



An Anthem Company

Member Handbook

New York
Medicaid

1-800-300-8181 (TTY 711)

www.empireblue.com/ny



An Anthem Company

Member Handbook

New York

Medicaid

1-800-300-8181 (TTY 711)

www.empireblue.com/ny

Empire BlueCross BlueShield HealthPlus is the trade name of HealthPlus HP, LLC, an independent licensee of the Blue Cross and Blue Shield Association.

ENY-MHB-0034-17



An Anthem Company

Residential Health Care Facility services (nursing home)

Covered nursing home services include:

- medical supervision
- 24-hour nursing care
- assistance with daily living
- physical therapy
- occupational therapy
- speech-language pathology and other services

To get these nursing home services:

- the services must be ordered by your physician
- the services must be authorized by Empire

Rehabilitation:

Empire BlueCross BlueShield HealthPlus covers short term, or rehabilitation (also known as “rehab”) stays, in a skilled nursing home facility.

Long-term placement:

Empire covers long-term placement in a nursing home facility for members 21 years of age and older.

Long-term placement means you will live in a nursing home.

When you are eligible for long-term placement, you may select one of the nursing homes that are in Empire’s plan that meets your needs.

If you want to live in a nursing home that is not part of Empire’s plan, you must first transfer to another plan that has your chosen nursing home in its plan.

Eligible veterans, spouses of eligible veterans, and Gold Star parents of eligible veterans may choose to stay in a Veterans’ nursing home.

Determining your Medicaid eligibility for long-term nursing home services

You must apply to your Local Department of Social Services (LDSS) to have Medicaid and/or Empire pay for long-term nursing home services. The LDSS will review your income and assets to determine your eligibility for long-term nursing home services. The LDSS will let you know about any costs you may have to contribute toward your long-term nursing home care.

Questions

If you have any questions about these benefits, call our Member Services department at 1-800-300-8181 (TTY 711).

Additional resources

If you have concerns about long-term nursing home care, choosing a nursing home, or the effect on your finances, there are additional resources to help.

- Independent Consumer Advocacy Network (ICAN) provides free and confidential assistance. Call 1-844-614-8800 or visit www.icannys.org.
- New York State Office for the Aging
 - Health Insurance Information, Counseling and Assistance (HIICAP) provides free counseling and advocacy on health insurance questions. Call 1-800-701-0501.
 - NY CONNECTS is a link to long term service and supports. Call 1-800-342-9871 or visit www.nyconnects.ny.gov.
- Nursing Home Bill of Rights (NHBOR) describes your rights and responsibilities as a nursing home resident. To learn more about NHBOR, visit www.health.ny.gov/facilities/nursing/rights.

Keep this update with your member handbook.

www.empireblue.com/ny

Empire BlueCross BlueShield HealthPlus is the trade name of HealthPlus HP, LLC, an independent licensee of the Blue Cross and Blue Shield Association.



An Anthem Company

Member Rights and Responsibilities Update

We've added more rights and responsibilities to help you work with your doctors to get the right care. Along with the rights listed in this handbook, you may also:

- Get information about Empire BlueCross BlueShield HealthPlus, our services, policies, procedures and doctors.
- Be told about your rights and responsibilities and make suggestions about them.
- Hear about all available treatment options no matter what your benefits cover or how much it costs.
- Work with your doctor to improve your health.
- Be told if any changes are made to these items.

In addition to the responsibilities listed in this handbook, it is also your responsibility to do these things:

- Give your doctor the correct information about your health.
- Ask questions so you can understand your health conditions and/or treatment options.
- Talk with your doctor about treatment and follow the instructions for care.

Statement of Technology

Empire keeps up with changes in technology to see if they should be part of the benefits in our plans. Our medical director and the doctors in our plans review new medical advances or changes to technology in:

- Behavioral health.
- Devices.
- Medical treatment.
- Prescription drugs.

They also look at scientific findings to see if these new medical advances and treatments:

- Are considered safe and effective by the government.
- Give equal or better outcomes than the treatment or therapy that exists now.

www.empireblue.com/ny

Empire BlueCross BlueShield HealthPlus is the trade name of HealthPlus HP, LLC, an independent licensee of the Blue Cross and Blue Shield Association.

NEW YORK STATE
MEDICAID MANAGED CARE
MEMBER HANDBOOK

Revised May 2017

Medicaid Managed Care Model Member Handbook

Medicaid Managed Care Model Handbook
Empire BlueCross BlueShield HealthPlus
Member Services Department 1-800-300-8181 (TTY 711)
Crisis Line: 1-800-300-8181
ENY-MHB-0034-17

HERE'S WHERE TO FIND INFORMATION YOU WANT

Table of Contents

WELCOME to Empire BlueCross BlueShield HealthPlus' Medicaid Managed Care Program....	3
How managed care plans work	3
How to use this handbook	4
Help from Member Services	4
Your health plan ID card.....	5
PART I - FIRST THINGS YOU SHOULD KNOW	6
How to choose your primary care provider (PCP).....	6
Empire Federally Qualified Health Centers.....	6
How to get regular health care	10
How to get specialty care and referrals.....	11
Get these services from Empire <i>without</i> a referral.....	12
Emergencies	14
Urgent care	15
We want to keep you healthy	16
Health home care management	16
Disease Management Centralized Care Unit program.....	17
PART II - YOUR BENEFITS AND PLAN PROCEDURES	19
Benefits	19
Services covered by Empire.....	19
Benefits you can Get From Empire <i>OR</i> With Your Medicaid Card	26
Benefits using your MEDICAID CARD only	27
Services not covered	28
Service authorization and actions.....	29
Prior authorization and timeframes.....	29
Other decisions about your care.....	31
You can help with plan policies	32
Information from Member Services.....	32
Keep us informed	33
Disenrollment and transfers	33
If YOU want to leave Empire	33
You could become ineligible for Medicaid Managed Care	34
We Can Ask You to Leave Empire.....	35
Action appeals.....	35
External appeals	38
Fair Hearings.....	40
Complaint Process.....	41
How to file a complaint with our plan	41
What happens next.....	41
Complaint Appeals.....	42
Member rights and responsibilities	43
Advance directives	44
HIPAA Notice of Privacy Practices.....	46
Important Phone Numbers	50

WELCOME TO EMPIRE BLUECROSS BLUESHIELD HEALTHPLUS' MEDICAID MANAGED CARE PROGRAM

We are glad that you enrolled in Empire BlueCross BlueShield HealthPlus. This handbook will be your guide to the full range of health care services available to you. We want to be sure you get off to a good start as a new member. 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 **1-800-300-8181 (TTY 711)**.

How managed care plans work

The plan, our providers, and you

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

Empire has a contract with the 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 will find a list in our provider directory. If you do not have a provider directory, call 1-800-300-8181 (TTY 711) to get a copy or visit our website at www.empireblue.com/nymedicaid.

When you join Empire, one of our providers will take care of you. Most of the time that person will be your Primary Care Provider (PCP). 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 every day, day and night. If you need to speak to him or her after hours or weekends, leave a message and how you can be reached. Your PCP will get back to you as soon as possible. Even though your PCP is your main source for health care, in some cases, you can self-refer to certain doctors for some services. See section "Get these services from Empire *without* a referral" for details.

