NEW YORK STATE MEDICAID MANAGED CARE MODEL MEMBER HANDBOOK

REVISED FOR 2010

Revised January 2009

HERE'S WHERE TO FIND INFORMATION YOU WANT

WELCOME to [Insert Plan Name]'s Medicaid Managed Care Program

We are glad that you chose [Insert Plan Name]. We want to be sure you get off to a good start as a new member. In order to get to know you better, we will get in touch with you in the next two or three weeks. You can ask us any questions you have, or get help making appointments. If you need to speak with us before we call on you, however, just call us at [Insert Member Services Toll-Free Number].

HOW MANAGED CARE WORKS

The Plan, Our Providers, and You

- No doubt you have seen or heard about the changes in health care. Many consumers now get their health benefits through managed care. Many counties in New York State, including New York City, offer a choice of managed care health plans. In some counties, people with Medicaid must join a health care plan. Such counties operate a mandatory managed care program. Other counties allow Medicaid consumers to choose whether they want to join managed care. These counties operate a voluntary Medicaid managed care program. Both programs, though, allow for some people to keep getting care through regular Medicaid.

  [Plans using one handbook for multiple service areas should be specific regarding the enrollment status of each service area.]

- [Insert Plan Name] members who live in _____ [Insert name of counties] County, are in a voluntary Medicaid managed care program.

- [Insert Plan Name] members who live in _____ [Insert name of counties] County, are in a mandatory Medicaid managed care program.

[Insert Plan Name] has a contract with the State Department of Health. [For Medicaid in NYC, use "New York City Department of Health and Mental Hygiene" instead of State Department of Health] to meet the health care needs of people with Medicaid. In turn, we choose a group of health care providers to help us meet your needs. These doctors and specialists, hospitals, labs and other health care facilities make up our **provider network**. You'll find a list in our provider directory. If you don't have a provider directory, call [Insert Member Services Toll-Free Number] to get a copy.

- When you join [Insert Plan Name] one of our providers will take care of you. Most of the time that person will be your PCP (Primary Care Provider). If you need to have a test, see a specialist, or go into the hospital, your PCP will arrange it. Your PCP is available to you everyday, day and night. If you need to speak to him or her after hours or weekends, leave a message and how you can be reached. Your PCP will get back to you as soon as possible. Even though your PCP is your main source for health care, in some cases, you can self-refer to certain doctors for some services. See page [Insert correct page reference] for details.

HOW TO USE THIS HANDBOOK

- Whether you have to join or you choose to join a managed care plan, this handbook will help. It will tell you how your new health care system will work and how you can get the most from [Insert Plan Name]. This handbook is your guide to health services. It tells you the steps to take to make the plan work for you.

  The first several pages will tell you what you need to know **right** away. The rest of the handbook can wait until you need it. Use it for reference or check it out a bit at a time.

  When you have a question, check this Handbook or call our Member Services unit. You can also call the managed care staff at your local Department of Social Services.

  [For Health Plans that serve counties and/or New York City that use the enrollment broker, use the following language:] If you live in **[List plan's service areas that are served by New York Medicaid CHOICE]** County(ies), you can also call the New York Medicaid CHOICE HelpLine at 1-800-505-5678.

HELP FROM MEMBER SERVICES

There is someone to help you at Member Services:
Insert days, hours and toll-free phone number for member services.
Health plans must be sure to include the TTY phone number here.
Also insert instructions as to how to reach the plan during non-business hours and how those calls will be handled or returned.

- You can call to get help **anytime you have a question.** You may call us to choose or change your Primary Care Provider (PCP for short), to ask about benefits and services, to get help with referrals, to replace a lost ID card, to report the birth of a new baby or ask about any change that might affect you or your family's benefits.

- If you are or become pregnant, your child will become part of [Insert Plan Name] on the day he or she is born. This will happen unless your newborn child is in a group that cannot join managed care. You should call us and your LDSS right away if you become pregnant and let us help you to choose a doctor for your **newborn baby** before he or she is born.

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

- **If you do not speak English**, we can help. We want you to know how to use your health care plan, no matter what language you speak. Just call us and we will find a way to talk to you in your own language. We have a group of people who can help. We will also help you find a PCP (Primary Care Provider) who can serve you in your language.

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

    - TTY machine (Our TTY phone number is [Insert the health plan TTY number]).
    - Information in Large Print
    - Case Management
    - Help in Making or Getting to Appointments
    - Names and Addresses of Providers Who Specialize in Your Disability

YOUR HEALTH PLAN ID CARD

After you enroll, we'll send you a welcome letter. Your [Insert Plan Name] ID card should arrive within 14 days after your enrollment date. Your card has your PCP's (primary care provider's) name and phone number on it. It will also have your Client Identification Number (CIN). If anything is wrong, call us right away. Carry your ID card at all times and show it each time you go for care. If you need care before the card comes, your welcome letter is proof that you are a member. You should keep your Medicaid benefit card. You will need the card to get services that [Insert plan name] does not cover. These services include pharmacy benefits (include **dental** if not covered by the plan).

PART I FIRST THINGS YOU SHOULD KNOW

HOW TO CHOOSE YOUR PCP

- You may have already picked your PCP (Primary Care Provider) to serve as your regular doctor. This person could be a doctor or a nurse practitioner. **If you have not chosen a PCP for you and your family, you should do so right away.** If you do not choose a doctor within 30 days, we will choose one for you. Each family member can have a different PCP, or you can choose one PCP to take care of the whole family. A pediatrician treats children. Family practice doctors treat the whole family. Internal medicine doctors treat adults. Member Services can help you choose a PCP.

- With this Handbook, you should have a provider directory. This is a list of all the doctors, clinics, hospitals, labs, and others who work with [Insert Plan Name]. It lists the address, phone, and special training of the doctors. The provider directory will show which doctors and providers are taking new patients. You should call their offices to make sure that they are taking new patients at the time you choose a PCP.

  You may want to find a doctor:

  - whom you have seen before,
  - who understands your health problems,
  - who is taking new patients,
  - who can serve you in your language, or
  - who is easy to get to.

