

Child Health Plus

English



February 1, 2009

CHPlus Family Number: F2L60ZQ7D5

Dear Mr./Ms. BARBARA SAMPLE:

Welcome to Child Health Plus B with MetroPlus Health Plan, your choice for quality care!

Enclosed you will find a copy of the Subscriber Contract.

Your child should have received his/her Child Health Plus B Identification Card. If not, please contact Member Services at **1-800-303-9626**.

Please carry the Child Health Plus B identification card with you at all times. You should also **use this card when your child(ren) need dental care and to fill prescriptions at the pharmacy**. The card contains important information regarding member coverage, effective date and the Primary Care Provider. If your child needs medical care before the Child Health Plus B identification card arrives, this letter will explain that the child's enrollment effective date is 02/20/2009.

Listed below are the Primary Care Providers (PCP) you selected for your child(ren) when they were enrolled. If you have not selected a PCP or wish to change PCP's, please contact Member Services for help.

Child's Name	Child's ID Number	PCP's Name	PCP Site
CAROL SAMPLE	M2L60ZQ7D7	Doctor Whom	Ellis Hospital

If additional information is needed, we will let you know.

If you have any questions or concerns, please call MetroPlus Health Plan Member Services at **1-800-303-9626** from Monday through Saturday 8 AM - 8 PM. Or, **visit our website at www.metroplus.org**

Please note that there are other Child Health Plus B health plans available in your area. If you were not aware of these other options or wish to change health plans for any reason, you may do so at any time. To make a change, you need to disenroll your child(ren) with us and reapply to another health plan. To ensure you have no lapse in coverage, you must disenroll with us and apply to a new plan before the 20th of any given month.

Thank you again for applying to Child Health Plus B offered by MetroPlus Health Plan. We look forward to serving you.

Sincerely,

MetroPlus Health Plan



MetroPlus Health Plan Quick Reference Guide

MetroPlus Member Services **1-800-303-9626**
MetroPlus 24-Hour Hotline **1-800-442-2560**
MetroPlus TDD Telephone **1-800-881-2812**
MetroPlus Website www.metroplus.org

WHAT IS AN EMERGENCY?

Examples include:

Broken bones, trouble breathing, seizures (fits), severe bleeding, medicine overdose, loss of consciousness, paralysis, severe chest pain, heart attack, stroke.
If pregnant: vaginal bleeding, severe abdominal pain or cramps, water breaking or leaking.

WHAT TO DO: Call **911** or go immediately to the nearest Emergency Room.

WHAT IS AN URGENT HEALTH CARE PROBLEM?

Examples include:

A serious health problem that does not require an Emergency Room: flu, earache, sore throat.

WHAT TO DO? Call your PCPs office Monday to Friday from 8:30a.m. to 5:30p.m.
All other times call the 24-Hour Health Care Hotline number above.

(MetroPlus Health Plan is operated by the New York City Health and Hospitals Corporation)



NEW MEMBER HEALTH ASSESSMENT FORM

Welcome: Please, complete this form and return it in the enclosed envelope. The information is confidential and will be used only by the plan, by your PCP to learn what your medical needs are and to send you health education materials. If you have a child 2 years or less we are enclosing an immunization card that you can use to help you keep track of your child's immunizations. To help us reach you, please let us know if there are any changes in your address or telephone number.

You can reach us @ 1-800-303-9626. We look forward to helping you stay healthy.

Name:		Best Phone number to reach you at and Second Contact #:				<input type="checkbox"/> Male <input type="checkbox"/> Female	
MetroPlus Member Information (Please answer questions for each member)							
Member Name(s): →	Member 1.		Member 2.		Member 3.		Member 4
SS #(s) or Medicaid#(s) or Alternate ID # →							
PCP name or Site							
1. Does anyone in your family (covered by MetroPlus) have a hearing or seeing problem?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
2. In the last 6 months have you or your child been hospitalized or visited the ER?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
3. Do the above noted members have any of the following conditions or problems? (Please answer questions for each member)							
Asthma or Problems Breathing	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
Cancer	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
Liver Disease	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
Bruises/ Bleeds easily (Sickle Cell Anemia)	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
Diabetes	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
Cholesterol Problem	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
Overweight	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
HIV/AIDS	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
Heart Problems or High Blood Pressure	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
Thyroid Problem	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
Seizures (Fits or Convulsions)	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
Domestic Violence	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
Depression	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
Smoke/ Tobacco Use	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
Drug or Alcohol Use	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
Disabilities:							
Vision Loss/ Eye Problem (Glaucoma or Other)	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
Physically Handicapped	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
Developmental Disability	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
List any other problem or condition not listed	Other: _____		Other: _____		Other: _____		Other: _____
4. Are any of the MetroPlus members listed above pregnant? Name: _____ Due Date: _____	Yes <input type="checkbox"/>						No <input type="checkbox"/>
5. Do you need or would you like information about immunizations? (shots, vaccinations)	Yes <input type="checkbox"/>						No <input type="checkbox"/>
6. Have any of the MetroPlus members, noted above, seen a doctor yet?	Yes <input type="checkbox"/>						No <input type="checkbox"/>
7. Will any of the MetroPlus members need to have a prescription filled or refilled in the next month?	Yes <input type="checkbox"/>						No <input type="checkbox"/>
8. In what language would you like to receive information? English <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese <input type="checkbox"/> Russian <input type="checkbox"/> Creole <input type="checkbox"/> Other _____							

Bienvenidos: Por favor, conteste a las siguientes preguntas y envíe este formulario en el sobre adjunto. La información que nos proporcione es confidencial y será usada sólo por el plan y por su médico de cabecera para conocer sus necesidades con respecto a su salud y para enviarle información referente a la salud. Para aquellas personas que tengan hijos que hayan cumplido o que sean menores de 2 años, hemos incluido una tarjeta de inmunizaciones que podrá utilizar para controlar las inmunizaciones que reciba su hijo(a).

A fin de que podamos comunicarnos sin inconvenientes, recuerde informarnos sus cambios de dirección o número telefónico.

Comuníquese con nosotros llamando al 1-800-303-9626. Esperamos poder ayudar a que usted y su familia se mantengan saludables.

Nombre:	Mejor número de teléfono para comunicarnos con usted y segundo número de contacto:	<input type="checkbox"/> Masculino <input type="checkbox"/> Femenino
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Información sobre el miembro de MetroPlus

(conteste a las preguntas correspondientes a cada miembro)

Nombre del miembro →	Miembro 1	Miembro 2	Miembro 3	Miembro 4
Nº de SS o Nº Medicaid o ID alternativa →				
Establecimiento o nombre del médico de cabecera (PCP)				
1. ¿Alguna persona de su familia (con cobertura de MetroPlus) tiene problemas de audición o de la vista?	Sí <input type="checkbox"/> No <input type="checkbox"/>	Sí <input type="checkbox"/> No <input type="checkbox"/>	Sí <input type="checkbox"/> No <input type="checkbox"/>	Sí <input type="checkbox"/> No <input type="checkbox"/>
2. Durante los últimos 6 meses, ¿usted o su hijo(a) fueron hospitalizados o visitaron la sala de emergencias?	Sí <input type="checkbox"/> No <input type="checkbox"/>	Sí <input type="checkbox"/> No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>
3. Usted o alguno de los miembros antes mencionados padece alguna de las siguientes enfermedades o problemas? (Conteste a las preguntas correspondientes a cada miembro)				
Asma o problemas respiratorios	Sí <input type="checkbox"/>	Sí <input type="checkbox"/>	Sí <input type="checkbox"/>	Sí <input type="checkbox"/>
Cáncer	Sí <input type="checkbox"/>	Sí <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Enfermedades del hígado	Sí <input type="checkbox"/>	Sí <input type="checkbox"/>	Sí <input type="checkbox"/>	Sí <input type="checkbox"/>
Moretones/Sangra con facilidad (Anemia drepanocítica)	Sí <input type="checkbox"/>	Sí <input type="checkbox"/>	Sí <input type="checkbox"/>	Sí <input type="checkbox"/>
Diabetes	Sí <input type="checkbox"/>	Sí <input type="checkbox"/>	Sí <input type="checkbox"/>	Sí <input type="checkbox"/>
Problemas de colesterol	Sí <input type="checkbox"/>	Sí <input type="checkbox"/>	Sí <input type="checkbox"/>	Sí <input type="checkbox"/>
Sobrepeso	Sí <input type="checkbox"/>	Sí <input type="checkbox"/>	Sí <input type="checkbox"/>	Sí <input type="checkbox"/>
VIH/SIDA	Sí <input type="checkbox"/>	Sí <input type="checkbox"/>	Sí <input type="checkbox"/>	Sí <input type="checkbox"/>
Enfermedades cardíacas o presión arterial alta	Sí <input type="checkbox"/>	Sí <input type="checkbox"/>	Sí <input type="checkbox"/>	Sí <input type="checkbox"/>
Problemas de tiroides	Sí <input type="checkbox"/>	Sí <input type="checkbox"/>	Sí <input type="checkbox"/>	Sí <input type="checkbox"/>
Convulsiones o ataques	Sí <input type="checkbox"/>	Sí <input type="checkbox"/>	Sí <input type="checkbox"/>	Sí <input type="checkbox"/>
Violencia doméstica	Sí <input type="checkbox"/>	Sí <input type="checkbox"/>	Sí <input type="checkbox"/>	Sí <input type="checkbox"/>
Depresión	Sí <input type="checkbox"/>	Sí <input type="checkbox"/>	Sí <input type="checkbox"/>	Sí <input type="checkbox"/>
Tabaquismo (fumar o consumir tabaco)	Sí <input type="checkbox"/>	Sí <input type="checkbox"/>	Sí <input type="checkbox"/>	Sí <input type="checkbox"/>
Consumo de drogas o alcohol	Sí <input type="checkbox"/>	Sí <input type="checkbox"/>	Sí <input type="checkbox"/>	Sí <input type="checkbox"/>
Incapacidades:				
Problemas en los ojos / pérdida de la visión (glaucoma u otra enfermedad)	Sí <input type="checkbox"/>	Sí <input type="checkbox"/>	Sí <input type="checkbox"/>	Sí <input type="checkbox"/>
Discapacidades físicas	Sí <input type="checkbox"/>	Sí <input type="checkbox"/>	Sí <input type="checkbox"/>	Sí <input type="checkbox"/>
Discapacidades de crecimiento	Sí <input type="checkbox"/>	Sí <input type="checkbox"/>	Sí <input type="checkbox"/>	Sí <input type="checkbox"/>
Indique cualquier otro problema o enfermedad no mencionada	Otro: _____	Otro: _____	Otro: _____	Otro: _____
4. ¿Alguna de las mujeres miembro de MetroPlus mencionada anteriormente está embarazada? Nombre: _____ Fecha de parto: _____			Sí <input type="checkbox"/>	No <input type="checkbox"/>
5. ¿Necesita o le gustaría recibir información sobre los planes de inmunización o vacunación?			Sí <input type="checkbox"/>	No <input type="checkbox"/>
6. ¿Alguno de los miembros de MetroPlus mencionados anteriormente ya ha consultado a un médico?			Sí <input type="checkbox"/>	No <input type="checkbox"/>
7. ¿Alguno de los miembros de MetroPlus mencionados anteriormente necesitará que le completen por primera o segunda vez una receta durante el próximo mes?			Sí <input type="checkbox"/>	No <input type="checkbox"/>
8. ¿En que idioma prefiere usted recibir la información? Inglés <input type="checkbox"/> Español <input type="checkbox"/> Chino <input type="checkbox"/> Ruso <input type="checkbox"/> Creole <input type="checkbox"/> Otro _____				