You may be restricted to certain plan providers if you have been identified as a restricted recipient. Here are some examples of why you may be restricted:

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

Confidentiality

We respect your right to privacy. Empire recognizes the trust needed between you, your family, your doctors and other care providers. Empire will never give out your medical or behavioral health history without your written approval.

The only persons that will have your clinical information will be Empire, your Primary Care Provider and other providers who give you care and you authorized representative. Referrals to such providers will always be discussed with you in advance by your Primary Care Provider or your Health Home Care Manager, if you have one. Empire staff have been trained in keeping strict member confidentiality.

How to use this handbook

This handbook will help you, when you join a managed care plan. It will tell you how your new health care system will work and how you can get the most from Empire. This handbook is your guide to health and wellness services. It tells you the steps to take to make the plan work for you.

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

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

If you live in **New York City, Nassau County, or Putnam County**, you can also call the New York Medicaid Choice Help Line at 1-800-505-5678.

Help from Member Services

There is someone to help you at Member Services Monday through Friday from 8 a.m. to 8 p.m. and on Saturday from 9 a.m. to 5 p.m. Call 1-800-300-8181 (TTY 711).

If you need help or health care advice outside of these times, call our 24/7 NurseLine at 1-800-300-8181 (TTY 711). Follow the phone options to speak with a nurse 24 hours a day, 7 days a week.

You can call Member Services 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 Empire 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 is best for you.

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

language. We have a group of people who can help. We will also help you find a PCP (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 711).
- Information in Large Print
- Case Management
- Help in making or getting to appointments
- Names and addresses of providers who specialize in your disability

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

Your health plan ID card

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

Carry your ID card at all times and show it each time you go for care. If you need care before the card comes, your welcome letter is proof that you are a member. You should keep your Medicaid benefit card. You will need the card to get services that Empire does not cover.

PART I - FIRST THINGS YOU SHOULD KNOW

How to choose your primary care provider (PCP)

You may have already picked your Primary Care Provider (PCP) 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. Member Services (1-800-300-8181 (TTY 711)) can check to see if you already have a PCP or 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 Empire. It lists the address, phone, and special training of the doctors. The provider directory will show which doctors and providers are taking new patients. You should call their offices to make sure that they are taking new patients at the time you choose a PCP. You can also get a list of providers on our website at www.empireblue.com/nymedicaid.

You may want to find a doctor that:

- You have seen before
- Understands your health problems
- Is taking new patients
- Can serve you in your language
- Is easy to get to

Women can also choose one of our OB/GYN doctors to deal with women's health care. Women do not need a PCP referral to see a plan OB/GYN doctor. They can have routine checkups (twice a year), follow-up care if needed, 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 1-800-300-8181 (TTY 711) for help.

Empire Federally Qualified Health Centers

Amsterdam Avenue Family Health Center
690 Amsterdam Ave.
New York, NY 10025
1-212-865-4104

Lutheran Medical Center
150 55th St.
Brooklyn, NY 11220
1-718-630-7000

Beacon Christian Community
Health Center Inc.
2079 Forest Ave.
Staten Island, NY 10303
1-718-815-6560

Bedford Stuyvesant Family Health Center
1413 Fulton St.
Brooklyn, NY 11216
1-718-636-4500

Betances Health Center
280 Henry St., # A
New York, NY 10002
1-212-227-8843

Brooklyn Plaza Medical Center
650 Fulton St.
Brooklyn, NY 11217
1-718-596-9800

Brownsville Multi-services Family
Health Center
592 Rockaway Ave.
Brooklyn, NY 11212
1-718-345-5000

Brownsville Multi-services Family Health
Center at Genesis
592 Rockaway Ave.
Brooklyn, NY 11212
1-718-345-5000

Charles B. Wang Community Health Center
125 Walker St.
New York, NY 10013
1-212-379-6988

CHN - Betty Shabazz Health Center
999 Blake Ave.
Brooklyn, NY 11208
1-718-277-8303

CHN – Bronx Center
975 Westchester Ave.
Bronx, NY 10459
1-718-991-9250

CHN – CABS Center
94-98 Manhattan Ave.
Brooklyn, NY 11206
1-718-388-0390

Morris Heights Health Center
85 W. Burnside Ave.
Bronx, NY 10453
1-718-716-4400

Mt. Hope Family Practice
1731 Harrison Ave.
Bronx, NY 10453
1-718-583-9000

New Cassel/Westbury Health Center
682 Union Ave.
Westbury, NY 11590
1-516-571-9535

ODA Primary Care Health Center
14 Heyward St.
Brooklyn, NY 11211
1-718-852-0803

Park Slope Family Health Center
220 13th St.
New York, NY 11215
1-718-832-5980

Parkchester Family Practice
1597 Unionport Road
Bronx, NY 10462-5902
1-718-822-1818

Phillips Family Practice
16 E. 16th St.
New York, NY 10003
1-212-206-5200

Ramon S Velez Health Center
754 E. 151 St.
Bronx, NY 10455
1-718-402-2800

Refuah Health Center – Spring Valley
Location
728 N. Main St.
Spring Valley, NY 10977
1-845-354-9300

Refuah Health Center – Twin Location
5 Twin Ave.
Spring Valley, NY 10977
1-845-354-9300

CHN – Caribbean House Center
1167 Nostrand Ave.
Brooklyn, NY 11225
1-718-778-0198

CHN - Community League Center
1996 Amsterdam Ave.
New York, NY 10032
1-212-781-7979

CHN – Downtown Health Center
150 Essex St.
New York NY 10002
1-212-477-1120

CHN – Helen B Atkinson Center
81 W. 115th St.
New York, NY 10026
1-212-426-0088

CHN – Queens Center
97-04 Sutphin Blvd.
Jamaica, NY 11435
1-718-657-7088

Community Health Center of Richmond
235 Port Richmond Ave.
Staten Island, NY 10302
1-718-876-1732

Damian Family Care Center
13750 Jamaica Ave.
Jamaica, NY 11435
1-718-298-5100

Dr. Martin Luther King, Jr. Health Center
1265 Franklin Ave.
Bronx, NY 10456
1-718-503-7700

East 13th Street Family Practice
113 E. 13th St.
New York, NY 10003
1-212-253-1830

Refuah Health Center – South Fallsburg
Location
South Fallsburg Family Medical
36 Laurel Ave.
South Fallsburg, NY 12779
1-845-354-9300

Roosevelt/Freeport Family Health Center
380 Nassau Road
Roosevelt, NY 11575
1-516-571-8600

Ryan/Chelsea-Clinton Community
Health Center
645 10th Ave.
New York, NY 10036
1-212-265-4500

Ryan-Nena Community Health Center
279 E. Third St.
New York, NY 10009
1-212-477-8500

Settlement Health & Medical Service
212 E. 106 St.
New York, NY 10029
1-212-360-2600

Sidney Hillman Family Practice
16 E. 16th St.
(Between Fifth Ave. and W. Union Square)
New York, NY 10003
1-212-924-7744

