDD. To order prescription refills directly from Express Scripts, call (800) 224-5502 Monday through Friday, between 6:00 am and 10:00 pm.
DEFINITIONS

These definitions may help you understand your drug coverage.

HIP’s Drug Formulary: The drug formulary is a list of medications – including both brand-name and generic – that are covered under HIP’s Prescription Drug benefit.

Formulary Medication: A formulary medication is one that is listed on HIP’s Drug Formulary. Depending on the prescription benefit, members are covered for formulary items minus any applicable coinsurance, copayment and/or deductible.

Non-Formulary Medication: A non-formulary medication is one that is not listed on HIP’s Drug Formulary. A member can receive coverage for a non-formulary medication through a Prior Approval or a non-formulary copayment.

Brand-Name Medication: A brand-name medication is the first version of a particular drug marketed by a specific drug company.

Generic Medication: When the patent on a specific brand-name drug expires, a generic version can be marketed, with FDA approval, usually at a much lower price. The FDA regulates generic drugs with the same strict standards used for brand-name drugs. Generic drugs have different ratings. “A” rated generics are deemed as safe and efficacious as their brand counterparts. HIP’s Drug Formulary only contains “A” rated generic drugs.

Maintenance Medication: HIP has a list of drugs that are considered maintenance medications. These medications are used in the treatment of chronic “lifelong” conditions. Members on HIP-approved maintenance medications can receive up to a 90-day supply of medication. Many drugs, although they may be used to treat chronic conditions, are not covered as maintenance medications due to issues of patient safety and the need for constant supervision.

MENTAL HEALTH CARE AND SUBSTANCE ABUSE DISORDER TREATMENT

For any mental health or substance abuse disorder service, you can contact HIP directly by calling (888) 447-2526 for help in selecting a provider. When you call, you will be transferred to a trained professional who will assess the appropriate level of care needed and make arrangements for you to see a HIP participating provider. The provider may be in independent practice or at a multi-specialty mental health center.

For mental health services only, you have another option: you can call a participating mental health center directly. There, too, a trained professional will assess treatment and make arrangements for you to see a provider practicing at the center.

All calls will be treated as confidential.
DENTAL COVERAGE

HIP offers group members dental coverage through an arrangement with Careington International, a national dental referral network.

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

- One examination (comprehensive or periodic) every six months – your copayment is $5 per visit. *(See Important Note A on this page.)*

- One prophylaxis (cleaning) every six months – your copayment is $10 per visit. *(See Important Note B on this page.)*

Additional services, including but not limited to X-rays, fillings, crowns or dentures, will be provided at a discounted rate subject to fee schedules that HIP has negotiated. These schedules may change from time to time. There are several fee schedules based on the location of the provider’s office. Therefore, members will pay different fees based on the location (region) of the dentist’s office.

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

Both general and specialist dental services may be self-referred, referred by a participating dentist or arranged through Careington International. You must use participating dentists for all care under this benefit to take advantage of the discounted rates. You may select any participating HIP dentist and may change your provider at any time.

For help locating a participating dentist near you, for answers to benefits questions or for a fee schedule or directory, call (800) HIP-TALK (800-447-8255) Monday through Friday from 8:00 am to 6:00 pm.

**Important Notes:**

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

B. An examination and X-rays are required prior to cleaning.
SECTION II. F
HOSPITAL BENEFITS

- Prior Approval
- Prenatal and Maternity Care
- Exclusions and Limitations

BENEFITS SUMMARY

<table>
<thead>
<tr>
<th>Inpatient Hospital Services</th>
<th>EPO Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Semi-private room and board</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Operating and recovery room, intensive and special care unit, general nursing care, staff physician services, prescribed drugs, anesthesia, X-rays and lab tests</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Short-term speech, physical, occupational and respiratory therapy (when part of an acute admission)</td>
<td>$0 copay Short-term only</td>
</tr>
<tr>
<td>Speech, physical, occupational and respiratory therapy (when part of a rehabilitation admission)</td>
<td>$0 copay 90 days per calendar year</td>
</tr>
<tr>
<td>Radiation therapy and chemotherapy</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Pre-admission testing</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Surgeon and Specialist services</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Human organ transplants</td>
<td>$0 copay</td>
</tr>
</tbody>
</table>

All Inpatient Hospital Services must be approved in advance by the HIP Care Management Program (CMP) Prior Approval Program, described on page 70.
PRIOR APPROVAL

The services described on page xx must be approved in advance by the HIP CMP Prior Approval Program, described on page 70.

This includes:

- All inpatient admissions (non-emergency), including mental health and alcohol or substance abuse-related admissions, and
- All ambulatory surgery services.

Failure to Obtain HIP CMP Prior Approval

You must comply with the provisions of the HIP CMP Prior Approval Program; failure to comply will result in reduced payments, as follows:

Failure to obtain prior approval from HIP through the CMP Prior Approval Program will result in HIP reducing benefits otherwise payable by 50 percent. Additionally, HIP will not pay benefits for any charges incurred that HIP determines not to be Medically Necessary and Appropriate. This includes, but is not limited to, inpatient care and treatment that could have been provided on an outpatient basis or in an alternate care facility.

YOUR RIGHTS UNDER THE WOMEN’S HEALTH AND CANCER ACT OF 1998

HIP complies with federal law related to mastectomies. Members are entitled to reconstructive breast surgery following a mastectomy. Covered services include:

- Reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prosthesis and treatment of physical complications at all stages of the mastectomy including lymph edemas.

These benefits do not apply to elective cosmetic surgery, which is not covered under this Plan.
PRENATAL AND MATERNITY CARE

Members who suspect they are pregnant should schedule an appointment with their PCP. The PCP will order a blood test to confirm pregnancy and check the woman’s overall health. If the PCP confirms pregnancy, the expectant mother should select a participating OB/GYN or midwife for continued Prenatal Care.

Covered maternity care services include hospital, surgical and medical and midwifery care during the term of pregnancy, upon delivery and during the postpartum period for normal delivery, spontaneous abortion (miscarriage) and complications of pregnancy in a Hospital or licensed Birthing Center as well as parent education, assistance and training in breast- or bottle-feeding, and the performance of any necessary maternal and newborn clinical assessments.

Such maternity care services include inpatient Hospital coverage for mother and routine nursery care for the newborn for at least forty-eight (48) hours after childbirth for any delivery other than a Caesarean section, and for at least ninety-six (96) hours following a Caesarean section.

The Member has the option to be discharged earlier than the time periods stated above. In such case, the inpatient Hospital coverage will include one (1) home care visit, in addition to any Home Health Care benefits otherwise available under this Plan.

The home care visit may be requested and will be provided at any time within twenty-four (24) hours after discharge of the mother from the hospital or after the mother’s request, whichever is later and is not subject to any copayments otherwise required under this Plan.

Healthy Beginnings PATH Program

The Healthy Beginnings PATH Program is designed for expectant mothers to help them better understand their pregnancy and to provide information and support during pregnancy and the first few weeks of parenting.

The program provides expectant mothers with the following:

- Comprehensive educational materials about pregnancy;
- Two (2) pregnancy risk surveys, done over the phone, to help identify possible complications to their pregnancy; and
- Twenty-four (24) hour, seven (7) day-a-week access to perinatal nurses to answer questions during the pregnancy.

To register for the program, please call (866) 943-BABY (866-943-2229.)
EXCLUSIONS AND LIMITATIONS

The following benefits are not covered under this Plan:

- Private room. If you occupy a private room, you will have to pay the difference between the Hospital’s charges for a private room and the Hospital’s most common charge for semi-private accommodations.
- Private duty nursing.
- Non-medical items, such as television rental and telephone charges.
- Medications, supplies and equipment you take home from the Hospital or other facility.
- Any expense incurred for staying in the Hospital after the discharge time or date established by HIP or your Physician.
- Care for the sole purpose of obtaining a non-covered benefit.

YOUR RIGHTS UNDER THE NEWBORNS’ AND MOTHERS’ HEALTH PROTECTION ACT OF 1996

HIP complies with federal law in that:

- A mother and her newborn child are allowed to stay in the hospital for at least 48 hours after delivery (or 96 hours after a Caesarean section); and
- A provider is not required to obtain authorization for prescribing these minimum lengths of stay.

However, the mother and her provider still may decide that the mother and newborn should be discharged before 48 (or 96) hours.
SECTION II. G
DIAGNOSTIC SERVICES

- At Your Health Center
- Through a HIP Participating Provider in Independent Practice

SECTION HIGHLIGHTS

Diagnostic services at your health center
- Most routine diagnostic services such as lab tests and X-rays will be provided at the center. If your PCP determines that you need a specialized service not available at your health center, he or she will usually make the arrangements.

Diagnostic services in a participating provider’s office
- PCPs in independent practice may provide some diagnostic testing in their own offices. For other services, your PCP may refer you to a health center or other participating provider

BENEFITS SUMMARY

<table>
<thead>
<tr>
<th>Diagnostic Services</th>
<th>EPO Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic services including X-ray, lab tests, EKGs, MRIs and CAT scans</td>
<td>$0 copay</td>
</tr>
</tbody>
</table>
AT YOUR HEALTH CENTER

If you have chosen to receive your primary care at a health center, most routine diagnostic services such as lab tests and X-rays will be provided right there, at your center. If your PCP determines that you need a specialized service not available at the center, he or she will make the necessary arrangements. Usually, this will mean going to another health center or another participating provider. In rare instances where the service is not available from within the HIP participating network, your PCP can seek prior approval from HIP for you to see a non-participating provider without losing EPO benefits.