- Women can also choose one of our OB/GYN doctors to deal with women's health issues.
  [NOTE: Use if plan allows separate selection of OB/GYN]
  Women do not need a PCP referral to see a plan OB/GYN doctor. They can have routine check ups (twice a year), follow-up care if there is a problem, and regular care during pregnancy.

- We also contract with FQHCs (Federally Qualified Health Centers). All FQHCs give primary and specialty care. Some consumers want to get their care from FQHCs because the centers have a long history in the neighborhood. Maybe you want to try them because they are easy to get to. You should know that you have a choice. You can choose any one of the providers listed in our directory. Or you can sign up with a primary care physician at one of the FQHCs that we work with, listed below. Just call Member Services at [Insert member services toll free number] for help.

  [List available FQHCs here]

ALTERNATE LANGUAGE: If not contracting with FQHCs:

- FQHCs (Federally Qualified Health Centers) give primary and specialty care. Some people want to get their care from FQHCs because the centers have a long history in the neighborhood. Besides primary and specialty care, FQHCs have social support services, case management, and classes to help you stop smoking, control diabetes, or lose weight. We have all these services too, but if you decide you want to get your care from a FQHC, you can disenroll from our health plan at any time.. For information, call **[Insert Plan's toll free number]**.

- In almost all cases, your doctors will be [Insert Plan Name] providers. In some cases you can continue to see another doctor that you had before you joined [Insert Plan Name], even if he or she does not work with our plan. You can continue to see your doctor if:

  - You are more than 3 months pregnant when you join and you are getting prenatal care. In that case, you can keep your doctor until after your delivery and follow up care.
  - At the time you join, you have a life threatening disease or condition that gets worse with time. In that case, you can ask to keep your doctor for up to 60 days.

  In both cases, however, your doctor must agree to work with [Insert Plan Name].

- If you have a long-lasting illness, like HIV/AIDS or other long term health problems, you may be able to **choose a specialist to act as your PCP (primary care provider).** [Plans must describe the process for choosing a specialist as PCP.]

- If you need to, you can **change your PCP** in the first 30 days after your first appointment with your PCP. After that, you can change [Insert Plan policies and procedures, and frequency, for allowing PCP changes, up to once every six months. Plans may allow changes more often than every six months.] without cause, or more often if you have a good reason. You can also change your OB/GYN or a specialist to which your PCP has referred you.

- If your **provider leaves [Insert Plan Name]**, we will tell you within 15 days from when we know about this. If you wish, you may be able to see that provider **if** you are more than three months pregnant or if you are receiving ongoing treatment for a condition. If you are pregnant, you may continue to see your doctor for up to 60 days after delivery. If you are seeing a doctor regularly for an ongoing condition, you may continue your present course of treatment for up to 90 days. Your doctor must agree to work with the Plan during this time. If any of these conditions apply to you, check with your PCP or call Member Services at [Insert Member Services number].

HOW TO GET REGULAR CARE

- Regular care means exams, regular check-ups, shots or other treatments to keep you well, give you advice when you need it, and refer you to the hospital or specialists when needed. It means you and your PCP working together to keep you well or to see that you get the care you need. Day or night, your PCP is only a phone call away. Be sure to call him or her whenever you have a medical question or concern. If you call after hours or weekends, leave a message and where or how you can be reached. Your PCP will call you back as quickly as possible. Remember, your PCP knows you and knows how the health plan works.

- Your care must be **medically necessary.** The services you get must be needed:
    1. to prevent, or diagnose and correct what could cause more suffering, or
    2. to deal with a danger to your life, or
    3. to deal with a problem that could cause illness, or
    4. to deal with something that could limit your normal activities.

- Your PCP will take care of most of your health care needs, but you must have an appointment to see your PCP. If ever you can't keep an appointment, call to let your PCP know. If you can, prepare for your first appointment. As soon as you choose a PCP, call to make a first appointment. Your PCP will need to know as much about your medical history as you can tell him or her. Make a list of your medical background, any problems you have now, and the questions you want to ask your PCP. In most cases, your first visit should be within three months of your joining the plan.

- If you need care before your first appointment, call your PCP's office to explain the problem. He or she will give you an earlier appointment. (You should still keep the first appointment.)

- Use the following list as an **appointment guide for our limits on how long you may have to wait after your request for an appointment:**

    - adult baseline and routine physicals: within 12 weeks
    - urgent care: within 24 hours
    - non-urgent sick visits: within 3 days
    - routine, preventive care: within 4 weeks
    - first pre-natal visit: within 3 weeks during 1^{nt} trimester (2 weeks during 2nd, 1 week during 3rd)
    - first newborn visit: within 2 weeks of hospital discharge
    - first family planning visit: within 2 weeks
    - follow-up visit after mental health/substance abuse ER or inpatient visit: 5 days
    - non-urgent mental health or substance abuse visit: 2 weeks .

HOW TO GET SPECIALTY CARE AND REFERRALS

- If you need care that your PCP cannot give, he or she will REFER you to a specialist who can. If your PCP refers you to another doctor, we will pay for your care. Most of these specialists are plan providers. Talk with your PCP to be sure you know how referrals work. If you think a specialist does not meet your needs, talk to your PCP. Your PCP can help you if you need to see a different specialist. There are some treatments and services that your PCP must ask [Insert Plan Name] to approve *before* you can get them. Your PCP will be able to tell you what they are.
- If we do not have a specialist in [Insert Plan Name] who can give you the care you need, we will get you the care you need from a specialist outside [Insert Plan Name]. [Insert plan-specific process for how members request care from a specialist outside the network. Include the timeframes for resolving the request for out-of-network specialists, the process for appeal, the required documentation, and a phone number for the member to use to contact the plan regarding the request. Include information needed to file a UR appeal for a decision that the out-of-network service requested is not materially different from an alternate in-network service.)] If your PCP or [Insert plan name] refers you to a provider outside our network, you are not responsible for any of the costs except any co-payments as described in this handbook.
- Plans must indicate whether there are any limitations on accessing the entire approved network, if applicable, other than standard referral process.
- If you need to see a specialist for ongoing care, your PCP may be able to refer you for a specified number of visits or length of time (a **standing referral**). If you have a standing referral, you will not need a new referral for each time you need care.
- If you have a long-term disease or a disabling illness that gets worse over time, your PCP may be able to arrange for:
  - your specialist to act as your PCP; or
  - a referral to a specialty care center that deals with the treatment of your problem.