Sunset Park Family Health Center
150 55th St.
Brooklyn, NY 11220
1-718-630-7095

Sunset Terrace Family Health Center
514 49th St.
Brooklyn, NY 11220
1-718-431-2600

Urban Health Plan – Bella Vista
Health Center
1065 Southern Blvd.
Bronx, NY 10459
1-718-589-2440
1-212-517-1891

EHCHS Inc. Boriken Neighborhood
Health Center
2253 Third Ave., Third Floor
New York, NY 10035
1-212-289-6650

Elmont Health Center
161 Hempstead Turnpike
Elmont, NY 11003
1-516-571-8200

Hempstead Health Center
135 Main St.
Hempstead, NY 11550-2414
1-516-572-1300

Institute for Family Health – Sidney Hillman
Family Practice
16 E. 16th St.
New York, NY 10003
1-212-633-0800, ext. 1337
1-212-206-5200 (medical)

Joseph P. Addabbo Family Health Center
67-10 Rockaway Beach Blvd.
Arverne, NY 11692
1-718-945-7150

Urban Health Plan – El Nuevo San Juan
Health Center
1065 Southern Blvd.
Bronx, NY 10459
1-718-589-2440

Urban Health Plan – Plaza Del Castilo
Health Center
1515 Southern Blvd.
Bronx, NY 10460
1-718-589-1600

Urban Horizons Family Practice
50 E. 168th St.
Bronx, NY 10452
1-718-293-3961

Walton Family Health Center
1894 Walton Ave.
Bronx, NY 10453
1-718-583-3060

William F. Ryan Community Health Center
110 W. 97th St.
New York, NY 10025
1-212-316-7906

In almost all cases, your doctors will be Empire providers. There are four instances when you can still **see another provider that you had before you joined Empire**. In these cases, your provider must agree to work with Empire. You can continue to see your doctor if:

- You are more than three months pregnant when you join Empire and you are getting prenatal care. In that case, you can keep your provider until after your delivery through post-partum care.
- At the time you join Empire, you have a life threatening disease or condition that gets worse with time. In that case, you can ask to keep your provider for up to 60 days.
- At the time you join Empire, you are being treated for a behavioral health condition. In that case, you can ask to keep your provider through treatment for up to two years.
- At the time you join Empire, regular Medicaid paid for your home care and you need to keep getting that care for at least 120 days. In that case, you can keep your same home care agency, nurse or attendant, and the same amount of home care, for at least 90 days.
- Empire must tell you about any changes to your home care before the changes take effect.

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**. Please call Member Services and they will help you make this change.

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 once 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 whom your PCP has referred you.

If your **provider leaves Empire**, 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 1-800-300-8181 (TTY 711).

How to get regular health care

Regular health 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 to:

- Prevent, or diagnose and correct what could cause more suffering
- Deal with a danger to your life
- Deal with a problem that could cause illness
- 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.

As soon as you choose a PCP, call to make a first appointment. If you can, prepare for your first appointment. Your PCP will need to know as much about your medical history as you can tell him or her. Make a list of your medical background, any problems you have now, any medications you are taking, and the questions you want to ask your PCP. In most cases, your first visit should be within three months of your joining the plan.

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

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 three days
- Routine, preventive care: within four weeks
- First prenatal visit: within three weeks during first trimester (two weeks during second, one week during third)
- First newborn visit: within two weeks of hospital discharge
- First family planning visit: within two weeks
- Follow-up visit after mental health/substance abuse ER or inpatient visit: five days
- Non-urgent mental health or substance abuse visit: two 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 Empire 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 Empire to approve *before* you can get them. Your PCP will be able to tell you what they are.

If you are having trouble getting a referral you think you need, contact Member Services at 1-800-300-8181 (TTY 711).

If we do not have a specialist in our provider network who can give you the care you need, we will get you the care you need from a specialist outside our plan. This is called an **out-of-network referral**. Your PCP or plan provider must ask Empire for approval *before* you can get an out-of-network referral. If your PCP or plan provider refers you to a provider who is not in our network, you are not responsible for any of the costs except any co-payments as described in this handbook.

Your PCP can obtain a preauthorization for services with out-of-network providers by calling 1-800-450-8753. Time frames for review can be found in the “Service authorizations and actions” section of this handbook.

Sometimes we may not approve an out-of-network referral because we have a provider in Empire that can treat you. If you think our plan provider does not have the right training or experience to treat you, you can ask us to check if your out-of-network referral is medically needed. You will need to ask for an **action appeal**. See section “Action appeals” to find out how.

You will need to ask your doctor to send the following information with your action appeal:

- 1) a statement in writing that says an Empire BlueCross BlueShield HealthPlus provider does not have the right training and experience to meet your needs, and
- 2) that recommends an out-of-network provider with the right training and experience who is able to treat you.

Your doctor must be a board-certified or board-eligible specialist who treats people who need the treatment you are asking for.

Sometimes, we may not approve an out-of-network referral for a specific treatment because you asked for care that is not very different from what you can get from Empire's provider. You can ask us to check if your out-of-network referral for the treatment you want is medically needed. You will need to ask for an **action appeal**. See section "Action appeals" to find out how.

You will need to ask your doctor to send the following information with your action appeal:

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

If your doctor does not send this information, we will still review your action appeal. However, you may not be eligible for an external appeal. See section "External appeals" for more information about external appeals.

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
- A referral to a specialty care center that deals with the treatment of your illness

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

Get these services from Empire *without* a referral

Women's health care

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

- Are pregnant
- Need OB/GYN services
- Need family planning services

- Want to see a mid-wife
- Need to have a breast or pelvic exam

Family planning

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

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

Or, you can *use your Medicaid card* if you want to go to a doctor or clinic outside our plan. Ask your PCP or Member Services 1-800-300-8181 (TTY 711) 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.

HIV and STI screening

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

You can get an HIV or STI test any time you have an office or clinic visit.

You can get an HIV or STI test any time you have family planning services. You do not need a referral from your PCP (Primary Care Provider). Just make an appointment with any family planning provider. If you want an HIV or STI test, but *not as part of a family planning service*, your PCP can provide or arrange it for you.

Or, if you'd rather not see one of our Empire providers, you can use your Medicaid card to see a family planning provider outside Empire. For help in finding either a Plan provider or a Medicaid provider for family planning services call Member Services at **1-800-300-8181 (TTY 711)**.

Everyone should talk to their doctor about having an HIV test. To get free HIV testing or testing where your name isn't given, call 1-800-541-AIDS (English) or 1-800-233-SIDA (Spanish).

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

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 12-month period. You just choose one of our participating providers.

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

Behavioral health – (Mental health and substance use)

We want to help you get the mental health and drug or alcohol abuse services that you may need. If at any time you think you need help with mental health or substance use, you can see any participating behavioral health provider that accepts Empire to see what services you may need. This includes services like clinic and detox services. You do not need a referral from your PCP.

Smoking cessation

You can get medication, supplies and counseling if you want help to quit smoking. You do not need a referral from your PCP to get these services.

Maternal depression screening

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

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.