THROUGH A HIP PARTICIPATING PROVIDER IN INDEPENDENT PRACTICE

If you have chosen to receive your primary care from a HIP participating provider in independent practice, your PCP may provide some diagnostic testing in his or her own office. For other services, your PCP may refer you to a HIP participating medical center or other participating provider. In rare instances where the service is not available from within the HIP participating network, your PCP will seek prior approval from HIP for a referral to a non-participating provider.
SECTION II. H
EMERGENCY AND OUT-OF-AREA CARE

• What Constitutes an Emergency
• Getting Help in an Emergency
• Getting Non-Emergency, but Urgently Needed Care
• Care While Traveling in Other Areas of the Country

BENEFITS SUMMARY

<table>
<thead>
<tr>
<th>Emergency and Urgent Care</th>
<th>EPO Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>In hospital emergency room</td>
<td>$35 copay (waived if admitted)</td>
</tr>
<tr>
<td>In urgent care facility</td>
<td>$10 copay</td>
</tr>
<tr>
<td>In physician’s office</td>
<td>$10 copay</td>
</tr>
<tr>
<td>Ambulance service</td>
<td>$0 copay</td>
</tr>
<tr>
<td>to hospital</td>
<td></td>
</tr>
</tbody>
</table>
What Constitutes an Emergency

- An emergency is a medical or behavioral condition that comes on all of a sudden and is accompanied by pain or other symptoms. It is a condition that makes a person with an average knowledge of health fear that someone will suffer serious harm to body parts or functions or serious disfigurement without immediate care.

Getting Help in an Emergency

- In a true emergency, call 911 or go to an emergency room, whether at home or traveling in the U.S. or territories. There is no need for prior approval.

- All HIP network PCPs have 24-hour telephone coverage, so you will be able to reach your PCP or another doctor at any time. If you are not sure whether you have an emergency, call your PCP at the telephone number on your HIP ID Card.

- When you get care, you or someone on your behalf must notify your PCP within 48 hours, or as soon as possible after you get emergency care. HIP also suggests that you or someone acting on your behalf contact HIP at (800) 447-2884 if you are admitted to a hospital in an emergency.

Getting Non-Emergency, but Urgently Needed, Care

- In case of non-emergency, but urgent injury or illness, contact your PCP. Examples of non-emergency, but urgently needed care, could be one of the following: a sprained ankle, or a bad splinter you can’t remove.

Important Emergency and Urgent Care Tips

- There are a lot of things you can do if you need emergency or urgent care. Most importantly, keep as much information about your health plan (e.g., HIP ID Card), your doctor and other information, such as any medications you are taking, handy, so you won’t have to search for this information during a crisis. Also, stay calm so that you will be able to answer any questions from your PCP or HIP, if necessary.
WHAT CONSTITUTES AN EMERGENCY

An emergency is a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy:
- Serious impairment to such person’s bodily functions;
- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of such person.

Examples of an Emergency are:
- A heart attack or chest pain.
- Bleeding that won’t stop.
- A bad burn.
- Broken bones.
- Trouble breathing.
- Convulsions.
- Loss of consciousness.
- When you feel like you might hurt yourself or others.
- If you are pregnant and have pain, bleeding, fever or vomiting.

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

COVERAGE FOR EMERGENCY CARE

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

No claim for such emergency care will be denied because HIP’s prior approval was not obtained. Also, emergency services will be covered if an authorized person, acting on behalf of HIP, has approved the service. However, all claims for coverage of emergency services are subject to HIP’s retrospective review to determine if the services were medically necessary. (See The Quality of Your Care: Care Management Program, page 60.)

GETTING HELP IN AN EMERGENCY

In an emergency as defined above, go to the nearest emergency room or call 911 to get immediate help. You do not need to call your PCP first.

All HIP network PCPs have arranged for 24-hour coverage of their telephones. So, you will be able to reach your PCP or another doctor at anytime. If you are not sure whether you have an emergency, call your PCP at the telephone number on your HIP ID Card. Your PCP or the doctor covering for your PCP will tell you:

- Actions you can take at home.
- To come to his/her office.
• To go to the nearest emergency room.

When you get care, you or someone on your behalf should notify your PCP within 48 hours, or as soon as possible after you get emergency care. HIP also suggests that you or someone on your behalf contact HIP at (888) 447-2884 if you are admitted to a hospital in an emergency. This is to insure that HIP and your PCP know.

If you are admitted to a hospital within HIP’s service area that is not in its network, HIP may move you to a HIP network hospital as soon as it is safe to do so. If you are admitted to a hospital outside HIP’s service area that is not in the network, you may also be moved as soon as it is safe to do so. In both instances, network providers in HIP’s service area must provide the necessary follow-up care.

GETTING NON-EMERGENCY, BUT URGENTLY NEEDED, CARE

In case of non-emergency but urgent injury or illness, contact your PCP. An injury or illness that might require urgent care could be a:

• Sprained ankle, or
• Bad splinter you can’t remove.

Your PCP, or the physician covering for your PCP, will arrange for the care you need, which might include:

• A same-day appointment.
• A visit to a HIP after-hours treatment facility.

CARE WHILE TRAVELING IN OTHER AREAS OF THE COUNTRY

Emergency care is covered anywhere and does not require making any special arrangements.

REMEMBER

• If you have any questions, call your PCP at the phone number on your HIP ID Card.
• The Emergency Room should NOT be used for problems like the flu, sore throats or ear infections.

Use the emergency room only if you have a true emergency.
SECTION II. I
STAYING HEALTHY

• Prenatal Care
• “Free & Clear” Quit Smoking Program
• Disease Management Programs
• Fitness Facilities Discount Program

SECTION HIGHLIGHTS

• If you suspect that you are pregnant, schedule an appointment with your PCP. Your PCP can order the blood test necessary to confirm your pregnancy. You can then self-refer to a participating OB/GYN or midwife for continued prenatal care.

• If you are a smoker, consider joining the “Free & Clear” Quit Smoking Program. This self-help program provides members who want to stop smoking with a comprehensive education kit, support and financial reimbursement for the nicotine patch and Zyban. To register, call (800) 292-2336.

• To encourage you to exercise regularly, HIP offers discounts at participating fitness facilities throughout HIP’s service area. For more information, please call (800) HIP-TALK (800-447-8255) Monday through Friday, 8:00 am to 6:00 pm. If you have a hearing or speech impairment and use a TDD, call (888) HIP-4TDD (888-447-4833) Monday through Friday, 8:30 am to 5:00 pm.

Disease Management Programs

• HIP has special programs for members with asthma, diabetes and arthritis. Each program is designed to provide support, education and other resources to help members improve their quality of life.
# BENEFITS SUMMARY

## EPO Benefits

<table>
<thead>
<tr>
<th>Outpatient Medical Care</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>PCP office visits</td>
<td>$10 copay</td>
</tr>
<tr>
<td>Specialists’ office visits</td>
<td>$10 copay</td>
</tr>
<tr>
<td>Preventive care, including physical exams, health education and counseling, immunizations and associated diagnostic services</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Well-woman care, including pap smears and mammography</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Prenatal and postnatal care in physician’s office</td>
<td>$0 copay</td>
</tr>
</tbody>
</table>
PRENATAL CARE

Prenatal care is the care an expectant mother receives during pregnancy. Good healthcare during pregnancy increases the chances of having a healthy baby. Therefore, members who suspect they are pregnant should schedule an appointment with their PCP. The PCP will order a blood test to confirm pregnancy and check the woman’s overall health. If the PCP confirms pregnancy, the expectant mother should select a participating OB/GYN or midwife for continued prenatal care.

“FREE & CLEAR” QUIT SMOKING PROGRAM

“No & Clear” Quit Smoking Program is a self-help program that provides members who want to stop smoking with a comprehensive educational kit, support calls from a smoking cessation specialist, and nicotine replacement therapy and pharmacology for one year to help you quit.

To register for the Free & Clear Quit Smoking Program, call (866) 611-7948.

DISEASE MANAGEMENT PROGRAMS

Asthma Program

Through this program, all HIP members with asthma can get a peak flow meter, a seasonal newsletter and an asthma management plan to be completed with their PCP. High-risk asthma patients will also get telephonic case management by a nurse experienced in caring for asthma patients.

Diabetes Support Program

If your doctor has told you that you have diabetes, you know how important it is to manage your condition. At regular intervals, HIP will send you a letter encouraging you to take important tests and examinations that will help control your diabetes. These tests and examinations let you and your doctor know if your diabetes is under control.

HIP also sends your doctor information on these tests. If you receive this letter, make sure to schedule an appointment to take the required tests.

HIP offers diabetes education classes. These free, two-hour classes are offered at select medical centers throughout HIP’s service area. Certified Diabetes Educators share valuable information on various topics.
Arthritis Programs

- **PACE (People with Arthritis Can Exercise)** – This eight-week program uses gentle exercises to assist in achieving the following: reduce pain, increase joint flexibility, improve joint range of motion, overall stamina, maintain muscular strength, decrease depression, improve self-care behaviors and increase self-esteem. Classes are small and held once a week for about an hour in various sites throughout New York City.

- **ASHC (Arthritis Self-Help Course)** – This six-week educational program is designed to teach people with arthritis to be more pro-active in managing their arthritis (also available in Spanish).

- **Educational Brochures** – The brochures offered include: Osteoarthritis, Rheumatoid Arthritis, Back Pain, Lyme Disease, Lupus, Fibromyalgia Syndrome, Water Exercise and Arthritis and many other topics (materials are also available in Spanish).

For details on arthritis programs and educational brochures:

**Call:**
New York Arthritis Exchange
at (212) 984-8730

or

**Write:**
Arthritis Foundation
New York Chapter
122 East 42nd Street
New York, NY 10168

Fitness Facilities Discount Program

To encourage members to exercise regularly, HIP offers discounts at participating fitness facilities throughout HIP’s service area. To receive a discount, just choose a participating facility and present your HIP ID Card when you enroll. For more information, please call (800) HIP-TALK (800-447-8255), Monday through Friday, 8:00 am to 6:00 pm. If you are hearing- or speech-impaired and use a telephone device for the deaf, please call (888) HIP-4TDD (888-447-4833), Monday through Friday, 8:30 am to 5:00 pm.
SECTION II. J
THE QUALITY OF YOUR CARE

- Care Management Program
- Prior Approval Program
- Adverse Determination

SECTION HIGHLIGHTS

Care Management Program
- The Care Management Program (CMP) helps members to understand their treatment options and coverage.
- CMP consists of these programs:
  - Prior Approval – A provider must receive approval from the HIPIC Care Management Program (CMP) or its designee before the member has access to in-network Medically Necessary and Appropriate Covered Services. Prior Approval helps make decisions about care or diagnostic services that members and their physicians anticipate the members will need to receive.
  - Concurrent Review Program – Supports appropriate hospital care and length of stay while you are undergoing a course of treatment.
  - Case Management Program – Helps with complex or serious medical conditions.
  - Post Service (Retrospective) Review Program – Assures coverage for only medically necessary and appropriate treatment.
  - Technology Evaluation Program – Continually updates information on non-covered experimental and investigational procedures. Services, supplies, procedures and items considered to be experimental or investigational are not covered by EPO benefits.
- Generally, your PCP or other HIP participating physician will contact CMP when a decision has been made for you to undergo certain medical services. If you need to contact CMP directly, call (888) 447-2884.

