NEW YORK STATE MEDICAID MANAGED CARE MODEL MEMBER HANDBOOK

Revised February 1, 2024

NOTICE OF NON-DISCRIMINATION

[PLAN NAME**]** complies with Federal civil rights laws, and State laws. **[**PLAN NAME**]** does not exclude people or treat them differently because of race, color, national origin, age, disability, or gender.

[PLAN NAME] provides the following:

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

If you need these services, call **[PLAN NAME]** at <toll free number>. For TTY/TDD services, call <TTY>.

If you believe that **[PLAN NAME]** has not given you these services or treated you differently because of race, color, national origin, age, disability, or gender, you can file a grievance with **[**PLAN NAME**]** by:

Mail:	[ADDRESS], [CITY], [STATE] [ZIP CODE],
Phone:	[PHONE NUMBER] (for TTY/TDD services, call <TTY>)
Fax:	[FAX NUMBER]
In person:	[ADDRESS], [CITY], [STATE] [ZIP CODE]
Email:	[EMAIL ADDRESS]

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by:

Web:	Office for Civil Rights Complaint Portal at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Mail:	U.S. Department of Health and Human Services 200 Independence Avenue SW., Room 509F, HHH Building Washington, DC 20201 Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html
Phone:	1-800-368-1019 (TTY/TDD 800-537-7697)

ATTENTION: Language assistance services, free of charge, are available to you. Call <toll free number> <TTY/TDD> .	English
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al <toll free number> <TTY/TDD>.	Spanish
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 <toll free number> <TTY/TDD>.	Chinese
ملاحظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوفر لك بالمجان. اتصل برقم toll free number > والمالكم < TTY/TDD	Arabic
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다 <toll free number> <TTY/TDD> 번으로 전화해 주십시오.	Korean
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните <toll free number> (телетайп: TTY/TDD).	Russian
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero <toll free number> <TTY/TDD>.	Italian
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le <toll free number> <TTY/TDD>.	French
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele <toll free number> <TTY/TDD>.	French Creole
אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט toll free number/TTY/TDD.	Yiddish
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer <toll free number> <TTY/TDD>	Polish
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa <toll free number/TTY/TDD>.	Tagalog
লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১-<toll free number> <TTY/TDD>	Bengali
KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në <toll free number> <TTY/TDD>.	Albanian
ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε <toll free number> <TTY/TDD>.	Greek
خبردار: اگر آپ اردو بولتے ہیں تو آپکے لیے زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔ کال کریں <toll free number> <TTY.	Urdu

HERE'S WHERE TO FIND INFORMATION YOU WANT

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

We are glad that you enrolled in [Insert Plan Name]. 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 you, however, just call us at [Insert Member Services Toll-Free Number].

How Managed Care Plans Work

The Plan, Our Providers, and You

Managed care provides a central home for your care.

- We have a group of health care providers to meet your needs. These doctors and specialists, hospitals, labs, and other health care facilities make up our **provider network**. Our provider network is listed in our **provider directory**. To get a provider directory, call [Insert Member Services Toll-Free Number] to get a copy or visit our website at [Web Address].

- When you join [Insert Plan Name], you will need to select a primary care provider (PCP) from our provider network. If you need to have a test, see a specialist, or go into the hospital, your PCP will arrange it.

- Even though your PCP is your main source for health care, in some cases, you can self-refer to certain doctors for some services. See page [Insert correct page reference] for details.

Your PCP is available to you every day, day and night. If you need to speak to them after hours or weekends, leave a message and how you can be reached. Your PCP will get back to you as soon as possible.

You may be restricted to certain plan providers if you have been identified as a restricted recipient. Below are 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. [Insert Plan Name] recognizes the trust needed

between you, your family, your doctors, and other care providers. [Insert Plan Name] 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 [Insert Plan Name], your Primary Care Provider, your authorized representative, and other providers who give you care. 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. [Insert Plan Name] 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 [Insert Plan Name]. 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**. Use this handbook 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 (LDSS).

[**For Health Plans that serve counties that use the enrollment broker, use the following language:**] If you live in [**list plan's service areas served by New York Medicaid Choice**], you can also call the New York Medicaid Choice Helpline at 1-800-505-5678.

Help From Member Services

There is someone to help you at Member Services:

Insert days, hours and toll-free phone number for member services.

Health plans must be sure to include the TTY (teletypewriter) phone number here.

Also insert instructions as to how to reach [Insert Plan Name] during non-business hours and how those calls will be handled or returned.

- 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 let us know if you are pregnant or have a new baby, or ask about any change that might affect you or your family's benefits.

- If you are or become pregnant, your child will become part of [Insert Plan Name] on the day they are 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 they are 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, are blind, or have trouble hearing or understanding, call us if you need extra help. We can tell you if a particular provider's office is wheelchair accessible or is equipped with special communications devices. Also, we have services like:
    - TTY machine (Our TTY phone number is [Insert the health plan TTY number]).
    - Information in Large Print
    - Case Management
    - Help in making or getting to appointments
    - Names and addresses of providers who specialize in your disability
- **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 [Insert Plan Name] ID card should arrive within 14 days after your enrollment date. Your card has your PCP's (primary care provider's) name and phone number on it. It will also have your Client Identification Number (CIN). If anything is wrong on your [Insert Plan Name] ID card, call us right away. Your ID card does not show that you have Medicaid or that [Insert Plan Name] 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 of [Insert Plan Name]. You should keep your Medicaid benefit card. You will need this card to get services that [Insert Plan Name] 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, nurse practitioner, or other healthcare provider. **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 from when you receive your welcome packet, 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 ([Insert Member Services Toll-Free Number]) can check to see if you already have a PCP or help you choose one.

- With this Handbook, you should have a provider directory. This is a list of all the doctors, clinics, hospitals, labs, and others who work with [Insert Plan Name]. It lists the address, phone number, 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 [Insert Plan Web Address].

  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.

- We also contract with Federally Qualified Health Centers (FQHCs). All FQHCs give primary and specialty care. Some consumers want to get their care from FQHCs because the centers have a long history in the neighborhood. Maybe you want to try them because they are easy to get to. You should know that you have a choice. You can choose any one of the providers listed in our directory, or you can sign up with a primary care physician at one of the FQHCs that we work with

listed below. Just call Member Services at [Insert Member Services Toll-Free Number] for help.