An emergency 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
- A drug overdose

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

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

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

If you believe you have an **emergency**, call 911 or go to the emergency room. You do not need your plans 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 Empire

Tell the person you speak with what is happening. Your PCP or member services representative will tell you:

- What to do at home
- To come to the PCP's office
- 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 Empire at 1-800-300-8181 (TTY 711).

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.
- This could be the flu or if you need stitches.

- It could be a sprained ankle, or a bad splinter you can't remove.

You can get an appointment for an urgent care visit for the same or next day. Whether you are at home or away, call your PCP any time, day or night. If you cannot reach your PCP, call us at 1-800-300-8181 (TTY 711). Tell the person who answers what is happening. They will tell you what to do.

Care outside of the United States

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

We want to keep you healthy

Besides the regular checkups and the shots you 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
- Sexually Transmitted Infection (STI) Testing & Protecting Yourself from STIs
- Domestic Violence Services

Call Member Services at 1-800-300-8181 (TTY 711) or visit our website at www.empireblue.com/nymedicaid to find out more and get a list of upcoming classes.

Health home care management

Empire BlueCross BlueShield HealthPlus wants to meet all of your health needs. If you have multiple health issues, you may benefit from Health Home Care Management to help coordinate all of your health services.

A Health Home Care Manager can:

- Work with your PCP and other providers to coordinate all of your health care;

- Work with the people you trust, like family members or friends, to help you plan and get your care;
- Help with appointments with your PCP and other providers; and
- Help manage ongoing medical issues like diabetes, asthma and high blood pressure.

To learn more about Health Home, contact Member Services at 1-800-300-8181 (TTY 711).

Disease Management Centralized Care Unit program

Empire has a team of licensed nurses and social workers called case managers who help educate you about your condition and help you learn how to manage your care. Your PCP and our team of case managers will assist you with your health care needs. This is a voluntary program, and you can choose whether to participate or not. Case managers can also provide support over the phone for members with certain health conditions, such as:

- Diabetes
- HIV/AIDS
- Heart conditions like coronary artery disease, congestive heart failure and hypertension
- Lung conditions like asthma and chronic obstructive pulmonary disease (COPD)
- Behavioral health disorders, such as bipolar disorder, major depressive disorder, schizophrenia and substance use disorder

DMCCU case managers work with you to create health goals and help you develop a plan to reach them. As a member in the program, you will benefit from having a case manager who:

- Listens to you and takes the time to understand your specific needs.
- Helps you create a care plan to reach your health care goals.
- Gives you the tools, support and community resources that can help you improve your quality of life.
- Gives health information that can help you make better choices.
- Assists you in coordinating care with your providers.

As an Empire member enrolled in the DMCCU program, you have certain rights and responsibilities.

You have the right to:

- Get details about us, including:
 - Programs and services we provide.
 - Our staff and their qualifications.
 - Any contractual relationships.
- Opt out of DMCCU services.
- Know which case manager is handling your disease management services, as well as how to ask for a change.

- Get support from us to make health care choices with your providers.
- Be told about all disease management-related treatment options mentioned in clinical guidelines (even if a treatment is not covered), and to discuss options with treating providers.
- Have personal data and medical information kept private.
- Know who has access to your information and know our procedures used to ensure security, privacy and confidentiality.
- Be treated politely and with respect by our staff.
- File complaints to Empire and receive guidance on how to use the complaint process, including our standards of timeliness for responding to and resolving issues of quality and complaints.
- Receive information that is clear and easy to understand.

You are encouraged to:

- Follow the plan of care you and your case manager agree on.
- Provide us with information needed to carry out our services.
- Tell us and your provider if you decide to leave the program.

If you have questions or would like to know more about our disease management program, please call 1-888-830-4300, Monday through Friday from 8:30 a.m. to 5:30 p.m. local time. Ask to speak with a case manager. You can also visit our website at www.empireblue.com/nymedicaid.

PART II - YOUR BENEFITS AND PLAN PROCEDURES

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

Benefits

Medicaid managed care provides a number of services you get in addition to those you get with regular Medicaid. Empire 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 Empire and some that you can choose to go to any Medicaid provider of the service. Please call our member services department at 1-800-300-8181 (TTY 711) if you have any questions or need help with any of the services below.

Services covered by Empire

You must get these services from the providers who are in Empire. All services must be medically or clinically necessary and provided or referred by your PCP (Primary Care Provider). Please call our Member Services department at 1-800-300-8181 (TTY 711) if you have any questions or need help with any of the services below.

Regular medical care

- Office visits with your PCP
- Referrals to specialists
- Eye / hearing exams

Preventive care

- Well-baby care
- Well-child care
- Regular check-ups
- Shots for children from birth through childhood
- Access to Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services for enrollees from birth until age 21 years
- Smoking cessation counseling
- Access to free needles and syringes
- Smoking cessation counseling
- HIV education and risk reduction

Maternity care

- Pregnancy care
- Doctors/mid-wife and hospital services
- Newborn nursery care
- Screening for depression during pregnancy and up to a year after delivery

Home health care

- Must be medically needed and arranged by Empire
- One medically necessary post-partum home health visit, additional visits as medically necessary for high-risk women
- At least 2 visits to high-risk infants (newborns)
- Other home health care visits as needed and ordered by your PCP/specialist

Personal care/Home attendant/ Consumer directed personal assistance services (CDPAS)

- Must be medically needed and arranged by Empire
- Personal Care/Home Attendant – Help with bathing, dressing and feeding and help with preparing meals and housekeeping
- CDPAS – Help with bathing, dressing and feeding, help preparing meals and housekeeping, plus home health aide and nursing tasks. This is provided by an aide chosen and directed by you
- If you want more information, contact Empire at 1-800-300-8181 (TTY 711)

Personal Emergency Response System (PERS)

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

Adult day health care services

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

AIDS adult day health care services

- Must be recommended by your Primary Care Provider (PCP).
- Provides general medical and nursing care, substance use supportive services, mental health supportive services, nutritional services, plus socialization, recreational and wellness/health promotion activities.

Therapy for tuberculosis

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

Hospice care

- Hospice helps patients and their families with their special needs that come during the final stages of illness and after death.
- Must be medically needed and arranged by Empire.
- Provides support services and some medical services to patients who are ill and expect to live for one year or less.
- You can get these services in your home or in a hospital or nursing home.

Children under age twenty-one (21) who are getting hospice services can also get medically needed curative services and palliative care.

If you have any questions about this benefit, you can call Member Services Department at 1-800-300-8181 (TTY 711).

Dental Care

- Empire believes that providing you with good dental care is important to your overall health care. We offer dental care through a contract with HealthPlex, an expert in providing high quality dental services; 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 get dental services

Once you enroll in Empire, you will receive a letter from our Member Services department letting you know that it is time to choose your primary care dentist (PCD). You must choose a PCD within 30 days from the date of this letter, or we will choose one for you.

If you need to find a dentist or change your dentist, please call HealthPlex toll-free at 1-800-468-9868 or

please call Empire at 1-800-300-8181 (TTY 711). Customer Services Representatives are there to help you. Many speak your language or have a contract with Language Line Services.