Child Health Plus

Subscriber Contract

Thank you for choosing MetroPlus Health Plan.
This booklet contains your Child Health Plus Contract with MetroPlus Health Plan and other information about the Plan that will help you make the most of your Child Health Plus benefits. Please take the time to read it carefully.

YOUR METROPLUS HEALTH PLAN CHILD HEALTH PLUS SUBSCRIBER CONTRACT

PART I of this booklet is your Child Health Plus Contract with MetroPlus Health Plan. It entitles you to the benefits set forth in the Contract. Coverage begins on the effective date stated on your identification card. This Contract will continue unless it is terminated for any of the reasons described in the Contract.

Notice of 10-Day Right to Examine Contract

You have the right to return this Contract. Examine it carefully. You may return it and ask us to cancel it. Your request must be made in writing within ten (10) days of the date you receive this Contract. We will refund any premium you paid. If you return this contract, we will not provide you with any benefits.

IMPORTANT NOTICE:

All services covered under this Contract must be provided, arranged or authorized by your Primary Care Provider. You must contact your Primary Care Provider in advance in order to receive benefits, except for emergency care described in Section Seven, certain obstetric and gynecological care described in Section Four, and vision care and dental care described in Section Six of this Contract.

TABLE OF CONTENTS

PART I YOUR SUBSCRIBER CONTRACT

Section 1	Introduction	3
Section 2	Who is Covered	5
Section 3	Hospital Benefits	6
Section 4	Medical Services	8
Section 5	Emergency Care	10
Section 6	Other Covered Services	11
Section 7	Additional Information on How This Plan Works	16
Section 8	Limitations and Exclusions	17
Section 9	Premiums for This Contract	19
Section 10	Termination of Coverage	20
Section 11	Actions and Grievances	21
Section 12	General Provisions	27

PART II METROPLUS INFORMATION AND SPECIAL SERVICES

A	About MetroPlus Health Plan	28
B	Getting Started With MetroPlus	28
C	Member's Responsibilities	29
D	Emergency and Urgent Care	29
E	Getting Care in Special Situations	30
F	Utilization Review	31
G	Getting Help From Member Services	32
H	Help for Members Who do not Speak English and Those Who Have Hearing or Vision Impairments	33
I	Fraud Prevention	33
J	Office of Professional Medical Conduct	33
K	Member Input Into Plan Policies and Procedures	33
L	Provider Payment Methods	34
M	Other Information Available to You Upon Request	34
N	Your MetroPlus Member Bill of Rights	34

PART I
YOUR SUBSCRIBER CONTRACT

SECTION ONE - INTRODUCTION

1. **Child Health Plus Program.** This Contract is being issued pursuant to a special New York State Department of Health (DOH) program designed to provide subsidized health insurance coverage for uninsured children in New York State. MetroPlus Health Plan will enroll you in the Child Health Plus program if you meet the eligibility requirements established by New York State and you will be entitled to the health care services described in this Contract. You and/or the responsible adult, as listed on the application, must report to us any change in status, such as residency, income, or other health insurance, that may make you ineligible for participation in Child Health Plus within 60 days of that change.

2. **Health Care through an HMO.** This Contract provides coverage through MetroPlus Health Plan, which is a health maintenance organization (HMO). In an HMO, all care must be Medically Necessary and provided, arranged or authorized in advance by your Primary Care Provider (PCP). Except for Emergency Services, certain obstetric and gynecological services, vision care and dental care, there is no coverage for care you receive without the approval of your PCP. In addition, coverage is only provided for care rendered by a Participating Provider, except in an emergency or when your PCP refers you to a Non-Participating Provider with the approval of MetroPlus.

Selecting a PCP. It is your responsibility to select a PCP from the MetroPlus Health Plan list of PCPs when you enroll for this coverage. The list includes a phone number to call to find out if a provider is accepting new patients. You may change your PCP by calling MetroPlus Member Services toll free at **1-800-303-9626** . The PCP you have chosen is referred to as “your PCP” throughout this Contract.

3. **Words We Use.** Throughout this Contract, MetroPlus Health Plan will be referred to as “we”, “us” or “our.” The words “you”, “your” or “yours” refer to you, the child to whom this Contract is issued and who is named on the identification card.

4. **Definitions.** The following definitions apply to this Contract:
 - A. **Contract** means this document. It forms the legal agreement between you and us. Keep this Contract with your important papers so it is available for your reference.

- B. **Emergency Condition** means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (A) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy, or (B) serious impairment of such person's bodily functions; or (C) serious dysfunction of any bodily organ or part of such person; or (D) serious disfigurement of such person.
- C. **Emergency Services** means those physician and outpatient hospital services necessary for treatment of an Emergency Condition.
- D. **Hospital** means a short-term, acute, general hospital, which:
- is primarily engaged in providing, by or under the continuous supervision of physicians, to inpatients, diagnostic services and therapeutic services for diagnosis, treatment and care of injured or sick persons;
 - has organized departments of medicine and major surgery;
 - has a requirement that every patient must be under the care of a physician or dentist;
 - provides 24-hour nursing service by or under the supervision of a registered professional nurse (R.N.);
 - if located in New York State, has in effect a hospitalization review plan applicable to all patients which meets at least the standards set forth in Section 1861 (k) of United States Public Law 89-97 (42 USCA 1395x[k]);
 - is duly licensed by the agency responsible for licensing such hospitals; and
 - is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial, education or rehabilitary care.
- E. **Medically Necessary** applies to those services and supplies which are necessary to prevent, diagnose, correct or cure conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity, or threaten some significant handicap. These services must be (1) consistent with the symptoms or diagnosis and treatment of the member's condition, disease, ailment or injury; (2) appropriate with regard to standards of good medical practice as recognized and accepted by the medical community; (3) not solely for the convenience of the member, his or her provider, contractor, or other health care provider; and (4) in the case of inpatient hospital services, Medically Necessary shall also mean that safe and adequate care could not be provided as appropriately on an

outpatient basis or in a less intensive treatment setting.

- F. **Participating Hospital** means a Hospital authorized under an agreement with us to provide covered services to our members.
- G. **Participating Pharmacy** means a pharmacy authorized under an agreement with us to provide covered services to our members.
- H. **Participating Physician** means a physician authorized under an agreement with us to provide covered services to our members.
- I. **Participating Provider** means any Participating Physician, dentist or other licensed health care practitioner, Hospital, home health care agency, laboratory, pharmacy, or other entity, authorized under an agreement with us to provide covered services to our members.
- J. **Non-Participating Provider** means a provider who is not authorized under an agreement with us to provide covered services to our members. We will not pay for health services from a Non-Participating Provider except in an emergency or when your PCP sends you to that Non-Participating Provider with our approval.
- K. **Premium** means the money paid for health insurance coverage. New York State will pay for all or part of your premium; you may have to contribute part of the payment, depending on your income. (See Section 9 for more information.)
- L. **Primary Care Provider ("PCP")** means the Participating Provider (physician or nurse practitioner) you select when you enroll, or change to thereafter according to our rules, and who provides or arranges for all your covered health care services.
- M. **Service Area** means the following counties: Manhattan, Bronx, Queens, and Brooklyn. You must reside in the Service Area to be covered under this Contract.