[List available FQHCs here]

- In almost all cases, your doctors will be [Insert Plan Name] providers. **There are four instances when you can still see another provider that you had before you joined [Insert Plan Name].** In these cases, your provider must agree to work with [Insert Plan Name]. You can continue to see your doctor if:
    - You are more than 3 months pregnant when you join [Insert Plan Name] and you are getting prenatal care. In that case, you can keep your provider until after your delivery through post-partum care. This post-partum care continues up to 12 weeks after delivery.
    - At the time you join [Insert Plan Name], 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 [Insert Plan Name], 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.
    - At the time you join [Insert Plan Name], you are being treated for a Behavioral Health condition. In most cases, you can still go to the same provider. Some people may have to choose a provider that works with the health plan. Be sure to talk to your provider about this change. [Insert Plan Name] will work with you and your provider to make sure you keep getting the care you need.

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

- If your **provider leaves** [**Insert Plan Name**], we will tell you within 15 days from when we know about this. If you wish, you may be able to see that provider **if** you are more than three months pregnant or if you are receiving ongoing treatment for a condition. If you are pregnant, you may continue to see your doctor for up to 12 weeks 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 [Insert Plan Name] during this time.
- If any of these conditions apply to you, check with your PCP or call Member Services at [Insert Member Services Number].

How To Get Regular Care

- Regular health care means exams, regular check-ups, shots or other treatments to keep you well, advice when you need it, and referral 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 your PCP whenever you have a medical question or concern. If you call after hours or weekends, leave a message and where or how you can be reached. Your PCP will call you back as quickly as possible. Remember, your PCP knows you and knows how the health plan works.

- Your care must be **medically necessary**. The services you get must be needed:
    1. to prevent, or diagnose and correct what could cause more suffering;
    2. to deal with a danger to your life;
    3. to deal with a problem that could cause illness; or
    4. to deal with something that could limit your normal activities.
- Your PCP will take care of most of your health care needs, but you must have an appointment to see your PCP. If ever you can't keep an appointment, call to let your PCP know.

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

- **If you need care before your first appointment**, call your PCP's office to explain your concern. They 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 3 days
    - routine, preventive care: within 4 weeks
    - follow-up visit after mental health/substance abuse emergency room (ER) or inpatient visit: 5 days
    - non-urgent mental health or substance abuse visit: 1 week

- Use the following list as an **appointment guide for our limits on how long you may have to wait after your request for a perinatal appointment**:
    - first trimester: visit must occur within 3 weeks of the request for care
    - second trimester: visit must occur within 2 weeks of the request for care
    - third trimester**:** visit must occur within 1 week of the request for care
    - first newborn visit: within 2 weeks of hospital discharge
    - initial family planning visit must occur within 2 weeks of the request for care
    - for specialist referrals and urgent matters during pregnancy:
        - urgent specialist referrals must be seen as soon as clinically indicated, not to exceed 72 hours
        - non-urgent specialist referrals must be seen as soon as clinically indicated, not to exceed 2 to 4 weeks of when the request was made
        - for non-emergent, but urgent matters**,** pregnant persons must be seen within 24-hours of request for care

How To Get Specialty Care – Referral

- If you need care that your PCP cannot give, they will REFER you to a specialist who can. If your PCP refers you to another doctor, we will pay for your care. Most of these specialists are [Insert Plan Name] providers. Talk with your PCP to be sure you know how referrals work.
- If you think a specialist does not meet your needs, talk to your PCP. Your PCP can help you if you need to see a different specialist.

- There are some treatments and services that your PCP must ask [Insert Plan Name] to approve *before* you can get them. Your PCP will be able to tell you what they are.
- If you are having trouble getting a referral you think you need, contact Member Services at [Insert Member Service Number].
- 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 [Insert Plan Name] 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.
- [Insert plan-specific process for how members request care from a specialist or providers outside the network. Include the timeframes for resolving the request for out-of-network specialists/providers, the required documentation, and a phone number for the member to use to contact the plan regarding the request.]
    - Sometimes we may not approve an out-of-network referral because we have a provider in [Insert Plan Name] that can treat you. If you think our plan provider does not have the right training or experience to treat you, you can ask us to check if your out-of-network referral is medically needed. You will need to ask for a **Plan Appeal**. See page [XX] to find out how.
    - Sometimes, we may not approve an out-of-network referral for a specific treatment because you asked for care that is not very different from what you can get from a [Insert Plan Name] provider. You can ask us to check if your out-of-network referral for the treatment you want is medically needed. You will need to ask for a **Plan Appeal**. See page [XX] to find out how.
- [Plans must indicate whether there are any limitations on accessing the entire approved network, if applicable, other than standard referral process].
- If you need to see a specialist for ongoing care, your PCP may be able to refer you for a specified number of visits or length of time (a **standing referral**). If you have a standing referral, you will not need a new referral for each time you need care.
- *If you have a long-term disease or a disabling illness that gets worse over time*, your PCP may be able to arrange for:
    - your specialist to act as your PCP
    - a referral to a specialty care center that deals with the treatment of your illness

- a call to Member Services for help in getting access to a specialty care center

Get These Services From [Insert Plan Name] *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
- you need OB/GYN services
- you need family planning services
- you want to see a midwife
- you need to have a breast or pelvic exam

Family Planning

- You can get the following family planning services: advice about birth control, birth control prescriptions, male and female condoms, pregnancy tests, sterilization, and 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* [Insert Plan Name] *ID card* to see one of our family planning providers. Check our 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 [Insert Member Service Toll-Free Number] for a list of places to go to get these services. You can also call the New York State Growing Up Healthy Hotline (1-800-522-5006) for the names of family planning providers near you.

HIV and Sexually Transmitted Infection (STI) Screening

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

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

- You can get an HIV or STI test any time you have family planning services. You do not need a referral from your PCP (Primary Care Provider). Just make an appointment with any family planning provider. If you want an HIV or STI test, but

not as part of a family planning service, your PCP can provide or arrange it for you.

- Or, if you'd rather not see one of our providers, you can use your Medicaid card to see a family planning provider outside [Insert Plan Name]'s network. For help in finding either a Plan provider or a Medicaid provider for family planning services call Member Services at [Insert Member Services Toll-Free Number].

- 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 must choose one of our participating providers.

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

Behavioral Health – (Mental Health and Substance Use)

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

Smoking Cessation

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

Maternal Depression Screening

If you are pregnant or recently had a baby 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 an average person fear that they, or someone, will suffer serious harm without care right away.

Examples of an emergency are:

- a heart attack or severe chest pain
- bleeding that won't stop
- 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
- drug overdose

Examples of **non-emergencies** are:

- colds
- sore throat
- upset stomach
- minor cuts and bruises
- 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 plan's or your PCP's approval before getting emergency care, and you

are not required to use our hospitals or doctors.

