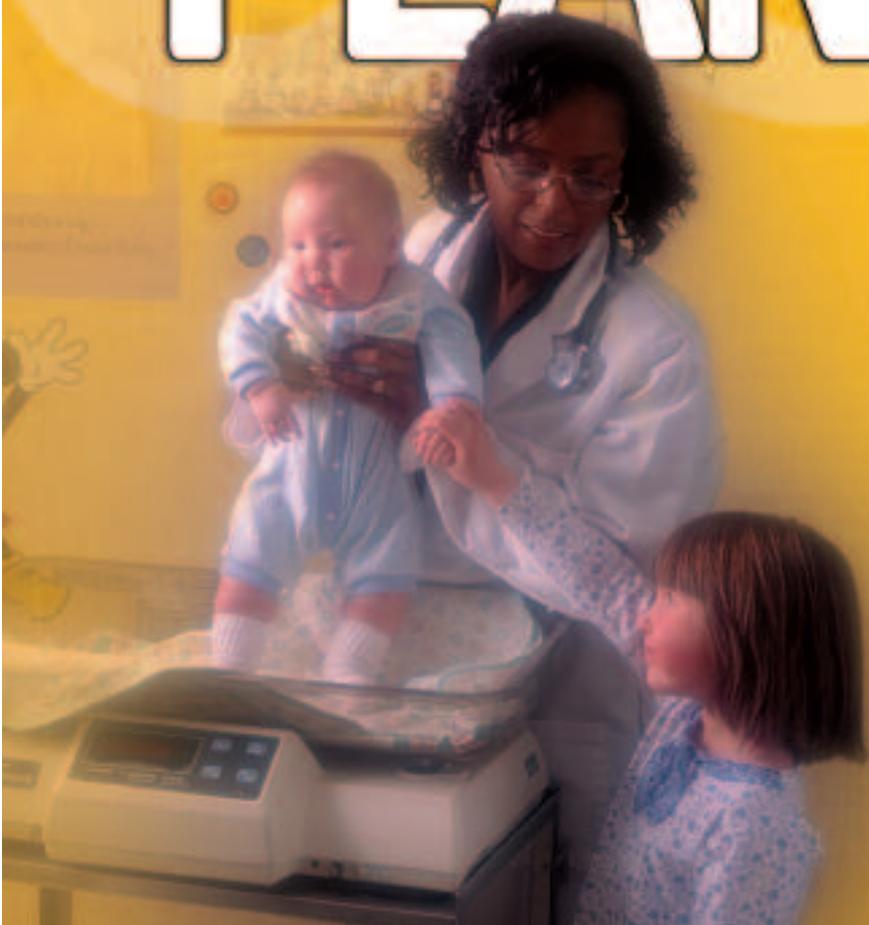


you have 60 days to choose a

HEALTH PLAN



You Have 60 Days to Choose a Health Plan

Choosing a Health Plan

From now on, most people with Medicaid in your county must join a health plan. This means that you now must choose a health plan to get most of your Medicaid benefits. This guide tells how to choose a health plan, and how it works.

You Have 60 Days to Choose a Health Plan

- If you received a letter with this guide, the letter gives the date by which you must choose a plan.
- You may choose a health plan at any time before that date.
- If you already have a health plan, you can stay in that plan or choose a different plan.
- To join, fill out and sign the enclosed enrollment form. Mail it to your Local Department of Social Services (LDSS) Managed Care Office.
- Send the form back before 60 days, or a health plan will be chosen for you.



Start Now

Look through this guide for answers to any of your questions. Or if you want to have a private, face-to-face talk, call your LDSS Managed Care Office. Anything you say will be confidential.

Some people with Medicaid are not required to join a health plan for special reasons. To see if any of these reasons apply to you, turn to page 4 of this guide.