Show your Member ID card to access dental benefits. You will not receive a separate dental ID card. When you visit your dentist, you should show your plan ID card.;

You can also go to a dental clinic that is run by an academic dental center without a referral. Plans should either list academic dental centers within a (30) thirty mile radius or include toll free member services number for members to call.

Orthodontic care

Empire will cover braces for children up to age 21 who have a severe problem with their teeth, such as; can't chew food due to severely crooked teeth, cleft palette or cleft lip.

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

Pharmacy

- Prescription drugs
- Over-the-counter medicines
- Insulin and diabetic supplies
- Smoking cessation agents, including OTC products
- Hearing aid batteries
- Enteral formula
- Emergency Contraception (6 per calendar year)
- Medical and surgical supplies

A pharmacy co-payment may be required for some people, for some medications and pharmacy items. There are no co-pays for the following members or services:

- Consumers younger than 21 years old.
- Consumers who are pregnant. Pregnant women are exempt during pregnancy and for the two months after the month in which the pregnancy ends.

- Consumers in an OMH or OPWDD Home and Community Based Services (HCBS) Waiver Program.
- Consumers in a DOH HCBS Waiver Program for Persons with Traumatic Brain Injury (TBI).
- Family Planning drugs and supplies like birth control pills and male or female condoms.
- Generic co-pays (if Plan is waiving copay)
- Drugs to treat mental illness (psychotropic) and tuberculosis

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

There is a co-payment for each new prescription *and* each refill.

If you have a co-pay, you are responsible for a maximum of \$200 per calendar year.

If you transferred plans during the calendar year, keep your receipts as proof of your co-payments or you may request proof of paid co-payments from your pharmacy. You will need to give a copy to your new plan.

Certain medications may require that your doctor get prior authorization from us before writing your prescription. Your doctor can work with Empire to make sure you get the medications that you need. Learn more about prior authorization later in this handbook.

You have a choice in where you fill your prescriptions. You can go to any Pharmacy that participates with our plan or you can fill your prescriptions by using a mail order pharmacy. For more information on your options, please contact Member Services at 1-800-300-8181 (TTY 711).

Hospital care

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

Emergency care

- Emergency care services are procedures, treatments or services needed to evaluate or stabilize an emergency.

- After you have received emergency care, you may need other care to make sure you remain in stable condition. Depending on 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 section “Emergencies.”

Specialty care

Includes the services of other practitioners, including

- Occupational, physical and speech therapists– Limited to twenty (20) visits per therapy per calendar year, except for children under age 21, or if you have been determined to be developmentally disabled by the Office for People with Developmental Disabilities or if you have a traumatic brain injury.
- Audiologists
- Midwives
- Cardiac rehabilitation
- Podiatrists if you are diabetic

Residential health care facility care (Nursing Home)

- Includes short term, or rehab, stays and long term care;
- Must be ordered by a physician and authorized by Empire;
- Covered nursing home services include medical supervision, 24-hour nursing care, assistance with daily living, physical therapy, occupational therapy, and speech-language pathology.

If you are in need of long term placement in a nursing home, your local department of social services must determine if you meet certain Medicaid income requirements. Empire and the nursing home can help you apply.

You must get this care from a nursing home that is in Empire’s provider network. If you choose a nursing home outside of Empire’s network, you may have to transfer to another plan. Call New York Medicaid Choice at Number for help with questions about nursing home providers and plan networks. Call 1-800-300-8181 (TTY 711) for help finding a nursing home in our network.

Behavioral health care

Behavioral health care includes mental health and substance use (alcohol and drugs) treatment and rehabilitation services. All of our members have access to services to help with emotional health, or to help with alcohol or other substance use issues. These services include:

Mental health care

- Intensive psychiatric rehab treatment
- Day treatment
- Clinic continuing day treatment
- Inpatient and outpatient mental health treatment
- Partial hospital care
- Rehab services if you are in a community home or in family-based treatment
- Continuing day treatment
- Personalized Recovery Oriented Services
- Assertive Community Treatment Services
- Individual and group counseling
- Crisis intervention services

Substance use disorder services

- Inpatient and outpatient substance use disorder (alcohol and drug) treatment
- Inpatient detoxification services
- Opioid, including Methadone Maintenance treatment
- Residential Substance Use Disorder Treatment
- Outpatient alcohol and drug treatment services Detox services

Transportation

Emergency: If you need emergency transportation, call 911.

Nonemergency:

If you live in Nassau County, you or your provider should call LogistiCare at 1-866-481-9488 (TTY 1-866-288-3133). If possible, you or your provider should call LogistiCare at least three days before your medical appointment and provide your Empire ID number (e.g., AB12345C), appointment date and time, address where you are going, and doctor you are seeing.

Routine and nonemergency medical transportation includes personal vehicle, bus, taxi, ambulette and public transportation.

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 1-800-300-8181 (TTY 711).

*Emergency and nonemergency transportation is covered by regular Medicaid in New York City. See section "Benefits using your Medicaid card only."

Other Covered Services

- Durable Medical Equipment (DME) / Hearing Aids / Prosthetics /Orthotics
- Court Ordered Services
- Case Management
- Help getting social support services
- FQHC
- Family Planning
- Services of a Podiatrist for children under 21 years old.

Benefits you can Get From Empire *OR* With Your Medicaid Card

For some services, you can choose where to get the care. You can get these services by using your Empire 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 1-800-300-8181 (TTY 711).

Family Planning

You can go to any doctor or clinic that takes Medicaid and offers family planning services. You can visit one of our family planning providers as well. Either way, you do not need a referral from your PCP.

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

HIV and STI screening

You can get this service any time from your PCP or Empire doctors. When you get this service as part of a family planning visit, you can go to any doctor or clinic that takes Medicaid and offers family planning

services. You do not need a referral when you get this service as part of a family planning visit.

Everyone should talk to their doctor about having an HIV test. To access free HIV testing or testing where your name isn't given, call 1-800-541-AIDS (English) or 1-800-233-SIDA (Spanish).

TB diagnosis and treatment

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

Benefits using your MEDICAID CARD only

There are some services Empire does not provide. You can get these services from a provider who takes Medicaid by using your Medicaid Benefit card.

Transportation

If you live in Putnam, emergency and/or non-emergency medical transportation will be covered by regular Medicaid. To get non-emergency transportation, you or your provider must call Medical Answering Services (MAS) at 1-800-850-5340. If possible, you or your provider should call MAS at least 3 days before your medical appointment and provide your Medicaid identification number (ex. AB12345C), appointment date and time, address where you are going, and doctor you are seeing. Non-emergency medical transportation includes: personal vehicle, bus, taxi, ambulette and public transportation.

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

If you live in New York City, emergency and/or non-emergency medical transportation will be covered by regular Medicaid. To get non-emergency transportation, you or your provider must call Medical Answering Services (MAS) at 1-800-850-5340. If possible, you or your provider should call MAS at least 3 days before your medical appointment and provide your Medicaid identification number (ex. AB12345C), appointment date and time, address where you are going, and doctor you are seeing. Non-emergency medical transportation includes: personal vehicle, bus, taxi, ambulette and public transportation.