- **If you're not sure, call your PCP or [Insert Plan Name].**
  Tell the person you speak with what is happening. Your PCP or member services representative will:
  - tell you what to do at home
  - tell you to come to the PCP's office, or
  - tell you to go to the nearest emergency room
- If you are **out of the area** when you have an emergency:
  - Go to the nearest emergency room. If you are discharged from the emergency room with prescriptions, they must be filled at an NYRx Medicaid-enrolled pharmacy.

Remember

You do not need prior approval for emergency services.
Use the emergency room **only** if you have an **Emergency**.

The Emergency Room should NOT be used for problems like the flu, sore throats, or ear infections.

If you have questions, call your PCP or [Insert Plan Name] at [Insert Member Services Toll-Free Number].

Urgent Care

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

- This could be a child with an earache 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 [Insert Member Services Toll-Free Number]. 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:

- Stop smoking classes
- Prenatal care and nutrition
- Grief / loss support
- Chest 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
- Other classes for you and your family

Call Member Services at [Insert Member Services Toll-Free Number] or visit our website at [Insert Plan Web Address] to find out more and get a list of upcoming classes.

Electronic Notice Option

[**Include only if the plan has implemented electronic noticing.** Plan should insert BPIE-approved Electronic Noticing Handbook Insert language here.]

PART II: YOUR BENEFITS AND PLAN PROCEDURES

BENEFITS

Medicaid Managed Care provides a number of services you get in addition to those you get with regular Medicaid. [Insert Plan Name] will provide or arrange for most services that you will need. You can get a few services without going through your PCP. These include emergency care, family planning, HIV testing and counseling, and specific self-referral services. Please call our member services department at [Insert Member Services Toll-Free Number] if you have any questions or need help with any of the

services below.

Services Covered By [Insert Plan Name]

You must get these services from the providers who are in [Insert Plan Name]. All services must be medically or clinically necessary and provided or referred by your PCP (Primary Care Provider). Please call our Member Services department at [Insert Member Services Toll-Free Number] 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 up to age 21
- smoking cessation counseling
- access to free needles and syringes
- smoking cessation counseling
- HIV education and risk reduction

Maternity Care

- pregnancy care
- doctors/midwife and hospital services
- newborn nursery care

Home Health Care

- Must be medically needed and arranged by [Insert Plan Name])
- one medically needed post-partum home health visit (additional visits as medically needed for high-risk women)
- at least 2 visits for 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 [Insert Plan Name]
- 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 [Insert Plan Name and Toll-Free Number]

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 (TB)

- 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 [Insert Plan Name]

- 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 our Member Services Department at [Insert Plan Toll-Free Number].

Dental Care

[Insert Plan Name] believes that providing you with good dental care is important to your overall health care. [We offer dental care through a contract with [Insert Name of Dental Vendor], an expert in providing high quality dental services. or We offer dental care through contracts with individual dentists who are experts in providing high quality dental services.] [Insert Plan Name] covers dental services such as:

- Preventive dental check-ups
- Cleanings
- X-rays
- Fillings

In certain circumstances, [Insert Plan Name] may cover additional services, such as:

- Dentures
- Implants
- Crowns
- Root Canals

You do not need a referral from your PCP to see a dentist!

How to Get Dental Services:

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

- If you need to find a dentist or change your dentist, please call [Insert Name of Dental Vendor] at [Insert Dental Toll-Free Number], or please call [Insert Plan Toll-Free Number]. Customer Services Representatives are there to help you.

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

- [Show your Member ID card to access dental benefits. You will not receive a separate dental ID card. When you visit your dentist, you should show your plan ID card.] or
- [You will receive a separate Dental ID card with the name of your assigned dentist. Show your Dental ID card to access dental benefits.]

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 thirty (30) mile radius or include toll free member services number for members to call.]

Orthodontic Care

[Insert Plan Name] 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
- Enrollees diagnosed with diabetes may self-refer for a dilated eye (retinal) examination once in any 12 month period

Hospital Care

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

Emergency Care

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

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

Specialty Care

Includes the services of other practitioners, including:

- physical therapist
- occupational and speech therapists
- audiologist
- midwives
- cardiac rehabilitation
- other specialty care [Insert Plans Highlight Key Specialty Services]

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 [Insert Plan Name];
- covered nursing home services include medical supervision, 24-hour nursing care, assistance with daily living, physical therapy, occupational therapy, and speech-language pathology

Rehabilitation:

<Insert Plan Name> covers short term, or rehabilitation (also known as "rehab") stays, in a skilled nursing home facility.

Long Term Placement:

<Insert Plan Name> 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 <Insert Plan Name>'s network that meets your needs. Call [Member Services Number] for help finding a nursing home in our network.

If you want to live in a nursing home that is not part of <Insert Plan Name>'s network, you must transfer to another plan that has your chosen nursing home in its network.

Eligible Veterans, Spouses of Eligible Veterans, and **Gold Star Parents of Eligible Veterans** may choose to stay in a Veterans' nursing home.

[*Include the following information only if it applies to your plan*: <insert Plan Name> does not have a Veterans' Home in its network. If you are an eligible Veteran, spouse of an eligible Veteran or a Gold Star Parent of an eligible Veteran and you want to live in a Veterans' Home, we will help arrange your admission. You must transfer to another Medicaid Managed Care health plan that has the Veterans' Home in its network.]

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 <Insert Plan Name> 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.

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/

BEHAVIORAL HEALTH CARE

Behavioral health care includes mental health and substance use treatment and rehabilitation services. All of our members have access to behavioral health services which include:

Adult Mental Health Care

- Psychiatric services
- Psychological services
- Inpatient and outpatient mental health treatment
- Injections for behavioral health related conditions
- Rehab services if you are in a community home or in family-based treatment
- Individual and group counseling through Office of Mental Health (OMH) clinics

Adult Outpatient Mental Health Care

- Continuing Day Treatment (CDT)
- Partial Hospitalization (PH)

Adult Outpatient Rehabilitative Mental Health Care

- Assertive Community Treatment (ACT)
- Personalized Recovery Oriented Services (PROS)

Adult Mental Health Crisis Services

- Comprehensive Psychiatric Emergency Program (CPEP) including extended observation bed
- Crisis intervention services
    - Mobile Crisis and Telephonic Crisis Services
- Crisis Residential Programs:
    - Residential Crisis Support: This is a program for people who are age 18 or older with symptoms of emotional distress. These symptoms cannot be managed at home or in the community without help.
    - Intensive Crisis Residence: This is a treatment program for people who are age 18 or older who are having severe emotional distress.