SECTION TWO - WHO IS COVERED

1. **Who is Covered Under this Contract.** You are covered under this Contract if you meet all of the following requirements:
 - You are younger than age 19.
 - You do not have other health care coverage.
 - You are not eligible for Medicaid.
 - You are a permanent New York State resident and a resident of our Service Area.

2. **Recertification.** We will review your application for coverage to determine if you meet the Child Health Plus eligibility requirements. You must periodically resubmit an application to us so that we can determine whether you still meet the eligibility requirements. This process is called "**recertification**". If more than one child in your family is currently covered by us, then the recertification date for all the children in your family covered by us is the month assigned to the child who has the closest recertification date on or after **October 1, 2000**. You must recertify once each year unless another child in your family applies for coverage with us, then you must recertify all children when that child applies for coverage. Thereafter, all the children in your family covered by us will recertify each year on the same date.
3. **Change in Circumstances.** You must notify us of any changes to your income, residency or health care coverage that might make you ineligible for this contract. You must give us this notice within sixty (60) days of the change. If you fail to give us notice of a change in circumstances, you may be asked to pay back any premium that has been paid for you.

SECTION THREE - HOSPITAL BENEFITS

1. **Care In a Hospital.** You are covered for Medically Necessary care as an inpatient in a Hospital if all the following conditions are met:
 - A. The Hospital must be a Participating Provider except if you are admitted to a non-participating Hospital for Emergency Services or your PCP arranged the admission to a non-participating Hospital with authorization in advance by MetroPlus.
 - B. Your admission must be authorized in advance by MetroPlus, except for Emergency Services.
 - C. You must be a registered bed patient for the proper treatment of an illness, injury or condition that cannot be treated on an outpatient basis.
2. **Covered Inpatient Services.** Covered inpatient services under this Contract include the following:
 - A. Daily bed and board, including special diet and nutritional therapy;
 - B. General, special and critical care nursing service, but not private duty nursing service;
 - C. Facilities, services, supplies and equipment related to surgical operations, recovery facilities, anesthesia, and facilities for intensive or special care;
 - D. Oxygen and other inhalation therapeutic services and supplies;

- E. Drugs and medications that are not experimental;
 - F. Sera, biologicals, vaccines, intravenous preparations, dressings, casts, and materials for diagnostic studies;
 - G. Blood products, except when participation in a volunteer blood replacement program is available;
 - H. Facilities, services, supplies and equipment related to diagnostic studies and the monitoring of physiologic functions, including but not limited to laboratory, pathology, cardiographic, endoscopic, radiologic and electroencephalographic studies and examinations;
 - I. Facilities, services and supplies related to physical medicine and occupational therapy and rehabilitation;
 - J. Facilities, services and supplies and equipment related to radiation and nuclear therapy;
 - K. Facilities, services, supplies and equipment related to emergency medical care;
 - L. Chemotherapy;
 - M. Radiation therapy; and
 - N. Any additional medical, surgical, or related services, supplies and equipment that are customarily furnished by the Hospital, except to the extent that they are excluded by this Contract.
3. **Maternity Care.** Other than for perinatal complications, we will pay for inpatient hospital care for at least 48 hours after childbirth for any delivery other than a Caesarean Section. We will pay for inpatient hospital care for at least 96 hours after a Caesarean Section. Maternity care coverage includes parent education, assistance and training in breast or bottle-feeding and performance of necessary maternal and newborn clinical assessments.

You have the option to be discharged earlier than 48 hours (96 hours for Cesarean Section). If you choose an early discharge, we will pay for one home care visit if you ask us to within 48 hours of delivery (96 hours for a delivery by Cesarean Section). The home care visit will be delivered within 24 hours of the later of your discharge from the Hospital or your request for home care. The home care visit will be in addition to home care visits covered under Section Six of this Contract.

4. **Inpatient Mental Health, Alcohol and Substance Abuse Services.** In the case of mental health services and alcohol and substance abuse services, we will pay for covered inpatient services provided in: Hospitals; facilities operated by OMH under Section 7.17 of the Mental Hygiene Law; and facilities issued an operating certificate pursuant to Article 23 or Article 31 of the Mental Hygiene Law. Except in an emergency, the provider must be a Participating Provider unless we authorize admission to a Non-Participating Provider.

5. **Limitations and Exclusions**
 - A. We will not provide any benefits for any day that you are out of the hospital, even for a portion of the day. We will not provide benefits for any day when inpatient care was not Medically Necessary.

 - B. Benefits are paid in full for a semi-private room. If you are in a private room, the difference between the cost of a private room and a semi-private room must be paid by you unless the private room is Medically Necessary and ordered by your physician.

 - C. Benefits for inpatient mental health services and for inpatient alcohol and substance abuse detoxification and rehabilitation services are limited to a combined total of 30 days per calendar year.

 - D. We will not pay for non-medical items such as television rental or telephone charges.

SECTION FOUR - MEDICAL SERVICES

1. **Your PCP Must Provide, Arrange or Authorize all Medical Services.** Except for Emergency Services or for certain obstetric and gynecological services, you are covered for the medical services listed below only if your PCP provides, arranges or authorizes the services. You are entitled to medical services provided at one of the following locations:
 - Your PCP's office.
 - Another provider's office or a facility if your PCP determines that care from that provider or facility is appropriate for the treatment of your condition.
 - The outpatient department of a Hospital.
 - As an inpatient in a Hospital, you are entitled to medical, surgical and anesthesia services. MetroPlus must authorize in advance all non-emergency Hospital admissions.

2. **Covered Medical Services.** We will pay for the following medical services:
 - A. General medical and specialist care, including consultations.
 - B. **Preventive health services and physical examinations.** We will pay for

preventive health services including:

- Well child visits in accordance with the visitation schedule established by the American Academy of Pediatrics,
- Nutrition education and counseling,
- Hearing testing,
- Medical social services,
- Eye screening,
- Routine immunizations in accordance with the New York State Department of Health recommended immunization schedule,
- Tuberculin testing,
- Dental and developmental screening,
- Clinical laboratory and radiological testing, and
- Lead screening.

C. **Diagnosis and Treatment of Illness, Injury or Other Conditions.** We will pay for the diagnosis and treatment of illness or injury including:

- Outpatient surgery performed in a provider's office or at an ambulatory surgery center, including anesthesia services,
- Dental care in connection with accidental injury to sound natural teeth within twelve months of the accident,
- Laboratory tests, x-rays and other diagnostic procedures,
- Renal dialysis,
- Radiation therapy,
- Chemotherapy,
- Injections and medications administered in a physician's office,
- Second surgical opinion from a board certified specialist, and
- Medically Necessary audiometric testing.

D. **Physical and Occupational Therapy.** We will pay for Short-Term physical and occupational therapy services. The therapy must be skilled therapy. Short-Term means not to exceed forty (40) visits within one calendar year.

E. **Radiation Therapy, Chemotherapy and Hemodialysis.** We will pay for radiation therapy and chemotherapy, including injection and medications provided at the time of therapy. We will pay for hemodialysis services in your home or at a facility, whichever we deem appropriate.

F. **Outpatient Visits for Treatment of Mental Health Conditions and for Treatment of Alcoholism and Substance Abuse.** We will pay for up to an aggregate of sixty (60) outpatient visits in each calendar year for the diagnosis and treatment of alcohol and substance abuse and mental illness, including family member visits if related to your alcoholism or substance abuse.

- G. **Obstetric and Gynecological Services** including prenatal, labor and delivery and post-partum services are covered with respect to pregnancy. You do not need your PCP's authorization for care related to pregnancy if you seek care from a qualified Participating Provider of obstetric and gynecologic services. You may also receive the following services from a qualified Participating Provider of obstetric and gynecologic services without your PCP's authorization:
- Up to two annual examinations for primary and preventive obstetric and gynecologic care; and
 - Care required as a result of the annual examinations or as a result of an acute gynecological condition.
- H. **Cervical Cancer Screening.** If you are a female who is eighteen years old, or younger and sexually active, we will pay for an annual cervical cancer screening, an annual pelvic examination, pap smear and evaluation of the pap smear. We will also pay for screening for sexually transmitted diseases.
- I. **Speech Therapy.** We will pay for speech therapy services required for a condition amenable to significant clinical improvement within a two month period, beginning with the first day of therapy, when performed by an audiologist, language pathologist, a speech therapist and/or otolaryngologist.

SECTION FIVE - EMERGENCY CARE

1. **Hospital Emergency Room Visits.** We will pay for Emergency Services provided in a Hospital emergency room. You may go directly to any emergency room to seek care. You do not have to call your PCP first. Emergency care is not subject to our prior approval.

