Empire BlueCross BlueShield

An Anthem Company

Member Handbook

New York
Managed Long-Term Care Program

1-800-950-7679 (TTY 711)

www.empireblue.com/ny

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Empire BlueCross BlueShield

An Anthem Company

Dear Member:

Welcome to Empire BlueCross BlueShield HealthPlus (Empire)! We are delighted that you have selected Empire as your managed long-term care plan and are confident that you will be very satisfied with your choice.

You will receive your Empire member ID card within 14 days of your enrollment effective date. Your ID card will tell you when your Empire membership starts. Please check your ID card right away. If any information is not right, we will send you a new ID card with the correct information.

Please take some time to review your member handbook and the provider directory you received during your home visit with a care coordinator.

Para recibir esta información en español, llame a Servicios al Miembro al 1-800-950-7679.

要接收此資訊的中文版本，請致電 1-800-950-7679 聯絡會員服務部。

You have been assigned your own care manager, who is a registered nurse. Your care manager will assess your condition and adjust your services to meet your individual needs.

Your care manager will also be available to answer your questions over the telephone and work with your providers to make sure that you have the right care at the right time. To reach your care manager, just call our Member Services department at 1-800-950-7679. You can call us Monday through Friday from 8:30 a.m. to 5 p.m.

We also have a **24/7 NurseLine**. You can call toll free at 1-800-950-7679 to talk to a nurse after normal business hours. This service is **free**.

If you have any questions about Empire, the member handbook or the provider directory, or you need additional copies of the handbook or directory, please call us. Please also be sure to let us know if your address changes. You can also tell us about your ideas or concerns.

Sincerely,

Member Services Department

www.empireblue.com/ny

Empire BlueCross BlueShield HealthPlus
Managed Long-Term Care Program
21 Penn Plaza, 360 W. 31st St., Fifth Floor • New York, NY 10001
1-800-950-7679 (TTY 711)
www.empireblue.com/ny

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Welcome to the Empire Managed Long-Term Care Plan

We are delighted that you have selected Empire as your managed long-term care plan. We want to make sure your needs are addressed appropriately and any questions are answered promptly. The Empire enrollment specialists and care managers, experienced in caring for those with chronic illness, will work closely with you, your informal supports and your physician(s) to help develop a plan of care that will effectively address your individual needs.

If you have any questions or concerns, or want to speak with <u>any</u> Empire staff, please call our Member Services department at 1-800-950-7679.

A representative will be happy to connect you with the appropriate individual to answer all of your questions. Once again, thank you for selecting Empire as your managed long-term care plan. We are confident that you will be very satisfied with your choice.

How to Use This Handbook

Use this member handbook as an important resource to obtain information about Empire. This member handbook is issued to each member in the Empire Managed Long-Term Care plan. The information in this member handbook, along with any attachments or changes, is the entire contract between the member and Empire. By enrolling, members agree to terms and conditions of membership as described in this member handbook. This contract describes the members' rights and responsibilities in relation to receiving covered benefits and the steps you can take to make Empire work right for you.

Keep this handbook in a convenient place for future reference. If you can't find the information that you are looking for, or need additional information or help, our Member Services department is available to assist you. The Member Services department will put you in touch with your care manager. To contact Member Services, please use the following number:

- **Member Services:** 1-800-950-7679
- **Hours of operation:** Monday through Friday, 8:30 a.m.-5 p.m.

After normal hours of operation, your call will automatically be transferred to the 24/7 NurseLine.

How Managed Long-Term Care Works

A managed long-term care plan is an entity that receives Medicaid funding to arrange, coordinate and pay for health and long-term care services for people who are chronically ill and/or have disabilities.

Empire has been approved by the New York State Department of Health to offer you managed long-term care. Through Empire, you will receive coordination of medical, specialty, and home- and community-based services to help maintain or improve your quality of life and overall health, despite chronic illness. Through our coordination and oversight, we will help you live fully and safely stay in your home and/or community for as long as possible.

As a member of Empire, you will also receive:

- A care manager, a registered nurse who will help ensure that you receive appropriate, timely care to meet your specific needs
- A reassessment nurse, an RN who will visit you in your home to assess your needs
- A personalized plan of care that you, the care manager and your primary care physician design just for you
- Extensive choices in providers that offer your managed long-term care benefits
- Access to the Empire NurseLine 24 hours a day, 7 days a week, to answer your questions

The Empire Managed Long-Term Care Plan Is Special

Empire was established in the early 1990s and is one of the fastest growing Medicaid managed care organizations in New York City. We currently provide health care coverage to over 115,000 New Yorkers across all of our product lines, which include Medicaid Managed Care, Child Health Plus, Managed Long-Term Care and our Medicare Amerivantage Managed Care product.

The Empire name represents a well-developed managed care framework and helps us to coordinate and ensure an outstanding level of service to meet your special needs. Through our years of experience in Medicaid Managed Care, we have established strong community ties and a respected relationship with local health care organizations and providers who have been carefully selected to meet the highest standards of care. As a member, you will receive a personalized plan of care through a wide range of long-term care and health-related services in your home, the community and, if necessary, in a nursing home. We will also assist you in obtaining other services that are not covered by Empire.

Your Privacy is Important to Empire

Empire will ask you questions to confirm your identity before we discuss or provide any information regarding your health records. We want to protect your right to privacy and confidentiality. We will only release information if it is specifically permitted by state and federal law or if it is required for use by programs that review medical records to monitor quality of care or to prevent fraud or abuse. We will also release information if we receive written permission from you or from someone you designate. For members who are HIV-positive, we follow all applicable New York state laws that govern the disclosure of HIV-related information.

Important Information about Advance Directives

You have a right to make your own health care decisions. Sometimes, as a result of a serious accident or illness, that may not be possible. You can prepare ahead of time for situations where you may be unable to make important health care decisions on your own. Preparing an advance directive will help ensure that all of your health care wishes are followed.

There are many different types of advance directives:

Health Care Proxy — This document enables competent adults to protect their health care wishes by appointing someone they trust — a health care agent — to decide about treatment on their behalf when they are unable to decide for themselves.

Do Not Resuscitate Order	You have the right to decide if you want emergency treatment to restart your heart or lungs if your breathing or circulation stops. If you do not want cardiopulmonary resuscitation, you should make your wishes known in writing. Your primary care physician can 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. You can also complete the back of your New York state driver's license or non-driver identification card to let others know if and how you want to donate your organs.
Living Will	You can give written specific instructions about treatment in advance of situations where you may be unable to make important health care decisions on your own.

It is your choice whether you wish to complete an advance directive and which type of advance directive is best for you. You may complete any, all, or none of the advance directives listed above. The law forbids any discrimination against providing you medical care based on whether you have an advance directive or not.

For more information regarding advance directives, please speak with your care manager or your primary care physician.

The enrollment packet for Empire contains forms to complete for advance directives. If you need additional forms, Empire will provide those to you if you wish to complete an advance directive. You do not have to use a lawyer, but you may wish to speak with one about this important issue. You can change your mind and these documents at any time. If you wish to make any changes, contact your care manager.

Joining Empire

Enrollment in Empire is voluntary. If you are an applicant, you may withdraw your application at any time prior to enrollment. If you are an Empire member, you may initiate disenrollment at any time, for any reason.

Any person who completes the enrollment agreement, the appropriate release of medical information, and meets <u>all</u> of the following criteria is eligible for the Empire Managed Long-Term Care plan.

Applicants cannot be discriminated against based on their health status, and/or the need for or cost of covered services.