Substance Use Disorder Services for Adults age 21+

- Crisis Services/Detoxification
    - Medically Managed Withdrawal and Stabilization Services
    - Medically Supervised Inpatient Withdrawal and Stabilization Services

    - Medically Supervised Outpatient Withdrawal and Stabilization Services
- Inpatient Rehabilitation Services
- Residential Addiction Treatment Services
    - Stabilization
    - Rehabilitation
    - Reintegration
- Outpatient Addiction Treatment Services
    - Outpatient Clinic
        - Intensive Outpatient Treatment
        - Ancillary Withdrawal Services
        - Medication Assisted Treatment
    - Outpatient Rehabilitation Services
    - Opioid Treatment Programs (OTP)
- Gambling Disorder Treatment Provided by Office of Addiction Services and Supports (OASAS) Certified Programs
    - [Name of plan] covers Gambling Disorder Treatment provided by Office of Addiction Services and Supports (OASAS) certified programs.
    - You can get Gambling Disorder Treatment:
        - face-to-face; or
        - through telehealth.
    - If you need Gambling Disorder Treatment, you can get it from an OASAS outpatient program or if necessary, an OASAS inpatient or residential program.
    - You do not need a referral from your primary care provider (PCP) to get these services. If you need help finding a provider, please call [Name of plan] member services at the number listed below.

Harm Reduction Services

If you need help related to a substance use disorder, Harm Reduction Services can offer a complete patient-oriented approach to your health and well-being. [Insert Plan Name] covers services that may help reduce substance use and other related harms. These services include:

- A plan of care developed by a person experienced in working with substance users
- Individual supportive counseling that assists in achieving your goals
- Group supportive counseling in a safe space to talk with others about issues that affect your health and well-being

- Counseling to help you with taking your prescribed medication and continuing treatment
- Support groups to help you better understand substance use and identify coping techniques and skills that will work for you

To learn more about these services, call Member Services at [Insert Plan Toll-Free Number].

Mental Health Care for Individuals Under Age 21

All eligible children under age 21:

- Comprehensive Psychiatric Emergency Program (CPEP) including Extended Observation bed
- Partial hospitalization
- Inpatient psychiatric services
- Individual and group counseling through OMH clinics
- Children and Family Treatment and Support Services (CFTSS), including:
    - Other Licensed Practitioner (OLP)
    - Psychosocial Rehabilitation (PSR)
    - Community Psychiatric Supports and Treatment (CPST)
    - Family Peer Support Services (FPSS)
    - Crisis Intervention
    - Youth Peer Support and Training (YPST)
- Psychiatric services
- Psychological services
- Injections for behavioral health related conditions
- Children's Crisis Residence: This is a support and treatment program for people under age 21. These services help people cope with an emotional crisis and return to their home and community.

Mental Health Services for Eligible children under age 21 (ages18-20):

- Assertive Community Treatment (ACT)
- Continuing Day Treatment (CDT)
- Personalized Recovery Oriented Services (PROS)
- Crisis Residential Programs:
    - Residential Crisis Support: This is a program for people who are age 18 or older with symptoms of emotional distress. These symptoms cannot be managed at home or in the community without help.
    - Intensive Crisis Residence: This is a treatment program for people who are age 18 or older who are having severe emotional distress.

Substance Use Disorder Care for Individuals Under Age 21

Crisis Services/Detoxification
  - Medically Managed Withdrawal and Stabilization Services
  - Medically Supervised Inpatient Withdrawal and Stabilization Services
  - Medically Supervised Outpatient Withdrawal and Stabilization Services
- Inpatient Rehabilitation Services
- Residential Addiction Treatment Services
  - Stabilization
  - Rehabilitation
  - Reintegration
- Outpatient Addiction Treatment Services
  - Outpatient Clinic
    - Intensive Outpatient Treatment
    - Ancillary Withdrawal Services
    - Medication Assisted Treatment
  - Outpatient Rehabilitation Services
  - Opioid Treatment Programs (OTP)

Children's Home and Community Based Services

New York State covers Children's Home and Community Based Services (HCBS) under the children's waiver. [Insert Plan Name] covers children's HCBS for members participating in the children's waiver and provides care management for these services.

Children's HCBS offer personal, flexible services to meet the needs of each child/youth. HCBS are provided where children/youth and families are most comfortable and supports them as they work towards goals and achievements.

Who can get Children's HCBS?

Children's HCBS are for children and youth who:

- Need extra care and support to remain at home/in the community
- Have complex health, developmental and/or behavioral health needs
- Want to avoid going to the hospital or a long-term care facility
- Are eligible for HCBS and participate in the children's waiver

Members under age 21 will be able to get these services from their health plan:

- Community habilitation
- Day habilitation

- Caregiver/ Family Advocacy and Support Services
- Prevocational services - *must be age 14 and older*
- Supported employment - *must be age 14 and older*
- Respite services (planned respite and crisis respite)
- Palliative care
- Environmental modifications
- Vehicle modifications
- Adaptive and Assistive Technology

Children/youth participating in the Children's Waiver must receive care management. Care management provides a person who can help you find and get the services that are right for you.

- If you are getting care management from a Health Home Care Management Agency (CMA), you can stay with your CMA. [Name of plan] will work with your CMA to help you get the services you need.
- If you are getting care management from the Children and Youth Evaluation Service (C-YES), [Name of plan] will work with C-YES and provide your care management.

Article 29-I Voluntary Foster Care Agency (VFCA) Health Facility Services

[Insert Plan Name] covers Article 29-I VFCA Health Facility services for children and youth under age 21.

29-I VFCA Health Facilities work with families to promote well-being and positive outcomes for children in their care. 29-I VFCA Health Facilities use trauma informed practices to meet the unique needs of each child.

29-I VFCA Health Facilities may only serve children and youth referred by the local district of social services.

Core Limited Health-Related Services

1. Skill Building
2. Nursing Supports and Medication Management
3. Medicaid Treatment Planning and Discharge Planning
4. Clinical Consultation and supervision
5. Managed Care Liaison/Administration

and

Other Limited Health-Related Services

1. Screening, diagnosis, and treatment services related to physical health
2. Screening, diagnosis, and treatment services related to developmental and behavioral health
3. Children and Family Treatment and Support Services (CFTSS)
4. Children's Home and Community Based Services (HCBS)

HEALTH HOME CARE MANAGEMENT

[Insert Plan Name] 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 Homes, contact Member Services at [insert Member Services number].

Infertility Services

If you are unable to get pregnant, [Insert Plan Name] covers services that may help.

[Insert Plan Name] will cover the coordination of care related to limited infertility drugs covered by the Medicaid pharmacy program. The infertility benefit includes:

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

Eligibility

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

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

National Diabetes Prevention Program (NDPP) Services

If you are at risk for developing Type 2 diabetes, [Name of plan] covers services that may help.