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

GET THESE SERVICES FROM [INSERT PLAN NAME] WITHOUT A REFERRAL

Women's Services

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

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

Family Planning [Only include here if Family Planning is covered by the plan.]

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

You do not need a referral from your PCP to get these services. In fact, you can choose where to get these services. You can use your [Insert Plan Name] ID card to see one of [Insert Plan Name]'s family planning providers. Check the plan's Provider Directory or call Member Services for help in finding a provider. Or, you can use your Medicaid card if you want to go to a doctor or clinic outside [Insert Plan Name]. Ask your PCP or call Member Services at [Insert Member Services Number] for a list of places to go to get these services. You can also call the New York State Growing Up Healthy Hotline (1-800-522-5006) for the names of family planning providers near you.

[ALTERNATIVE LANGUAGE for plans that <u>don't cover</u> family planning]

This plan does not cover family planning and reproductive health services such as birth control services, sterilizations and abortions. You can get these services from any doctor or clinic that provides them and who takes Medicaid. Just use your Medicaid card. You don't need a referral from your PCP. Ask your PCP for a list of places to get these services or call Member Services at [Insert Member Services Number]. You can also call the New York State Growing Up Healthy Hotline (1-800-522-5006) for nearby places to get these services.

HIV counseling and testing [Only include here if Family Planning is covered by the plan]

- You can get HIV testing and counseling any time you have family planning services. You do not need a referral from your PCP (primary care provider). Just make an appointment with one of our family planning providers.
- Or, if you'd rather not see one of [Insert Plan Name]'s providers, you can use your Medicaid card to see a family planning provider outside [Insert Plan Name]. For help in finding either a Plan provider or a Medicaid provider for family planning services, call Member Services at [Insert Member Services number].
- If you want HIV testing and counseling but *not as part of a family planning service*, your PCP can arrange it for you. Or you can visit an anonymous HIV testing and counseling site. For information, call the New York State HIV Counseling Hotline at 1-800-872-2777 or 1-800-541-AIDS.
- If you need HIV treatment after the testing and counseling service, your PCP will help you get follow-up care.

[ALTERNATE TEXT for plans that do not offer family planning]

- [Insert Plan Name] does not provide family planning services. If you want HIV testing and counseling as part of family planning services, you must use your Medicaid card to see a family planning provider outside that takes Medicaid. For help in finding a Medicaid family planning provider, call Member Services at [Insert Member Services Number].

- You can get HIV testing and counseling without family planning. You can visit an anonymous testing and counseling site. To get more information about anonymous sites, call the New York State HIV Counseling Hotline at 1-800-872-2777 or 1-800-541-AIDS. Or you can use your [Insert Plan Name] ID card and ask your PCP to arrange it.
- If you need HIV treatment after the testing and counseling service, your PCP will arrange it.

Eye Care

The covered benefits include the needed services of an ophthalmologist, optometrist and an ophthalmic dispenser, and include an eye exam and pair of eyeglasses, if needed. Generally, you can get these once every two years, or more often if medically needed. Enrollees diagnosed with diabetes may self-refer for a dilated eye (retinal) examination once in any twelve (12) month period. You just choose one of our participating providers. New eyeglasses (with Medicaid approved frames) are usually provided once every two years. New lenses may be ordered more often, if, for example, your vision changes more than one-half diopter. If you break your glasses, they can be repaired. Lost eyeglasses, or broken eyeglasses that can't be fixed, will be replaced with the same prescription and style of frames. If you need to see an eye specialist for care of an eye disease or defect, your PCP will refer you.

Mental Health / Chemical Dependence (including alcohol and substance abuse)

You may go for one mental health assessment without a referral in any 12 month period. You must use a [Insert Plan Name] provider, but you do not need an OK from your PCP. You may also go for one chemical dependence assessment for all inpatient detoxification, inpatient rehabilitation, or outpatient detoxification services, without a referral in any 12 month period. If you need more visits, your PCP will help you get a referral. If you want a chemical dependence assessment for any alcohol and/or substance abuse outpatient treatment services, except outpatient detoxification services, you must use your Medicaid Benefit card to go to any provider that takes Medicaid.

Emergencies

You are always covered for emergencies.
An emergency means a medical or behavioral condition:

- that comes on all of a sudden, and
- has pain or other symptoms.

This would make a person with an average knowledge of health fear that someone will suffer serious harm to body parts or functions or serious disfigurement without care right away.
Examples of an emergency are:

- a heart attack or severe chest pain
- bleeding that won't stop or a bad burn
- broken bones
- trouble breathing, convulsions, or loss of consciousness
- when you feel you might hurt yourself or others

- if you are pregnant and have signs like pain, bleeding, fever, or vomiting

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

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

- **If you're not sure, call your PCP or [Insert Plan Name].**
  Tell the person you speak with what is happening. Your PCP or member services representative will:
  - tell you what to do at home,
  - tell you to come to the PCP's office, or
  - tell you to go to the nearest emergency room.

- If you are **out of the area** when you have an emergency:
  - Go to the nearest emergency room.

> **Remember**
> **You do not need prior approval for emergency services. Use** the emergency room **only** if you have an **Emergency.**
>
> **The Emergency Room should NOT be used for problems like the flu, sore throats, or ear infections.**
>
> If you have questions, call your PCP or [Insert Plan Name] at [Insert Member Services Number].

Urgent Care

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

- This could be a child with an ear ache who wakes up in the middle of the night and won't stop crying.
- It could be a sprained ankle, or a bad splinter you can't remove.

You can get an appointment for an urgent care visit for the same or next day. Whether you are at home or away, call your PCP any time, day or night. If you cannot reach your PCP, call us at [Insert Member Services Number]. Tell the person who answers what is happening. They will tell you what to do.