Enrollment Criteria
The applicant must:
• Be 18 years of age or older
• Be eligible for New York State Medicaid as determined by New York City Human Resources Administration (HRA)
• Live in Brooklyn, Bronx, Manhattan, Queens or Staten Island
• At the time of enrollment, have health problems and/or limitations that would qualify for nursing home level of care*
• Require at least one of the following services and care management, from Empire for at least 120 days from the effective date of enrollment:* – Nursing services in the home – Private-duty nursing – Therapies in the home – Home health aide services – Personal care services in the home – Adult day health care – Social day care (if used as a substitute for in-home personal care services)
• At the time of enrollment, be able to return to/or remain safely at home without jeopardy to his/her health*

*Determination is made based upon individual circumstances in accordance with New York state assessment guidelines.

If it is determined through the screening process that the applicant is enrolled in another managed care plan capitated by Medicaid, a Home- and Community-based Services Medicaid Waiver program or State Office for People with Developmental Disabilities (OPWDD) Day Treatment Program or is receiving services from a hospice, the individual may be enrolled with Empire upon termination from such other plans or programs.

Applications for enrollment may be accepted from otherwise eligible inpatients or residents of hospitals or residential facilities operated under the auspices of the State Office of Mental Health (OMH), the Office of Alcoholism and Substance Abuse Services (OASAS) or the State OPWDD, but enrollment may only begin upon discharge to the applicant's home in the community. A person who resides in a nursing home is permitted to enroll in Empire as long as a safe discharge plan has been identified.

The Enrollment Process

Eligibility for enrollment in Empire must be established through a clinical assessment process and reviewed and approved by the New York City Human Resources Administration (HRA). Enrollment is voluntary and you may choose to withdraw your application at any time.

Obtaining Information

If you would like to learn more about Empire, an enrollment coordinator can speak to you on the telephone or visit you face to face in your home.

One of our enrollment coordinators will contact you within five days of learning of your possible interest in Empire. Enrollment coordinators can review the enrollment criteria chart with you (please see the Joining Empire section), help you determine if you meet the minimum eligibility requirements (age, residence, Medicaid eligibility) to continue with your inquiry, and explain what you can expect to

experience as an Empire member. If you would like to complete the enrollment application process, the enrollment coordinator will schedule a home visit for you with one of our enrollment specialist RNs who will complete the enrollment eligibility assessment.

The Enrollment Eligibility Assessment

Enrollment specialists are registered nurses who have experience and expertise in home care, and community-based long-term care services. The enrollment specialists determine your clinical eligibility for Empire by visiting you in your home and completing a health assessment to establish the level of care needed; a health and safety assessment; and a social and environmental assessment. Home assessment visits are scheduled as soon as possible, generally within five business days of you expressing interest in applying for membership to an Empire enrollment coordinator, if you meet the minimum eligibility requirements of age, residence and service area.

During your home visit, the enrollment specialist will develop a plan of care to meet your needs. Your participation is needed and input from any family or an informal support is encouraged. The enrollment specialist will give you an enrollment application and a proposed care plan for you, and any family or informal supports you would like involved, to review. You will be advised that Empire is a voluntary program, and you are not obligated to join.

If you are interested in joining Empire, you can sign an Enrollment Agreement and Attestation, a HIPAA Release of Information and a Medical Release of Information at the end of the enrollment visit. You will only be requested to sign a Medical Release of Information if you meet the eligibility criteria and choose to enroll in the plan. It is necessary to sign a Medical Release of Information so Empire can speak with your primary care physician (PCP) and your other health care providers in order to establish and coordinate the services included in the plan of care. A HIPAA Release of Information allows Empire to contact the New York City Human Resources Administration (HRA). Following the enrollment visit, Empire will contact your PCP to discuss the proposed care plan. If your physician agrees to collaborate with Empire, your application will be submitted for processing to the HRA. If your physician does not want to collaborate with Empire, you will be notified before your application can be processed. The reason(s) that your physician does not want to collaborate with Empire will be discussed with you and you can decide whether you want to change physicians.

If you would like time to think about joining Empire or need more information, we can schedule additional home visits to address any questions that you may have.

Your enrollment in Empire is subject to review and approval by the HRA.

Upon enrollment, you will be issued an Empire member ID card. **It is important that you bring this membership card along with your Medicare and Medicaid cards to all appointments.**

Denial of Enrollment

An applicant can be denied enrollment by HRA for one or more of the following reasons:

- Applicant is not at least 18 years of age
- Applicant is not Medicaid-eligible
- Applicant is not eligible for nursing home level of care
- Applicant is not capable of returning to or remaining in the home without jeopardy to his/her health or safety at the time of enrollment
- Applicant does not require long-term care services from the Empire Managed Long-Term Care plan for 120 days or more
- Applicant's physician will not collaborate with Empire Managed Long-Term Care plan, and applicant does not want to change primary care physicians (collaboration by a physician means the willingness to write orders for covered services that allows you to receive care from network providers)
- Applicant has been previously involuntarily disenrolled from Empire
- Applicant is currently enrolled in another Medicaid managed care plan, a home- and community-based services waiver program, a State Office for People with Developmental Disabilities (OPWDD) Day Treatment Program, or is receiving services from a hospice and does not wish to end his/her enrollment in one of these programs
- Applicant is an inpatient or resident of a hospital or residential facility operated by the state Office of Mental Health (OMH), Office of Alcohol and Substance Abuse Services (OASAS) or the State OPWDD; applications for enrollment may be taken, but enrollment may only begin upon discharge to the applicant's home in the community

If Empire determines that the enrollment should be denied based on failure to meet the enrollment criteria, Empire will recommend to HRA that the enrollment application should be denied. Empire will also send you a letter. HRA makes the final determination in the denial of enrollment, and HRA will notify you of your rights. You may withdraw your application at any time prior to the effective date of enrollment by indicating your wishes verbally or in writing, and a written acknowledgement of your withdrawal will be sent to you.

If it is determined that you are ineligible due to age, residence location, or Medicaid eligibility, Empire will advise you. If you disagree with Empire that you are ineligible due to age, residence or Medicaid eligibility, any information you have provided to Empire will be sent in writing to HRA with a copy to you. HRA will decide if Empire was correct in informing you that you are ineligible to enroll in Empire. If HRA agrees that you are ineligible to enroll, then you will be denied enrollment.

If you are determined to be clinically ineligible for Empire, you will be advised and you may withdraw the application. Clinical ineligibility means that, based on the in-home assessment, you do not require a nursing home level of care (SAAM score of five or more); and/or you do not meet health and safety criteria; and/or you do not require managed long-term care services of the plan for at least 120 days. If you do not wish to withdraw, the application will be processed as a proposed denial, pending HRA agreement.

Your Care Team

The most important benefit of joining Empire is that you will have a single number to call to access the appropriate, medically necessary care for your health needs: 1-800-950-7679. All of your care will be coordinated and managed by a registered nurse care manager. An Empire coordinator, a registered nurse with expertise in community-based home care, will also make periodic visits to your home to reassess your condition. Our number one priority is to help you manage your chronic condition and live in the

comforts of your own home as independently as possible for as long as possible. Empire arranges for the provision of the right care at the right time based upon medical necessity. We can change your plan of care as rapidly as your needs change. (Please see the section on Your Managed Long-Term Care Benefits for medical necessity rules.)

Your care team will consist of your assigned care manager, your primary care physician and other Empire support staff. Any other physicians providing you care will be involved in the care planning process. Empire support staff consists of Member Services coordinators, medical social workers, entitlement coordinators, and our medical director. Together, Empire will work with you and your physicians to help ensure you receive the appropriate services in your plan of care. If at any time the care manager notices changes in your health status, he or she will address the problem with you and your PCP.