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

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

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

- At least 18 years old,
- Not currently pregnant,
- Overweight, and
- Have not been previously diagnosed with Type 1 or Type 2 Diabetes.

And, you meet one of the following criteria:

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

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

Transportation [Include if covered by the Plan].

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

- **Emergency:** [Include if covered by the Plan] If you need emergency transportation, call 911.
- **Non-Emergency:** [Include if covered by the Plan] [If non-emergency transportation is covered by the plan, specify the type of service provided; the name of the provider (if there is a single contractor); the phone number to call to request the service; and if applicable, how far in advance a member needs to call to request the service. Also include the following statement:] If you require an attendant to go with you to your doctor's appointment or if your child is the member of [Insert Plan Name], transportation is also covered for the attendant or parent or guardian.

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

Applied Behavior Analysis (ABA) Services

[Name of plan] covers Applied Behavior Analysis (ABA) therapy provided by:
- Licensed Behavioral Analyst (LBA), or
- Certified Behavioral Analyst Assistant (CBAA) under the supervision of an LBA.

Who can get ABA?
Children/youth under the age of 21 with a diagnosis of autism spectrum disorder and/or Rett Syndrome. If you think you are eligible to get ABA services, talk to your provider about this service. [Name of plan] will work with you and your provider to make sure you get the service you need.

The ABA services include:
- assessment and treatment by a physician, licensed behavioral analyst, or certified behavior analyst assistant,
- individual treatments delivered in the home or other setting,
- group adaptive behavior treatment, and
- training and support to family and caregivers.

Gender Dysphoria Related Care and Services
[Name of plan] covers the following gender dysphoria related care and services:
- Gender Reassignment (sex change) Surgeries, Services, and Procedures,
- Puberty Suppressants (medications used to delay the effects of puberty), and
- Cross-Sex Hormone Therapy (hormone medications used to help with sex change).

What is Gender Dysphoria?
Gender Dysphoria is the feeling of discomfort or distress that might occur when there is

a conflict between the sex you were assigned at birth and the gender you identify with.

Gender Reassignment Surgery
Prior to surgery for the treatment of gender dysphoria, you must:

- receive a medical necessity determination from a qualified medical professional,
- be 18 years of age or older. Members under 18 years of age will be reviewed on a case-by-case basis for medical necessity and must receive prior approval from [Name of plan], as applicable.
- have lived in a gender role consistent with your gender identity for 12 months. During this time, you must have received behavioral health counseling, as deemed necessary by your treating qualified medical professional, and
- have two letters from qualified New York State licensed health professionals recommending surgery based upon their own assessment.

Puberty Suppressants and Cross-Sex Hormones
[Name of plan] will provide medically necessary hormone therapy for treatment of gender dysphoria.
Treatment with puberty suppressants, must be:

- based upon a determination from a qualified medical professional.

Treatment with cross-sex hormones, must meet the following age specific criteria:

- members 16 years of age or older must receive a determination of medical necessity made by a qualified professional.
- members 16 and 17 years of age must also receive a determination from a qualified medical professional that you are eligible and ready for treatment.
- members under 16 years of age, must meet the above criteria and receive prior approval from [Name of plan], as applicable.

Talk to your health care provider to see if you qualify for gender dysphoria related care and services. To learn more about these services, call Member Services at [Insert Member Services Toll-Free Number].

In Lieu of Services (ILS)

ILS are services or settings that are not covered by Medicaid but are medically appropriate substitutes for covered services or settings.

[Insert Plan-Specific ILS Information If Applicable]

Other Covered Services

- Durable Medical Equipment (DME) / Hearing Aids / Prosthetics /Orthotics

- Court Ordered Services
- Case Management
- Help getting social support services
- Federally Qualified Health Centers (FQHC)
- Services of a Podiatrist as medically needed

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

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

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 (when receiving this service as part of a family planning visit)

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.

- If you'd rather not see one of our [Insert Plan's Name] providers, you can use your Medicaid card to see a family planning provider outside [Insert Plan Name]. For help

in finding either a Plan provider or a Medicaid provider for family planning services call Member Services at [Insert Member Services Toll-Free Number].

- 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.

You can ask your PCP for a list of places to get these services or call Member Services at [Insert Member Services Number]. You can also call the New York State Growing Up Healthy Hotline (1-800-522-5006) for nearby places to get these services.

Tuberculosis (TB) Diagnosis and Treatment

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

Benefits Using Your MEDICAID CARD Only

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

Pharmacy

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

Certain medications may require that your doctor get prior authorization from Medicaid before the pharmacy can dispense your medication. Getting prior authorization is a simple process for your doctor and does not prevent you from getting medications that you need.

Do you have questions or need help? The Medicaid Helpline can assist you. They can talk to you in your preferred language. They can be reached at 1-800-541-2831. TTY 1-800-662-1220

They can answer your call:

- Monday - Friday, 8 am – 8pm
- Saturday, 9am – 1 pm

Transportation

[Include here if transportation services (emergency/non-emergency) are not covered through the plan].

[Emergency and/or non-emergency medical transportation] will be covered by regular Medicaid. To get non-emergency transportation, you or your provider must call [Insert Transportation Vendor Name] at [inset county-specific phone number]. If possible, you or your provider should call [Insert Transportation Vendor Name] 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.

Note: For undocumented non-citizens age 65 and over, non-emergency transportation is not covered.

Developmental Disabilities

- Long-term therapies
- Day treatment
- Housing services
- Medicaid Service Coordination (MSC) program

Services NOT Covered:

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

- Cosmetic surgery if not medically needed
- Personal and comfort items
- Services from a provider that is not part of [Insert Plan Name], unless it is a provider you are allowed to see as described elsewhere in this handbook or [Insert Plan Name] or your PCP send you to that provider

- Services for which you need a referral (approval) in advance and you did not get it.
- Drugs when used to treat erectile dysfunction or sexual dysfunction

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:

- non-covered services (listed above)
- unauthorized services
- services provided by providers not part of [Insert Plan Name]

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 [Insert Plan Name] at [Insert Member Service Toll-Free Number] right away. [Insert Plan Name] can help you understand why you may have gotten a bill. If you are not responsible for payment, [Insert Plan Name] will contact the provider and help fix the problem for you.

You have the right to ask for a plan appeal if you think you are being asked to pay for something Medicaid or [Insert Plan Name] should cover. See the Plan Appeal section later in this handbook.
If you have any questions, call Member Services at [Insert Member Service Toll-Free Number].

Service Authorization

Prior Authorization:

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

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

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

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

You will also need to get prior authorization if you are getting one of these services now

but need to continue or get more of the care. This is called **concurrent review**.