WE WANT TO KEEP YOU HEALTHY

Besides the regular check ups and the shots you and your family need, here are some other ways to keep you in good health:

- Classes for you and your family
- Stop-smoking classes
- Pre-natal care and nutrition
- Grief / Loss support
- Breast feeding and baby care
- Stress management
- Weight control
- Cholesterol control
- Diabetes counseling and self-management training
- Asthma counseling and self-management training

Call Member Services at [Insert Member Services Number] to find out more and get a list of upcoming classes.

PART II YOUR BENEFITS AND PLAN PROCEDURES

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

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BENEFITS

Medicaid managed care provides a number of services you get in addition to those you get with regular Medicaid. [Insert Plan Name] will provide or arrange for most services that you will need. You can get a few services, however, without going through your PCP. These include emergency care; family planning/HIV testing and counseling; and specific self referral services, including those you can get from within the plan and some that you can choose to go to any Medicaid provider of the service.

SERVICES COVERED BY [INSERT PLAN NAME]

You must get these services from the providers who are in [Insert Plan Name]. All services must be medically necessary and provided or referred by your PCP (primary care provider).

Regular Medical Care

- office visits with your PCP
- referrals to specialists
- eye / hearing exams

Preventive Care

- well-baby care
- well-child care
- regular check-ups
- shots for children from birth through childhood

Maternity Care

- pregnancy care
- doctors/mid-wife and hospital services
- newborn nursery care
- smoking cessation counseling for pregnant women

Home Health Care (must be medically needed and arranged by [Insert Plan Name])

- at least 2 visits to high-risk infants (newborns)
- visit to women who stay in the hospital less than 48 hours after birth
- visit to women who stay in the hospital less than 96 hours after a Cesarean birth

- other home health care visits as needed and ordered by your PCP/specialist

Dental Care [Include in this section when dental services are covered by the plan.]

(Plan Name) believes that providing you with good dental care is important to your overall health care. We offer dental care through a contract with (Name of Dental Vendor), an expert in providing high quality dental services; or We offer dental care through contracts with individual dentists who are experts in providing high quality dental services. Covered services include regular and routine dental services such as preventive dental check-ups, cleaning, x-rays, fillings and other services to check for any changes or abnormalities that may require treatment and/or follow-up care for you. *You do not need a referral from your PCP to see a dentist!*

How to Access Dental Services:
[Describe the process the member uses to access dental services. State whether the member will be assigned a primary care dentist (PCD) with the option of selecting an alternate network dentist (include the timeframe, if any, for changing PCD) OR state whether the member may see any dentist in the provider's network.]

- If you need to find a dentist or change your dentist, please call (Name of Dental Vendor) at (800 number) or please call (Name of Plan and (800 number). Customer Services Representatives are there to help you. Many speak your language or have a contract with language Line Services.

Note: **State which one of the following 2 bullets applies.**

- Show your Member ID card to access dental benefits. You will not receive a separate dental ID card. When you visit your dentist, you should show your plan ID card. or;
- You will receive a separate Dental ID card wit the name of your assigned dentist. Show your Dental ID card to access dental benefits.
- You can also self refer to a dental clinic that is run by an academic dental center.

Plans should either list academic dental centers within a (30) thirty mile radius or include toll free member services number for members to call.

Vision Care

- services of an ophthalmologist, ophthalmic dispenser and optometrist, and coverage for contact lenses, polycarbonate lenses, artificial eyes, and or replacement of lost or destroyed glasses, including repairs, when medically necessary. Artificial eyes are covered as ordered by a plan provider
- eye exams, generally every two years, unless medically needed more often
- glasses (new pair of Medicaid approved frames every two years, or more often if medically needed)
- low vision exam and vision aids ordered by your doctor
- specialist referrals for eye diseases or defects

Hospital Care

- inpatient care
- outpatient care

- lab, x-ray, other tests

Emergency Care

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

Mental Health / Chemical Dependence (including Alcohol and Substance Abuse)

- all inpatient mental health and chemical dependence services (including alcohol and substance abuse)
- most outpatient mental health services (contact plan for specifics)
- Medicaid recipients who receive SSI or who are certified blind or disabled get mental health and chemical dependence (including alcohol and substance abuse) services from any Medicaid provider by using their Medicaid Benefit Card. Detoxification services, however, are covered by [Insert Plan Name] as a benefit.

Specialty Care

Includes the services of other practitioners, including

- occupational, physical and speech therapists and audiologists
- midwives

Residential Health Care Facility Care (Nursing Home)

- when ordered by your physician and authorized by [Insert Plan Name]
- when the stay in the nursing home is not determined permanent by your LDSS
- covered nursing home services include medical supervision, 24-hour nursing care, assistance with activities of daily living, physical therapy, occupational therapy, and speech-language pathology.

Transportation [Include if covered by plan.]
Plans shall inform member of their responsibility to arrange and pay for transportation to their PCP if member elects to select a participating PCP outside of the time and distance standards.

Emergency: [Include if covered by plan.] If you need emergency transportation, call 911.

Non-Emergency: [Include if covered by plan.] [If non-emergency transportation is covered by the plan, specify the type of service provided; the name of the provider (if there is a single

contractor); the phone number to call to request the service; and if applicable, how far in advance a member needs to call to request the service. Also include the following statement:]

If you require an attendant to go with you to your doctor's appointment or if your child is the member of the plan, transportation is also covered for the attendant or parent or guardian.

If you have questions about transportation, please call Member Services at [Insert Member Services Number].

Other Covered Services

- Durable Medical Equipment (DME) / Hearing Aids / Prosthetics /Orthotics
- Court Ordered Services
- Case Management
- Help getting social support services
- FQHC **[Delete FQHC if plan does not contract with them]**
- Family Planning [Include if covered by the plan]
- Podiatry for children and persons with special problems (i.e., diabetes, etc)

Benefits You Can Get From [Insert Plan Name] or With Your Medicaid Card

For some services, you can choose where to get the care. You can get these services by using your [Insert Plan Name] membership card. You can also go to providers who will take your Medicaid Benefit card. You do not need a referral from your PCP to get these services. Call us if you have questions at [Insert Member Services Number].