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Who Does Not Have to Join a Health Plan

Some people with Medicaid do not have to join a health plan. They are exempt. This means that they can stay in regular Medicaid or they can join a plan if they wish. You have to tell the LDSS if you think you don't have to join. Here is a list of persons who are exempt and do not have to join:

- People with HIV Infection.
- People in long-term alcohol or drug residential programs.
- Pregnant women who are getting prenatal care from a provider who is not in any Medicaid health plan.
- People who live in facilities for the mentally retarded and people with similar needs.
- Some developmentally disabled people or physically disabled children who get care at home or in their community through the Care at Home or Community-Based waiver programs, or those who need the same kinds of care as people getting services through those programs.
- People with long-term health problems being treated by a specialist who is not in any Medicaid health plan.
- Adults who have serious mental illness and children who have serious emotional problems.
- Native American persons.
- People who cannot find providers in any Medicaid health plan who can serve them in their language.
- People who live where they can't get to a Medicaid health plan.
- People with Supplemental Security Income (SSI/SSI Related) or Social Security Disability.
- People 65 years or older.
- People certified blind.
- People certified disabled by Medicaid.
- People temporarily living outside of the county.
- People scheduled for major surgery in the next 30 days, whose provider is not in a health plan.
- People with end-stage renal disease.
- People who are homeless, depending on the local social services district.
- Foster care children, depending on the local social services district.
- People eligible for Medicaid Buy-In (MBI) for working disabled, with income at or below 150% of the poverty level and do not pay a premium.
- People with both Medicaid and Medicare may join a Medicaid Advantage plan, if available.

Be sure to tell your County DSS if you think you do not have to join a health plan for any of the reasons listed above.



Note: Health Plans and HIV

- People living with HIV may join a health plan or keep regular Medicaid.
- If you have HIV and want to join a health plan, you can keep seeing your doctor if he or she is in the plan you join. Ask your doctor what plan he or she works with.
- To keep the health care you have now, apply for an exemption, as explained at the bottom of this page.
- New York State plans to offer special health plans with providers who have treated many persons with HIV. You will receive more information on special HIV health plans as soon as they are available.

For more information on HIV, call 1-800-732-9503, Monday through Friday, 9:00 a.m. to 5:00 p.m.

Note: Native Americans and Health Plans

Native Americans may join a health plan or keep regular Medicaid. If you are a Native American and you join a health plan, you can still go to your tribal health center for care. You can also go to your health plan doctor. If you have been seeing a Medicaid doctor who is not part of a health plan, and who is not working in a tribal center, you will not be able to keep seeing that doctor if you join a plan. If you want to keep seeing that doctor, ask for an exemption so you won't have to join a health plan.

To get an exemption, you must have one of the following:

- An ID card from the Bureau of Indian Affairs, Tribal Health, Resolution, Long House or Canadian Department of Indian Affairs; or
- Documentation of roll or band number, documentation of parents' or grandparents' roll or band number, together with birth certificate(s) or baptismal record indicating descent from the parent or grandparent; or
- Notarized letter from a federal or state recognized American Indian/Alaska Native/Tribe; or
- Notarized letter from a tribe village office stating heritage or a birth certificate indicating heritage.



Call your LDSS Managed Care Office for more information on exemptions. If you think that you are exempt (don't have to join), call your LDSS Managed Care Unit and ask for a Request for Exemption Form. Anything you say is confidential.

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Some People Must Stay With Regular Medicaid

Some people with Medicaid are not allowed to join a Medicaid health plan. This means they are excluded from joining a health plan and must stay with regular Medicaid. Here is the list of people who cannot join Medicaid managed care.