What happens after we get your service authorization request:

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

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

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

We will fast track your review if:

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

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

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

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 72 hours. We will tell you within 72 hours if we need more information.

Timeframes for concurrent review requests:

- **Standard review:** We will make a decision within 1 work day of when we have all the information we need, but you will hear from us no later than 14 days after we received your request. We will tell you by the 14th day if we need more information.
- **Fast track review:** We will make a decision within 1 work day of when we have all the information we need. You will hear from us no later than 72 hours after we received your request. We will tell you within 1 work day if we need more information.

Special timeframes for other requests:

- If you are in the hospital or have just left the hospital and you are asking for home health care we will make a decision within 72 hours of your request.
- 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 within 24 hours of your request.
- If you are asking for mental health or substance use disorder services that may be related to a court appearance, we will make a decision within 72 hours of your request.
- If you are asking for a practitioner administered drug when provided in an outpatient hospital, clinic, or doctor's office, we will make a decision within 24 hours of your request, after your health care provider has provided [Name of plan] with a completed prior authorization form with all necessary information included to review the request.
- A step therapy protocol means we require you to try another drug first before we will approve the drug you are requesting. If you are asking for approval to override a step therapy protocol, we will make a decision within 24 hours for practitioner administered drugs when provided in an outpatient hospital, clinic, or physician's office, after your health care provider has provided [Name of plan] with a completed prior authorization form with all necessary information included to review the request.

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

- Write and tell you what information is needed. If your request is in a fast track review, we will call you right away and send a written notice later.
- Tell you why the delay is in your best interest.

- Make a decision no later than 14 days from the day we asked for more information.

You, your provider, or your representative may also ask us to take more time to make a decision. This may be because you have more information to give us to help decide your case. This can be done by calling [Insert Appropriate Toll-Free Health Plan Number] or writing to [Insert Appropriate Address].

You or your representative can file a complaint with [Insert Plan Name] 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 we do not respond to a request to override a step therapy protocol on time, your request will be approved.

If you think our decision to deny your service authorization request is wrong, you have the right to file a Plan Appeal with us. *See the Plan 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 make these decisions.

Timeframes for other decisions about your care:

- In most cases, if we make a decision to reduce, suspend or stop a service we have already approved and you are now getting, we must tell you at least 10 days before we change the service.
- We must tell you at least 10 days before we make any decision about long term services and supports, such as home health care, personal care, CDPAS, adult day health care, and nursing home care.
- If we are checking care that has been given in the past, we will make a decision about paying for it within 30 days of receiving all information we need for the retrospective review. If we deny payment for a service, we will send a notice to you and your provider the day the payment is denied. These notices are not bills. **You will not have to pay for any care you received that was covered by** [Insert Plan Name] **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 providers that might affect health care. You can call Member Services at [Insert Member Services Toll-Free Number] if you have specific concerns. Most of our providers are paid in one or more of the following ways:

- Most PCPs who work in a clinic or health center, get a **salary.** The number of patients they see does not affect their salary.
- PCPs who work from their own offices may get a set fee each month for each patient for whom they are the PCP. The fee stays the same regardless of the number of times the patient visits the PCP. This is called **capitation.**
- Providers may get a set fee for each person on their patient list, but some money may be held back for an **incentive** fund. At the end of the year, PCPs who have met the incentive standards set by [insert plan name] receive additional payments.
- Providers may also receive **fee-for-service payment**. This means they get a set fee for each service they provide.

You Can Help With Plan Policies

You can help us develop policies that best serve our members. If you have ideas, please tell us about them. Please let us know if you would like to work with one of our member advisory boards or committees. Call Member Services at [Insert Member Services Toll-Free Number] to find out how you can help.

Additional Information From Member Services

Here is information you can get by calling Member Services at [Insert Member Services Toll-Free Number]:

- A list of names, addresses, and titles of [Insert Plan Name]'s Board of Directors, Officers, Controlling Parties, Owners and Partners
- A copy of the most recent financial statements/balance sheets, summaries of income and expenses
- A copy of the most recent individual direct pay subscriber contract
- Information from the Department of Financial Services about consumer complaints about [Insert Plan Name]
- How we keep your medical records and member information private
- In writing, we will tell you how [Insert Plan Name] checks on the quality of care to our members
- We will tell you which hospitals our health providers work with

- If you ask us in writing, we will tell you the guidelines we use to review conditions or diseases that are covered by [Insert Plan Name]
- If you ask in writing, we will tell you the qualifications needed and how health care providers can apply to be part of [Insert Plan Name]
- If you ask, we will tell you:
    1. whether our contracts or subcontracts include physician incentive plans that affect the use of referral services, and, if so,
    2. information on the type of incentive arrangements used; and
    3. whether stop loss protection is provided for physicians and physicians groups
- Information about how our company is organized and how it works

Keep Us Informed

Call Member Services at [Insert Member Services Toll-Free Number] 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, you *may* be able to enroll in another program. Contact your local Department of Social Services, or NY State of Health, The Official Health Plan Marketplace, at 1-855-355-5777 or nystateofhealth.ny.gov.

Disenrollment And Transfers

- **If YOU Want to Leave** [Insert Plan Name]

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

  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, [Insert Plan Name], and the LDSS all agree that disenrollment is best for you

- You are or become exempt or excluded from managed care
- We have not been able to provide services to you as we are required to under our contract with the State

To change plans:

[NOTE: Plans should include either ONE or BOTH of the following bullets containing language for plans that operate in counties with and/or without the enrollment broker.]

If you've enrolled through your local Department of Social Services (LDSS):

- Call the Managed Care staff at your LDSS
- If you live in [List Counties Served by the Enrollment Broker], call New York Medicaid Choice at 1-800-505-5678. The New York Medicaid Choice counselors can help you change health plans

If you've enrolled through NY State of Heath:

- Log your NY State of Health account at www.nystateofhealth.ny.gov, or
- Meet with an enrollment assistor to receive assistance with updating your account, or
- Call the NY State of Health Customer Service Center at 1-855-355-5777 (TTY: 1-800-662-1220).

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. [Insert Plan Name] 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. Call your local Department of Social Services or New York Medicaid Choice.