Adverse Determinations
- In rare instances, CMP may determine that a particular service was not medically necessary. If that happens, you will be notified. An appeals process is available to you and your physician to request a reconsideration. See page 72.
CARE MANAGEMENT

HIP’s first priority is giving you access to quality care. HIP starts by ensuring that all HIP participating physicians meet HIP’s rigorous credentialing standards before they are granted participating physician status. HIP also makes sure that participating hospitals are among the finest in the region.

But healthcare today is complicated. Sometimes it is difficult to understand all the treatment options available in every case. Sometimes it is difficult to be certain exactly what is covered and what is not – even though HIP provides detailed information to ensure full disclosure and to facilitate understanding.

For these reasons, HIP has developed a series of special information, support and review programs, which are described in this section.

HIP believes these programs support sound medical choices and optimal health outcomes. However, it is up to you and your physician to decide which healthcare choices are best for you. HIP reserves the right to determine if the medical services provided are necessary and/or covered under the Plan.

CARE MANAGEMENT PROGRAM

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

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

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

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

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

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

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

Prior approval must be obtained from the CMP for these services:

- Inpatient nonemergency procedures that provide acute, rehabilitation and skilled nursing care.
- All outpatient invasive and surgical procedures and surgical treatments in a facility or doctor's office.
- Inpatient treatment of mental illness and substance use disorder, detoxification treatment of substance use disorder, and rehabilitation treatment of substance use disorder.
- Outpatient treatment of mental illness and substance use disorder, which includes:
  - Partial hospitalization
  - Intensive outpatient treatment
  - Ambulatory detoxification treatment
  - Outpatient ECT (electro-convulsive treatment)
  - Neuropsychological testing
  - Psychological testing
  - Non-emergency transportation
  - Hyperbaric oxygen therapy
  - Home health care
  - Hospice care
  - Services obtained by Non-Participating Providers with specialty expertise
  - Pre-transplant evaluation and transplant services
  - Outpatient cardiac and pulmonary rehabilitation
  - Outpatient diagnostic radiology services
  - Outpatient physical, occupational and speech therapies
  - Radiation oncology
  - Pain management
  - Sleep studies
  - Advanced molecular diagnostics and genetic testing, and
  - Experimental and/or investigational treatments and procedures

CONTACTING PRE-SERVICE REVIEW

If you need to contact the Pre-service Review Department, call (877) 846-3625, Monday through Friday from 9:00 am to 5:00 pm. If you call after those hours, and your call concerns an urgent or emergency admission, you will be prompted to leave a message, and a Pre-Service Review representative will call you or your doctor back, if necessary. If the
Pre-service Review Department receives sufficient information to approve your care, your case will be routed to the appropriate Concurrent Reviewer. If your call concerns an elective admission, you will be advised to call back the next business day when representatives are available. (Please refer to your HIP Member ID card for the number to call.)

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

**HIP’S COMMITMENT TO YOU FOR TIMELY PRE-SERVICE REVIEW PROGRAM DETERMINATIONS AND NOTIFICATIONS**

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

**Determinations for urgent coverage** — If HIP has all information necessary to make a determination, HIP will make a determination and notify you (or your designee) and your provider, by telephone and in writing, within twenty-four (24) hours of receipt of the request. If HIP needs additional information, HIP will request it within twenty-four (24) hours. You or your provider will then have forty-eight (48) hours to submit the information. HIP will make a determination and notify you and your provider by telephone and in writing within forty-eight (48) hours of the earlier of our receipt of the information or the end of the forty-eight (48)-hour time period. If HIP has approved a course of treatment, HIP will not reduce or terminate the approved services unless HIP has given you enough prior notice of the reduction or termination so that you can complete the appeal process before the services are reduced or terminated.
The Concurrent Care Review Program (CCP) facilitates the coordination and continuity of services rendered to a member when in a hospital or other facility. You are automatically entered into the program when you are admitted to the hospital.

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

HIP’S COMMITMENT TO YOU FOR TIMELY CONCURRENT REVIEW PROGRAM DETERMINATIONS AND NOTIFICATIONS

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

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

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

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

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

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

**EXPERIMENTAL/INVESTIGATIONAL TREATMENT**

HIP will not provide coverage for any procedure or service, which in HIP’s judgment is experimental, investigational or for a rare disease, unless required by an external appeals agent. You may request utilization review for experimental or investigational health care services or rare disease treatment. The procedure for filing an external appeal is described in the section entitled *If You Disagree With A Decision.*
CASE MANAGEMENT PROGRAM

The Case Management Program consists of nurses, behavioral health specialists, social workers, pharmacists and physicians who identify and assist members who have complex needs, serious diseases or chronic conditions and would benefit from clinical support and management. Members are regularly screened for possible candidates and may be referred directly for management. Members may be in the program from weeks, to months, to years, and Case Management Program contact may be daily, weekly or monthly – it all depends on the individual condition and the circumstances. All contacts and services have one main purpose: the most optimal healthcare outcome for you.

RETROSPECTIVE REVIEW PROGRAM

The Retrospective Review Program provides determinations and electronic or written notification for retrospective reviews when services have already been delivered and a claim has been submitted.

The Retrospective Review Program reviews medical and hospital records after services have been provided to determine if such services were medically necessary and appropriate. For example, a retrospective review may be triggered by a history of unusually high number of tests ordered by the physician for the service provided. Reviews may result in a retrospective denial if, for example, the services you received were not:

- Approved before you received them
- A medical emergency as defined in Emergency and Out-of-Area Care
- Medically necessary (see definition of medical necessity under Care Management: Adverse Determinations) or are otherwise excluded from coverage as provided in your Contract or Certificate of Coverage.

Please remember: HIP is obligated to administer coverage to ensure that all contract provisions are honored. That means providing all benefits to which members are entitled. It also means not providing benefits that are excluded from coverage. For example, members are generally not entitled to benefits for experimental or investigational procedures.

RETROSPECTIVE REVIEW PROGRAM

If HIP has all the information necessary to make a determination about a retrospective claim, HIP will make a determination and provide notify you (or your designee) and your provider within thirty (30) calendar days of receipt of the claim. If HIP needs additional information, HIP will request it within thirty (30) calendar days. You or your provider will then have forty-five (45) calendar days to submit the information. HIP will make a determination and notify you (or your provider) within fifteen (15) calendar days of the earlier of our receipt of the information or the end of the forty-five (45) day time period.
If HIP fails to make a decision within the above-noted timeframes, then the denial of the healthcare service and/or treatment is considered deemed to be an Adverse Determination subject to Your Appeal rights.

TECHNOLOGY EVALUATION PROGRAM

The Technology Evaluation Program consists of the continual clinical identification of new technology, and updates information on non-covered experimental and investigational procedures.

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

- There are insufficient outcomes data available from controlled clinical trials published in the peer-reviewed literature to substantiate its safety and effectiveness for the disease or injury involved.
- The FDA has not granted the required approval for general use.
- A recognized national medical or dental society, or regulatory agency, has determined, in writing, that it is experimental, investigational or for research purposes.
- The written protocols or informed consent used by the treating facility, or the protocols or informed consent of any other facility studying substantially the same drug, device, procedure or treatment, state it is experimental, investigational or for research purposes.

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

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

HIP’s Medical Policy Subcommittee meets at least 10 times a year to decide when certain technologies previously considered experimental have come to satisfy the general medical standards in effect in our service area at the time of their evaluation. Also, in making a coverage determination in an individual patient case, HIP’s professional staff will consult with physicians involved in the care of a member.
DELEGATED MANAGEMENT ARRANGEMENTS

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

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

ADVERSE DETERMINATIONS

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

For more information about adverse determinations, please see If You Disagree With A Decision.

WHAT DOES MEDICALLY AND APPROPRIATE NECESSARY MEAN?

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

All determinations are conducted by qualified personnel as follows:

- Licensed healthcare professionals who are trained in the principles and procedures of intake screening and data collection. Administrative personnel only perform intake screening, data collection and nonclinical review functions. They are supervised by licensed healthcare professionals.
• A healthcare professional who is appropriately trained in the principles, procedures and standards of utilization management.

• A clinical peer reviewer, if the review involves an adverse determination.

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

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

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

Points to remember about a provider reconsideration include:

• Except in cases of retrospective review, such reconsideration will occur within one business day of notice of adverse determination.

• The reconsideration will be conducted by your healthcare provider and the original clinical peer reviewer who made the initial determination, or a designated clinical peer reviewer if the original clinical peer reviewer is not available.

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

You or your representative may submit a grievance at any time directly to HIP Health Plan of New York. A grievance is either a complaint or a request for a Benefit Determination. If you are dissatisfied with our response to a grievance, you may appeal the response by following the appeal process for a Benefit Determination. To submit a grievance by phone, please call (800) 447-8255.

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

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

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

PRIOR APPROVAL PROGRAM

Prior Approval means a system whereby a provider must receive approval from the HIPIC Care Management Program (CMP) or its designee before the member has access to in-network Medically Necessary and Appropriate Covered Services.