- People with both Medicaid and Medicare and no Medicaid Advantage plan is available.
 - People in nursing homes, hospices, or long term health care demonstration programs.
 - Children or adults in state psychiatric or residential treatment facilities.
 - People who live in Family Care Homes licensed by the Office of Mental Health.
 - People who will get Medicaid for less than 6 months, except for pregnant women.
 - People who are on Medicaid only after they spend some of their own money for medical needs (spenddown cases) or pay a Medicaid premium.
 - People with other cost effective health insurance.
 - Medicaid Buy-In for working disabled with income at 150% to 250% of poverty level, and who pay a premium.
 - Babies under six months old who can get Supplemental Security Income (SSI), including low birth weight infants.
 - Infants living with their mothers in jail or prison.
 - People in the recipient restriction program.
 - Blind or disabled children living apart from their parents for 30 days or more.
 - People who are eligible for special Medicaid programs that only cover some medical services (You are not eligible for full Medicaid).
 - Children in the care and custody of the Office of Children and Family Services.
 - People eligible for Medicaid through the Breast and Cervical Cancer Early Detection Program.
- If you become excluded from managed care after you join a health plan, you must disenroll from the health plan. Call your LDSS Managed Care Unit if you think you are excluded from joining a health plan.



You Have the Right to a Fair Hearing

If you request an exemption or exclusion, and do not get it, you may ask for a fair hearing. If you are told you must disenroll from managed care, you may ask for a fair hearing. For more information about fair hearings, call your LDSS Managed Care Office.

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How to Choose a Medicaid Health Plan

1. Think About the Doctors You Want

When you join your new Medicaid health plan, you will choose a doctor to be your Primary Care Provider (PCP). Your PCP will provide your health care and refer you to other doctors if you need them. If you like the doctor you have now, or you have chosen a new doctor to see, and want to stay with that doctor, you must pick a plan that includes that doctor. You should call your doctor or the new doctor you want to see to find out what Medicaid health plans they are in. If you are choosing a new doctor, call and make sure the doctor is taking new patients. Making this call will ensure that you can have the doctor you want. If you don't know what doctor you want and need help choosing, you can call your LDSS Managed Care Office.

2. Think About the Services Your Family Needs

Look for the health plans that have health care providers, clinics, and hospitals that meet your family's needs.

3. Find Out About Medicaid Health Plans Available to You

Health plans are not all the same. To learn more about each health plan, call your LDSS Managed Care Office to find out about the health plans available to you, the hospitals they work with, and whether the plan offers dental care and family planning (refer to page 10 and 11 for more information).



Get Ready to Join

Choose one health plan and the doctors for you and your family. Make sure the doctor you want to see is in the health plan you choose. Call the doctors to make sure they are taking new patients. Fill out and sign the enrollment form. Mail it in the enclosed envelope to your LDSS Managed Care Office.

After you join a plan, you must use the hospitals, clinics, and doctors that work with the plan. Remember, you won't be able to see your former doctor, or use the clinics and hospitals you do now unless they are in the health plan you choose. So think about which plan is right for you and your family.

Don't put off a decision. If you do not choose a plan by the 60th day, one will be chosen for you. This is called an auto-assignment.

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After You Choose a Medicaid Health Plan

What Will Happen Next?

- You will get a letter to confirm the plan you chose and the date that you can begin using your health plan.
- Your new health plan will send you a welcome letter and a member ID card. If you need care before your ID card arrives, use the plan's welcome letter to show that you are a member.

Keep Both Your Medicaid Benefit Card and Your Health Plan ID Card

- You will need to use your Medicaid benefit card to get pharmacy services and other services that may not be covered by your health plan, such as transportation, family planning, dental care and outpatient chemical dependence services. In addition, you will need your Medicaid benefit card to get mental health and some chemical dependence services if you get SSI, Social Security Disability (SSD) or you are over 65, certified blind or disabled.



Make Sure the Plan You Picked Is Right for You!

To see if your new health plan meets your needs, you should:

- Call the Medicaid health plan right away. The phone number for the Member Services Department is on your health plan card.
- Ask the people in the health plan's Member Services Department any questions that you have about the plan and its services.
- Choose a Primary Care Provider (PCP) and visit him or her as soon as you can. You will know if the PCP's office is easy for you to reach, and you can ask any questions you have about your future care.

If You're Not Satisfied, You Have Time to Change Plans

- You have the first 90 days to try out your new health plan. During that time, you can change to another plan for any reason.
- To change health plans, call your LDSS Managed Care Unit.