- **You Could Become Ineligible for [Insert Plan Name]**

- You or your child may have to leave [Insert Plan Name] if you or the child:
    - move out of the County or service area
    - change to another managed care plan
    - have access to an HMO or other insurance plan through work
    - go to prison, or
    - otherwise lose Medicaid eligibility
- Your child may have to leave [Insert Plan Name] if they:
    - join a Physically Handicapped Children's Program
- **If you have to leave [Insert Plan Name] 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 [Insert Maximus Phone Number] right away if this happens

- **We Can Ask You to Leave [Insert Plan Name]**

  You can also lose your [Insert Plan Name] membership if you often:
  - refuse to work with your PCP regarding your care,
  - don't follow [Insert Plan Name]'s rules,
  - do not fill out forms honestly or do not give true information (commit fraud),
  - cause abuse or harm to plan members, providers or staff, or
  - act in ways that make it hard for us to do our best for you and other members even after we have tried to fix the problems

Plan Appeals

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

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

Your provider can ask for reconsideration:

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

You can file a Plan Appeal:

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

- You have **60 calendar days** from the date of the Initial Adverse Determination notice to ask for a Plan Appeal.
- You can call Member Services [Insert Appropriate Health Plan Toll-Free Number] if you need help asking for a Plan Appeal or following the steps of the appeal process. We can help if you have any special needs like a hearing or vision impairment, or if you need translation services.
- You can ask for a Plan Appeal, or you can have someone else, like a family member, friend, doctor or lawyer, ask for you. You and that person will need to sign and date a statement saying you want that person to represent you.
- We will not treat you any differently or act badly toward you because you ask for a Plan Appeal.

Aid to Continue while appealing a decision about your care:

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

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

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

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

- Your name and address
- Enrollee number
- Service you asked for and reason(s) for appealing
- Any information that you want us to review, such as medical records, doctors' letters or other information that explains why you need the service.

- Any specific information we said we needed in the Initial Adverse Determination notice.
- To help you prepare for your Plan Appeal, you can ask to see the guidelines, medical records and other documents we used to make the Initial Adverse Determination. If your Plan Appeal is fast tracked, there may be a short time to give us information you want us to review. You can ask to see these documents or ask for a free copy by calling [1-800 MCO number].

Give us your information and materials by :

Phone ..... [1-800 MCO number]
Fax ..... [fax number]
Email ..... [email address]
Mail ..... [address], [city, state zip]
Online ..... [web address]
In Person ..... [address], [city, state zip]

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

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

- If we said that the service you asked for is not very different from a service available from a participating provider, you can ask us to check if this service is medically necessary for you. You will need to ask your doctor to send this information with your Plan Appeal:
    1. a statement in writing from your doctor that the out of network service is very different from the service the plan can provide from a participating provider. Your doctor must be a board certified or board eligible specialist who treats people who need the service you are asking for.
    2. two medical or scientific documents that prove the service you are asking for is more helpful to you and will not cause you more harm than the service the plan can provide from a participating provider.

  If your doctor does not send this information, we will still review your Plan Appeal. However, you may not be eligible for an External Appeal. *See the External Appeal section later in this handbook*.

- If you think our participating provider does not have the correct training or experience to provide a service, you can ask us to check if it is medically necessary for you to be referred to an out of network provider. You will need to ask your doctor to send this information with your appeal:
    1. a statement in writing that says our participating provider does not have the correct training and experience to meet your needs, and
    2. a recommendation to an out of network provider with the correct training and experience who is able to provide the service.

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

What happens after we get your Plan Appeal:

- Within 15 days, we will send you a letter to let you know we are working on your Plan Appeal.
- We will send you a free copy of the medical records and any other information we will use to make the appeal decision. If your Plan Appeal is fast tracked, there may be a short time to review this information.
- You can also provide information to be used in making the decision in person or in writing. Call [Insert Plan Name] at [Insert Plan Toll-Free Number] if you are not sure what information to give us.
- Plan Appeals of clinical matters will be decided by qualified health care professionals who did not make the first decision, at least one of whom will be a clinical peer reviewer.
- Non-clinical decisions will be handled by persons who work at a higher level than the people who worked on your first decision.
- You will be given the reasons for our decision and our clinical rationale, if it applies. The notice of the Plan Appeal decision to deny your request or to approve it for an amount that is less than requested is called a **Final Adverse Determination**.
- **If you think our Final Adverse Determination is wrong**:
    - you can ask for a Fair Hearing. See the Fair Hearing section of this handbook.
    - for some decisions, you may be able to ask for an External Appeal. See the External Appeal section of this handbook.
    - you may file a complaint with the New York State Department of Health at 1-800-206-8125.

Timeframes for Plan Appeals:

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

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

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

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

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

You or your representative may also ask us to take more time to make a decision. This may be because you have more information to give [Insert Plan Name] to help decide your case. This can be done by calling [Insert Appropriate Health Plan Toll-Free Number] or writing.

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

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

The original denial will be reversed and your service authorization request will be approved if we do not decide your Plan Appeal on time and we said the service you are asking for is:

1. not medically necessary, or
2. experimental or investigational, or
3. not different from care you can get in the plan's network, or
4. available from a participating provider who has correct training and experience to meet your needs.

External Appeals

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

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

For these types of decisions, you can ask New York State (NYS) 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 NYS. These reviewers are qualified people approved by NYS. The service must be in the plan's benefit package or be an experimental treatment, clinical trial, or treatment for a rare disease. You do not have to pay for an External Appeal.

Before you ask for an External Appeal:

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

You have **4 months** after you receive [Insert Plan Name]'s Final Adverse Determination to ask for an External Appeal. If you and [Insert Plan Name] agreed to skip our appeals process, then you must ask for the External Appeal within 4 months of when you made

that agreement.

To ask for an External Appeal, fill out an application and send it to the Department of Financial Services. You can call Member Services at [Insert Appropriate Health Plan Toll-Free Number] if you need help filing an appeal. You and your doctors will have to give information about your medical problem. The External Appeal application says what information will be needed.
Here are some ways to get an application:

- Call the Department of Financial Services, 1-800-400-8882
- Go to the Department of Financial Services' web site at www.dfs.ny.gov.
- Contact the health plan at [Insert Appropriate Health Plan Toll-Free Number]

Your External Appeal will be decided in 30 days. More time (up to five work days) may be needed if the External Appeal reviewer asks for more information. You and [Insert Plan Name] 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 your plan.

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

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

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

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

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

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

Fair Hearings

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

- You are not happy with a decision your Local Department of Social Services or the State Department of Health made about your staying or leaving [Insert Plan Name]

- You are not happy with a decision we made to restrict your services. You feel the decision limits your Medicaid benefits. You have 60 calendar days from the date of the Notice of Intent to Restrict to ask for a Fair Hearing. If you ask for a Fair Hearing within 10 days of the Notice of Intent to Restrict, or by the effective date of the restriction, whichever is later, you can continue to get your services until the Fair Hearing decision. However, if you lose your Fair Hearing, you may have to pay the cost for the services you received while waiting for the decision.