Providers must notify and obtain approval in advance from the CMP for the following services:

- Inpatient non-emergency procedures that provide acute, rehabilitation and skilled nursing care.
- All outpatient invasive and surgical procedures and treatments in a facility or doctor’s office.
- Inpatient treatment of Mental Illness and Substance Use Disorder, Detoxification treatment of Substance Use Disorder, and Rehabilitation treatment of Substance Use Disorder.
- Non-routine outpatient treatment of Mental Illness and Substance Use Disorder, which includes:
  - partial hospitalization;
  - intensive outpatient treatment;
  - ambulatory detoxification treatment;
  - outpatient ECT (electro-convulsive treatment);
• neuropsychological testing; and
• psychological testing.
• Non emergent transportation.
• Home Health Care.
• Hospice Care.
• Services obtained by Non-Participating Providers with specialty expertise.
• Pre-transplant evaluation and transplant services.
• Outpatient cardiac and pulmonary rehabilitation.
• Outpatient Diagnostic Radiology Services.
• Outpatient Physical, Occupational and Speech Therapies.
• Radiation Oncology.
• Pain Management.
• Sleep Studies.
• Advanced molecular diagnostics and genetic testing.
• Hyperbaric Oxygen Therapy.
• Experimental and/or Investigational Treatments and Procedures.
SECTION II. K
IF YOU DISAGREE WITH
A COVERAGE DECISION OR SERVICE

- Introduction
- Standard Internal Appeals
- Expedited Internal Appeals
- External Appeals
- Complaints
- Other Agencies

SECTION HIGHLIGHTS

Appeals
You can appeal any adverse HIP determination.

- Standard internal appeals must be filed within 180 days of your receipt of HIP’s adverse determination notice. Expedited internal appeals are available in the event of an urgent medical condition.

- External appeals are available to you if you have received a denial of coverage based on medical necessity or because the service is experimental and/or investigational. An external appeal must be filed within 45 days of your receipt of the final adverse determination from the standard or expedited internal plan appeal process.

- You will lose your right to an external appeal if you do not file an application for an external appeal within 45 days of your receipt of the final adverse determination from the standard or expedited internal appeal process.

Complaints and Grievances

- You can file a complaint or grievance when your dissatisfaction does not involve changing a plan determination.

- Complaints must be filed within 60 working days of the dispute.

- You may ask various regulatory agencies at any time to review your concerns. Two such agencies are the New York State Department of Health Bureau of Certification and Surveillance (800-206-8126) and the State of New York Insurance Department Consumer Services Bureau (212-480-6420).
INTRODUCTION

This section describes the appeals processes available to you if you disagree with a Benefit Determination or Clinical Determination.

DEFINITIONS

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adverse Determination</td>
<td>A determination by a utilization review agent that an admission extension of stay, or other healthcare service, upon review has been denied, reduced, terminated, or a failure to provide or make a payment in whole or in part for a benefit based on a determination that a benefit is experimental, investigational or not medically necessary or appropriate</td>
</tr>
<tr>
<td>Appeal</td>
<td>A request that you, your designee, and – under certain circumstances – your physician makes for HIP to reverse a Benefit Determination or a Clinical Determination.</td>
</tr>
<tr>
<td>Benefit Determination</td>
<td>A decision HIP makes about benefits, eligibility and claims payments, as well as issues of dissatisfaction with services received under your coverage, including denials or referrals. A Benefit Determination does not include decisions as to whether a service is medically necessary and appropriate, or experimental and/or investigational.</td>
</tr>
<tr>
<td>Clinical Determination</td>
<td>A determination on whether a service is medically necessary or experimental or investigational in nature.</td>
</tr>
<tr>
<td>Complaint</td>
<td>An issue of dissatisfaction with HIP’s operations other than a Benefit Determination.</td>
</tr>
<tr>
<td>External Appeal</td>
<td>You may also request that an independent New York State-licensed External Review Agent review HIP’s internal clinical appeal decision. Please see External Appeals for additional information.</td>
</tr>
<tr>
<td>Grievance</td>
<td>A request for HIP to reverse a previous plan determination other than an Adverse Determination.</td>
</tr>
<tr>
<td>Out-of-Network Denials</td>
<td>A denial of a request for prior approval of an out-of-network health service on the basis that the service is not materially different than the health service available in-network.</td>
</tr>
<tr>
<td>Rare Disease</td>
<td>A life-threatening or disabling condition or disease that (1)(a) is currently or has been subject to a research study by the National Institutes of Health Rare Disease Clinical Research Network; or (b) affects fewer than two hundred thousand (200,000) United States residents annually; and (2), for which there does not exist a standard health service or procedure covered by the healthcare plan that is more clinically beneficial than the requested health service or treatment. A Physician, other than your attending Physician shall certify in writing that the condition is a Rare Disease.</td>
</tr>
</tbody>
</table>
Note: You will lose your right to an external appeal of a Clinical Determination if you do not file an application for an external appeal within 45 days of your receipt of the final adverse determination from the standard internal appeal process. Time frames when you can expect to receive written determinations are indicated in this section.

APPEALS PROCESS

- You can appeal any adverse HIP determination.
- Standard or Expedited internal appeals must be filed within 180 days of your receipt of HIP’s written adverse determination notice or the date the decision was due. Expedited appeals are available in the event of an urgent medical condition.
- External appeals are only available for Clinical Determinations. You must have received a final adverse determination as a result of HIP’s standard appeals process or both you and HIP must have jointly agreed to waive the HIP appeals process.

You will lose your right to an external appeal of a Clinical Determination if you do not file an application for an external appeal within 45 days of your receipt of the final adverse determination from the standard internal appeal process. You may ask various regulatory agencies at any time to review your concerns. Two such agencies are the New York State Department of Health Bureau of Certification and Surveillance (1-800-206-8125) and the State of New York Insurance Department Consumer Services Bureau (1-212-480-6420).

Important Note: Before pursuing the appeals process, you should always consider seeking immediate assistance from your HIP participating provider in resolving your issues.

COMPLAINTS

This section also helps you understand the complaint process available to you in addressing other concerns.

COMPLAINT PROCESS

You can file a Complaint when your dissatisfaction does not involve changing a Plan determination. For example, Complaints may involve concerns regarding your encounter with a health care provider.

If you believe you have a complaint, you must file the Complaint within 60 working days of the occurrence.

You may ask various regulatory agencies at any time to review your concerns. Two such agencies are the New York State Department of Health Bureau of Certification and Surveillance (1-800-206-8125) and the State of New York Insurance Department Consumer Services Bureau (1-212-480-6420).
Important Note: Before pursuing the Complaint process, you should always consider seeking immediate assistance from your HIP participating provider in resolving your issues.

If you’re not sure which definition matches your concern, start by calling 1-800-HIP-TALK (1-800-447-8255), Monday through Friday, 8 am to 6 pm.

COMPLAINTS AND APPEALS

If you’re not sure which definition matches your concern, start by calling 1-800-HIP-TALK (1-800-447-8255), Monday through Friday, 8 am to 6 pm.

STANDARD INTERNAL APPEALS

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

HIP will decide internal appeals related to pre-service reviews within fifteen (15) calendar days of receipt of the appeal request. Written notice of the determination will be provided to you or your designee (and, where appropriate, your healthcare provider) within two (2) business days after the determination is made, but no later than fifteen (15) calendar days after receipt of the appeal request.

HIP will decide internal appeals related to retrospective reviews within thirty (30) calendar days of receipt of the appeal request. Written notice of the determination will be provided to you or your designee (and, where appropriate, your healthcare provider) within two (2) business days after the determination is made, but no later than thirty (30) calendar days after receipt of the appeal request.

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

In the case of out-of-network treatment, your attending Physician, who must be a licensed, board-certified or board-eligible Physician, must submit a written statement that the requested out-of-network health service is materially different from the health service that HIP approved to treat your healthcare needs; and two (2) documents from the available medical and scientific evidence, that the out-of-network health service is likely to be more clinically beneficial to you than the alternative recommended in-network health service, and for which the adverse risk of the requested health service would likely not be substantially increased over the in-network health service.
For Expedited Appeals, your provider will have reasonable access to the clinical peer reviewer HIP assigned to the Appeal within twenty-four (24) hours of receipt of the request for an appeal. Your provider and a clinical peer reviewer may exchange information by telephone or fax. Expedited Appeals will be determined within the lesser of seventy-two (72) hours of receipt of the Appeal request or forty-eight (48) hours of receipt of the necessary information. Written notice will follow within twenty-four (24) hours of the determination but no later than seventy-two (72) hours of receipt of the appeal request.

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

**By phone:**
(800) HIP-TALK (800-447-8255)
Monday through Friday
8:00 am to 6:00 pm

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

**In person:**
Health Insurance Plan of New York
55 Water Street, Lobby
New York, NY 10041-8190
Monday through Friday
8:00 am to 6:00 pm

If you are not satisfied with the resolution of your expedited appeal, you may file an internal appeal or an External Appeal.

HIP’s failure to render a determination of your internal appeal within sixty (60) calendar days of receipt of the necessary information for a standard appeal or two (2) business days of receipt of the necessary information for an Expedited Appeal shall be deemed a reversal of the initial adverse determination.

**COMPLAINTS AND GRIEVANCES**

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

1. Acknowledgement of Your Complaint or first-level Grievance. HIP will send you a written acknowledgement within five (5) business days but no later than fifteen (15) calendar days of HIP’s receipt of your Complaint or Grievance. This letter will include a notice specifying what information must be provided to HIP in order for HIP to make a decision on your Complaint or grievance.
2. Review of Your Complaint or first-level Grievance. Any Complaint or Grievance concerning a medical issue will be reviewed and decided by qualified personnel including licensed, certified or registered healthcare professionals. Once HIP has received all the information necessary to review your Complaint or Grievance, HIP’s review must be completed and a decision must be made within the following time limits:

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

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

If you disagree with the outcome of the first-level review of a grievance, HIP provides the following second-level Grievance process. You or your designee may file a second-level Grievance by contacting a Member service representative between the hours of 8:00 a.m. and 6:00 p.m., Monday through Friday, at 1-800-HIP-TALK (1-800-447-8255). You have at least sixty (60) business days from receipt of HIP’s written first-level Grievance decision to file a second level grievance.