If you go to the emergency room, you or someone on your behalf must notify the MetroPlus Utilization Management Department by the next business day or as soon as it is reasonably possible. To notify us, call the Utilization Management toll-free telephone number: **1-800-303-9629**.

If, in our sole judgment, the emergency room services rendered were not in treatment of an Emergency Condition as defined in Section One, page 4, the visit to the emergency room will not be covered.

2. **Emergency Hospital Admissions.** If you are admitted to the Hospital you or someone on your behalf must notify the MetroPlus Utilization Management Department by the next business day or as soon as it is reasonably possible. If you are admitted to a non-participating hospital, we may require that you be moved to a Participating Hospital as soon as your condition permits.

3. **Ambulance Services.** We will pay for pre-hospital emergency medical services, including prompt evaluation and treatment of an Emergency Condition and/or non-airborne transportation to a hospital, provided by an ambulance service issued a certificate to operate pursuant to section 3005 of the Public Health Law.

You do not need our prior approval to obtain ambulance services for an Emergency Condition as defined under the prudent layperson standard set forth in Section One, page 4. If pre-hospital emergency medical services, including evaluation and treatment and/or non-airborne transportation to a hospital, are necessary under the prudent layperson standard, they will be covered. Ambulance services rendered in the absence of an Emergency Condition will not be covered.

SECTION SIX - OTHER COVERED SERVICES

1. **Diabetic Equipment and Supplies.** We will pay for the following equipment and supplies for the treatment of diabetes which are Medically Necessary and prescribed or recommended by your PCP or other Participating Provider legally authorized to prescribe under Title 8 of the New York State Education Law:

- Blood glucose monitors,
- Blood glucose monitors for legally blind,
- Data management systems,
- Test strips for monitors and visual reading,
- Urine test strips,
- Injection aids,
- Cartridges for the legally blind,
- Insulin,
- Syringes,
- Insulin pumps and appurtenances thereto,
- Insulin infusion devices,
- Oral agents, and
- Additional equipment and supplies designated by the Commissioner of Health as appropriate for the treatment of diabetes.

2. **Diabetes Self-Management Education.** We will pay for diabetes self-management education provided by your PCP or another Participating Provider. Education will be provided upon the diagnosis of diabetes, a significant change in your condition, the onset of a condition which makes changes in self-management necessary or where re-education is Medically Necessary as determined by us. We will also pay for home visits if Medically Necessary.

3. **Durable Medical Equipment.**

- A. **Scope of Coverage.** We will pay for devices and equipment that are ordered by your PCP or other Participating Provider for the treatment of a specific medical condition and which:

- Can withstand repeated use for a protracted period of time;
- Are primarily and customarily used for medical purposes;
- Are generally not useful in the absence of illness or injury; and
- Are usually not fitted, designed or fashioned for a particular person's use, though equipment intended for use by one person may be custom-made or customized.

Durable medical equipment includes: hearing aids; prosthetic appliances (devices that replace or perform the function of any missing part of the body); orthotic devices (devices used to support a weak or deformed body member or to restrict or eliminate motion in a diseased or injured part of the body); hospital beds and accessories; oxygen and oxygen supplies; pressure pads; volume ventilators, therapeutic ventilators, nebulizers and other equipment for respiratory care; traction equipment; walkers; canes; crutches; wheelchairs and accessories; commode chairs; toilet rails; apnea monitors; patient lifts; nutrition infusion pumps; ambulatory infusion pumps. We will also pay for equipment servicing (labor and parts).

B. **Participating Pharmacy or Other Participating Provider of DME.** Except in an emergency, the prescription for durable medical equipment must be filled by a Participating Pharmacy or other Participating Provider.

C. **Exclusions and Limitations.** Under this section we will not pay for the following:

- Experimental appliances and devices;
- Orthotic devices prescribed solely for use during sports;
- Cranial prostheses (wigs); and
- Dental prostheses, except those made necessary due to accidental injury to sound, natural teeth and provided within 12 months of the accident, and except for dental prostheses needed in treatment of a congenital abnormality or as part of reconstructive surgery.

4. **Prescription and Non-Prescription Drugs.**

A. **Scope of Coverage.** We will pay for Medically Necessary FDA approved drugs requiring a prescription and non-prescription medications which appear in the Medicaid formulary. Coverage includes Medically Necessary enteral formulas (nutritional supplements) for home use (including formulas for the treatment of PKU, branched-chain ketonuria, galactosemia and homocystinuria) and modified solid food products that are low-protein or which contain modified protein for treatment of certain inherited diseases of amino acid and organic acid metabolism. We will also pay for contraceptive devices and drugs.

B. **Participating Provider and Pharmacy.** We will only pay for drugs prescribed for use outside of a hospital. Except in an emergency, the prescription must be issued by a Participating Provider or a Non-Participating Provider to whom you have been referred by your PCP with our approval. Except in an emergency, prescriptions must be filled at a Participating Pharmacy.

C. **Exclusions and Limitations.** Under this Section we will not pay for the following:

- Administration or injection of any drugs,
- Replacement of lost or stolen prescriptions,
- Prescribed drugs used for cosmetic purposes only,
- Experimental or investigational drugs unless approved by the Plan Medical Director or an External Appeal Agent,
- Non-FDA approved drugs except that we will pay for a prescription drug that is approved by the FDA for treatment of cancer when the drug is prescribed for a different type of cancer than the type for which FDA approval was obtained. However the drug must be recognized for treatment of the type of cancer for which it has been prescribed by one of these publications:
 - (a) AMA Drug Evaluations,
 - (b) American Hospital Formulary Service,
 - (c) U.S. Pharmacopoeia Drug Information, or
 - (d) A review article or editorial comment in a major peer-reviewed professional journal.
- Devices and supplies of any kind, except family planning or contraceptive devices, basal thermometers, male and female condoms, and diaphragms.
- Vitamins and other nutritional supplements, except when necessary to treat a diagnosed illness or condition.
- Modified solid food products in excess of \$2,500 per calendar year.
- Prescription drugs used for purposes of treating erectile dysfunction are not covered.

5. **Home Health Care.** We will pay for up to forty (40) visits per calendar year for home health care provided by a certified home health agency that is a Participating Provider. We will pay for home health care only if you would have to be admitted to a Hospital if home care was not provided.

Home care includes one or more of the following services:

- part-time or intermittent home nursing care by or under the supervision of a registered professional nurse,
- part-time or intermittent home health aide services which consist primarily of caring for the patient,
- physical, occupational or speech therapy if provided by the home health agency, and
- medical supplies, drugs and medications prescribed by a physician and laboratory services by or on behalf of a certified home health agency to the extent such items

would have been covered if the covered person had been in a Hospital.

6. **Preadmission Testing.** We will pay for preadmission testing when performed at the Hospital where surgery is scheduled to take place, if:

- reservations for a Hospital bed and for an operating room at that Hospital have been made, prior to performance of tests;
- your physician has ordered the tests; and
- surgery actually takes place within seven days of such preadmission tests.

If surgery is canceled because of the preadmission test findings, we will still cover the cost of these tests.

7. **Dental Care.**

A. **Scope of Coverage.** We will pay for emergency, preventive and routine dental services provided by a Participating Provider. You do not need your PCP's authorization for covered dental care if you seek such care from a qualified Participating Provider. Covered dental services include the following:

- Emergency treatment required to alleviate pain and suffering caused by dental disease or trauma,
- Procedures that help prevent oral disease from occurring, including but not limited to: prophylaxis (scaling and polishing the teeth) at 6 month intervals; topical fluoride application at 6 month intervals where local water supply is not fluoridated; and sealants on unrestored permanent molar teeth.
- After primary teeth erupt, routine dental examinations once within a 6-month consecutive period.
- X-rays, including full mouth x-rays at 36-month intervals and, if necessary, bitewing x-rays at 6 to 12-month intervals, or panoramic x-rays at 36-month intervals if necessary, and other x-rays as required once primary teeth erupt.
- All necessary procedures for simple extractions and other routine dental surgery not requiring hospitalization, including preoperative care and postoperative care.
- In-office conscious sedation.
- Amalgam, composite restorations and stainless steel crowns.
- Other restorative materials appropriate for children.
- Endodontic care, including all procedures for treatment of diseased pulp chamber and pulp canals, where hospitalization is not required.
- Periodontic services, except for those services in anticipation of, or leading to, orthodontia.
- Prosthodontics, including removable complete or partial dentures with six months follow-up care and, if one or more of the following conditions are met, fixed bridges:
 - Required for replacement of a single upper anterior

(central/lateral incisor or cuspid) in a patient with an otherwise full complement of natural, functional and/or restored teeth; or

- Required for cleft-palate stabilization; or
- Required, as demonstrated by medical documentation, due to the presence of any neurologic or physiologic condition that would preclude the placement of a removable prosthesis.
- Insertion of identification slips, repairs, relines and rebases in prosthodontics.
- Space maintainers, unilateral or bilateral, for placement in a restored deciduous and/or mixed dentition to maintain space for normally developing permanent teeth.