Care Manager

The care manager is an employee of Empire and is the individual you speak with when you call Empire about your long-term care needs. Your care manager is responsible for seeking and coordinating creative solutions to meet your health and long-term care needs while ensuring quality outcomes with the goal to enhance your functionality and quality of life. Your care manager will create a care plan considering your wishes and health and long-term care needs; obtain authorization for your services; and make your access to needed services as easy as possible by coordinating and integrating covered and noncovered acute and long-term care services. Each care manager is a registered nurse whose field of expertise is caring for individuals with chronic medical needs. Your care manager will speak with you, the community care coordinator and your physician(s) to authorize and order the services outlined in the plan of care that is personally designed for you. Your care manager will work cooperatively with your primary care physician as well as other health care professionals (such as your home health care provider, nurses and physical therapists) to coordinate all of your health care needs for both covered and noncovered services. Your care manager is matched, based upon availability, to best meet your individual language and cultural needs.

Reassessment Nurse

The reassessment nurse is a registered nurse who is an employee of Empire or a qualified designee and is responsible for the community-based management and oversight of your care. The reassessment nurse conducts clinical assessments in your home; assists with the care plan development; and visits you periodically to clinically reassess you so that your care manager can adjust your care plan as your condition changes. Your reassessment nurse is matched, based upon availability, to best meet your individual language and cultural needs.

To contact your assigned care manager, call the Member Services department at 1-800-950-7679.

Empire Behavioral Health Department

The Empire Behavioral Health department will work closely with you and your care manager to assist you with your social and environmental concerns. Empire is available to advise members and their families on how to cope with chronic illness and social problems. With a referral from your care manager, a medical social worker will assist in the coordination of behavioral health care. Entitlement coordinators can also assist you with applying for any entitlements (i.e., Home Energy Assistance Program and/or food stamps), the Medicaid application and recertification process as well as any other benefits for which you are eligible. If you need assistance, let your care manager know.

If you have a situation that requires intensive intervention, contact your care manager to request that a medical social worker come to your home to meet with you and your family or informal supports.

Getting Help

Member Services Department

Empire wants you to understand your managed long-term care plan and receive the best possible care. The Member Services department exists for this purpose. If you need to reach your care manager; have any questions about benefits, services or procedures, or replacing a lost ID card; or have a concern about any aspect of Empire, please contact Member Services.

Our Member Service coordinators are available by telephone to help you regarding your membership, including benefit questions, what services are or are not covered, to verify the date and time that you have scheduled appointments, or if you need to arrange medical transportation. These courteous staff members work with your care team to schedule your appointments and order the supplies and services that you need. We also welcome any ideas or suggestions you might have regarding Empire.

Call Member Services with your comments to help us improve our services to you:

- **Member Services:** 1-800-950-7679
- **Hours of operation:** Monday through Friday, 8:30 a.m.-5 p.m.

24/7 NurseLine/After-hours Assistance

If you have medical questions and cannot reach your PCP or care manager, or if it is after normal business hours (8:30 a.m.-5 p.m.), you can always call Empire and speak directly to a nurse. The 24/7 NurseLine can give you guidance about whether you should go to the emergency room, how to deal with a personal crisis in the home, or provide instructions on how to take your medications in accordance with your prescription.

Through the 24/7 NurseLine you will have access to all interpreter services described below.

- **Member Services:** 1-800-950-7679
- **Hours of operation:** Monday through Friday, 8:30 a.m.-5 p.m.

Interpreter Services

We want you to know how to use your managed long-term care plan no matter what language you speak. The Empire staff speaks a wide variety of languages, but if you speak a language that our staff does not know, we can access an oral interpretation service (ATT Language Line) to make sure that you receive all of the information you need and that your questions are answered in your language. We also have written information in the most prevalent languages (English, Spanish and Chinese) of our members. Oral interpretation of Empire written material is also available to all our members in different languages. Taped (English and Spanish) versions of our member handbook are also available.

Please feel free to call Member Services at 1-800-950-7679 and request to speak to an interpreter or request written materials in your language.

Services for Visually Impaired Members

Empire has a LARGE print handbook available upon request for those members who are visually impaired. Taped (English and Spanish) and Braille versions of our member handbook are also available.

Our staff can also read the handbook to those members with visual impairment. Please contact Member Services to review these options.

Services for Hearing-Impaired Members

Hearing-impaired members who wish to speak with a Member Services representative should first contact our AT&T Relay Service operator at **1-800-421-1220.** The operator will then facilitate calls between hearing-impaired members and Empire. We can also set up and pay for you to have a person who knows sign language to help you.

Keep us informed

Call Member Services whenever these changes happen in your life:

- You change your name, address, or telephone number
- You have a change in circumstances that may affect your eligibility for managed long-term care, such as changes in income/resources, or living conditions
- You become covered under another health insurance such as a private health insurance

Help Improve Plan Policies

We value your ideas. You can help us develop policies that best serve our members by sharing your ideas with us. If you have an idea you would like to share or would like to work with one of our member advisory boards or committees, please let us know. You can call Member Services at 1-800-950-7679 to find out how you can help.

Your ID Card

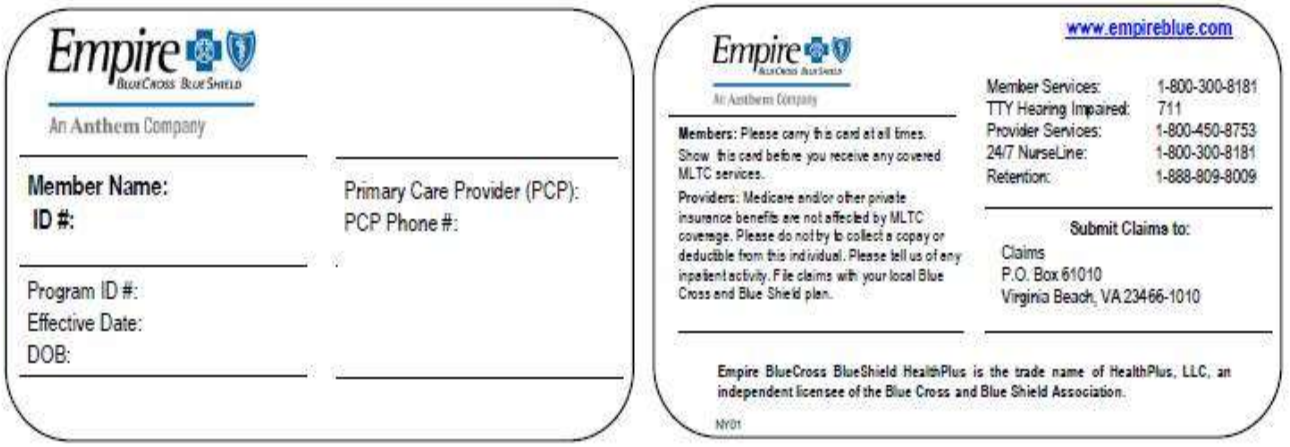
Each member will receive an Empire ID card. Empire phone numbers will appear on the front and back of this card. Carry your member ID card at all times.

You may use your ID card to receive services and benefits covered by Empire Managed Long-Term Care Plan.

You will also have continued coverage through Medicare and/or Medicaid fee-for-service and may have private insurance coverage for some of your medical needs. It is important that you carry all of your ID cards along with your Empire card.

You do not need to show your Empire ID card before you receive emergency care. Call 911 or go to the nearest emergency room.

Next is a sample indicating what your Empire identification card will look like.