1. Acknowledgement of Your Complaint or second-level Grievance. HIP will send you a written acknowledgement within five (5) business days but no later than fifteen (15) calendar days of HIP’s receipt of your Complaint or Grievance. This letter will include a notice specifying what information must be provided to HIP in order for HIP to make a decision on Your Complaint or second-level Grievance.
2. Review of Your Complaint or second-level Grievance. Second-level Grievances of an Appeal on a clinical matter must be made by personnel qualified to review the Appeal, including licensed, certified or registered health professionals who did not make the initial determination, at least one of whom must be a clinical peer reviewer. The determination of an Appeal on a matter which is not clinical shall be made by qualified personnel at a higher level than those who made the initial determination.

3. Decision on Your Complaint or second-level Grievance. Any Complaint or second-level Grievance concerning a medical issue will be reviewed and decided by qualified personnel, including licensed, certified or registered healthcare professionals. Once HIP has received all the information necessary to review your Complaint or second-level Grievance, HIP’s review must be completed and a decision must be made within the following time limits:

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

   You also have the right to contact the New York State Department of Health at any time. If necessary, please contact:
   New York State Department of Health
   Division of Managed Care
   Bureau of Managed Care Certification & Surveillance
   Empire State Plaza
   Corning Tower, Room 1911
   Albany, NY 12237-0062
   Complaint Hotline:
   (800) 206-8125

   YOUR RIGHT TO AN IMMEDIATE EXTERNAL APPEAL.

   If HIP fails to adhere to the utilization review requirements described in your Certificate, you will be deemed to have exhausted the internal claims and Appeals process and may initiate an external appeal.
EXTERNAL APPEALS

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

Your Right to Appeal a Determination That a Service Is Not Medically Necessary and Appropriate

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

• The service, procedure, or treatment must otherwise be a Covered Service; and

• You must have received a final adverse determination through the first level of HIP’s internal appeal process, and HIP must have upheld the denial or both HIP and you have jointly agreed to waive any internal appeal.

Your Right to Appeal a Determination That a Service Is Experimental Or Investigational

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

• The service must otherwise be a Covered Service; and

• You must have received a final adverse determination through the first level of HIP’s internal appeal process, and HIP must have upheld the denial or both HIP and you have jointly agreed to waive any internal appeal.

Your attending Physician, or the certifying Physician – in the case of a Rare Disease – must certify that you have a life-threatening or disabling condition or disease. A “life-threatening condition or disease” is one which, according to the current diagnosis of your attending physician, has a high probability of death. A “disabling condition or disease” is any medically determinable physical or mental impairment that can be expected to result in death, or that has lasted or can be expected to last for a continuous period of not less than twelve (12) months, which renders you unable to engage in any substantial gainful activities.

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

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

- A health service or procedure (including a pharmaceutical product) that, based on two documents from the available medical and scientific evidence, is likely to be more beneficial to you than any covered standard health service or procedure; or

- A clinical trial for which you are eligible is likely to benefit you in the treatment of the condition or disease (only certain clinical trials can be considered).

Your Right to Appeal a Determination That a Service Is Out-Of-Network

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

- The service must otherwise be a Covered Service;
- You must have requested pre-authorization for the out-of-network treatment; and
- You must have received a final adverse determination through the first level of HIP’s internal appeal process, and HIP must have upheld the denial or both HIP and you have jointly agreed to waive any internal appeal.

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

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

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

The External Appeal Process

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

You may also request an external Appeal application from New York State by contacting the New York State Department of Insurance at (800) 400-8882, or its website at www.ins.state.ny.us.

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

**Additional Documentation**

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

**Decision Making**

In general, the external Appeal agent must make a decision within no more than forty-five (45) days of receipt of your completed application. The external Appeal agent may request additional information from you, the attending Physician or HIP within the forty-five (45) day period.

**Avoiding Delays**

If your attending Physician certifies that a delay in providing the healthcare service that has been denied poses an imminent or serious threat to your health, then you may request an expedited external Appeal. In that case, the external Appeal agent must make a decision as soon as reasonably possible but not later than seventy-two (72) hours of receipt of your completed application. If the external Appeal agent’s decision is not in writing, the external Appeal agent must provide written confirmation of its decision within forty-eight (48) hours after the date of the notice of the decision.
Reviewing the Final Adverse Determination
If the external appeal agent overturns HIP’s decision that a service is not Medically Necessary and Appropriate or approves coverage of an experimental or investigational treatment or an out-of-network treatment. HIP will provide coverage subject to the other terms and conditions of the health insurance contract. Please note that if the external Appeal agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, HIP will only cover the costs of services required to provide treatment to you according to the design of the trial. HIP shall not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research or costs which would not be covered under this health insurance contract for non-experimental or non-investigational treatments provided in such clinical trial. The external Appeal agent’s decision is binding on both you and HIP. The external Appeal agent’s decision is admissible in any court proceeding.

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

Under Federal law, your completed request for Appeal must be filed within four (4) months of either the date upon which you receive written notification from HIP that it has upheld an Adverse Determination of coverage or the date that you receive a written waiver of any internal Appeal. HIP is not authorized to grant an extension of this deadline.

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

When the healthcare provider requests an external Appeal of a concurrent Adverse Determination, including when the Physician requests an external Appeal as your designee, the healthcare provider shall not pursue any reimbursement from you for services the external Appeal agent determines not to be Medically Necessary and Appropriate, except to collect a copayment, coinsurance or deductible if required.
SECTION II. L
IF YOUR HIP MEMBERSHIP ENDS

SECTION HIGHLIGHTS

Continuation of Benefits
• If your HIP membership ends, you can continue your current group coverage for 18 months under COBRA. You will receive a COBRA notification upon termination of benefits. See pages 23-25.

Rest assured that HIP cannot cancel your membership for reasons of health, regardless of your medical situation. HIP will no longer provide benefits:
• If you move outside the HIP geographic service area
• If you fail to follow recommended treatments or if your behavior is such that is disrupts the operation of your healthcare provider(s), despite their reasonable effort to help you follow treatments or alter behavior.
• If you engage in fraud in seeking any benefits or if you misuse your HIP Member ID card.
• If there is any other reason approved by the New York State Superintendent of Insurance, including filing false or improper claims.

Note: You will also no longer be eligible for Fund benefits if you don’t work the required number of hours (see page 20).
SECTION II. M
HIP AT YOUR SERVICE

SECTION HIGHLIGHTS

Accessing information about HIP and your coverage
• Log on to HIP’s website at www.emblemhealth.com 24 hours a day/7 days a week for links to important areas providing information about HIP. If you register as a member, you’ll receive a secured password that will allow you to conduct a number of transactions online, including changing your PCP.

• Call (800) HIP-TALK (800-447-8255) and use the Interactive Voice Response system 24 hours a day/7 days a week. This automated system also allows you to conduct transactions online.

• Call (800) HIP-TALK to speak with Customer Service Representatives between from 8:00 am to 6:00 pm, Monday through Friday.

If you need help in a language other than English
• You can connect with a representative working the Language Line by calling (800) HIP-TALK (800-447-8255).

If you have a hearing or speech impairment
• If you have a hearing- or speech-impairment and use a TDD, please call (888) HIP-4TDD (888-447-4833).

Information you can request
• New York State law entitles you to receive a wide range of information upon request. To request available information, call HIP Customer Service or write HIP at: 7 West 34th Street, New York, NY 10001.

Protecting your confidentiality
• HIP regularly instructs participating providers and their medical departments on keeping medical records confidential. If a group asks HIP for reports about HIP’s service performance or the use of medical care by member, HIP will only summarize group member utilization. No individual is identified.
KEEPING THE PLAN INFORMED

Please let the Benefit Fund know whenever you change your name, address or phone number by contacting the Member Services Department at (646) 473-9200.

CONTACTING HIP CUSTOMER SERVICE

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

You can also get answers to your questions by calling (800) HIP-TALK (800-447-8255). You can speak with a Customer Service Representative Monday through Friday, 8:00 am to 6:00 pm. At all times, you can verify information and make requests through the Interactive Voice Response (IVR) system. You should be ready to enter your Social Security number when asked, and then just follow the easy instructions.

A helpful hint: Phone volume is heaviest on Mondays and between 11:00 am and 3:00 pm on other days. So if you need to speak with a Customer Service Representative, you may minimize delay by calling at other times. You may also write to HIP at: HIP Customer Service Department, 7 West 34th Street, New York, NY 10001. Or, visit HIP’s Walk-In Unit at 55 Water Street, Lobby, in Manhattan, Monday through Friday, 8:30 am to 5:00 pm.

IF YOU NEED HELP IN A LANGUAGE OTHER THAN ENGLISH

HIP has a long-standing commitment to full services for HIP’s ethnically diverse membership. Accordingly, you can receive assistance through:

- The Language Line available through Customer Service at (800) HIP-TALK (800-447-8255). The Language Line provides over-the-telephone interpretation services in more than 100 languages, including Spanish, Russian, Chinese, French, Japanese and Korean.
- Bilingual and multilingual staff and providers working in private offices and medical centers. Where the needed language is not available, HIP can use the Language Line. This line can be connected to an examination room with a two-way speaker system.
The following languages are available:

- Spanish
- Chinese
- Korean
- Japanese
- Russian

Please call (800) 447-8879 to request these translations.

IF YOU HAVE A HEARING OR SPEECH IMPAIRMENT

HIP maintains a special telephone message relay system that helps HIP communicate with hearing-impaired members. A HIP operator using a special telephone device for those who are hearing-impaired (TDD) is available with benefits information Monday through Friday, 8:30 am to 5:00 pm. After hours and on weekends, TDD communications are reserved for medical emergencies.

You can also arrange with HIP to have a sign language interpreter present when you visit your PCP or for any regularly scheduled medical visit.

To communicate via TDD or arrange for a sign language interpreter, call (888) 447-4833 Monday through Friday, 8:30 am to 5:00 pm.