B. **Exclusions and Limitations.** We will not pay for orthodontia services.

8. **Vision Care.**

A. **Scope of Coverage.** We will pay for emergency, preventive, and routine vision care. You do not need your PCP's authorization for covered vision care if you seek such care from a qualified Participating Provider of vision care services. Covered vision services include the following:

- **Vision Examinations.** We will pay for vision examinations for the purpose of determining the need for corrective lenses, and if needed, to provide a prescription for corrective lenses. We will pay for one vision examination in any twelve (12) month period, unless required more frequently with the appropriate documentation. The vision examination may include, but is not limited to: case history; external examination of the eye or internal examination of the eye; ophthalmoscopic exam; determination of refractive status; binocular distance; tonometry tests for glaucoma; gross visual fields and color vision testing; summary findings and recommendation for corrective lenses.
- **Prescribed Lenses.** We will pay for quality standard prescription lenses once in any twelve (12) month period, unless required more frequently with appropriate documentation. Prescription lenses may be constructed of either glass or plastic.
- **Frames.** We will pay for standard frames adequate to hold lenses once in any twelve (12) month period, unless required more frequently with appropriate documentation.
- **Contact Lenses.** We will pay for contact lenses only when deemed Medically Necessary.

B. **Exclusions and Limitations.** We will not pay for contact lenses that are not Medically Necessary.

9. **Hospice Services.** We will pay for a coordinated hospice program to provide non-curative medical and support services (either at home or in an inpatient hospital setting) for children (up to age 19) that have been certified by a doctor to be terminally ill with a life expectancy of six months or less.

Hospice services will cover palliative and supportive care provided to a child that meets the special needs arising out of physical, psychological, spiritual, social and economic stress which are experienced during the final stages of illness and during dying and bereavement. Additionally, family members are eligible for up to five visits for bereavement counseling.

Hospice service programs must be certified under Article 40 of the New York State Public Health Law. All services must be provided by qualified employees and volunteers of the hospice program or by qualified staff through contractual arrangements to the extent permitted by federal and state requirements.

SECTION SEVEN - ADDITIONAL INFORMATION ON HOW THIS PLAN WORKS

1. **When a Specialist Can Be Your PCP.** If you have a life threatening condition or disease or a degenerative and disabling condition or disease, you may ask that a specialist who is a Participating Provider be your PCP. We will consult with the specialist and your PCP and decide whether it would be appropriate for the specialist to serve in this capacity.
2. **Standing Referral to a Network Specialist.** If you need ongoing specialty care, you may receive a "standing referral", to a specialist who is a Participating Provider. This means that you will not need to obtain a new referral from your PCP every time you need to see that specialist. We will consult with the specialist and your PCP and decide whether a "standing referral" would be appropriate in your situation.
3. **Standing Referral to a Specialty Care Center.** If you have a life-threatening condition or disease or a degenerative and disabling condition or disease, you may request a standing referral to a specialty care center that is a Participating Provider. We will consult with your PCP, your specialist and the specialty care center to decide whether such a referral is appropriate.
4. **When Your Provider Leaves the Network.** If you are undergoing a course of treatment when your provider leaves our network, then you may be able to continue to receive care from the former Participating Provider, in certain instances, for up to 90 days after you are notified by us of the provider's leaving. If you are pregnant and in your second trimester, you may be able to continue care with the former Participating Provider through delivery and postpartum care directly related to the delivery. However, in order for you to continue care for up to 90 days or through a pregnancy with a former Participating Provider, the provider must agree to accept our payment and to adhere to our procedures and policies, including those for assuring quality of

care.

5. **When New Members Are In a Course of Treatment.** If you are in a course of treatment with a Non-Participating Provider when you enroll with us, you may be able to receive care from the Non-Participating Provider for up to 60 days from the date you become covered under this Contract. The course of treatment must be for a life-threatening disease or condition or a degenerative and disabling condition or disease. You may also continue care with a Non-Participating Provider if you are in the second trimester of a pregnancy when you become covered under this Contract. You may continue care through delivery and any post-partum services directly related to the delivery. However, in order for you to continue care for up to 60 days or through pregnancy, the Non-Participating Provider must agree to accept our payment and to adhere to our policies and procedures including those for assuring quality of care.

SECTION EIGHT - LIMITATIONS AND EXCLUSIONS

In addition to the limitations and exclusions already described, we will not pay for the following:

1. **Care That Is Not Medically Necessary.** In general, the Plan will not cover any health care service that the Plan, in its sole judgment, determines is not medically necessary. If an External Appeal Agent certified by the State overturns the Plan's denial, however, the Plan shall cover the procedure, treatment, service, pharmaceutical product, or durable medical equipment for which coverage had been denied, to the extent that such procedure, treatment, service, pharmaceutical product, or durable medical equipment is otherwise covered under the terms of this Subscriber Contract. (For further information on external appeals, consult Section 11 of this Subscriber Contract.)
2. **Accepted Medical Practice.** You are not entitled to services which are not in accordance with accepted medical or psychiatric practices and standards in effect at the time of treatment.
3. **Care Which Is Not Provided, Authorized or Arranged by Your PCP.** Except as otherwise set forth in this Contract, you are entitled to benefits for services only when provided, authorized, or arranged by your PCP. If you choose to obtain care that is not provided, authorized or arranged by your PCP, we will not be responsible for any cost you incur.
4. **Inpatient Services in a Nursing Home, Rehabilitation Facility, or Any Other Facility Not Expressly Covered by This Contract.**
5. **Physician Services While an Inpatient of a Nursing Home, Rehabilitation Facility or Any Other Facility Not Expressly Covered by This Contract.**

6. **Experimental or Investigational Services.** In general, the Plan does not cover experimental or investigational treatments. However, the Plan shall cover an experimental or investigational treatment approved by an External Appeal Agent certified by the State. If the External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, the Plan will only cover the costs of services required to provide treatment to you according to the design of the trial. The Plan shall not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be covered under this Subscriber Contract for non-experimental or non-investigational treatments. (For further information on external appeals, consult Section 11 of this Subscriber Contract.)
7. **Cosmetic Surgery.** We will not pay for cosmetic surgery, except that we will pay for reconstructive surgery:
 - When following surgery resulting from trauma, infection or other diseases of the part of the body involved; or
 - When required to correct a functional defect resulting from congenital disease or anomaly.
8. **Personal or Comfort Items.**
9. **In Vitro Fertilization, Artificial Insemination or Other Assisted Means of Conception.**
10. **Private Duty Nursing.**
11. **Autologous Blood Donation.**
12. **Physical Manipulation Services.** We will not pay for any services in connection with the detection and correction (by manual or mechanical means) of structural imbalance; or distortion; or subluxation in the human body for the purpose of removing nerve interference and the effects thereof. This exclusion applies when the nerve interference is the result of or related to distortion, misalignment, or subluxation of or in the vertebral column.
13. **Routine Foot Care.**
14. **Other Health Insurance, Health Benefits and Governmental Programs.** We will reduce our payments under this Contract by the amount you are eligible to receive for the same service under other health insurance, health benefits plans or governmental programs. Other health insurance includes coverage by insurers, Blue Cross and Blue Shield Plans or HMOs or similar programs. Health benefit plans includes any self-insured or non-insured plan such as those offered by or arranged through employers, trustees, unions, employer organizations or employee benefit organizations. Government programs include Medicare or any other federal, state or local programs, except the Physically Handicapped Children's Program and the Early Intervention

Program.

15. **No-Fault Automobile Insurance.** We will not pay for any service which is covered by mandatory automobile no-fault benefits. We will not make any payments even if you do not claim the benefits you are entitled to receive under the no-fault automobile insurance.
16. **Other Exclusions.** We will not pay for:
 - A. Sex transformation procedures; or
 - B. Custodial care.
17. **Workers' Compensation.** We will not provide coverage for any service or care for an injury, condition or disease if benefits are available to you under a Workers' Compensation Law or similar legislation. We will not provide benefits even if you do not claim the benefits you are entitled to receive under the Workers' Compensation Law.

SECTION NINE - PREMIUMS FOR THIS CONTRACT

1. **Amount of Premiums.** The amount of premium for this Contract is determined by us and approved by the Superintendent of Insurance of the State of New York.
2. **Your Contribution Toward the Premium.** Under New York State Law, you may be required to contribute toward the cost of your premium. We will notify you of the required contribution, if any.
3. **Grace Period.** All premiums for this Contract are due one month in advance. However, we will allow a 30 day grace period for the payment of all premiums, except the first month's. This means that, except for the first month's premium for each child, if we receive payment within 30 days of the date the payment was due, we will continue coverage under this Contract for the entire period covered by the payment. If we do not receive payment within the 30 day grace period, the coverage under this Contract will terminate as of the last day of the month when payment is due.
4. **Agreement to Pay for Services if Premium is Not Paid.** You are not entitled to any services for periods for which the premium has not been paid. If services are received during such period, you agree to pay for the services received.
5. **Change in Premiums.** If there is to be an increase or decrease in the premium or your contribution toward the premium for this Contract, we will give you at least thirty days written notice of the change.
6. **Changes in Your Income or Household Size.** You may request that we review your family premium contribution whenever your income or household size changes. You may request a review by calling us at 1-800-475-METRO or by calling the Child

Health Plus Hotline at 1-800-698-4543. At that time, we will provide you with the form and documentation requirements necessary to conduct the review. We will re-evaluate your family premium contribution and notify you of the results within 10 business days of receipt of the request and documentation necessary to conduct the review. If the review results in a change in your family premium contribution, we will apply that change no later than 40 days from receipt of the completed review request and supporting documentation.