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

Developmental disabilities

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

Services not covered

These services are **not available** from Empire or Medicaid. If you get any of these services, you may have to pay the bill.

- Cosmetic surgery if not medically needed
- Services of a Podiatrist (for those 21 years and older unless you are a diabetic)
- Personal and comfort items
- Infertility treatments
- Services from a provider that is not part of Empire, unless it is a provider you are allowed to see as described elsewhere in this handbook or Empire 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. Or, 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:

- Noncovered services (listed above),
- Unauthorized services,
- Services provided by providers not part of Empire

If you get a bill

If you get a bill for a treatment or service you do not think you should pay for, do not ignore it. Call Empire at 1-800-300-8181 (TTY 711) right away. Empire can help you understand why you may have gotten a bill. If you are not responsible for payment, Empire will contact the provider and help fix the problem for you.

You have the right to ask for fair hearing if you think you are being asked to pay for something Medicaid or Empire should cover. See the Fair Hearing section later in this handbook.

If you have any questions, call Member Services at 1-800-300-8181 (TTY 711).

Service authorization and actions

Prior authorization and timeframes

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:

- Some ambulatory surgery
- Chemotherapy
- Dialysis
- Durable medical equipment
- Growth hormone evaluation and therapy
- Digital hearing aids
- Home care
- Hyperbaric oxygen therapy
- Inpatient services
- Lithotripsy
- Non-emergent fixed wing transportation
- Obstetrical services (except family planning services)
- Oxygen equipment — respiratory therapy
- Prosthetics and orthotics
- Some drugs
- Transplant evaluation

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:

Ask your doctor to call the Empire Medical Management department at 1-800-450-8753. If necessary, your doctor can call for an approval after hours and on weekends by calling this number.

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 within 14 days if we need more information.

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

- 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.
- If you are getting inpatient substance use disorder treatment, and you ask for more services at least 24 hours before you are to be discharged, we will make a decision no later than 24 hours.

In all cases, you will hear from us no later than three working 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 1-800-300-8181 (TTY 711) or writing to:

Health Care Management Services
Empire BlueCross BlueShield HealthPlus
9 Pine St., 14th Floor
New York, NY 10005.

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.

We must tell you at least 10 days before we make any decision about long term services and supports, such as home health care, personal care, CDPAS, adult day health care, and permanent nursing home care.

If we are checking care that has been given in the past, we will make a decision about paying for it within 30 days of receiving 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. These notices are not bills.

You will not have to pay for any care you received that was covered by the plan or by Medicaid even if we later deny payment to the provider.

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 1-800-300-8181 (TTY 711) 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 1-800-300-8181 (TTY 711) to find out how you can help.

Information from Member Services

Here is information you can get by calling Member Services at 1-800-300-8181 (TTY 711):

- A list of names, addresses, and titles of Empire'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 Department of Financial Services about consumer complaints about Empire.
- How we keep your medical records and member information private.
- In writing, we will tell you how Empire 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 Empire.
- If you ask in writing, we will tell you the qualifications needed and how health care providers can apply to be part of Empire.

- 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 at 1-800-300-8181 (TTY 711) 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 in another program.

Disenrollment and transfers

If YOU want to leave Empire

You can try us out for 90 days. You may leave Empire 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 Empire for nine more months, *unless* you have a good reason (good cause).

Some examples of good cause include:

- Our health plan does not meet New York State requirements and members are harmed because of it.
- You move out of our service area.
- You, the plan, and the 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.

To change plans:

- Call the Managed Care staff at your local Department of Social Services.
- If you live in New York City, Nassau, or Putnam, call New York Medicaid Choice at 1-800-505-5678. The New York Medicaid Choice counselors can help you change health plans.

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

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

You can ask for faster action if you believe the timing of the regular process will cause added damage to your health. You can also ask for faster action if you have complained because you did not agree to the enrollment. Just call your local Department of Social Services (see “Important Phone Numbers”) or New York Medicaid Choice at 1-800-505-5678.

You could become ineligible for Medicaid Managed Care

You or your child may have to leave Empire BlueCross BlueShield HealthPlus if you or the child:

- Move out of the County or service area
- Change to another managed care plan
- Join an HMO or other insurance plan through work
- Go to prison
- Otherwise lose eligibility

Your child may have to leave Empire or *change plans if he or she:

- Joins a Physically Handicapped Children’s Program, or
- Is placed in foster care by an agency that has a contract to provide that service for the local Department of Social Services, including all children in foster care in New York City, or
- Is placed in foster care by the local Department of Social Services in an area that is not served by your child’s current plan.
- If you have to leave Empire or become ineligible for Medicaid, all of your services may stop unexpectedly, including any care you receive at home. Call New York Medicaid Choice at 1-800-505-5769 right away if this happens.

We Can Ask You to Leave Empire

You can also lose your Empire 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 Empire'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
- 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 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 at 1-800-300-8181 (TTY 711) 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.

To file an action appeal, write to:

Medical Appeals
Empire BlueCross BlueShield HealthPlus

P.O. Box 62429
Virginia Beach, VA 23466-2429

To file an action appeal by phone, call 1-800-300-8181 (TTY 711).

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; or
- If your request was denied when you asked for more inpatient substance use disorder treatment at least 24 hours before you were to leave the hospital.

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.
- Nonclinical 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 the Empire Appeals Department at 1-866-696-4701 if you are not sure what information to give us.
- 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 working 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 working days from your action appeal.

- We will tell you within three working days after giving us your action appeal if we need more information.
- If your request was denied when you asked for more inpatient substance use disorder treatment at least 24 hours before you were to leave the hospital, we will make a decision about your appeal within 24 hours.
- We will tell you our decision by phone and send a written notice later.

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 1-866-696-4701 or writing:

Quality Management Department
 Empire BlueCross BlueShield HealthPlus
 9 Pine St., 11th Floor
 New York, NY 10005

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; or
- The out-of-network service was available from a plan provider who have the training and experience to meet your needs, or
- 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 **10 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

You do not have to pay for an external appeal 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; or
- The out-of-network service was available from a plan provider who have the training and experience to meet your needs, you can ask New York State for an independent **external appeal**. This is called an external appeal because it is decided by reviewers who do not work for the health plan or the state. These reviewers are qualified people approved by New York State. The service must be in the plan's benefit package or be an experimental treatment, clinical trial, or treatment for a rare disease. You do not have to pay for an external appeal.

Before you ask for an external appeal:

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

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

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 ask for an external appeal. If you choose to file a standard

action appeal with the plan, and the plan upholds its decision, you will receive a new final adverse determination and have another chance to ask for an external appeal.

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 New York State Department of Financial Services within four months 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 Department of Financial Services. You can call Member Services at 1-800-300-8181 (TTY 711) if you need help filing an appeal. You and your doctors will have to give information about your medical problem. The external appeal application says what information will be needed.

Here are some ways to get an application:

- Call the Department of Financial Services, 1-800-400-8882
- Go to the Department of Financial Services' website at www.dfs.ny.gov
- Contact the health plan at 1-866-696-4701

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: or
- You are in the hospital after an emergency room visit and the hospital care is denied by the plan.