OTHER INFORMATION YOU CAN REQUEST

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

- A list of the names, business addresses and official positions of the membership of the board of directors, officers, controlling persons, owners or partners of the organization.
- A copy of the most recent annual certified financial statement of the organization, including a balance sheet and summary or receipts and disbursements prepared by a certified public accountant.
- A copy of the most recent individual, direct pay subscriber contracts.
- Information about consumer complaints compiled pursuant to Section 210 of the insurance law.
- HIP's Drug Formulary, as well as information about whether individual drugs are included or excluded from coverage.
- A written description of the organizational arrangements and ongoing procedures of the organization's quality assurance program.
• A description of the procedures followed by the organization in making decisions about the experimental or investigational nature of individual drugs, medical devices or treatments in clinical trials.

• Individual health practitioner affiliations with participating hospitals, if any.

• Upon written request, specific written clinical review criteria relating to a particular condition or disease and, when appropriate, other clinical information that the organization might consider in its utilization review. The organization may include with the information a description of how it will be used in the utilization review.

• The written application procedures and minimum qualification requirements for healthcare providers to be considered by the organization.

• Other information as required by the Commissioner of Health, provided that such requirements are put forth pursuant to the State Administrative Procedure Act.

To request any of these items, call HIP at (800) HIP-TALK (1-800-447-8255). Or, you may write HIP at:

HIP Customer Service Department
7 West 34th Street
New York, NY 10001
SECTION II. N
MEMBER RIGHTS AND RESPONSIBILITIES

SECTION HIGHLIGHTS

Your Responsibilities as a Member
Some of your responsibilities are to:

- Provide HIP and its participating physicians and other providers with accurate and relevant information about your medical history and health so that appropriate treatment and care can be rendered.
- Keep scheduled appointments or to cancel appointments, giving as much notice as possible.
- Update the Benefit Fund’s records with accurate personal data, including changes in name, address, phone number and additional health insurance carriers.

Your Rights as a Member
Some of your rights are:

- The right to understand your rights. If for any reason you do not understand these rights or how to interpret them, HIP and its participating physicians will help you.
- The right to change physicians, in accordance with the provision of your policy.
- The right to receive from your physicians information necessary to allow you to give informed consent prior to the start of any procedure or treatment.
As a HIP member, you share a special relationship with HIP and with HIP’s participating providers. From HIP’s side, that means HIP is committed to protecting your rights to confidentiality, clear information, timely responses and care that meets or exceeds clinical standards. You are expected to meet certain responsibilities for keeping HIP informed, following treatment plans and complying with all provisions of your HIP coverage.

YOUR RIGHTS AS A HIP MEMBER

- The right to understand your rights. If for any reason you do not understand these rights or how to interpret them, HIP and its participating physicians will help you.
- The right to treatment without discrimination as to race, color, religion, gender, national origin, disability, sexual orientation or source of payment.
- The right to a non-smoking environment.
- The right to receive considerate and respectful care in a clean and safe environment.
- The right to be provided, upon request, with a list of the participating physicians serving you and the times that such physicians are normally available for appointments, with the understanding that these are subject to change.
- The right to refuse to participate in, or be a patient for, research. In deciding whether to participate, you have the right to a full explanation.
- The right to change physicians, in accordance with the provisions of your policy.
- The right to be assured that medical services will be provided only by persons having the qualifications set forth in the Professional Standards established by HIP’s Credentialing Committee, whose Professional Standards shall be made available upon request.
- The right to know the names, positions and functions of any participating provider’s staff and to refuse their treatment, examination or observation.
- The right to obtain from your physician, at reasonable times, comprehensive information about your diagnosis, treatment and prognosis in terms you can reasonably be expected to understand. When it is not medically advisable to give such information to you, or when the member is a minor or incompetent, the information shall be made available to an appropriate person on the member’s behalf.
- The right to receive from your physician information necessary to allow you to give informed consent prior to the start of any procedure or treatment.
• The right to refuse treatment, to the extent permitted by law, and to be informed of the medical consequences of such an action.

• The right to have all lab reports, X-rays, specialists’ reports and other medical records completed and placed in your chart as promptly as practicable so as to make them available, if possible, to your physician at the time of consultation.

• The right to be informed as to all medication given to you, as well as the reasons for prescribing the medication and its expected effects.

• The right to receive all information you need to give informed consent for an order not to resuscitate. You also have the right to designate an individual to give this consent if you are too ill to do so.

• The right to request a medical consultation with a second specialist from within the HIP participating physician network.

• The right to every consideration of privacy concerning your medical care program that shall mean, among other things, that no person not directly involved in your care may be present without your permission during any portion of your discussion, consultation, examination or treatment.

• The right to expect that all communications, records and other information pertaining to your care or personal condition will be kept confidential, except if disclosure is required by law permitted by you, or as otherwise prescribed in this booklet.

• The right to request that unaltered copies of your complete medical records be forwarded to a physician or hospital of your choice, with the cost of duplicating and forwarding to be paid by you.

• The right, upon written request, to have made available to you copies of your medical records. Reasonable fees (in accordance with the applicable law) may be charged for such copies. Information may be withheld from you, however, if in the reasonable exercise of a physician’s judgment it is believed that the release of such information would adversely affect your health. Additionally, a parent or guardian may be properly denied access to medical records or information relating to a minor’s pregnancy, abortion, birth control or sexually transmitted diseases if the minor’s consent is not obtained.

• The right to have a person of your choice accompany you in any meeting or discussion with medical or administrative personnel.
• The right to consult by appointment, at reasonable times, with responsible administrative officials at HIP and your participating physician’s office to make specific recommendations for the improvement of the delivery of health services.

• The right to file a grievance, appeal or external review about a determination about care and services rendered. For additional information on filing a grievance, review the section on If You Disagree with a Decision or Service, page xx, and/or call HIP’s Customer Service Department at (800) HIP-TALK (800-447-8255).

**Important:** State and federal laws give adults in New York State the right to accept or refuse medical treatment, including life-sustaining treatment, in the event of catastrophic illness or injury. As your health insurer, it is HIP’s duty to make you aware of your rights in these matters. Included with your membership kit are materials on advance directives with written instructions such as a living will or healthcare proxy containing your wishes relating to healthcare should you become incapacitated. Please read this material carefully.

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**YOUR RESPONSIBILITIES AS A HIP MEMBER**

• The responsibility to provide HIP and its participating physicians and other providers with accurate and relevant information about your medical history and health so that appropriate treatment and care can be rendered.

• The responsibility to keep prescheduled appointments or to cancel appointments, giving as much notice as possible.

• The responsibility to update your record with accurate personal data including changes in name, address, phone number, and additional health insurance carriers within 30 days of the event.

• The responsibility to treat with consideration and courtesy all persons associated with HIP or any hospital or health facility to which you are referred.

• The responsibility to be actively involved in your own healthcare by seeking and obtaining information, by discussing treatment options with your physician and by making informed decisions about your healthcare.

• The responsibility to follow through with treatment plans agreed upon by all partners in your healthcare: you, HIP and participating physicians.
• The responsibility to understand HIP's benefits, policies and procedures and to utilize the HIP system as outlined in your Contract and Handbook.

• The responsibility to pay copayments, if applicable, at the time services are rendered.

• The responsibility to abide by the policies and procedures of your participating physician's office.
SECTION II.0
UNDERSTANDING HOW HIP PARTICIPATING PROVIDERS ARE COMPENSATED FOR THEIR SERVICES

SECTION HIGHLIGHTS

How HIP Compensates Participating Providers
HIP provides access to care and coverage for services. HIP contracts with providers or groups of providers to provide care to members. These “participating providers” are not HIP agents or employees.

HIP’s provider compensation is not intended to limit or reduce the quality or scope of medical care you receive. Participating providers are compensated in a variety of ways. For example:

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

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

The physicians and healthcare providers that treat you are not HIP agents or employees. They alone are responsible for the medical care they provide. HIP does not provide medical care, nor is HIP responsible for any acts or omissions of any physician or other healthcare provider. Rather, HIP’s obligation to you is to provide access to and pay for covered services in accordance with the terms of this Plan.

You and your doctor are responsible for decisions about your medical care. If you have questions about payment arrangements, please discuss them with your primary care physician as well as with other participating providers, such as hospitals and other inpatient facilities.

To assist you in these discussions, some important definitions are listed...
below. These are terms commonly used by healthcare providers and health plans such as HIP when discussing compensation. Following the definitions, HIP has provided some general descriptions of the various methods HIP uses to compensate participating healthcare providers.

DEFINITIONS

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

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

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

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

Risk means the responsibility the provider assumes to deliver covered healthcare services under a Capitation arrangement. When a provider accepts Capitation for a member for a particular month, that provider has been paid in full for the covered service the member requires. That payment is made based on services the provider has agreed to deliver or arrange regardless of whether the member actually uses any services. In any given month, Capitation payment is received by the provider whether or not the member receives any services in that month or if the costs of services provided to the member exceed the Capitation payment for that month.
Independent Practice Association or IPA means an organization of healthcare providers authorized by New York State to contract with health plans such as HIP and to negotiate fee schedules or other compensation arrangements on behalf of its member physicians, hospitals and other providers.

Medical Group means, for purposes of this section, the professional corporations organized by the physicians that operate the HIP-affiliated medical centers in Queens, Brooklyn, Staten Island and Long Island. These professional corporations negotiate compensation arrangements and contract with HIP to provide services to members at the centers. The Medical Groups employ physicians, healthcare professionals and staff that operate the medical centers.

COMMON REIMBURSEMENT ARRANGEMENTS CURRENTLY USED BY HIP

Medical Group Compensation
To compensate primary care physicians practicing at a medical center, HIP contracts with Medical Groups that employ these physicians. HIP pays the Medical Groups a Capitation for medical services these physicians provide at the medical center.

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

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

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

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

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

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

COMPENSATION FOR HIP PARTICIPATING PHYSICIANS DIRECTLY CONTRACTING WITH HIP

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

FACILITY COMPENSATION

HIP pays participating hospitals or other inpatient care facilities on a Per Diem or DRG basis. With certain high-volume hospitals, the per diem fee may be subject to adjustments if certain volume utilization levels are achieved over time.
In addition to the various exclusions set forth elsewhere in this SPD, the Fund does not cover:

**Alternative Medicine** – Benefits are not available for services, testing, equipment and supplies associated with alternative modalities of care including, but not limited to, acupuncture, hypnosis, biofeedback, naturopathy, homeopathy, massage therapy and aromatherapy.