SECTION TEN - TERMINATION OF COVERAGE

1. **For Non-Payment of Premium.** If you are required to pay a premium for this Contract, this Contract will terminate at the end of the 30 day grace period if we do not receive your payment. For example, if your premium is due on July 1, and it is not paid by July 31, the end of the 30 day grace period, no payment will be made under this Contract for any service given to you after July 31.
2. **When You Move Outside the Service Area.** This Contract shall terminate when you cease to reside permanently in the Service Area.
3. **When You No Longer Meet Eligibility Requirements.** This Contract shall terminate as follows:
 - A. On the last day of the month in which you reach the age of 19; or
 - B. The date on which you are enrolled in the Medicaid program; or
 - C. The date on which you become covered under another health benefits program (including an insured or self-insured program through an employer group, union or other association.)
4. **Termination of the Child Health Plus Program.** This Contract shall automatically terminate on the date when the New York State law which establishes the Child Health Plus program is terminated or the State terminates this Contract or when funding from New York State for this Child Health Plus program is no longer available to us.
5. **Our Option To Terminate This Contract.** We may terminate this Contract at any time for one or more of the following reasons:
 - A. Fraud in applying for enrollment under this Contract or in receiving any services.
 - B. Such other reasons on file with the Superintendent of Insurance at the time of such termination and approved by him. A copy of such other reasons shall be forwarded to you. We shall give you no less than thirty (30) days prior written notice of such termination.
 - C. Discontinuance of the class of Contracts to which this Contract belongs upon not less than five months prior written notice of such termination.
 - D. If you do not provide the documentation we request for recertification.

6. **Your Option to Terminate This Contract.** You may terminate this Contract at any time by giving us at least one month's prior notice. We will refund any portion of the premium for this Contract that has been prepaid by you.
7. **On Your Death.** This Contract will automatically terminate on the date of your death.
8. **Benefits After Termination.** If you are totally disabled on the date this Contract terminates and you have received medical services for the illness, injury or condition which caused the total disability while covered under this Contract we will continue to pay for the illness, injury or condition related to the total disability during an uninterrupted period of total disability until the first of the following dates:
 - A date on which you are in our sole judgment, no longer totally disabled; or
 - A date twelve (12) months from the date this Contract terminates.

We will not pay for more care than you would have received if your coverage under this Contract had not terminated.

9. **Replacing Terminated Coverage.** MetroPlus Health Plan is not licensed to offer commercial insurance products other than a group managed care plan for employees of the New York City Health and Hospitals Corporation. If this contract terminates because you reach age 19 or because the Child Health Plus program ends, we will give you information about other insurance companies that sell individual health insurance policies.

SECTION ELEVEN - ACTIONS AND GRIEVANCES

Action Appeals

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

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

Your provider can ask for reconsideration:

If we made a decision about your service authorization request without talking to your doctor, your doctor may ask to speak with the plan's Medical Director. The Medical Director will talk to your doctor within one workday.

You can file an action appeal:

- If you are not satisfied with an action we took or what we decide about your service authorization request, you have 90 calendar days after hearing from us to file an appeal.
- You can do this yourself or ask someone you trust to file the appeal for you. You can call Member Services 1-800-303-9626 if you need help filing an appeal.
- We will not treat you any differently or act badly toward you because you file an appeal.
- The appeal can be made by phone or in writing. If you make an appeal by phone it must be followed up in writing

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

- If you or your doctor asks to have your 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 appeal will be reviewed under the standard process; **or**
- If your request was denied when you asked to continue receiving care that you are now getting or need to extend a service that has been provided.
- Fast track appeals can be made by phone and do not have to be followed up in writing.

What happens after we get your Appeal:

- Within 15 days, we will send you a letter to let you know we are working on your appeal.
- Action Appeals of clinical matters will be decided by qualified health care professionals who did not make the first decision, at least one of whom will be a clinical peer reviewer.
- Non-clinical decisions will be handled by persons who work at a higher level than the people who worked on your first decision.
- Before and during the appeal you or your designee can see your case file, including medical records and any other documents and records being used to make a decision on your case;
- You can also provide information to be used in making the decision in person or in writing.
- You will be given the reasons for our decision and our clinical rationale, if it applies. If you are still not satisfied, any further appeal rights you have will be explained or you or someone you trust can file a complaint with the New York State Department of Health at 1-800-206-8125.

Timeframes for Action Appeals:

- Standard appeals: If we have all the information we need we will tell you our decision in thirty working days from your appeal. A written notice of our decision

will be sent within 2 work days from when we make the decision.

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

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

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

You, your provider, or someone you trust may also ask us to take more time to make a decision. This may be because you have more information to give the plan to help decide your case. This can be done by calling 1-800-303-9626 or writing.

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

If we do not make a decision about your appeal, the original decision against you will automatically be reversed, which means your service authorization request will be approved.

Aid to Continue while appealing a decision about your care:

In some cases you may be able to continue the services while you wait for your appeal case to be decided. You may be able to continue the services that are scheduled to end or be reduced if you appeal:

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

If your appeal you may have to pay for the cost of any continued benefits that you received.

External Appeals

If the plan decides to deny coverage for a medical service you and your doctor asked for because it is not medically necessary or because it is experimental or investigational, you can ask New York State for an independent **external appeal**. This is called an external appeal because it is decided by reviewers who do not work for the health plan or the state. These reviewers are qualified people approved by New York State. The service must be in the plan's benefit package or be an experimental treatment. You do not have to pay for an external appeal.

Before you appeal to the state:

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

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

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

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

To ask for an external appeal, fill out an application and send it to the State Insurance Department. You can call Member Services at 1-800-303-9626 if you need help filing an appeal. You and your doctors will have to give information about your medical problem.

Here are some ways to get an application:

- Call the State Insurance Department, 1-800-400-8882
- Go to the State Insurance Department's website at www.ins.state.ny.us
- Contact the health plan at 1-800-303-9626

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

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

Complaint Process

Complaints:

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

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

You also have the right to contact the New York State Department of Health about your complaint at 1-800-205-8125 or write to: NYSDOH Office of Managed Care, Bureau of Managed Care Certification and Surveillance, Room 1911 Corning Tower ESP, Albany, NY 12237. You may also contact your local Department of Social Services with your complaint at anytime. You may call the New York State Insurance Department at (1-800-342-3736) if your complaint involves a billing problem.

How to File a Complaint with the Plan:

To file by phone, call Member Services at 1-800-303-9626 Monday through Saturday 8AM to 8PM. If you call us after hours, leave a message. We will call you back the next working day. If we need more information to make a decision, we will tell you.

You can also submit your Complaint in writing. It should be mailed to:

MetroPlus Health Plan
160 Water Street, 3rd Floor
New York, NY 10038

Attention: Member Services

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 working days. The letter will tell you:

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

Your complaint will be reviewed by one or more qualified people. If your complaint involves

clinical matters your case will be reviewed by one or more qualified health care professionals

After we review your complaint:

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

Complaint Appeals:

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

How to make a complaint appeal:

- If you are not satisfied with what we decide, you have 90 calendar days after hearing from us to file an appeal;
- You can do this yourself or ask someone you trust to file the appeal for you;
- The appeal must be made in writing. If you make an appeal by phone it must be followed up in writing.

What happens after we get your complaint appeal:

After we get your complaint appeal we will send you a letter within 15 working 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 working days of when we have all the information we need to decide the appeal. You will be given the reasons for our decision and our clinical rationale, if it applies. If you are still not satisfied, you or someone on your behalf can file a complaint at any time with the New York State Department of Health at 1-800-206-8125.

SECTION TWELVE - GENERAL PROVISIONS

1. **No Assignment.** You cannot assign the benefits of this Contract. Any assignment or attempt to do so is void. Assignment means the transfer to another person or organization of your right to the benefits provided by this Contract.
2. **Legal Action.** You must bring any legal action against us under this Contract within twelve (12) months from the date we refused to pay for a service under this Contract. If you are bringing any legal action against us claiming personal injury, wrongful death or damage to real or personal property, you must file a Notice of Claim form within ninety (90) days as prescribed by General Municipal Law Section 50-i.
3. **Amendment of Contract.** We may change this Contract if the change is approved by the Superintendent of Insurance of the State of New York. We will give you at least 30 days written notice of any change.
4. **Medical Records.** We agree to preserve the confidentiality of the your medical records. In order to administer this Contract, it may be necessary for us to obtain your medical records from hospitals, physicians or other providers who have treated you. When you become covered under this Contract, you give us permission to obtain and use such records.
5. **Who Receives Payment Under This Contract.** We will pay Participating Providers directly to provide services to you. If you receive covered services from any other provider, we reserve the right to pay either you or the provider.
6. **Notice** Any notice under this Contract may be given by United States mail, postage prepaid, addressed as follows:

If to us: MetroPlus Health Plan
160 Water Street, 3rd Floor
New York, NY 10038

If to you: To the latest address provided by
you on enrollment or official
change-of-address form.