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

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

- You ask for a fast track Internal Appeal within 24 hours and
- You ask for a fast track External Appeal at the same time

The plan will continue to pay for your stay until there is a decision made on your appeals. Your plan will make a decision about your fast track Internal Appeal in 24 hours. The fast track External Appeal will be decided in 72 hours. 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 Empire.
- You are not happy with a decision that we made about 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 care you wanted. You feel the decision limits your Medicaid benefits.
- You are not happy about a decision we made to deny payment for care you received. 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 Empire. If Empire 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 going to be reduced, stopped, or restricted, you can choose to ask to continue the services your doctor ordered while you wait for your case to be decided.

You must ask for a fair hearing **within 10 days** from the date of the notice that says your care will change or by the time the action takes effect. 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:

- By phone – call toll-free 1-800-342-3334
- By fax – 1-518-473-6735
- By internet – www.otda.state.ny.us/oah/forms.asp
- By mail – NYS Office of Temporary and Disability Assistance

Office of Administrative Hearings
Managed Care Hearing Unit
P.O. Box 22023
Albany, New York 12201-2023

When you ask for a fair hearing about a decision Empire made, we must send you a copy of the **evidence packet**. This is information we used to make our decision about your care. The plan will give this information to the hearing officer to explain our action. If there is not time enough to mail it to you, we will bring a copy of the evidence packet to the hearing for you. If you do not get your evidence packet by the week before your hearing, you can call 1-800-300-8181 TTY 711 to ask for it.

Remember, you may 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 Health Plan Contracting & Oversight
Bureau of Consumer Services
ESP Corning Tower Room 2019
Albany, NY 12237

You may also contact your local Department of Social Services with your complaint at any time. You may call the New York State Department of Financial Services at 1-800-342-3736 if your complaint involves a billing problem.

How to file a complaint with our plan

To file by phone, call Member Services at 1-800-300-8181 (TTY 711) Monday through Friday from 8 a.m. to 8 p.m. If you call us after hours, leave a message. We will call you back the next work day. If we need more information to make a decision, we will tell you.

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

Complaint Specialist
Quality Management Department
Empire BlueCross BlueShield HealthPlus
9 Pine St., 14th Floor
New York, NY 10005

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 Empire, 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 Empire.
- 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 Empire complaint system to settle any complaints, or you can complain to the New York State Department of Health or the local Department of Social Services any time you feel you were not fairly treated.
- Use the State Fair Hearing system
- Appoint someone (relative, friend, lawyer, etc.) to speak for you if you are unable to speak for yourself about your care and treatment.
- Receive considerate and respectful care in a clean and safe environment free of unnecessary restraints

Your Responsibilities

As a member of Empire, 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.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION WITH REGARD TO YOUR HEALTH BENEFITS. PLEASE REVIEW IT CAREFULLY.

HIPAA Notice of Privacy Practices

The original effective date of this notice was April 14, 2003. The most recent revision date is shown at the end of this notice.

Please read this notice carefully. This tells you who can see your protected health information (PHI). It tells you when we have to ask for your OK before we share it. It tells you when we can share it without your OK. It also tells you what rights you have to see and change your information.

Information about your health and money is private. The law says we must keep this kind of information, called PHI, safe for our members. That means if you're a member right now or if you used to be, your information is safe.

We get information about you from state agencies for Medicaid, the Essential Plan, and the Children's Health Insurance Program after you become eligible and sign up for our health plan. We also get it from your doctors, clinics, labs and hospitals so we can OK and pay for your health care.

Federal law says we must tell you what the law says we have to do to protect PHI that's told to us, in writing or saved on a computer. We also have to tell you how we keep it safe. To protect PHI:

- On paper (called physical), we:
 - Lock our offices and files
 - Destroy paper with health information so others can't get it
- Saved on a computer (called technical), we:
 - Use passwords so only the right people can get in
 - Use special programs to watch our systems
- Used or shared by people who work for us, doctors or the state, we:
 - Make rules for keeping information safe (called policies and procedures)
 - Teach people who work for us to follow the rules

When is it OK for us to use and share your PHI?

We can share your PHI with your family or a person you choose who helps with or pays for your health care if you tell us it's OK. Sometimes, we can use and share it **without** your OK:

- **For your medical care**
 - To help doctors, hospitals and others get you the care you need
- **For payment, health care operations and treatment**
 - To share information with the doctors, clinics and others who bill us for your care
 - When we say we'll pay for health care or services before you get them
 - To find ways to make our programs better, as well as giving your PHI to health information exchanges for payment, health care operations and treatment. If you don't want this, please visit www.empireblue.com/ny for more information.

- **For health care business reasons**
 - To help with audits, fraud and abuse prevention programs, planning, and everyday work
 - To find ways to make our programs better
- **For public health reasons**
 - To help public health officials keep people from getting sick or hurt
- **With others who help with or pay for your care**
 - With your family or a person you choose who helps with or pays for your health care, if you tell us it's OK
 - With someone who helps with or pays for your health care, if you can't speak for yourself and it's best for you

We must get your OK in writing before we use or share your PHI for all but your care, payment, everyday business, research or other things listed below. We have to get your written OK before we share psychotherapy notes from your doctor about you.

You may tell us in writing that you want to take back your written OK. We can't take back what we used or shared when we had your OK. But we will stop using or sharing your PHI in the future.

Other ways we can — or the law says we have to — use your PHI:

- To help the police and other people who make sure others follow laws
- To report abuse and neglect
- To help the court when we're asked
- To answer legal documents
- To give information to health oversight agencies for things like audits or exams
- To help coroners, medical examiners or funeral directors find out your name and cause of death
- To help when you've asked to give your body parts to science
- For research
- To keep you or others from getting sick or badly hurt
- To help people who work for the government with certain jobs
- To give information to workers' compensation if you get sick or hurt at work

What are your rights?

- You can ask to look at your PHI and get a copy of it. We don't have your whole medical record, though. **If you want a copy of your whole medical record, ask your doctor or health clinic.**
- You can ask us to change the medical record we have for you if you think something is wrong or missing.
- Sometimes, you can ask us not to share your PHI. But we don't have to agree to your request.
- You can ask us to send PHI to a different address than the one we have for you or in some other way. We can do this if sending it to the address we have for you may put you in danger.
- You can ask us to tell you all the times over the past six years we've shared your PHI with someone else. This won't list the times we've shared it because of health care, payment, everyday health care business or some other reasons we didn't list here.
- You can ask for a paper copy of this notice at any time, even if you asked for this one by email.
- If you pay the whole bill for a service, you can ask your doctor not to share the information about that service with us.

What do we have to do?

- The law says we must keep your PHI private except as we've said in this notice.
- We must tell you what the law says we have to do about privacy.
- We must do what we say we'll do in this notice.
- We must send your PHI to some other address or in a way other than regular mail if you ask for reasons that make sense, like if you're in danger.
- We must tell you if we have to share your PHI after you've asked us not to.
- If state laws say we have to do more than what we've said here, we'll follow those laws.
- We have to let you know if we think your PHI has been breached.