**Blood** – Benefits are not available for the drawing and storage of blood and blood products, unless taken from a member pre-operatively for an approved surgical procedure or for blood products and storage.

**Care Ordered by a Court of Law** or any governmental agency that would not otherwise be covered under this Plan is not available.

**Care Provided Outside of the HIP Service Area** – Benefits are not available for services provided when the Member is traveling, visiting, or temporarily residing outside of the Service Area, except for Emergency Medical Conditions as defined on page 53.

**Cosmetic Surgery** – Benefits are not available for any professional services and/or hospitalization in connection with elective cosmetic surgery, including but not limited to, rhinoplasty, liposuction, abdominoplasty, breast reduction mammoplasty, blepharoplasty, varicose vein injections, removal of nevi, cherry angiomas, telangiectasias and spider angiomas. However, benefits may be available for reconstructive surgery if it is incidental to or follows surgery from trauma, infection or other diseases of the part of the body involved.

**Custodial Care** – Benefits are not available for hospital care, nursing home care, skilled nursing facility care or home health care that is primarily or wholly custodial.

**Dental Care** – Benefits are not available for dental care, except treatment required in connection with an accidental injury to sound natural teeth if the service is provided within twelve (12) months after the accident. However, orthodontics and fixed and removable prosthetics are not covered.

**Disposable Medical Supplies and Personal Convenience** – Benefits are not available for supplies, equipment or personal convenience items such as, but not limited to, combs, lotions, bandages, alcohol pads, incontinence pads, surgical face masks, disposable sheets and bags or the use of telephones or television while an inpatient.
Durable Medical Equipment – DME benefits are not available out of network, including, but not limited to, wheelchairs and hospital beds.

Educational Materials and Supplies – Benefits are not available for educational materials and supplies commonly available for purchase such as diet and nutritional books or magazines or literature about medical conditions and treatments.

Eye care – Benefits are not available for eyeglasses and/or contact lenses unless indicated on the attached Schedule of Benefits. Benefits are not available for radial keratotomy and other intended procedures to correct eyesight. However, eyeglasses and/or contact lenses used solely for treatment of keratoconus or in post-cataract surgery for aphakia cases shall be covered.

Experimental and/or Investigational Treatments and Procedures – Benefits are not available for services, supplies, procedures and items considered to be investigational or experimental. A drug, device, procedure, or treatment will be determined to be experimental if any of the following applies:

- There are insufficient outcomes data available from controlled clinical trials published in the peer-reviewed literature to substantiate its safety and effectiveness for the disease or injury involved;
- The FDA has not granted the required approval for general use;
- A recognized national medical or dental society or regulatory agency has determined in writing that it is experimental, investigational or for research purposes;
- The written protocols or informed consent used by the treating facility or the protocols or informed consent of any other facility studying substantially the same drug, device, procedure, or treatment state that it is experimental, investigational or for research purposes.

Also, the Fund does not cover any Technology or any hospitalization in connection with such Technology if, in HIP’s sole judgment, such Technology is obsolete or ineffective and is not used generally by the medical community for the diagnosis or treatment of the particular condition. Governmental approval of a Technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a diagnosis or treatment of a particular condition.

If HIP has denied coverage on the basis that the service is an experimental or investigational treatment, the Member or his or her representative may appeal that decision to an External Appeal Agent, an entity certified by the State of New York to conduct such appeals. If the External Appeal Agent approves coverage of an experimental or investigational treatment that is part
of a clinical trial, HIP will only cover the costs of services required to provide treatment to the Member according to the design of the trial. HIP will not be responsible for the costs of managing research, or costs that would not be covered under this Fund for non-experimental or non-investigational treatments. For additional information on External Appeals, see page 72.

**Free Care and Care Provided by Family Members** – Benefits are not available for any care if the care is furnished to the Member without charge or would normally be furnished to the Member without charge if he or she were not covered under Fund or under any other insurance. No benefits are provided for services rendered by an immediate family member of a person covered under this Fund.

**Government Hospital** – Benefits are not available for care in any Hospital or other institution which is owned, operated or maintained by the federal government, a state government, or any local government, unless the Hospital is a Participating Hospital. However, this exclusion does not apply to the United States Veterans Administration or Department of Defense hospitals, except for care provided in connection with a service-related disability. In addition, benefits are provided for care covered under this Fund in such a Hospital if, because of an Emergency Medical Condition, if the Member is taken to one of these Hospitals for emergency care. In this instance, HIP will continue to cover services only for as long as emergency care, in HIP’s sole judgment, is Medically Necessary and Appropriate and it is not possible for the Member to be transferred to a Participating Hospital.

**Government Programs** – Benefits are not available for any service that is covered, and payment is therefore available to the Member, under any federal, state or local government program, except that HIP will pay even though the Member is eligible for Medicaid.

**Hearing Aids** – Benefits are not available for hearing aids. However, cochlear implants are covered when Medically Necessary and Appropriate.

**Home Hemodialysis** – Benefits are not available for any furniture, plumbing, electrical or other fixtures needed to perform dialysis treatments at home. Only home peritoneal dialysis is covered.

**Home Oxygen Equipment** – Benefits are not available for certain home oxygen equipment items including, but not limited to, emergency oxygen inhalators, portable preset oxygen units and oxygen administration equipment.

**Immunizations** – Benefits are not available for immunizations including, but not limited to, autogenous vaccines and adult immunizations related to foreign travel. Coverage is provided for childhood immunizations, pneumococcal and flu vaccinations, and immunizations required because of an injury or immediate risk of infection.
Learning Disorders – Benefits are not available for learning disorders including special education, vocational rehabilitation, neuropsychological testing, braille teaching, sleep therapy, behavioral training, employment counseling, psychological counseling and educational therapy for conditions related to the learning disorders or developmental delays, including, but not limited to conditions such as mental retardation, attention deficit disorder (ADD), attention deficit hyperactivity disorder (ADHD), pervasive deficit disorder (PDD), and dyslexia.

Medical Necessity – Benefits are not available for any service, supply, diagnostic test, surgical procedure or treatment which HIP, in its sole discretion, determines is not Medically Necessary and Appropriate.

If HIP has denied coverage on the basis that the service is not Medically Necessary, the Member or his or her representative may appeal that decision to an External Appeal Agent, an entity certified by the State of New York to conduct such appeals. If an External Appeal Agent overturns the denial, HIP will cover the procedure, treatment, service, pharmaceutical product or durable medical equipment for which coverage had been denied, to the extent that the procedure, treatment, service, pharmaceutical product or durable medical equipment is otherwise covered under the terms of the Fund. For additional information on External Appeals, see page 72.

No-Fault Automobile Insurance – Benefits are not available for any service that is covered by mandatory automobile no-fault benefits. HIP will not provide any benefits even if the Member does not claim the benefits he or she is eligible to receive under the no-fault automobile insurance.

Non-Participating Providers – Except in Emergencies, or as indicated in this booklet or on the Schedule of Benefits, Members are entitled to benefits for services only when provided or arranged by the PCP as described on page 32, or other treating Physician.

Nutrition – Benefits are not available for nutritional services, all supplements (unless they are the sole source of nutrition) or nutrition replacement products that are primarily intended for weight control, diet or weight-reduction programs including, but not limited to diet clinics or the diet clinic’s required lab work and X-rays, physician visits, and any testing performed in relation to a liquid protein or other diet, except for diabetes self-management education.

Orthognathic Surgery – Benefits are not available for development or occlusion-only related treatment that is not considered medically necessary; reconstruction for ridge atrophy or dental alveolar loss; treatment for mandibular prognathism, retrognathism, or asymmetry not considered medically necessary; treatment for maxillary hyperplasia, hypoplasia, asymmetry or
apertognathia not considered Medically Necessary; surgical augmentation for orthodontics; orthognathic surgery to correct non-Medically Necessary malocclusions or for cosmetic reasons; pre-prosthetic surgery: surgical preparation of the mouth for the insertion of dentures to include jaw augmentation or implants.

**Pharmacy** – Benefits are not available for prescription drugs, except medications administered in the course of covered treatment by the Member’s Physician during an office visit and immunosuppressive drugs for one (1) year after a covered organ transplant and drugs administered in the course of covered treatment.

**Photography** – Benefits are not available for photographs, slides, movies or video tapings and services of medical photographers even when required to make a benefit determination.

**Physical Examinations** – Benefits are not available for physical examinations in order to obtain employment or insurance, for medical research, or for camp, school, immigration, fitness and other programs.

**Routine Foot Care** – Benefits are not available for routine, non-diabetic related foot care, including, but not limited to, simple trimming, cutting, or clipping of the distal nail plate and treatment of corns and calluses.

**Temporomandibular Joint (TMJ) Syndrome** – Benefits are not available for any diagnostic studies or treatment in connection with temporomandibular joint syndrome (TMJ) or disease, except treatment that is considered Medically Necessary and/or is incidental to or follows surgery from external trauma, infection or other diseases of the part of the body involved.

**Transportation** – Benefits are not available for transportation for reasons not related to an Emergency Medical Condition. There is no benefit for ambulance service, amбуlette service, transfers, or transport for patient or family convenience.

**Unapproved Services** – HIP will not provide benefits for any service or care unless treatment is performed, prescribed, approved in advance or referred by the PCP and/or HIP or its designee, unless otherwise indicated.