Family Planning [Include here if family planning is covered by the plan.]
You can go to any doctor or clinic that takes Medicaid and offers family planning services. You can visit one of our family planning providers as well. Either way, you do not need a referral from your PCP.

HIV Testing and Counseling
You can get these services from [Insert Plan Name] doctors if you talk to your PCP first. When you get these services as part of a family planning visit, you can go to any doctor or clinic that takes Medicaid and offers family planning services. You do not need a referral when you get this service as part of a family planning visit. You can also go to anonymous counseling and testing clinics offered by the state and local health departments. To get more information about these sites, call the New York State HIV Counseling Hotline at 1-800-872-2777 or 1-800-541-AIDS.

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

Benefits Using Your MEDICAID CARD Only

There are some services [Insert Plan Name] does not provide. You can get these services from a provider who takes Medicaid by using your Medicaid Benefit card.

Pharmacy
You can get prescriptions, over-the-counter medicines, enteral formulas, and some medical supplies from any pharmacy that takes Medicaid. A co-payment may be required for some people, for some medications and pharmacy items.

Certain medications may require that your doctor get prior authorization from Medicaid before writing your prescription. Getting prior authorization is a simple process for your doctor and does not prevent you from getting medications that you need.

Family Planning [Include here if family planning is not covered by the plan.]
You can go to any Medicaid doctor or clinic that provides family planning.

Dental Services **[**Include here if dental services are not covered by the plan.]
(Plan Name), believes that providing you with good dental care is important to your overall health care. Although we do not cover dental services in our benefit package, you can still get dental care using your Medicaid Benefit Card. Medicaid covers regular and routine dental services such as preventive dental check-ups, cleaning, x-rays, fillings and other services to check for any changes or abnormalities that may require treatment and/or follow-up care for you. *You do not need a referral from your PCP to see a dentist!*

How to access Dental Services:

- You can go to any dentist who accepts Medicaid.
- If you need help finding a dentist or a dental clinic that is run by an academic dental center, call the New York State Hotline at (800) 541-2831 and they will send you a list of "dentist in your neighborhood".

Transportation [Include here if transportation services are not covered through the plan. The description must be clear if only emergent or non-emergent transportation is accessed through fee-for-service. The description must also direct member how to get information as to how to access carved-out transportation services, such as the phone number(s) for the local Department of Social Services or direction to refer to the last page of this handbook if those phone numbers are listed there.]

Mental Health

- Intensive psychiatric rehab treatment
- Day treatment
- Intensive case management
- Partial hospital care
- Rehab services to those in community homes or in family-based treatment
- Clinic services for children with a diagnosis of Serious Emotional Disturbance (SED), at mental health clinics certified by the State Office of Mental Health

- Continuing day treatment
- All covered mental health services for people who receive SSI or who are certified blind or disabled are available by using the Medicaid benefit card.

Mental Retardation and Developmental Disabilities

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

Alcohol and Substance Abuse Services

- Methadone treatment
- Out-patient substance abuse treatment
- Out-patient alcohol rehab
- Out-patient alcohol clinic services
- Out-patient chemical dependence for youth programs
- Chemical dependence (including alcohol and substance abuse)services ordered by the LDSS
- All covered alcohol and substance abuse services (except detox) are available for people who receive SSI or who are certified blind or disabled by using their Medicaid benefit card. Detox services are available using your [Insert Plan Name] ID card.

Other Medicaid Services

- Personal care services
- Pre-school and school services programs (early intervention)
- Early start programs
- Comprehensive Medicaid Case Management program ("CMCM" program)
- TB therapy/DOT
- Adult day treatment for persons with HIV
-
- Hospice services

Services NOT Covered:

These services are **not available** from [Insert Plan Name] **or** Medicaid. If you get any of these services, you may have to pay the bill.

- Cosmetic surgery if not medically needed
- Routine foot care (for those 21 years and older)
- Personal and comfort items
- Infertility treatments

- Services from a provider that is not part of [Insert Plan Name], unless it is a provider you are allowed to see as described elsewhere in this handbook or [Insert Plan Name] or your PCP send you to that provider.
- Services for which you need a referral (approval) in advance and you did not get it.

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

- non-covered services (listed above),
- unauthorized services,
- services provided by providers not part of the Plan

If you have any questions, call Member Services at [Insert Member Services Number].

Service Authorization and Actions

Prior Authorization:

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

[List services requiring preauthorization and the process for obtaining prior authorization.]

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

[Insert instructions for submitting a service authorization request: e.g., You or your doctor may call our toll-free Member Services number at [Insert Member Services Number] or send your request in writing to [Insert Plan Address].]

You will also need to get prior authorization if you are getting one of these services now, but need to continue or get more of the care. This includes a request for home health care while you are in the hospital or after you have just left the hospital. This is called **concurrent review**.

What happens after we get your service authorization request**:**

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

Any decision to deny a service authorization request or to approve it for an amount that is less

than requested is called an **action**. These decisions will be made by a qualified health care professional. If we decide that the requested service is not medically necessary, the decision will be made by a clinical peer reviewer, who may be a doctor or may be a health care professional who typically provides the care you requested. You can request the specific medical standards, called **clinical review criteria**, used to make the decision for actions related to medical necessity.

After we get your request we will review it under a **standard** or **fast track** process. You or your doctor can ask for a fast track review if it is believed that a delay will cause serious harm to your health. If your request for a fast track review is denied, we will tell you and your case will be handled under the standard review process. If you are in the hospital or have just left the hospital and we receive a request for home health care, we will handle the request as a fast track review. In all cases, we will review your request as fast as your medical condition requires us to do so but no later than mentioned below.

We will tell you and your provider both by phone and in writing if your request is approved or denied. We will also tell you the reason for the decision. We will explain what options for appeals or fair hearings you will have if you don't agree with our decision.

Timeframes for prior authorization requests:

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

- Fast track review: We will make a decision and you will hear from us within 3 work days. We will tell you by the third work day if we need more information.

Timeframes for concurrent review requests:

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

- Fast track review: We will make a decision within 1 work day of when we have all the information we need.