We may contact you

You agree that we, along with our affiliates and/or vendors, may call or text any phone numbers you give us, including a wireless phone number, using an automatic telephone dialing system and/or a pre-recorded message. Without limit, these calls or texts may be about treatment options, other health-related benefits and services, enrollment, payment, or billing.

What if you have questions?

If you have questions about our privacy rules or want to use your rights, please call Member Services at **1-800-300-8181 (TTY 711)**.

What if you have a complaint?

We're here to help. If you feel your PHI hasn't been kept safe, you may call Member Services or contact the Department of Health and Human Services. Nothing bad will happen to you if you complain.

Write to or call the Department of Health and Human Services:

Office for Civil Rights
U.S. Department of Health and Human Services
Jacob Javits Federal Building
26 Federal Plaza, Suite 3312
New York, NY 10278
Phone: 1-800-368-1019
TDD: 1-800-537-7697
Fax: 1-212-264-3039

We reserve the right to change this Health Insurance Portability and Accountability Act (HIPAA) notice and the ways we keep your PHI safe. If that happens, we'll tell you about the changes in a newsletter. We'll also post them on the Web at **www.empireblue.com/ny**.

Race, ethnicity and language

We receive race, ethnicity and language information about you from the state Medicaid agency, the Essential Plan and the Children's Health Insurance Program. We protect this information as described in this notice.

We use this information to:

- Make sure you get the care you need
- Create programs to improve health outcomes
- Develop and send health education information
- Let doctors know about your language needs
- Provide translator services

We do **not** use this information to:

- Issue health insurance
- Decide how much to charge for services
- Determine benefits
- Disclose to unapproved users

Your personal information

We may ask for, use and share personal information (PI) as we talked about in this notice. Your PI is not public and tells us who you are. It's often taken for insurance reasons.

- We may use your PI to make decisions about your:
 - Health
 - Habits
 - Hobbies
- We may get PI about you from other people or groups like:
 - Doctors
 - Hospitals
 - Other insurance companies
- We may share PI with people or groups outside of our company without your OK in some cases.
- We'll let you know before we do anything where we have to give you a chance to say no.
- We'll tell you how to let us know if you don't want us to use or share your PI.
- You have the right to see and change your PI.
- We make sure your PI is kept safe.

Revised January 11, 2016

IMPORTANT PHONE NUMBERS

Your PCP..... _____
(write number above)

Empire BlueCross BlueShield HealthPlus
Member Services..... 1-800-300-8181)
Member Services TTY/TDD 711
24/7 NurseLine 1-800-300-8181
Quality Management (Complaints and Appeals) 1-866-696-4701

Your nearest Emergency Room..... _____
(write number above)

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

Human Resources Administration (HRA) 1-718-557-1399
Putnam County Department of Social Services (LDSS) 1-845-225-7040
New York City Department of Social Services (LDSS) 1-877-472-8411

New York Medicaid Choice 1-800-505-5678

Local Pharmacy _____
(write number above)

Other Health Providers:

(write number above)

(write number above)

(write number above)

Empire BlueCross BlueShield HealthPlus is the trade name of HealthPlus HP, LLC, an independent licensee of the Blue Cross and Blue Shield Association.

Empire BlueCross BlueShield HealthPlus follows Federal civil rights laws. We don't discriminate against people because of their:

- Race
- Color
- National origin
- Age
- Disability
- Sex or gender identity

That means we won't exclude you or treat you differently because of these things.

Communicating with you is important

For people with disabilities or who speak a language other than English, we offer these services at no cost to you:

- Qualified sign language interpreters
- Written materials in large print, audio, electronic, and other formats
- Help from qualified interpreters in the language you speak
- Written materials in the language you speak

To get these services, call the Member Services number on your ID card. Or you can call our Grievance Coordinator at 1-212-563-5570, ext. 66578.

Your rights

Do you feel you didn't get these services or we discriminated against you for reasons listed above? If so, you can file a grievance (complaint). File by mail or phone:

Grievance Coordinator
9 Pine St., 14th Floor
New York, NY 10005
Phone: 1-212-563-5570, ext. 66578 (TTY 711)

Need help filing? Call our Grievance Coordinator at the number above. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights:

- **On the Web:** <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>
- **By mail:** U.S. Department of Health and Human Services
200 Independence Avenue
SW Room 509F, HHH Building
Washington, D.C. 20201
- **By phone:** 1-800-368-1019 (TTY/TDD 1-800-537-7697)

For a complaint form, visit www.hhs.gov/ocr/office/file/index.html.

LANGUAGE ASSISTANCE

We can translate this at no cost. Call Member Services at 1-800-300-8181 (TTY 711).	English
Ofrecemos servicios de traducción sin costo. Comuníquese con Servicios para los Miembros al 1-800-300-8181 (TTY 711).	Spanish
我們可以免費翻譯該文件。請致電會員服務號碼 1-800-300-8181 (TTY 711)。	Chinese
يمكننا ترجمة هذا المستند مجاناً، اتصل (بخدمات الأعضاء) على رقم 1-800-300-8181 (TTY 711).	Arabic
비용 없이 이 자료를 저희가 번역해드립니다. 가입자 서비스부에 1-800-300-8181 (TTY 711)번으로 연락해 주십시오.	Korean
Мы можем это бесплатно перевести. Позвоните в Member Services по телефону 1-800-300-8181 (TTY 711).	Russian
Possiamo fornire la traduzione gratuitamente. Chiamare i Servizi per il Cliente al 1-800-300-8181 (TTY 711).	Italian
Nous pouvons traduire cela sans frais. Appelez Services aux membres au 1-800-300-8181 (TTY 711).	French
Nou ka tradui dokiman sa a gratis. Rele Sèvis Manm lan nan 1-800-300-8181 (TTY 711).	French Creole
מיר קענען איבערזעצן דעם פֿאַר קיין באַצאָלן. רופֿבאַדינונגס פֿאַר מיטגלידע ביי 1-800-300-8181 (טטי 711).	Yiddish
Możemy przetłumaczyć to bezpłatnie. Zadzwoń do usług członkowskich pod numer 1-800-300-8181 (TTY 711).	Polish
Maaaari kaming magsalin nang walang bayad. Tumawag sa Member Services sa 1-800-300-8181 (TTY 711).	Tagalog
আমরা এটা বিনামূল্যে অনুবাদ করতে পারি। 1-800-300-8181 (TTY 711) নম্বরে সদস্য পরিষেবায় ফোন করুন	Bengali
Këtë mund ta përkthejmë pa pagesë. Telefononi Member Services në numrin 1-800-300-8181 (TTY 711).	Albanian
Μπορούμε να το μεταφράσουμε δωρεάν. Καλέστε τις Υπηρεσίες για τα μέλη στο τηλέφωνο 1-800-300-8181 (TTY 711).	Greek
ہم بنا کسی اخراجات اس کا ترجمہ کر سکتے ہیں۔ Member Services کو 1-800-300-8181 (TTY 711) پر کال کریں۔	Urdu