**Workers’ Compensation** – No benefits are available for any injury, condition or disease if payment is available to the Member under a Workers’ Compensation Law or similar legislation. HIP will not provide benefits even if the Member does not claim the benefits he or she is eligible to receive under the Workers’ Compensation Law.
The following services, treatments and benefits are also excluded under this Plan:

- Services required for a condition arising out of participation in a felony, riot or insurrection.
- Foot orthotics.
- Services required by participation in a war or act of war, whether declared or undeclared or by international armed conflict.
- Surgery or any related care (or after-care) in connection with gender transformation.
- Services and supplies related to infertility treatment, including but not limited to artificial insemination, reversal of sterilization (male or female), any costs related to donors or semen banks, in-vitro fertilization or other artificial means of conception, except that treatment for conditions that result in infertility are covered.
- Private room. If you occupy a private room, you will have to pay the difference between the Hospital's charges for a private room and the Hospital's most common charge for semi-private accommodations, unless a private room is medically necessary for a benefit covered by the plan.
- Private duty nursing (unless provided during a hospital admission that is covered under the Certificate of Coverage and the Private Duty Nursing Amendment Rider)
- Non-medical items, such as television rental and telephone charges.
- Medications, supplies and equipment that you take home from the Hospital or other facility.
- Any expense incurred for staying in the Hospital after the discharge time or date established by HIP or your Physician.
- Care for the sole purpose of obtaining a non-covered benefit.

Hospice Care Services do not include the following:

- Services of a person who is the patient's family member or who normally resides in the patient's house;
- Services or supplies not listed in the Hospice Care Program;
- Services for which any other benefits are available under this Certificate.
- Services or supplies that are primarily to aid the patient or patient's family in daily living;
- Services for respite care;
- Nutritional supplements, non-prescription drugs or substances, vitamins or minerals and prescription drugs not provided by the Hospice Program.
- Charges for claims containing misrepresentations or false, incomplete or misleading information.

See General Information.
SECTION III – GENERAL INFORMATION

A. Your ERISA Rights
B. Plan Amendment, Modification, and Termination
C. Authority of the Plan Administrator
D. Information on Your Plan
SECTION III. A
YOUR ERISA RIGHTS

You have certain rights and protection under the Employee Retirement Income Security Act of 1974, as amended (ERISA).

GETTING INFORMATION

You have the right to:

- Examine, without charge, at the Fund office, all required Fund documents, including collective bargaining agreements, insurance contracts, detailed annual reports (Form 5500 series) and descriptions.
- Obtain copies of all required Fund documents, such as insurance contracts, collective bargaining agreements, copies of the latest annual report (Form 5500 Series) and summary plan description, and any other Fund information by writing to the Fund Administrator. The Fund Administrator can make a reasonable charge for copies.
- Receive a summary of the Fund’s Annual Financial Report. The Fund Administrator is required by law to provide each member with a copy of this Summary Annual Report. Union and Fund periodicals may be used for this purpose.

CONTINUE GROUP HEALTH PLAN COVERAGE

You have the right to:

- Continue healthcare coverage for yourself if there is a loss of coverage under the Plan as a result of a qualifying event. You may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.
- Reduce or eliminate the exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a Certificate of Creditable Coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.
**FIDUCIARY RESPONSIBILITY**

In addition to creating rights for Fund participants, ERISA imposes duties on the people responsible for operating the Fund, called “fiduciaries.”

The fiduciaries have a responsibility to operate the Fund prudently and in the interest of all Fund members.

No one, including your employer, your union, or any other person, may fire you or discriminate against you in any way to prevent you from obtaining a benefit from this Fund or from otherwise exercising your rights under ERISA.

If your claim for benefits is entirely or partially denied:

- You must receive a written explanation of the reason for the denial, obtain copies of documents relating to the decision without charge, and

- You have the right to have HIP review and reconsider your claim, using the appeal procedure on pages 72-83.

**ENFORCING YOUR RIGHTS**

Under ERISA, there are steps you can take to enforce your rights:

- If you request a copy of plan documents or the latest annual report from the Plan and you do not receive them within 30 days, you may file suit in Federal Court. In this case, the court may require the Plan Administrator to provide the documents and possibly pay you up to $110 a day until you receive the materials, unless the documents were not sent because of reasons beyond the control of the Plan Administrator.

- If you have a claim for benefits which is entirely or partially denied or ignored, you may file suit in a State or Federal Court, after you have completed the Appeals procedure (see pages 72-83), if you believe that the decision against you is arbitrary and capricious.

- If you disagree with the Plan’s decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal Court.

- If it should happen that the Fund’s fiduciaries misuse the Fund’s money or if you are discriminated against for asserting your rights, you may get help from the U.S. Department of Labor, or you may file suit in a Federal Court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order that you be paid these costs and fees. If you lose, the court may require you to pay these costs and fees (for example, if it finds your claim is frivolous).
QUESTIONS?

If you have any questions about:

• Your Fund, contact the Fund office at (646) 473-9200.

• Your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator contact the nearest area office of the U.S. Department of Labor, Employee Benefits Security Administration, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the Publications Hotline of the Employee Benefits Security Administration.
SECTION III. B
PLAN AMENDMENT, MODIFICATION AND TERMINATION

The Plan Administrator reserves the right, within its sole and absolute discretion, to amend, modify or terminate, in whole or in part, any or all of the provisions of this Plan (including any related documents and underlying policies), at any time and for any reason, by action of the Board of Trustees, or any duly authorized delegate of the Board of Trustees, in such manner as may be duly authorized by the Board of Trustees.

Neither you, your beneficiaries, or any other person have or will have a vested or nonforfeitable right to receive benefits under the Fund.
SECTION III. C
AUTHORITY OF THE PLAN ADMINISTRATOR

Notwithstanding any other provision in the Plan, and to the full extent permitted by ERISA and the Internal Revenue Code, the Plan Administrator shall have the exclusive right, power and authority, in its sole and absolute discretion:

- To administer, apply, construe and interpret the Plan and any related Plan documents;
- To decide all matters arising in connection with entitlement to benefits, the nature, type, form, amount and duration of benefits and the operation or administration of the Plan;
- To make all factual determinations required to administer, apply, construe and interpret the Plan (and all related Plan documents).

The Fund does not cover claims containing misrepresentations or false, incomplete or misleading information. If a false or fraudulent claim is filed, the Fund may seek full restitution plus interest and reimbursement of any expenses incurred by the Fund. In addition, the Fund may suspend the benefits to which the participant and his or her dependents(s) would otherwise be entitled until full restitution has been made. The Trustees reserve the right to turn any such matter over to the proper authorities for prosecution.

Without limiting the generality of the statements above, the Plan Administrator shall have the ultimate discretionary authority to:

(i) Determine whether any individual is eligible for any benefits under this Plan;
(ii) Determine the amount of benefits, if any, an individual is entitled to under this Plan;
(iii) Interpret all of the provisions of this Plan (and all related Plan documents);
(iv) Interpret all of the terms used in this Plan;
(v) Formulate, interpret and apply rules, regulations and policies necessary to administer the Plan in accordance with its terms;
(vi) Decide questions, including legal or factual questions, relating to the eligibility for, or calculation and payment of, benefits under the Plan;
(vii) Resolve and/or clarify any ambiguities, inconsistencies and omissions arising under the Plan or other related Plan documents; and
(viii) Process and approve or deny benefit claims and rule on any benefit exclusions.
All determinations made by the Plan Administrator (or any duly authorized designee thereof) and/or the Appeals Committee with respect to any matter arising under the Plan and any other Plan documents shall be final and binding on all parties.
SECTION III. D
INFORMATION ON YOUR PLAN

NAME OF THE PLAN
The 1199SEIU Home Health Aide Benefit Fund

TYPE OF PLAN
Taft-Hartley (Union-Employer) Jointly-Trusteed Employee Welfare Benefit Fund

ADDRESSES
Headquarters:
330 West 42nd Street
New York, NY 10036

SOURCE OF INCOME
Payments are made to the Fund by your employer and other contributing employers, according to the collective bargaining agreements with 1199SEIU National Health and Human Service Employees Union, AFL-CIO.

Contribution rates are set forth in the applicable collective bargaining agreements.

You may receive a copy of any collective bargaining agreement by writing to the Fund Administrator, or by examining a copy at the Fund office.

You can find out if a particular employer or employee organization is a plan sponsor, the address of the sponsor will also be given.

ACCUMULATION OF ASSETS
The Fund’s resources are held in interest bearing accounts to pay benefits and expenses.

PLAN YEAR
The Fund’s fiscal year is January 1 to December 31.

PLAN ADMINISTRATOR
Benefits are provided through a contract with HIPIC of NY. The Plan Administrator consists of the Home Health Aide Plan Board and its duly authorized delegates and subordinates, including, but not limited to, the Executive Director, and other senior employees.

The Trustees and the Home Health Aide Trustees may be contacted:
c/o Executive Director
1199SEIU Home Health Aide Benefit Fund
330 West 42nd Street
New York, NY 10036
FOR SERVICE OF LEGAL PROCESS
Legal papers may be served on the Fund Trustees or the Fund’s Counsel.

IDENTIFICATION NUMBERS
Employer Identification Number:
56-2299294

FUND’S PLAN NUMBER:
502

TRUSTEES
The Home Health Aide Plan Board is composed of an equal number of Union and Employer Home Health Aide Plan Trustees. Employer Home Health Aide Plan Trustees are elected by the Employers.

Union Home Health Aide Trustees are chosen by the Union. The Home Health Aide Trustees of the Fund are:

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<thead>
<tr>
<th>UNION TRUSTEES</th>
<th>EMPLOYER TRUSTEES</th>
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<tbody>
<tr>
<td>Aida Garcia</td>
<td>Michael Elsas</td>
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<tr>
<td>Executive Vice President</td>
<td>President</td>
</tr>
<tr>
<td>1199SEIU</td>
<td>Cooperative Home Care Associates</td>
</tr>
<tr>
<td>United Healthcare Workers East</td>
<td>349 East 149th Street</td>
</tr>
<tr>
<td>New York, NY 10036</td>
<td>Bronx, NY 10451</td>
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<tr>
<th>Keith Joseph</th>
<th>Elliott Greene</th>
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<tr>
<td>Vice President</td>
<td>Progressive Home Health Services</td>
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<tr>
<td>1199SEIU</td>
<td>132 West 31st Street</td>
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<tr>
<td>United Healthcare Workers East</td>
<td>New York, NY 10001</td>
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