Your Managed Long-Term Care Benefits

Following is a list of the Empire covered and noncovered (coordinated) services available under the managed long-term care plan. All benefits and services are provided when medically necessary.

> **Medically Necessary** – Services that are necessary to prevent, diagnose, correct or cure conditions with the enrollee that cause acute suffering, endanger life, result in illness or infirmity, interfere with such enrollee's capacity for normal activity or threaten some significant handicap.

Covered Services

Covered services are those services available through membership in managed long-term care, are generally rendered by a network provider, and are paid for by Empire. The specific service and that service's frequency and duration are based upon your medical condition, health and social needs. All covered services can be arranged by Empire on your behalf. To schedule provider appointments or arrange nonemergency transportation, please contact your care manager or Empire Member Services department who will do all of that for you.

Coordinated Services

Coordinated services are those services that are not covered by Empire. You may choose any provider for these noncovered services as long as that provider accepts Medicaid and/or Medicare, your third-party insurance coverage, or you pay privately, as applicable by service.

Your Empire care manager is here to assist you by arranging and coordinating these services for you. It is extremely important that there is communication between all the providers involved in your care as well as collaboration with you and your family or informal supports.

Your care manager is an invaluable source of information and assistance, since the care manager's primary job is to serve as a liaison between you and all of your health care providers to assure the smooth and seamless provision of care regardless of payer source.

Covered Services	Coordinated Services

• Care management
• Home health care +
• Nursing
  – Home health aide
  – Physical therapy
  – Occupational therapy
  – Speech therapy
  – Medical social services
  – Adult day health care
  – Personal care
• Medical/surgical supplies
• Durable medical equipment +
• Prosthetics and orthotics +
• Enteral and parenteral supplements
• Personal emergency response system
• Nonemergency transportation
• Podiatry +
• Dentistry
• Optometry/eyeglasses
• Audiology/hearing aids; hearing aid batteries
• Home-delivered or congregate meals
• Social day care
• Physical, occupational, speech or other therapies in a setting other than the home +
• Respiratory therapy +
• Nutritional counseling
• Social supports and modifications to the home
• Private-duty nursing
• Nursing home care *+
	• Emergency room services +
	• Physician services (including services provided in an office setting, a clinic, a facility or in the home) +
	• Inpatient hospital services +
	• Outpatient hospital services +
	• Laboratory services +
	• Radiology and radioisotope services +
	• Prescription and nonprescription drugs +
	• Emergency transportation +
	• Rural health clinic services +
	• Chronic renal dialysis +
	• Mental health services +
	• Alcohol/substance abuse services +
	• Office for People with Developmental Disabilities +
	• Family planning services +

* Institutional Medicaid eligibility rules apply; + Medicare coverage may apply

How to Obtain Covered Services

For some covered services listed on the Empire Benefit chart, you may need a physician's order and/or prior approval from Empire.

For others, you may access the service directly. Contact the Member Services department by calling 1-800-950-7679. The Member Services representative will gladly assist you with your needs or transfer your request to your care manager.

Authorization is the process by which a covered service in Empire Managed Long-Term Care is determined to be medically necessary for the member's condition, illness or ailment by the member's physician and/or Empire.

Below is a chart that will assist you in determining when you need authorization to access covered services and if you will need it from your physician, Empire or both.

Empire Benefit	Physician Order Required	Empire Authorization Required
Home Health Care	✓	✓
Adult Day Health Care	✓	✓
Personal Care	✓	✓
Durable Medical Equipment	✓	✓
Medical/Surgical Supplies	✓	✓
Prosthetics	✓	✓
Orthotics	✓	✓
Enteral and Parenteral Supplements	✓	✓
Personal Emergency Response System		✓
Nonemergent Transportation		**Call Member Services to Schedule**
Podiatry	**Member Can Access Directly**	
Dentistry		✓
Optometry/Eyeglasses		✓
Audiology/Hearing Aids		✓
Hearing Aid Batteries		✓
Home-Delivered/Congregate Meals		✓
Social Day Care		✓
Outpatient Therapy	✓	✓
Respiratory Therapy	✓	✓
Nutritional Counseling	✓	
Social Supports and Home Modifications		✓
Private-Duty Nursing	✓	✓
Nursing Home Care	✓	✓

Adult day health care is care and services given in a residential health care facility or other approved facility under the medical direction of a doctor to a member who is functionally impaired but not homebound, and who requires certain preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services.

Audiology and hearing aids includes hearing exams or testing, hearing aid evaluation, and hearing aid prescription or recommendations; services include selecting, fitting and dispensing of hearing aids, and hearing aid checks following dispensing and hearing aid repairs. Products include hearing aids, earmolds, batteries, special fittings and replacement parts.

Dentistry includes preventive exams and cleanings, prophylactic and other dental care, and orthotic appliances if required to alleviate a serious health condition.

Durable Medical Equipment (DME) includes **enteral** and **parenteral formula** and **hearing aid batteries**. Durable medical equipment are devices and equipment, other than prosthetic or orthotic appliances and devices, which have been ordered by a practitioner in the treatment of a specific medical condition; compression stockings will only be covered when used in treatment of an open venous stasis ulcer.

Medical and surgical supplies are items for medical use other than drugs, prosthetic or orthotic appliances and devices, durable medical equipment or orthopedic footwear, which treat a specific medical condition; they are usually nonreusable and disposable, and for a specific purpose.

Home care includes the following services, which are of a preventive, therapeutic rehabilitative, health guidance and/or supportive nature: nursing services, home health aide services, nutritional services, social work services, physical therapy, occupational therapy and speech/language pathology.

Home-delivered/congregate meals are meals provided to help support a member's specific plan of care.

Medical social services means assessing the need for, arranging for and providing aid for social problems related to the maintenance of a patient in the home where such services are performed by a qualified social worker and provided within a plan of care. These services must be provided by a qualified social worker.

Nursing services include intermittent, part-time and continuous nursing services ordered and outlined by a doctor and include care given to treat or maintain health.

Nursing home care is full-time care provided to members by a licensed facility.

Nutritional counseling means offering the member nutrition education and counseling to meet normal and therapeutic needs; services may include assessing nutritional status and food preferences, developing and planning proper dietary intake, regular evaluation and revision of nutritional plans.

Occupational therapy is one or more rehabilitation services offered by a licensed, registered occupational therapist to reduce physical or mental disability and restore a member to his or her best functional level.

Optometry includes the services of an eye doctor or optometrist, and includes exams and eyeglasses, medical necessary contact lenses and polycarbonate lenses, artificial eyes (stock or custom made) and low-vision aids.

Orthotics are appliances and devices used to support a weak or deformed part of the body or to restrict or eliminate motion in a diseased or injured part of the body.

Outpatient therapies are rehabilitation services provided by a licensed, registered therapist; these services should help the member restore as much of his or her physical or mental function as possible. Occupational, physical and speech therapy are limited to 20 visits per therapy a year, except for children younger than 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.

Personal care means some or total assistance with activities like personal hygiene, dressing and feeding, and nutritional and environmental support in the home.

Personal Emergency Response System (PERS) is an electronic used by certain high-risk patients so they can get help if they have a physical, emotional or environmental emergency.

Podiatry services include routine foot care when illness, injury or symptoms involving the foot pose a danger, or when performed as necessary for medical care.

Private-duty nursing is continuous, skilled nursing care given in the home by properly licensed, registered professional or licensed practical nurses.

Prosthetics is a service or device that includes artificial arms, legs, internal body parts, breasts (including reconstructive breast surgery) and eyes. Medically necessary prescription footwear coverage is limited to the treatment of diabetics, or when a shoe is part of a leg brace (see orthotics above) or for foot complications for children under age 21.