- You are not happy with a decision that your doctor would not order services you wanted. You feel the doctor's decision stops or limits your Medicaid benefits. You must file a complaint with [Insert Plan Name]. If we agree with your doctor, you may ask for a Plan Appeal. If you receive a Final Adverse Determination, you will have 120 calendar days from the date of the Final Adverse Determination to ask for a state Fair Hearing.

- You are not happy with a decision that we made about your care. You feel the decision limits your Medicaid benefits. You are not happy we decided to:

    - reduce, suspend or stop care you were getting
    - deny care you wanted
    - deny payment for care you received
    - did not let you dispute a co-pay amount, other amount you owe or payment you made for your health care

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

  If you asked for a Plan Appeal and receive a Final Adverse Determination that reduces, suspends, or stops care you are getting now, you can continue to get the services your doctor ordered while you wait for your Fair Hearing to be decided. You must ask for a fair hearing within 10 days from the date of the Final Adverse Determination or by the time the action takes effect, whichever is later. However, if you choose to ask for services to be continued, and you lose your Fair Hearing, you may have to pay the cost for the services you received while waiting for a decision.

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

The decision you receive from the fair hearing officer will be final.

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

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

When you ask for a Fair Hearing about a decision [Insert Plan Name] 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-MCO-PLAN] 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 [Insert Plan Name]. Problems that are not solved right away over the phone and any complaint that comes in the mail will be handled according to our complaint procedure described below.

You can call Member Services [Insert Appropriate Health Plan Toll-Free Number] if you need help filing a complaint or following the steps of the complaint process. We can help if you have any special needs like a hearing or vision impairment, or if you need translation services.

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

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

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

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

You can write us with your complaint or call the Member Services number and request a complaint form. It should be mailed to [Insert Appropriate Health Plan Toll-Free Number].

What Happens Next

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

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

You can also provide information to be used reviewing your complaint in person or in writing. Call [Insert Plan Name] at [Insert Plan Toll-Free Number] if you are not sure what information to give us.

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

After we review your complaint:

- We will let you know our decision within 45 days from when we have all the information we need to answer your complaint. 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 within 48 hours from when we have all the information we need to answer your complaint. 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. 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 to complete.
- If we are unable to make a decision about your Complaint because we don't have enough information, we will send a letter and let you know.

Complaint Appeals

If you disagree with a decision we made about your complaint, you can file a **complaint appeal** with [Insert Plan Name].

How to make a complaint appeal:

- If you are not satisfied with what we decide, you have at least 60 work days after hearing from us to file a complaint appeal.
- You can do this yourself or ask someone you trust to file the complaint appeal for you.
- The complaint appeal must be made in writing. If you make a complaint appeal by phone it must be followed up in writing.
- After your call, we will send you a form which is a summary of your phone appeal. If you agree with our summary, you must sign and return the form to us. You can make any needed changes before sending the form back to us.

What happens after we get your complaint appeal:

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

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

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

If we have all the information we need, you will know our decision in 30 working days. If a delay would risk your health, you will get our decision in 2 work days from when we

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

Member Rights And Responsibilities

Your Rights

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

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

Your Responsibilities

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

- Work with your PCP to guard and improve your health
- Find out how your health care system works
- Listen to your PCP's advice and ask questions when you are in doubt
- Call or go back to your PCP if you do not get better, or ask for a second opinion

- Treat health care staff with the respect you expect to receive yourself
- Tell us if you have problems with any health care staff. Call Member Services
- Keep your appointments. If you must cancel an appointment, 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

Advanced Directives

There may come a time when you are not able to 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 do not want
- Second, you can appoint an adult you trust to make decisions for you
- Third, it is best to put your thoughts in writing

Health Care Proxy

A health care proxy form allows you to name another adult that you trust (usually a family member or a friend) to make decisions about your medical care if you are not able to make your own decisions. You should talk with the person you chose so they know about your wishes. To get Health Care Proxy forms, talk to your provider or go to www.health.ny.gov/forms

Do Not Resuscitate (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 order for your medical records. You can also get a DNR form to carry with you and/or a bracelet to wear that will let any emergency medical provider know about your wishes.

Organ Donor Card

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

Important Phone Numbers

Your PCP ..... _____

Your nearest emergency room ..... _____

[Insert Plan Name]

Member services ..... [Insert Appropriate Number]
Member services TTY/TDD ..... [Insert Appropriate Number]

Other units (e.g., nurse hotline, utilization review, etc)
[Insert Appropriate Unit Name] ..... [Insert Appropriate Number]

New York State Department of Health (complaints) 1-800-206-8125
New York State Office of Mental Health Complaints 1-800-597-8481
New York State Office of Addiction Services and
Supports (OASAS) Complaints 1-518-473-3460

Ombudsman: CHAMP1 1-888-614-5400
Mailbox (Ombuds@oasas.ny.gov)

[Insert County Name] County Department
of Social Services ..... [Insert Appropriate Number]

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

New York Medicaid Choice 1-800-505-5678
New York State HIV/AIDS Hotline 1-800-541-AIDS (2437)
Spanish 1-800-233-SIDA (7432)
TDD 1-800-369-AIDS (2437)

New York City HIV/AIDS Hotline (English & Spanish) 1-800-TALK-HIV (8255-448)
HIV Uninsured Care Programs 1-800-542-AIDS (2437)
TDD ..... Relay, then 1-518-459-0121
Child Health Plus 1-855-693-6765
- Free or low-cost health insurance for children

PartNer Assistance Program 1-800-541-AIDS (2437)
- In New York City (CNAP) 1-212-693-1419

Social Security Administration 1-800-772-1213

New York State Domestic Violence Hotline 1-800-942-6906
Spanish 1-800-942-6908
Hearing Impaired 1-800-810-7444

Americans with Disabilities Act (ADA) Information Line.. 1-800-514-0301
TDD 1-800-514-0383

Local Pharmacy ..... _____

Other Health Providers:

Important Web Sites

[Insert Plan Name]
[Insert Plan Website]

New York State Department of Health (DOH):
https://www.health.ny.gov/

New York State Office of Mental Health (OMH):
https://omh.ny.gov/

New York State Office of Addiction Services and Supports (OASAS):
https://oasas.ny.gov/

New York State DOH HIV/AIDS Information:
https://www.health.ny.gov/diseases/aids/

New York State HIV Uninsured Care Programs:
http://www.health.state.ny.us/diseases/aids/resources/adap/index.htm

HIV Testing Resource Directory:
https://www.health.ny.gov/diseases/aids/consumers/testing/index.htm

New York City Department of Health & Mental Hygiene (DOHMH):
https://www.nyc.gov/site/doh/index.page

New York City DOHMH HIV/AIDS Information:
https://www.nyc.gov/site/doh/health/health-topics/aids-hiv.page