  However, if you are in the hospital or have just left the hospital, and you ask for home health care on a Friday or day before a holiday, we will make a decision no later than 72 hours of when we have all the information we need.

  In all cases, you will hear from us no later than 3 work days after we received your request. We will tell you by the third work day if we need more information.

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

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

You, your provider, or someone you trust may also ask us to take more time to make a decision. This may be because you have more information to give the plan to help decide your case. This can be done by calling [Insert appropriate toll-free health plan number] or writing to [Insert appropriate address].

You or someone you trust can file a complaint with the plan if you don't agree with our decision to take more time to review your request. You or someone you trust can also file a complaint about the review time with the New York State Department of Health by calling 1-800-206-8125.

We will notify you by the date our time for review has expired. But if for some reason you do not hear from us by that date, it is the same as if we denied your service authorization request. If you are not satisfied with this answer, you have the right to file an action appeal with us. See the Action Appeal section later in this handbook.

Other Decisions About Your Care:

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

Timeframes for notice of other actions:

- In most cases, if we make a decision to reduce, suspend or terminate a service we have already approved and you are now getting, we must tell you at least 10 days before we change the service.
- If we are checking care that has been given in the past, we will make a decision about paying for it within 30 days of receiving necessary information for the retrospective review. If we deny payment for a service, we will send a notice to you and your provider the day the payment is denied. You will not have to pay for any care you received that was covered by the plan or by Medicaid even if we later deny payment to the provider.

How Our Providers Are Paid

You have the right to ask us whether we have any special financial arrangement with our physicians that might affect your use of health care services. You can call Member Services at

[Insert Member Services number] if you have specific concerns. We also want you to know that most of our providers are paid in one or more of the following ways.

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

You Can Help With Plan Policies

We value your ideas. You can help us develop policies that best serve our members.
If you have ideas tell us about them. Maybe you'd like to work with one of our member advisory boards or committees. Call Member Services at [Insert Member Services number] to find out how you can help.

Information From Member Services

Here is information you can get by calling Member Services at [Insert Member Services number]

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

Keep Us Informed

Call Member Services whenever these changes happen in your life:

- You change your name, address or telephone number
- You have a change in Medicaid eligibility
- You are pregnant
- You give birth
- There is a change in insurance for you or your children

If you no longer get Medicaid, check with your local Department of Social Services. You **may** be able to enroll your children in Child Health Plus, even if you lose Medicaid. Adults age 19 to 64 may be able to get Family Health Plus coverage.

DISENROLLMENT AND TRANSFERS

When your county requires you to join a Medicaid health plan (a mandatory county): You can try us out for 90 days. You may leave [Insert Plan Name] and join another health plan at any time during that time. If you do not leave in the first 90 days, however, you must stay in [Insert Plan Name] for nine more months, *unless* you have a good reason (good cause).

Some examples of good cause include:

- Our health plan cannot provide a suitable primary care provider for you within acceptable travel times (if providers are routinely within 30 minutes or 30 miles from where you live).
- Our health plan does not meet New York State requirements and members are harmed because of it.
- You move out of our service area.
- You, the plan, and the LDSS all agree that disenrollment is best for you.
- You are or become exempt or excluded from managed care.
- We do not offer a Medicaid managed care service that you can get from another health plan in your area.
- You need a service that is related to a benefit we have chosen not to cover and getting the service separately would put your health at risk.
- We have not been able to provide services to you as we are required to under our contract with the State.
- We do not contract with FQHCs (Federally Qualified Health Centers) and you want to get your care from a FQHC. [Include this statement if plan does not contract with FQHCs]

When your county lets you decide to join a Medicaid health plan or not (a voluntary county): You can ask to leave the plan at any time for any reason.

To disenroll or change plans:

- Call the Managed Care staff at your local Social Services Department.

- **[Plans that serve counties and/or New York City that use the enrollment broker must use the following language as appropriate, depending upon whether the plan serves some or all of those districts that use the enrollment broker:]** If you live in [List plan's service areas that are served by New York Medicaid CHOICE] County(ies), call New York Medicaid CHOICE at 1-800-505-5678 to change health plans. The New York Medicaid CHOICE counselors can help you change health plans or disenroll.

It will take between two and six weeks to process, depending on when your request is received. You can ask for faster action if you believe the timing of the regular process will cause added damage to your health. You can also ask for faster action if you have complained because you did not agree to the enrollment. Just call your local Social Services Department or New York Medicaid CHOICE.

If you have to be in managed care, you will have to choose another health care plan. Call the managed care unit of your local Social Services Department or New York Medicaid CHOICE to get a transfer or disenrollment packet. Be sure to let them know you are disenrolling from [Insert Plan Name] and you want to re-enroll in a new plan. You will get a notice that the change will take place by a certain date. In most cases, we will provide the care you need until then.

You Could Become Ineligible for Medicaid Managed Care

- You or your child may have to leave [Insert Plan Name] if you or the child:

    - moves out of the County or service area
    - changes to another managed care plan,
    - joins an HMO or other insurance plan through work,
    - joins a long-term Home Health Care Program,
    - goes to prison, or
    - becomes a permanent resident of a nursing home

- Your child may have to leave [Insert Plan Name] if he or she:

    - joins a Physically Handicapped Children's Program, or
    - is placed in foster care (voluntarily by parent/guardian or by a decision of the local Social Services Commissioner)

- In some cases, you may be **guaranteed coverage** by [Insert Plan Name]. That means we will not drop you as a member during the first six months of your enrollment in our plan- even if you are no longer eligible for Medicaid and your Medicaid case is closed. The reasons for losing eligibility must not be related to death, moving out of state, or

incarceration. During this time you can get the services that [Insert Plan Name] covers. You can also get pharmacy and family planning care using your Medicaid card. Guaranteed coverage does not apply if you choose to leave [Insert Plan Name].

We Can Ask You to Leave [Insert Plan Name]

You can also lose your [Insert Plan Name] membership, if you often:

- refuse to work with your PCP in regard to your care,
- don't keep appointments,
- go to the emergency room for non-emergency care,
- don't follow [Insert Plan Name]'s rules,
- do not fill out forms honestly or do not give true information (commit fraud),
- cause abuse or harm to plan members, providers or staff, or
- act in ways that make it hard for us to do our best for you and other members even after we have tried to fix the problems.