What Happens After 90 Days?

- After the 90 day trial period, you will have to stay in your plan for 9 more months, unless you have a special reason to switch plans.
- To change health plans, call your LDSS Managed Care Unit.

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How Health Plans Work

You Have a Regular Doctor

When you join a health plan, you choose one doctor to be your regular health care provider. This person is your Primary Care Provider (PCP). Some plans will let you choose a nurse practitioner. Each of your family members will also have a PCP who works with the plan you join.

In order to see a specialist, or receive special services such as x-rays or lab tests, you must be referred by your Primary Care Provider (PCP). You will be referred only to health professionals who belong to your plan.

You can reach your PCP's office or health plan 24 hours a day, 7 days a week.

You Can Get Regular Check-ups

- Your PCP will give you regular check-ups to help prevent problems from starting or getting worse. Visit your PCP soon after you join a plan.
- Your children will have regular check-ups as babies, young children, teenagers and young adults.
- You will get health care during pregnancy to keep you and your baby healthy.



You Can See Specialists

- Your PCP will give you a referral (permission) when you need to see a specialist.
- If you see a specialist often, you can ask your plan to have your specialist be your PCP, or get special permission to see the specialist for a long period of time (standing referral).

You Do Not Need a Referral for Some Specialists

- You do not need a referral for your OB-GYN preventative services or for pregnancy care, or to see a doctor for glasses.
- You do not need a referral to see another provider in your plan for one mental health assessment and one chemical dependence (including alcohol and substance abuse) service assessment in one year.

In Most Cases, You'll Have Guaranteed Eligibility for Six Months

This means that you are promised the services your health plan covers, along with pharmacy and family planning services, six months from your start date, even if you no longer qualify for Medicaid.

You Can Learn How to Stay Healthy

Most plans offer special health education programs, such as "Asthma," "Diabetes Management," "How to Quit Smoking" or "How to Lose Weight." These programs can help you stay healthy.

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Medicaid Benefits

When you join a health plan, you keep the same Medicaid benefits. Most Medicaid services are provided by the health plans. Among these services offered by the plans are:

- Regular check-ups and shots
- Visits to the doctor when you are sick
- Care during pregnancy
- Hospital care, lab tests, X-rays
- Referrals to specialists, when needed
- Emergency care
- Mental health services
- Many other Medicaid services, such as eye care, medical equipment and HIV testing and counseling
- Transportation assistance varies by county

Remember to keep your Medicaid benefit card on hand. You will use it for services your Medicaid health plan does not cover. Bring your Medicaid card to the drugstore to get medicine, or for family planning and other services if they are not covered by your plan. You should also use your Medicaid benefit card for outpatient chemical dependence services. People who get SSI, SSD, are over 65, or certified blind or disabled will also use their Medicaid benefit card for mental health services.

About Your Dental Care

Some plans offer dental care. Ask your LDSS Managed Care Office which plans offer dental care. If a plan offers dental care, you must go to a dentist in the plan. If the plan does not offer dental care, you may go to any dentist who takes regular Medicaid.

Using the Emergency Room

Go to the Emergency Room when you think there is a real emergency. Do not use it for routine care. Your Primary Care Provider (PCP) can treat problems that are not emergencies.

Some examples of medical emergencies are:

- Passing out
- Convulsions (fits or spasms)
- Poisoning or drug overdose
- Broken bones
- Bad burns
- A lot of pain
- Bleeding that will not stop
- Head or eye injuries
- Trouble breathing
- Miscarriage
- Heart attack
- High fever
- Chest pains
- Rape
- Any other serious problem

If you go to the emergency room, call your health plan as soon as possible afterwards.