PART II METROPLUS INFORMATION AND SPECIAL SERVICES

A - ABOUT METROPLUS HEALTH PLAN

MetroPlus Health Plan is a health maintenance organization (an “HMO”) that provides a full range of health care benefits including coverage of preventive care as well as for treatment of illness and injuries. The Plan is owned and operated by the New York City Health and Hospitals Corporation (HHC). Our participating providers include HHC’s many hospitals and health centers as well as many other health care providers in your community.

MetroPlus Health Plan has its business office at the following address:

MetroPlus Health Plan
160 Water Street, 3rd Floor
New York, NY 10038

B - GETTING STARTED WITH METROPLUS

Welcome letter, identification (ID) card and prescription card: After your enrollment has been processed, we will send you a welcome letter giving the date on which your coverage will begin. You should receive your MetroPlus Child Health Plus identification (ID) card and prescription card shortly after your membership becomes effective. Your identification card will show your name, address, identification number, the name and telephone number of your Primary Care Provider, and your “effective date” (the date your insurance coverage begins). If any of this information is wrong or you do not receive a card in the mail, please call Member Services toll-free at **1-800-303-9626**. If you need services before your ID card arrives, you can show your provider the welcome letter. Your provider can call Member Services to confirm your coverage.

Orientation sessions for new members: When you join MetroPlus Health Plan, you will receive a letter inviting you to an orientation session for new members. The orientation session will take place at a convenient health care site in your community. A MetroPlus Member Services Representative will tell you more about your Child Health Plus benefits and how to use the Plan. We hope you will attend.

The baseline physical examination. A “baseline” is a complete check-up. We recommend and pay for it. Your PCP will gather complete health information so that he or she will be able to suggest a schedule of follow-up visits as well as immunizations (shots to prevent disease). The baseline examination is also a good way to get to know your PCP.

Important Note: If a medical problem comes up before the scheduled baseline examination, please call the PCP and make an earlier appointment.

On the first visit to the PCP, you may be asked to sign a consent form to get medical records from other health care providers. This is routine. Having complete information helps providers give the best care possible.

Scheduling appointments. To make or change an appointment, call your health care site. If you need to cancel or change it, please call as soon as possible. If you can, call at least 24 hours before the scheduled appointment. This way, you free up the time for someone else. When you make the call, be ready to give your name, MetroPlus Child Health Plus ID Number and Medical Record Number.

C - MEMBER'S RESPONSIBILITIES

We are committed to providing you with prompt, courteous, quality health care. You can help us do that by:

1. Always carrying your MetroPlus Child Health Plus ID card and pharmacy benefits card.
2. Keeping your appointments and arriving for them on time. If you need to cancel an appointment, please do so at least 24 hours in advance, or as soon as possible.
3. Letting your PCP know of any change in medical status, such as a pregnancy.
4. Obtaining prior authorizations and written referrals when required.
5. Remembering to recertify each year so that your membership can continue.
6. Letting Member Services know if your address or phone number changes.

D - EMERGENCY AND URGENT CARE

In an emergency, call 911 and follow instructions or go immediately to the nearest Emergency Room. Here are some examples of emergencies:

- Broken bones
- Breathing difficulty
- Seizures or fits
- Severe bleeding
- Danger of loss of an arm or leg
- Medicine overdose
- Loss of consciousness
- Paralysis
- Loss of speech
- Severe chest pains
- Heart attack
- Stroke

If you are pregnant, signs of an emergency may include vaginal bleeding, severe abdominal pain or cramps or your water breaking or leaking.

NOTE: If you have gone to an Emergency Room (whether or not it is in a Participating Hospital), you or someone else must tell the MetroPlus Utilization Management Department by the next business day (toll-free number: **1-800-303-9629**). We will tell your PCP about the Emergency Room visit so that you can receive the right follow-up care.

Not Quite An Emergency--But Urgent! An urgent problem is serious, but Emergency Room services are not required. Some examples of problems that are usually urgent rather than emergencies are:

- A bad flu
- A fever

- A bad earache

If there is an urgent problem or you are not sure how serious the problem is, call your PCP's office during business hours (8:30 a.m. to 5:30 p.m.). During non-business hours, call the 24-Hour Health Care Hotline at **1-800-442-2560**. You will be given an urgent appointment with the PCP or a medical professional will tell you what care is necessary.

What If the PCP's Office Is Closed? Don't worry. Call the 24-Hour Health Care Hotline at **1-800-442-2560**. Give the operator your name, your Child Health Plus ID number, the name of your PCP and the PCP's office location. Explain the problem. We will:

- Put you in direct contact with a provider, or
- Direct you to the nearest Emergency Room.

E - GETTING CARE IN SPECIAL SITUATIONS

Referrals to a Specialist. To see a specialist, you must first get a referral from the PCP. The PCP decides which specialist you need to see and fills out a referral form. The referral form is sent to the specialist by fax or mail or you may take a copy of the form to the specialist. Your PCP may help you make an appointment with the specialist. Section 7 of the Subscriber Contract (Part I of this booklet) gives information about when a specialist can be your PCP and about standing referrals to specialists and specialty care centers.

If we do not have a specialist in the MetroPlus network who can give you the care you need, we will find one for you outside the network. Before you can see the specialist, your doctor must ask MetroPlus for a referral. If you need to see a specialist right away, because you have an emergency, your doctor does not have to call for a referral.

To get the referral, your doctor must give us some information. Once we get all this information, we will decide within 3 work days if you can see the out-of-network specialist. But, we will never take longer than 14 days from the date we got your request to make that decision. You or your doctor can ask for a fast track review if your doctor feels that a delay will cause serious harm to your health. In that case, we will decide and get back to you in 3 work days.

If you disagree with the MetroPlus decision, you may file an appeal (see page 20 of this handbook for how to do this). You can also call the MetroPlus Customer Services at 1-800-303-9626.

If your PCP or MetroPlus refers you to a provider outside our network, you are not responsible for any of the costs except any co-payments as described in this handbook.

Self-Referral for Ob/Gyn Services. You do not need a referral from the PCP to make an appointment with a MetroPlus Ob/Gyn provider. This provider may be an obstetrician, gynecologist, nurse practitioner or licensed midwife.

HIV Testing and Counseling. All HIV testing and counseling is confidential. If you want to be tested, you can visit a MetroPlus provider. Or, you can go to a New York City or New York State anonymous testing program where only you will know your test results. Either way, you do not need a referral.

If you are pregnant, you and your baby may be eligible for Medicaid. We will tell you how to find out if this is the case. Call Member Services at **1-800-303-9626** .

Mastectomy related services. If you have a mastectomy, you can receive mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and treatment of complications resulting from mastectomy (including lymphedema). For more information, call Member Services at **1-800-303-9626**.

F - UTILIZATION REVIEW

Utilization Review (UR) is the process for deciding whether care is Medically Necessary and will be authorized or paid for by MetroPlus. Our UR staff can be reached from 8:30 a.m. to 5:00 p.m. Monday through Friday by calling the MetroPlus Utilization Management Department toll free at **1-800-303-9629** . If you call at other times, your call will be answered by voice mail. The voice mail message will tell you how to leave a message and how to tell us what we need to know to respond to your request. It will also refer you to the 24-hour toll free Health Care Hotline for a medical emergency. UR staff will respond to voice mail messages on the next business day.

Prior authorization: The following services must be approved in advance (pre-authorized) by either your PCP or MetroPlus, as indicated.

PCPs can authorize referrals for:

- Specialty care.
- Durable medical equipment.
- Radiology (including MRI, CT, etc.).
- Laboratory services.
- Home care.
- Hearing check/audiology.

PCPs must get prior authorization from MetroPlus for:

- A standing referral to a specialist.
- An elective hospital admission.
- An elective outpatient procedure.
- A referral to a provider who is not in the MetroPlus network.

When prior authorization is requested, a UR decision will be made and communicated to you (or a designated representative) and your health care provider within three business days after MetroPlus receives the information needed to make the decision.

Concurrent UR: When authorization is requested to continue or expand authorized treatment that you are currently receiving, a decision will be made and communicated to your health care provider by phone and in writing within one business day after we receive the information needed to make the decision.

After service delivery: When utilization review concerns payment for services already received, a decision will be made and communicated to the provider in writing within thirty days after all necessary information is received.

Failure by MetroPlus to make an initial UR determination within the required time period will be considered an adverse determination subject to appeal.

Notice of adverse determination: If MetroPlus decides that the services for which authorization or payment is requested are or were not medically necessary, we will state the reasons for the decision and explain how you or your provider can appeal if not satisfied.

Reconsideration and appeals: If we decide not to authorize services that your health care provider recommends and we have not talked with that provider, the provider can ask us to reconsider the decision. The reconsideration will be done within one business day of the request. Adverse determinations can be appealed. See Section 11 in Part I of this booklet (the Subscriber Contract) for information about MetroPlus UR appeals and New York State external appeals.

MetroPlus may reverse a pre-authorized treatment service, or procedure retrospectively, (1) when the relevant medical information presented to us is materially different from the information that was presented during the pre-authorization review; and (2) the relevant medical information presented to us upon the retrospective review existed at the time of the pre-authorization but was withheld from or not made available to us; and (3) we were not aware of the existence of the information at the time of the pre-authorization review; and (4) if we had been aware of this information, the treatment, service, or procedure being requested would have not been authorized. The determination is to be made using the same specific standards, criteria or procedures as used during the pre-authorization review.