Respiratory therapy is care to prevent breathing problems, to maintain breathing health or rehabilitate breathing using medicines, machines and patient education.

Social and environmental supports are services and items that support the medical needs of the member and are included in the member's plan of care; they include home maintenance tasks, homemaker chore services, home modifications and respite care.

Social day care is a structured, complete program that provides functionally impaired members with socialization, supervision and monitoring, personal care, and nutrition in a protective setting during any part of the day, and may include maintenance and enhancement of daily living skills, transportation, caregiver help, and case coordination and assistance.

Social services include information, referrals, and help with obtaining or maintaining benefits, which include financial aid, medical help, food stamps or other support programs.

Transportation shall mean transport by ambulance, ambulette, taxi or livery service or public transportation to obtain necessary medical care and services.

Coordination of Services

Plan of Care Development and Monitoring

When you enroll, your primary care physician, enrollment specialist, and your assigned care manager will work together with you to help develop a plan of care that meets your needs. Your plan of care is a written description of all the types of services you will receive to help maintain and improve your health status and be as independent as possible. Your plan of care will include both Empire covered services and noncovered services. Your plan of care is developed based on initial and follow-up assessments (called reassessments) of your health care needs by the community care coordinator.

Your initial plan of care is based upon the in-home assessment visit with the enrollment specialist in collaboration with the recommendations of your physician to address your specific care needs. Reassessments will occur as rapidly as your condition requires but not longer than 180 days from the previous assessment. A copy of the Empire approved plan of care will be provided to you no more than 14 calendar days from when your assessment or reassessment is completed or as rapidly as your

condition requires. In addition, you will receive a confirmation letter for each covered service listed in your plan of care that is arranged and will be paid for by Empire on your behalf. The confirmation letter explains, by service type, the duration (length of time) and frequency (how often) of each covered service on the Empire Benefit chart, as well as the date that the authorization expires.

Your plan of care is periodically evaluated and reviewed with you to help ensure the types of services you are receiving meet your specific needs. If your health care needs change, you may require different services or the same services, just more or less frequently. This will require that your plan of care changes. Your care manager will review the plan of care with you and your primary care physician and discuss any changes to your plan of care. The stability of your chronic condition will determine how often your plan of care is adjusted and how long it lasts. It may always be changed at any time as your medical needs increase or decrease, and we will notify you of any changes.

You are an important member of your health care team, so it is important for you to let us know what you need. Please talk with your primary care physician and care manager if you have a need for any service you are not currently receiving or wish to make changes in your plan of care (please see the section on Requesting New or Additional Services below). In addition, your care manager will work with you to help make certain that your medical conditions are being properly monitored.

Requesting New or Additional Services

How Do I Make Requests for Services?

Requests for new or additional benefits or services can be made orally or in writing to your care manager. Your provider, on your behalf, may also make a request for you. Any request that you make will be submitted to your assigned care manager for review.

For some requests, your care manager or your physician will conduct a medical necessity determination (please see the section on Medical Necessity) to help ensure that your request for a particular service or quantity of service(s) is most appropriate for your condition.

If an assessment is required, it will be conducted by the community care coordinator, or your physician, as fast as your condition requires or within three business days of receipt of your request. Once the medical necessity determination is completed, the care manager will discuss the evaluation with you, your family or informal supports.

Expedited Review

If Empire determines or your provider indicates that a delay in approving any service request would seriously jeopardize your life, health or ability to attain, maintain, or regain maximum function, the request will be expedited. You may also request an expedited review. If Empire denies the request for an expedited review, it will be handled using standard review time frames. Empire will send a written notice to you indicating that the request will not be handled as an expedited request, but will be handled as a standard request. You or your provider may file a grievance regarding the determination by Empire to complete the review using standard time frames. The care manager will notify you of any decision by phone and in writing as fast as your condition requires.

Prior Authorization (New Services)

When you, or a provider on your behalf, request a new benefit or service you have never had before, it is considered a prior authorization request. A request to change a service in the plan of care for a future authorization period is also considered a prior authorization request.

A prior authorization request decision will be rendered by phone and in writing as fast as your condition requires or within three business days of receipt of all necessary information, but not more than 14 days from the receipt of your request. For an expedited prior authorization request, you will be notified within no more than three business days from the request for service.

Concurrent Review (More of the Same Services)

When you, or a provider on your behalf, request additional services (more of the same) that are currently authorized in the plan of care, the request is considered a concurrent review.

A concurrent review decision will be rendered by phone and in writing as fast as your condition requires or within one business day of receipt of all necessary information, but not more than 14 days from the receipt of your request by Empire. For expedited concurrent review, you will be notified of the decision in one business day of receipt of necessary information, but not more than three business days of receipt of the request for services.

Extensions in Reviewing Requests

Empire may extend the review period by up to 14 days if we justify the need for additional information and the extension is in your best interest. You, or a provider on your behalf, can also request an extension verbally or in writing. Empire will send you a written notice of any extension that we initiate.

Prior Authorization and Concurrent Review Request Approvals

If your request is granted by Empire, the services will be authorized and ordered, and a confirmation letter will be mailed to you.

Prior Authorization and Concurrent Review Request Denials

If the determination by Empire is to deny coverage of your prior authorization request or concurrent review request, you will receive a Notice of Plan Action Letter by mail that will explain the decision. You or your provider may appeal the decision rendered by Empire (See section on Actions and Appeals of Actions).

Selection of Providers

Choosing Your Own Primary Care Physicians

Primary and acute care services are not covered services in the Empire Managed Long-Term Care plan. Instead, these services are covered by Medicaid and/or Medicare. This gives you the opportunity to maintain your relationship with your current primary care physician (PCP) to assure no disruption in medical care while gaining an additional support person, the care manager, to help guide your care. If, however, you want to change to a different PCP, your care manager will be happy to assist you in locating a qualified PCP.

Selection of Providers for Covered Services

For services covered by Empire, you may choose any provider from our network of providers that offers the service that you need. Since these network providers have a contractual obligation to Empire, we have the ability to monitor their services and hold them to our professional standards.

Affect on Members with Medicare Coverage

If you have Medicare benefits, your membership in Empire does not affect your Medicare eligibility. You will continue to be covered by Medicare for your physician visits, hospitalizations, lab tests, ambulance and other Medicare benefits. You do not need authorization from Empire to receive Medicare services. If your Medicare benefits are exhausted and Empire becomes the primary payer for a covered service, you will need to switch to one of our network providers.

However, for Medicare-covered services, Empire can:

- Refer you to a qualified physician (if you don't have one already)
- Schedule physician appointments and arrange nonemergency transportation for you
- Arrange for nonemergency transportation to laboratory, X-ray or diagnostic tests that are ordered by your physician
- Assist with discharge arrangements if you are admitted to a hospital
- Arrange Medicare-covered home care services

If you are receiving any services that are covered by both Empire and Medicare, Medicare will be billed as your primary insurance. If Medicare does not cover the entire cost of the service, then Empire will be billed for any deductibles or coinsurance.

If you are currently receiving a Medicare-covered service, you can continue using that provider.

Empire recommends that you use a provider in our network so that you will not have to change providers if Medicare coverage limits are met and Empire becomes responsible for primary payment for the care. If the provider of your choice is not in the Empire provider network, please contact your care manager or Member Services to discuss your options.

Changing Provider(s)

Empire wants you to be happy with your provider for covered and noncovered services. If you are dissatisfied, we want to know about it, and we can help you change your provider.