Family Planning Services

Most health plans offer family planning services. Every member of every plan can go to any Medicaid provider for family planning. You do not need a referral from your PCP for family planning. Here is a list of family planning services:

- Birth control pills, condoms, diaphragms, IUDs, Depo Provera, Norplant and foam
- Emergency contraception
- Pregnancy testing and counseling
- Sterilization
- Sexually transmitted disease testing and treatment
- HIV testing and counseling, when it is part of a family planning visit
- Abortions (that you and your doctor agree are necessary)



Problem Solving

Use your plan's Member Services Department. Each plan has a Member Service Department to:

- Tell you about the plan.
- Send you a member handbook.
- Invite you to an orientation session to learn about the plan, or tell you about it over the phone.
- Send you a member ID card with the plan's phone number on it and the name of your PCP.
- Help you choose a PCP.
- Answer questions and solve problems.

If You Have a Problem with Your Health Plan

You can do any of the following:

- Call the plan's Member Services Department and tell them your problem. Often they can help. The number is on your plan card.
- Call your LDSS Managed Care Office.
- Change plans. Call your LDSS Managed Care Office.
- Ask for a fair hearing if your plan has denied, stopped, or reduced covered services you think you should get. Call your LDSS Managed Care Unit to find out more about fair hearings.
- Call the State Department of Health Complaint Line, Monday through Friday, 8:30 a.m. to 4:30 p.m., at 1-800-206-8125, if you have a problem with your health services.

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Know Your Rights In a Health Plan

You have the right to:

- Choose the health plan that is right for you and your family.
- Have all information about your health care kept confidential.
- Know how the plan works, and what services it offers.
- Choose a PCP who will give you regular check-ups and keep track of all your health care.
- Get an appointment within 48 to 72 hours if you are sick and within 24 hours if you need care right away.
- If you do not need care right away, get an appointment for a check-up within 12 weeks of joining the plan.
- Get a second opinion about certain medical conditions from another provider in your plan.
- Change your PCP.
- Go to the Emergency Room for emergency care.
- Be treated with dignity and respect.
- Complain to the health plan, State Department of Health, or to your LDSS if you have problems with your plan.



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Preventive Care Helps Keep You and Your Family Healthy

A regular visit to your primary care provider (PCP) is a good idea.

Did you know that the following check-ups may identify health problems early and help keep you and your family healthy?

- Childhood immunization (shots)
- Diabetes screening
- Heart disease screening
- High blood pressure screening
- Lead screening for children
- Mammogram (breast exam)
- OB/GYN exam/pap smears
- Prostate exams



If You Lose Eligibility for Medicaid, You May Still Be Eligible for Family Health Plus (FHPlus)

FHPlus is a public health insurance program for the uninsured that will provide a comprehensive set of health care services. For most plans, all FHPlus services are provided through the health plan.

There is no cost to join Family Health Plus, and no yearly fee or deductibles. Once enrolled you may be asked to pay part of the costs of some medical care/services. This is called a co-payment or co-pay.

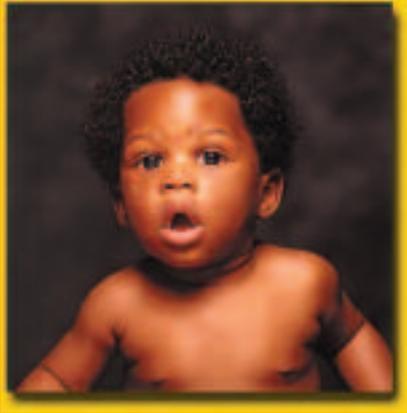
Who Can Join Family Health Plus (FHPlus)?

- Uninsured adults ages 19 through 64, who are permanent New York State residents, United States citizens or fall under certain immigration categories, are not eligible for Medicaid because of income or resources and are not eligible for employer-sponsored health coverage through federal, state, county, municipal or school district benefit plans.
- Income and resources must be below qualifying levels.

For More Information

- View the website at: www.health.state.ny.us
- Inquiries can be e-mailed to: FHPlus@health.state.ny.us
- Call the information hotline: 1-877-9FHPLUS or 1-877-934-7587

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State of New York
Eliot Spitzer, Governor
Department of Health
Richard F. Daines, M.D., Commissioner