Action Appeals

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

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

Your provider can ask for reconsideration:

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

You can file an action appeal:

- If you are not satisfied with an action we took or what we decide about your service authorization request, you have [Plans must insert a specific appeal timeframe. It must be at least 60 business days but no more than 90 calendar days.] after hearing from us to file an action appeal.
- You can do this yourself or ask someone you trust to file the action appeal for you. You can call Member Services [Insert appropriate health plan toll-free number] if you need help filing an action appeal.

- We will not treat you any differently or act badly toward you because you file an action appeal.
- The action appeal can be made by phone or in writing. If you make an action appeal by phone, it must be followed up in writing. [Optional: After your call, we will send you a form which is a summary of your phone action appeal. If you agree with our summary, you should sign and return the form to us. You can make any needed changes before sending the form back to us.]

Your action appeal will be reviewed under the fast track process if:

- If you or your doctor asks to have your action appeal reviewed under the fast track process. Your doctor would have to explain how a delay will cause harm to your health. If your request for fast track is denied we will tell you and your action appeal will be reviewed under the standard process; **or**
- If your request was denied when you asked to continue receiving care that you are now getting or need to extend a service that has been provided; **or**
- If your request was denied when you asked for home health care after you were in the hospital.
- Fast track action appeals can be made by phone and do not have to be followed up in writing.

What happens after we get your action appeal:

- Within 15 days, we will send you a letter to let you know we are working on your action appeal.
- Action appeals of clinical matters will be decided by qualified health care professionals who did not make the first decision, at least one of whom will be a clinical peer reviewer.
- Non-clinical decisions will be handled by persons who work at a higher level than the people who worked on your first decision.
- Before and during the action appeal, you or your designee can see your case file, including medical records and any other documents and records being used to make a decision on your case;
- You can also provide information to be used in making the decision in person or in writing. Call PLAN at 1-800-xxx-xxxx if you are not sure what information to give us. [insert if required by health plan for UR appeal] If you are appealing our decision that the out-of-network service you asked for was not different from a service that is available in our network, ask your doctor to send us:
    1. a written statement that the service you asked for is different from the service we have in our network; and
    2. two pieces of medical evidence (published articles or scientific studies) that show the service you asked for is better for you, and will not cause you more harm than the service we have in our network.

- You will be given the reasons for our decision and our clinical rationale, if it applies. If you are still not satisfied, any further appeal rights you have will be explained or you or someone you trust can file a complaint with the New York State Department of Health at 1-800-206-8125.

Timeframes for Action Appeals:

- Standard action appeals: If we have all the information we need we will tell you our decision in thirty days from your action appeal. A written notice of our decision will be sent within 2 work days from when we make the decision.

- Fast track action appeals: If we have all the information we need, fast track action appeal decisions will be made in 2 work days from your action appeal. We will tell you in 3 work days after giving us your action appeal, if we need more information. We will tell you our decision by phone and send a written notice later.

If we need more information to make either a standard or fast track decision about your action appeal we will:

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

You, your provider, or someone you trust may also ask us to take more time to make a decision. This may be because you have more information to give the plan to help decide your case. This can be done by calling [Insert appropriate health plan toll-free number] or writing.

You or someone your trust can file a complaint with the plan if you don't agree with our decision to take more time to review your action appeal. You or someone you trust can also file a complaint about the review time with the New York State Department of Health by calling 1-800-206-8125.

If your original denial was because we said:
- the service was not medically necessary; or
- the service was experimental or investigational; or
- the out-of-network service was not different from a service that is available in our network; and

we do not tell you our decision about your action appeal on time, the original denial against you will be reversed. This means your service authorization request will be approved.

Aid to Continue while appealing a decision about your care:

In some cases you may be able to continue the services while you wait for your action appeal to

be decided. You may be able to continue the services that are scheduled to end or be reduced if you ask for a fair hearing:

- Within ten days from being told that your request is denied or care is changing; or
- By the date the change in services is scheduled to occur.

If your fair hearing results in another denial you may have to pay for the cost of any continued benefits that you received. The decision you receive from the fair hearing officer will be final.

External Appeals

If the plan decides to deny coverage for a medical service you and your doctor asked for because:

- the service was not medically necessary; or
- the service was experimental or investigational ; or
- the out-of-network service was not different from a service that is available in our network;

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

Before you appeal to the state:

1. You must file an action appeal with the plan and get the plan's final adverse determination; **or**
2. If you had a fast track action appeal and are not satisfied with the plan's decision you can choose to file a standard action appeal with the plan or go directly to an external appeal; **or**
3. You and the plan may agree to skip the plan's appeals process and go directly to external appeal.

You have 45 days after you receive the plan's final adverse determination to ask for an external appeal. If you and the plan agreed to skip the plan's appeals process, then you must ask for the external appeal within 45 days of when you made that agreement.

Additional appeals to your health plan may be available to you if you want to use them. However, if you want an external appeal, you must still file the application with the State Department of Insurance within 45 days from the time the plan gives you the notice of final adverse determination or when you and the plan agreed to waive the plan's appeal process.

You will lose your right to an external appeal if you do not file an application for an

external appeal on time.

To ask for an external appeal, fill out an application and send it to the State Insurance Department. You can call Member Services at [Insert appropriate health plan toll-free number] if you need help filing an appeal. You and your doctors will have to give information about your medical problem. The external appeal application says what information will be needed.

Here are some ways to get an application:

- Call the State Insurance Department, 1-800-400-8882
- Go to the State Insurance Department's website at www.ins.state.ny.us
- Contact the health plan at [Insert appropriate health plan toll-free number]

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

You can get a faster decision if your doctor says that a delay will cause serious harm to your health. This is called an **expedited external appeal**. The external appeal reviewer will decide an expedited appeal in three days or less. The reviewer will tell you and the plan the decision right away by phone or fax. Later, a letter will be sent that tells you the decision.