To change your provider for covered services, contact our Member Services department. The transition from one provider to another can happen in as little as one business day, but may take longer. We always attempt to match your provider with your location, primary language and specific health care needs.

Empire is also available to assist you in selecting or changing providers for noncovered services. Just contact our Member Services department.

Emergency Care

You are NOT required to obtain Empire preauthorization or prior authorization to get emergency care.

Definition of an Emergency*

An emergency is a sudden or unexpected illness, accident or injury that could cause severe pain, serious injury or death if it is not treated immediately. If you have an emergency and need immediate medical attention, **call 911 or go to the nearest hospital emergency room**. If possible, call your PCP or your care manager at Empire.

After An Emergency

Notify your PCP and your care manager at Empire within 24 hours of the emergency. You may be in need of long-term care services that can only be provided by Empire.

If You Are Hospitalized

If you are hospitalized, a family member or informal support should contact Empire within 24 hours of admission. Your care manager will cancel your home care services and other appointments. If you are in the hospital, be sure to ask your primary care physician or hospital discharge planner to contact Empire. We will work with them to plan for your care upon discharge from the hospital.

Transitional, Out-of-Network and Out-of-Area Care

Transitional Care

Upon enrollment in Empire, you may continue an ongoing course of treatment for a transitional period of up to 60 days from enrollment with a non-network health care provider. Should your health care provider leave the Empire network, your ongoing course of treatment may be continued for a transitional period of up to 90 days.

The criteria listed below must be met in order for Empire to authorize and pay for transitional care:

- Your provider accepts Empire reimbursement rates as payment in full
- Your provider makes available to Empire any medical information related to your care
- Your provider agrees to follow Empire policies and procedures

If you feel you have a condition that meets the criteria for transitional care services, please notify your care manager.

Emergency Medical Care

Emergency medical care is defined as a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of severity, including severe pain, that a prudent layperson possessing an average knowledge of medicine and health could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition, placing the health of the person or others in serious jeopardy; or (ii) serious impairment to such person's bodily functions; or (iii) serious dysfunction of any bodily organ or part of such person; or (iv) serious disfigurement of such person.

Out-of-Network Care

As an Empire member, you may obtain a referral to a health care provider outside the network in the event Empire does not have a provider with appropriate training or experience to meet your needs. In the event you require an out-of-network provider, please contact your care manager to assist you in obtaining an authorization.

When using a provider outside of the Empire network for covered services, you must get an authorization from Empire before seeing the provider. Without first obtaining the required authorization, the provider will not be paid for services. If you have questions regarding this process, please call the Member Services department at 1-800-950-7679.

If You Are Leaving the Empire Service Area

Empire service area is the Bronx, Brooklyn, Manhattan, Queens, Staten Island and Nassau and Putnam counties. If you are planning to spend some time away from home, please let your care manager know immediately. If you are out of the service area for 60 days or less, we will make every effort to assist you in arranging temporary services for you while you are away. Please inform Empire at least one week in advance to obtain authorization for services if you are planning to be out of the service area. If you are planning to leave the service area for more than 60 consecutive days, it will be difficult for Empire to monitor your health needs properly. If this situation should occur, Empire will no longer be appropriate for you, and you must be disenrolled. In this case, you should call your care manager to discuss your options.

Out-of-Area Emergency Care

In the event of a medical emergency, call 911 or seek care in an emergency room even if you are out of your service area.

After the medical emergency, your family or informal support should contact Empire within 24 hours, if possible, so we can offer whatever help we can, and also adjust your plan of care to meet any changes in your medical needs.

Addressing Your Problems and Concerns

Empire will try its best to deal with your concerns or issues as quickly as possible and to your satisfaction. You may use either our grievance process or our appeal process, depending on what kind of problem you have.

There will be no change in your services or the way you are treated by Empire staff or a health care provider because you file a grievance or an appeal. We will maintain your privacy. We will give you any

help you may need to file a grievance or appeal. This includes providing you with interpreter services or help if you have vision and/or hearing problems. You may choose someone (like a relative or friend or a provider) to act for you.

To file a grievance or to appeal a plan action, please call: 1-800-950-7679 or write to:
Grievance and Appeals
Empire BlueCross BlueShield HealthPlus
P.O. Box 1198
New York, NY 10116

When you contact us, you will need to give us your name, address, telephone number and the details of the problem.

Complaints and Grievances

What is a Grievance?

A grievance is any communication by you to us of dissatisfaction about the care and treatment you receive from our staff or providers of covered services. For example, if someone was rude to you or you do not like the quality of care or services you have received from us, you can file a grievance with us.

The Grievance Process

You may file a grievance orally or in writing with us. The person who receives your grievance will record it, and appropriate plan staff will oversee the review of the grievance. If your grievance can be immediately decided (same day) to your satisfaction, we will not respond in writing. We will send you a letter telling you we received your grievance and a description of our review process if we cannot resolve the issue to your satisfaction as quickly as the same day. Our acknowledgment of the grievance will be sent within 15 business days of receipt. We will review your grievance and give you a written answer within one of two time frames:

- If a delay would significantly increase the risk to your health, we will decide within 48 hours after receipt of necessary information and not more than seven calendar days. You will be notified by phone and will also receive written notice of the decision within three business days of the decision.
- For all other types of grievances, we will notify you of our decision within 45 days of receipt of necessary information, but the process must be completed within 60 days of the receipt of the grievance.
- The review period can be increased up to 14 days if you request it, or if we need more information and the delay is in your interest. You will be notified by written notice of the decision within three business days of the decision.

Our answer will describe what we found when we reviewed your grievance and our decision about your grievance. All grievances, whether responded to in writing or not, will be logged, documented and tracked for quality improvement purposes.

How do I Appeal a Grievance Decision?

If you are not satisfied with the decision we make concerning your grievance, you may request a second review of your issue by filing a grievance appeal. You must file a grievance appeal in writing. It must be filed within 60 business days of receipt of our initial decision about your grievance. Once we receive your appeal, we will send you a written acknowledgement telling you the name, address and telephone number of the individual we have designated to respond to your appeal. All grievance appeals will be

conducted by appropriate professionals, including health care professionals for grievances involving clinical matters, who were not involved in the initial decision.

For standard appeals, we will make the appeal decision within 30 business days after we receive all necessary information to make our decision. If a delay in making our decision would significantly increase the risk to your health, we will use the expedited grievance appeal process. For expedited grievance appeals, we will make our appeal decision within two business days of receipt of necessary information. For both standard and expedited grievance appeals, we will provide you with written notice of our decision. The notice will include the detailed reasons for our decision and, in cases involving clinical matters, the clinical rationale for our decision.

Actions and Appeals of Actions

What is an Action?

When Empire denies or limits coverage of services requested by you or your provider; denies a request for a referral; decides that a requested service is not a covered benefit; reduces, suspends or terminates coverage of services that we already authorized; denies payment for services; doesn't provide timely services; or doesn't make grievance or appeal determinations within the required time frames, those are considered plan actions. An action is subject to appeal.

(Please see the section on How do I File an Appeal of an Action? for more information.)

Timing of Notice of Action

If we decide to deny or limit services you requested or decide not to pay for all or part of a service, we will send you a notice when we make our decision. If we are proposing to reduce, suspend or terminate a service that is authorized, our letter will be sent at least 10 days before we intend to change the service.

Contents of the Notice of Action

Any notice we send to you about an action will:

- Explain the action we have taken or intend to take
- Cite the reasons for the action, including the clinical rationale, if any
- Describe your right to file an appeal with us (including whether you may also have a right to the state's external appeal process)
- Describe how to file an internal appeal and the circumstances under which you can request that we speed up (expedite) our review of your internal appeal
- Describe the availability of the clinical review criteria relied upon in making the decision, if the action involved issues of medical necessity or whether the treatment or service in question was experimental or investigational
- Describe the information, if any, that must be provided by you and/or your provider in order for us to render a decision on appeal

If we are reducing, suspending or terminating an authorized service, the notice will also tell you about your right to have services continue while we decide on your appeal; how to request that services be continued; and the circumstances under which you might have to pay for services if they are continued while we were reviewing your appeal.

How Do I File an Appeal of an Action?

If you do not agree with an action that we have taken, you may appeal. When you file an appeal, it means that we must look again at the reason for our action to decide if we were correct. You can file an

appeal of an action with the plan orally or in writing. When the plan sends you a letter about an action it is taking (like denying or limiting services, or not paying for services), you must file your appeal request within 45 calendar days of the date on our letter notifying you of the action. If you call us to file your request for an appeal, you must send a written request unless you ask for an expedited review.

How Do I Contact Empire to File an Appeal?

We can be reached by calling **1-800-950-7679** or write to:
Grievance and Appeals
Empire BlueCross BlueShield HealthPlus
P.O. Box 1198
New York, NY 10116

If you need assistance in filing your appeal due to language barriers, hearing, speech or other issues, our Member Services department will assist you.

The person who receives your appeal will record it, and appropriate staff will oversee the review of the appeal. We will send a letter telling you that we received your appeal, and how we will handle it.

If your appeal was filed orally, we will also provide you with a summary of the appeal as you described it. Your appeal will be reviewed by knowledgeable clinical staff who was not involved in the plan's initial decision or action that you are appealing.

For Some Actions You May Request to Continue Service during the Appeal Process

If you are appealing coverage of a reduction, suspension or termination of services you are currently authorized to receive, you may request to continue to receive these services while we are deciding your appeal. We must continue your service if you make your request to us no later than 10 days from our mailing of the notice to you about our intent to reduce, suspend or terminate coverage of your services, or by the intended effective date of our action if the original period covered by the service authorization has not expired.

Your services will continue until you withdraw the appeal, the original authorization period for your services has been met or until 10 days after we mail your notice about our appeal decision, if our decision is not in your favor, unless you have requested a New York State Medicaid Fair Hearing with continuation of services. (See the section on State Fair Hearings for more information.)

Although you may request a continuation of services while your appeal is under review, if your appeal is not decided in your favor, we may require you to pay for these services if they were provided only because you asked to continue to receive them while your appeal was being reviewed.

How Long Will It Take Empire to Decide My Appeal of an Action?

Unless you ask for an expedited review, we will review your appeal of the action taken by us as a standard appeal and send you a written decision as quickly as your health condition requires, but no later than 30 days from the day we receive an appeal. The review period can be increased up to 14 days if you request an extension or we need more information, and the delay is in your interest.

During our review you will have a chance to present your case in person and in writing. You will also have the chance to look at any of your records that are part of the appeal review.

We will send you a notice about the decision we made about your appeal that will identify the decision we made and the date we reached that decision.

If we reverse our decision to deny or limit the coverage of requested services, or reduce, suspend or terminate services, and services were not furnished while your appeal was pending, we will provide you with the disputed services as quickly as your health condition requires.

In some cases you may request an expedited appeal (please see the Expedited Appeal Process section next for more information).

Expedited Appeal Process

If you or your provider feels that taking the time for a standard appeal could result in a serious problem to your health or life, you may ask for an expedited review of your appeal of the action. We will respond to you with our decision within two business days after we receive all necessary information. In no event will the time for issuing our decision be more than three business days after we receive your appeal. (The review period can be increased up to 14 days if you request an extension or we need more information, and the delay is in your interest.)

If we do not agree with your request to expedite your appeal, we will make our best efforts to contact you in person to let you know that we have denied your request for an expedited appeal and will handle it as a standard appeal. Also, we will send you a written notice of our decision to deny your request for an expedited appeal within two days of receiving your request.

If Empire Denies My Appeal, What Can I Do?

If our decision about your appeal is not totally in your favor, the notice you receive will explain your right to request a Medicaid fair hearing from the state of New York and how to obtain a fair hearing, who can appear at the fair hearing on your behalf, and, for some appeals, your right to request to receive services while the hearing is pending and how to make the request.

If we deny your appeal because of issues of medical necessity or because the service in question was experimental or investigational, the notice will also explain how to ask the state of New York for an external appeal of our decision.

State Fair Hearings

If we did not decide the appeal totally in your favor, you may request a Medicaid fair hearing from the state of New York within 60 days of the date we sent you the notice about our decision on your appeal.

A member of Empire must exhaust the Empire internal appeal process before the member can request a state fair hearing.

If your appeal involved the reduction, suspension or termination of authorized services you are currently receiving, and you have requested a fair hearing, you may also request to continue to receive these services while you are waiting for the fair hearing decision. You must check the box on the form you submit to request a fair hearing to indicate that you want the services at issue to continue. Your request to continue the services must be made within 10 days of the date the appeal decision was sent by us or by the intended effective date of our action to reduce, suspend or terminate your services, whichever occurs later. Your benefits will continue until you withdraw the appeal; the original authorization period for your services ends; or the state fair hearing officer issues a hearing decision that is not in your favor, whichever occurs first.

If the state fair hearing officer reverses our decision, we must make sure that you receive the disputed services promptly, and as soon as your health condition requires. If you received the disputed services while your appeal was pending, we will be responsible for payment for the covered services ordered by the fair hearing officer.

Although you may request to continue services while you are waiting for your fair hearing decision, if your fair hearing is not decided in your favor, you may be responsible for paying for the services that were the subject of the fair hearing.

State External Appeals

If we deny your appeal because we determine coverage of the service is not medically necessary or is experimental or investigational, you may ask for an external appeal from the state of New York. The external appeal is decided by reviewers who do not work for us or the state of New York.

These reviewers are qualified people approved by the state of New York. You do not have to pay for an external appeal.

When we make a decision to deny an appeal for lack of medical necessity or on the basis that the service is experimental or investigational, we will provide you with information about how to file an external appeal, including a form on which to file the external appeal along with our decision to deny an appeal. If you want an external appeal, you must file the form with the New York State Department of Insurance within four months from the date we denied your appeal.

Your external appeal will be decided within 30 days. More time (up to five business days) may be needed if the external appeal reviewer asks for more information. The reviewer will tell you and us of the final decision within two business days after the decision is made.

You can get a faster decision if your doctor can say that a delay will cause serious harm to your health. This is called an expedited external appeal. The external appeal reviewer will decide an expedited appeal in 72 hours or less. The reviewer will tell you and us the decision right away by phone or fax. Later, a letter will be sent that tells you the decision.

You may ask for both a fair hearing and an external appeal. If you ask for a fair hearing and an external appeal, the decision of the fair hearing officer will be the final decision.

If You Wish to Disenroll (Voluntary Disenrollment)

You may initiate disenrollment at any time for any reason by oral or written notification to Empire. If you disenroll orally, we will provide you with written confirmation of receipt of your oral request.

Your care manager will discuss your decision over the telephone and, at your request, a reassessment nurse can meet with you in your home and attempt to resolve the circumstance that led up to your request to disenroll. If we are unable to resolve the issue, we will help you plan for your care following disenrollment. The effective date of disenrollment is the first day of the month after the New York City Human Resources Administration (HRA) processes the request. Empire will continue to provide and arrange for covered services until the effective date of disenrollment. Empire will notify you of the date that the disenrollment will take effect.