You may also ask for a fair hearing if the plan decided to deny, reduce or end coverage for a medical service. You may request a fair hearing and ask for an external appeal. If you ask for a fair hearing and an external appeal, the decision of the fair hearing officer will be the one that counts.

Fair Hearings

In some cases you may ask for a fair hearing from New York State.

- You are not happy with a decision your local Department of Social Services or the State Department of Health made about your staying or leaving [Insert Plan Name].
- You are not happy with a decision that we made about medical care you were getting. You feel the decision limits your Medicaid benefits or that we did not make the decision in a reasonable amount of time.
- You are not happy about a decision we made that denied medical care you wanted. You feel the decision limits your Medicaid benefits.
- You are not happy with a decision that your doctor would not order services you wanted. You feel the doctor's decision stops or limits your Medicaid benefits. You must file a complaint with [Insert Plan Name]. If [Insert Plan Name] agrees with your doctor, you may ask for a state fair hearing.
- The decision you receive from the fair hearing officer will be final.

If the services you are now getting are scheduled to end, you can choose to ask to continue the services your doctor ordered while you wait for your case to be decided. However, if you choose to ask for services to be continued, and the fair hearing is decided against you, you may have to pay the cost for the services you received while waiting for a decision.

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

1. By phone, call toll-free 1-800-342-3334
2. By fax, 518-473-6735
3. By internet, www.otda.state.ny.us/oah/forms.asp
4. By mail, Fair Hearings, NYS Office of Temporary and Disability Assistance, P.O. Box 1930, Albany, NY 12201

Remember, you can complain anytime to the New York State Department of Health by calling 1-800-206-8125.

Complaint Process

Complaints:

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

You can ask someone you trust (such as a legal representative, a family member, or friend) to file the complaint for you. If you need our help because of a hearing or vision impairment, or if you need translation services, or help filing the forms we can help you. We will not make things hard for you or take any action against you for filing a complaint.

You also have the right to contact the New York State Department of Health about your complaint at 1-800-206-8125 or write to: NYS Department of Health, Division of Managed Care, Bureau of Managed Care Certification and Surveillance, Corning Tower ESP Room 1911, Albany, NY 12237. You may also contact your local Department of Social Services with your complaint at anytime. You may call the New York State Insurance Department at (1-800-342-3736) if your complaint involves a billing problem.

How to File a Complaint with the Plan:

To file by phone, call Member Services at [Insert Member Services number and the appropriate hours]. If you call us after hours, leave a message. We will call you back the next work day. If we need more information to make a decision, we will tell you.

You can write us with your complaint or call the Member Services number and request a complaint form. It should be mailed to [Insert appropriate health plan address].

What happens next:

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

- who is working on your complaint
- how to contact this person
- if we need more information

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

After we review your complaint:

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

Complaint Appeals:

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

How to make a complaint appeal:

- If you are not satisfied with what we decide, you have at least 60 business days after hearing from us to file an appeal;
- You can do this yourself or ask someone you trust to file the appeal for you;
- The appeal must be made in writing. If you make an appeal by phone it must be followed up in writing. After your call, we will send you a form which is a summary of your

phone appeal. If you agree with our summary, you must sign and return the form to us. You can make any needed changes before sending the form back to us.

What happens after we get your complaint appeal:

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

- who is working on your complaint appeal
- how to contact this person
- if we need more information

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

If we have all the information we need you will know our decision in 30 work days. If a delay would risk your health you will get our decision in 2 work days of when we have all the information we need to decide the appeal. You will be given the reasons for our decision and our clinical rationale, if it applies. If you are still not satisfied, you or someone on your behalf can file a complaint at any time with the New York State Department of Health at 1-800-206-8125.

MEMBER RIGHTS AND RESPONSIBILITIES

Your Rights

As a member of [Insert Plan Name], you have a right to:

- Be cared for with respect, without regard for health status, sex, race, color, religion, national origin, age, marital status or sexual orientation.
- Be told where, when and how to get the services you need from [Insert Plan Name].
- Be told by your PCP what is wrong, what can be done for you, and what will likely be the result in language you understand.
- Get a second opinion about your care.
- Give your OK to any treatment or plan for your care after that plan has been fully explained to you.
- Refuse care and be told what you may risk if you do.
- Get a copy of your medical record, and talk about it with your PCP, and to ask, if needed, that your medical record be amended or corrected.

- Be sure that your medical record is private and will not be shared with anyone except as required by law, contract, or with your approval.
- Use the [Insert Plan Name] complaint system to settle any complaints, or you can complain to the NY State Department of Health or the local Department of Social Services any time you feel you were not fairly treated.
- Use the State Fair Hearing system
- Appoint someone (relative, friend, lawyer, etc.) to speak for you if you are unable to speak for yourself about your care and treatment.
- Receive considerate and respectful care in a clean and safe environment free of unnecessary restraints

Your Responsibilities

As a member of [Insert Plan Name], you agree to:

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

Advance Directives

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

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

CPR and DNR - You have the right to decide if you want any special or emergency treatment to restart your heart or lungs if your breathing or circulation stops. If you do not want special

treatment, including cardiopulmonary resuscitation (CPR), you should make your wishes known in writing. Your PCP will provide a DNR (Do Not Resuscitate) order for your medical records. You can also get a DNR form to carry with you and/or a bracelet to wear that will let any emergency medical provider know about your wishes.

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

Important Phone Numbers

Your PCP.....…… --- ----

THE PLAN

Member Services.....……[Insert Member Services number]

Member Services TTY/TDD [Insert Member Services TTY number]

Other Units (e.g., Nurse Hotline, Utilization Review, etc)

.....…… --- ----

Your nearest Emergency Room.....…….. --- ----

New York State Department of Health (Complaints).....……. 1 800-206-8125

_____ County Department of Social Services.....…… --- ----

[For plans that serve the enrollment broker counties, insert the phone number for New York Medicaid CHOICE.]

New York Medicaid CHOICE……. 1-800-505-5678

Local Pharmacy .....…… --- ----

Other Health Providers:

_____ --- ----

_____ --- ----

_____ --- ----

Insert member services number and TTY number on every page, or every other page.