If you are in need of continuing services that are to be provided by the HRA, the effective date of your disenrollment may be affected by the time frame it takes HRA to approve your request for services.

Any Empire Managed Long-Term Care plan member who joins and/or receives services from another managed care plan capitated by Medicaid, a Home- and Community-based Medicaid Services Waiver program or an OPWDD Day Treatment Program or is participating in a hospice program is considered to have initiated disenrollment from Empire Managed Long-Term Care plan.

Membership Cancellation (Involuntary Disenrollment)

If Empire feels that it is necessary to disenroll you involuntarily, we must obtain authorization from the HRA.
Empire will not involuntarily disenroll you on the basis of adverse change in health status or the need for and/or cost of covered services. The reasons for involuntary disenrollment are outlined below.

Involuntarily disenrolled members will be notified of their appeal rights by the HRA. Empire will continue to provide and arrange for covered services until the effective date of disenrollment.

You may be disenrolled from the Empire Managed Long-Term Care Plan of care if:

- You, your family, informal support or informal caregiver engages in conduct or behavior that seriously impairs the ability of Empire to offer services to you or other enrollees
- You fail to pay for, or make arrangements to pay, any amount owed as Medicaid spend down/surplus to Empire within 30 days after the amount becomes due, provided that during that 30-day period Empire first makes a reasonable effort to collect the amount, including a written request for payment, and advising you in writing of your prospective disenrollment
- You knowingly fail to complete and submit any necessary consent or release
- You knowingly file false information or otherwise deceive Empire or engage in fraudulent conduct with respect to any significant aspect of your plan membership
- Your physician refuses to collaborate with Empire and the enrollee on developing and implementing the plan of care; physician collaboration means the willingness to use network providers and write orders for covered services

You will be disenrolled from the Empire Managed Long-Term Care Plan of care if:

- You are no longer eligible to receive Medicaid benefits
- You no longer reside in the service area
- You have been absent from the service area for more than 60 consecutive days
- You are hospitalized or have entered an Office of Mental Health, State Office for People with Developmental Disabilities, Office of Alcohol and Substance Abuse Services residential program for 45 days or longer
- You clinically require nursing home care but are ineligible for such care under the Medicaid program's institutional rules
- You are no longer eligible for nursing home level of care as determined at the last comprehensive assessment of the calendar year using the assessment tool prescribed by the New York State Department of Health; unless the HRA and Empire agree that termination of services provided by Empire would result in your being eligible for nursing home level of care within the succeeding six-month period

Rights and Responsibilities as an Empire Member

Your Rights Include[†]:

- You have the right to receive medically necessary care
- You have the right to timely access to care and services
- You have the right to privacy about your medical record and when you get treatment
- You have the right to get information on available treatment options and alternatives presented in a manner and language you understand
- You have the right to get information in a language you understand; you can get oral translation services free of charge
- You have the right to get information necessary to give informed consent before the start of treatment
- You have the right to be treated with respect and dignity
- You have the right to get a copy of your medical records and ask that the records be amended or corrected
- You have the right to take part in decisions about your health care, including the right to refuse treatment

[†] These rights are based on requirements found in PHL 4408, 10 NYCRR 98-1.14, and 42 CFR 438.100

- You have the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation
- You have the right to get care without regard to sex, race, health status, color, age, national origin, sexual orientation, marital status or religion
- You have the right to be told where, when and how to get the services you need from your managed long-term plan of care, including how you can get covered benefits from out-of-network providers if they are not available in the Empire network
- You have the right to complain to the New York State Department of Health or your local Department of Social Services; and, the right to use the New York State Fair Hearing System or in some instances request a New York state external appeal
- You have the right to appoint someone to speak for you about your care and treatment
- You have the right to make advance directives and plans about your care

Your Responsibilities include:

- To receive all of your covered benefits through Empire and get authorization for services as required
- To provide clear and complete medical and personal information about yourself to your Empire providers and representatives
- To contact us when you need help or have a question
- To follow your plan of care that was agreed upon and request changes as needed
- To make every effort to pay Empire any Medicaid surplus amount owed
- To maintain Medicaid eligibility
- To notify Empire when you go away or are out of town
- Empire Funding and Payment

When you enroll, Empire receives a single monthly payment from Medicaid to provide and pay for all of the covered services listed on the Empire Benefit chart. No premiums, copayments or deductibles will be charged to you.

Payment of Network Providers by Empire

All network providers are under contract with Empire for the services they provide. Empire providers should never charge you a copay. If you receive a bill directly from a provider, call the Member Services department at 1-800-950-7679, and they will resolve the situation for you.

If You Have a Medicaid Surplus

In the state of New York, you can receive Medicaid even if your monthly income is over the Medicaid allowable rate, as long as you are willing to pay what Medicaid calls a spend down. This amount is determined by the HRA, and Empire is responsible for collecting that amount from you. If you owe a monthly surplus, you will receive a bill from Empire for the amount owed. If you fail to pay the amount owed within 30 days of receipt of the bill, Empire has the right to initiate disenrollment proceedings. If you have a Medicaid surplus, specific details regarding the payment process will be explained to you. Please see the section on Membership Cancellation (Involuntary Disenrollment) for more information. Empire Managed Long-Term Care plan will coordinate with other payers. Medicare and other third-party insurances will be billed by providers before Empire Managed Long-Term Care plan will pay for the services. You <u>are not</u> liable for any payment related to covered services. If you are billed directly by a provider of covered services, you should contact the Member Services department at 1-800-950-7679 so they can assist you in resolving this issue.

Information Empire Will Provide Upon Request

The following information shall be provided upon request of a member or prospective member:

- A list of the names, business addresses and official positions of the membership of the Board of Directors and officers of Empire, including controlling persons, owners or partners of Empire
- Information on the structure and operation of Empire
- A copy of the most recent annual certified financial statement of Empire, including a balance sheet and a summary of receipts and disbursements prepared by a certified public accountant
- The procedures for protecting the confidentiality of medical records and other member information
- A written description of the organizational arrangements and ongoing procedure of the Empire Quality Assurance program
- Individual health practitioner affiliations with participating hospitals, if any
- Procedures followed by Empire in making decisions about the experimental or investigational nature of individual drugs, medical devices or treatment in clinical trials
- The written application procedures and minimum qualification requirements for health care providers to be considered by Empire
- Specific written clinical review criteria relating to a particular condition or disease

If you would like any of the above information, you or your designated representative can call 1-800-950-7679 or write to:
Empire BlueCross BlueShield HealthPlus
P.O. Box 1198
New York, NY 10116

Simply indicate what documents you are requesting, and we will mail them to you within 10 business days.

Important Phone Numbers for the Empire Managed Long-Term Care Plan

Empire Member Services……1-800-950-7679

Empire TTY ……711

AT&T Relay Service for the Hearing Impaired ……1-800-421-1220

24/7 NurseLine……1-800-950-7679

Care Manager ……..1-800-950-7679

What to Do in a Medical Emergency

Call 911 or go to the nearest emergency room.

New York State Managed Long-Term Care Complaint Hotline

New York State Department of Health (Complaints) ……1-866-712-7197

Empire BlueCross BlueShield HealthPlus
21 Penn Plaza
360 W. 31st St., Fifth Floor
New York, NY 10001

NOTICE OF PRIVACY PRACTICES

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.

The original effective date of this notice was April 14, 2003. The most recent revision date is shown in the footer 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 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 **mss.empireblue.com/pages/privacy-policy.aspx** 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 worker's 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.

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- 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**. If you're deaf or hard of hearing, call **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 **mss.empireblue.com/pages/privacy-policy.aspx**.

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.

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- We make sure your PI is kept safe.