G - GETTING HELP FROM MEMBER SERVICES

MetroPlus Member Service Representatives are here to help you. If you have a problem, complaint, or just need information, follow these steps:

1. Call Member Services Monday through Saturday from 8 AM - 8 PM using the toll-free number **1-800-303-9626**. A Member Services Representative will help solve the problem or provide the information you need.
2. You may also call outside of business hours with a Member Service issue that you think can't wait. A machine will answer your call and tell you what information to provide. A Member Services Representative will call you back in person the next business day.
3. If you have a problem that is not resolved by calling Member Services, you may file a

formal complaint with us or complain to the New York State Department of Health.
(See Section 11 for information about how to do this.)

While our Member Service Representatives will always try to help you resolve your problems and concerns, you should always contact your PCP first about any medical problems.

H - HELP FOR MEMBERS WHO DO NOT SPEAK ENGLISH AND THOSE WHO HAVE HEARING OR VISION IMPAIRMENTS

In addition to English, this booklet is available in Spanish. It is also available in Braille and on audiotape.

Our provider directory lists the languages spoken by providers in addition to English. Interpreter services are available at many of our provider sites. We have Member Service Representatives who can help you in Spanish, Haitian Creole, Russian and Chinese. If necessary, we will arrange for interpreter services through the ATT Language Bank.

Hearing-impaired members with access to a TDD machine may call **1-800-881-2812** with questions.

I - FRAUD PREVENTION

You can help prevent health care fraud. Protect your MetroPlus Health Plan identification card as you would a credit card. Be careful about giving your ID number to strangers. Someone could use your card to commit fraud. If your ID card is lost or stolen, call MetroPlus Member Services right away. Also, if you get a bill for services that should be paid for by MetroPlus, call Member Services.

J - OFFICE OF PROFESSIONAL MEDICAL CONDUCT

You can call the New York State Office of Professional Medical Conduct if you have questions about your provider's license. Call toll free (1-800-663-6114) Monday through Friday, between 8:30 a.m. and 5 p.m.

K - MEMBER INPUT INTO PLAN POLICIES AND PROCEDURES

We welcome your ideas on how to improve MetroPlus Health Plan. To give us your suggestions, please call **1-800-303-9626** or write to us at:

MetroPlus Health Plan
160 Water Street, 3rd Floor
New York, NY 10038
Attention: Member Services Department

L - PROVIDER PAYMENT METHODS

MetroPlus pays for services in two ways. For primary care, we pay a fixed amount each month for each MetroPlus member. The amount is not affected by how many times you visit your PCP or how many primary care services you receive. For all other services, we are billed by the provider for the services actually given and we pay at rates set in our contracts. We do not use withholds, profit sharing, or other payment methods that may encourage doctors to provide fewer services.

M - OTHER INFORMATION AVAILABLE TO YOU ON REQUEST

The following information is available to you. To request it, please call Member Services at **1-800-303-9626**.

- Names and addresses of MetroPlus officers and directors.
- A copy of our most recent annual financial statement.
- Department of Insurance consumer complaint information.
- MetroPlus confidentiality protection procedures.
- A list of medicines we will pay for.
- A description of what we do to ensure quality care.
- A description of how we decide to approve any experimental or investigational drugs, devices or treatments.
- Information on the MetroPlus hospital affiliations of our health care providers.
- MetroPlus' written medical standards of care for a particular sickness or medical problem (upon written request).
- Application procedures and minimum qualifications for health care providers to become MetroPlus providers.
- Additional information on advance directives.

N - METROPLUS MEMBERS' BILL OF RIGHTS

The MetroPlus Health Plan Member Bill of Rights gives members who are receiving care at any participating health center the following rights:

1. The right to be treated with consideration, dignity and respect, regardless of your physical and emotional condition.
2. The right to get complete information regarding diagnosis, treatment and outcome in a language that is easily understood by you.
3. The right to be informed of the name, title and function of anyone involved in your care, as well as information about their professional qualifications.
4. The right to receive necessary information in order to give informed consent before the beginning of any procedure or treatment (except in emergency situations when informed consent cannot be obtained).
5. The right to refuse treatment to the extent permitted by law, and to be informed of any medical problems you may experience from lack of treatment.

6. The right to receive necessary emergency medical care when you arrive at the emergency room.
7. The right to receive confidential care and treatment and to have all your medical records remain private except as provided by law.
8. The right to be told by a doctor, or his or her representative, of any special health care needs you may have after being discharged or transferred.
9. The right to refuse to take part in research and/or any experimental treatment as part of your care or treatment unless you have full knowledge and agree.
10. The right to receive treatment without discrimination as to age, race, color, religion, gender, sexual orientation or national origin.
11. The right to voice or file a written grievance without fear of reprisal.
12. The right to have decisions carried out as you request in an Advance Directive.

Important Phone Numbers

For help from **MetroPlus Member Services**, call **1-800-303-9626** (TDD: **1-800-881-2812**)

If you have a question or complaint or you need help of other kinds, call MetroPlus Member Services (toll free) 8:00 a.m. to 8:00 p.m. Monday through Saturday.

Health Care During Business Hours (8:30 a.m. to 5:30 p.m., Monday - Friday)

To make or change an appointment, or if you have questions about your health or medical treatment, call your health care provider. Write your providers' phone numbers here:

Name	Phone Number
PCP:	
OB/GYN:	
Other:	
Other:	

Outside normal business hours, call the 24-Hour Health Care Hotline: 1-800-442-2560

If you need health care after hours or on weekends, call our 24-Hour Health Care Hotline (toll free). The Hotline staff will put you in touch with your PCP or, if your PCP can't be reached, another MetroPlus provider who works with your PCP and can help you.

Emergency Services

In an emergency, *call 911 and follow instructions or go to the nearest emergency room*. **Emergency Condition** and **Emergency Services** are defined on page 4.

MetroPlus Utilization Review

For review of a decision that treatment is not medically necessary, call the MetroPlus Utilization Management Department at **1-800-303-9629** .

New York State Department of Health Complaint Hotline: 1-800-206-8125

Dear MetroPlus Member:

Like many people today, you may be wondering what happens to the personal information about you that your health plan receives. The two privacy notices included in your welcome packet tell you about your privacy rights, the personal information MetroPlus Health Plan collects, what we do with that information, and the steps we take to keep it confidential and secure. The one-page notice titled "Privacy Notice" gives you information required by New York Insurance Regulation 169. The longer "Notice of Health Information Privacy Practices" tells you about our use and disclosure of your medical information and your rights under the federal HIPAA privacy rule.

Our company's commitment to customer privacy is not new. MetroPlus members have trusted us with their personal information for as long as we have been in business. We value that trust and take seriously our responsibility to protect your privacy.

Please read the privacy notices carefully. No response is required. If you have questions, however, we would be happy to answer them. Please call our Member Services Department at 1-800-303-9626 (TDD 1-800-881-2812).

Sincerely,
MetroPlus Health Plan

Privacy Notice

MetroPlus Health Plan respects your privacy rights. This notice describes how we treat the nonpublic personal financial and health information (“Information”) we receive about you and what we do to keep it confidential and secure as required by New York State Insurance Law (Regulation 169).

Categories of Information we collect and may disclose

MetroPlus collects Information about you from the following sources:

- Information you give us on applications and other forms or that you tell us; and
- Information about your dealings with us, the health care providers we work with, and others.

What we do with your Information

We do not disclose Information about our members and former members to anyone, except as permitted by law.

We do use Information as permitted by law for health plan purposes, such as the following:

- To provide the health care benefits you receive as a member of MetroPlus Health Plan; for example, to arrange for treatment that you need and to pay for services you receive;
- To communicate with you about programs and services that are available to you as a MetroPlus member; and
- To manage our business and comply with legal and regulatory requirements.

How we protect your privacy

- We limit access to your Information to employees and other persons who need it to conduct MetroPlus Health Plan business or comply with legal and regulatory requirements.
- Employees are subject to discipline, and may be fired, if they violate our privacy policies and procedures.
- We also use physical, electronic and procedural safeguards to keep Information confidential and secure in accordance with state and federal regulations.

Former members

If your membership in MetroPlus Health Plan ends, your Information will remain protected in accordance with our policies and procedures for current members.

You can contact us at the address or phone number below to:

- Request more information about our privacy policies and practices,
- File a privacy-related complaint with us, or
- Request (in writing) to review Information about you in our records

**Member Services, MetroPlus Health Plan, 160 Water St., 3rd Floor, New York, NY 10038
Phone: 1-800-303-9626 (TDD 1-800-881-2812)**

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

MetroPlus Health Plan
Notice of Health Information Privacy Practices
Effective April 14, 2003

I. Our legal duty

By law, MetroPlus must protect the privacy of health information that shows who you are. MetroPlus also has to give you this notice to tell you about our legal duties and our privacy practices -- how MetroPlus may use and give out ("disclose") your protected health information ("PHI"). By law, MetroPlus must follow the practices described in our current privacy notice.

II. How we may use and disclose health information about you

A. MetroPlus MUST disclose your PHI:

- To you or someone who has the legal right to act for you (your personal representative),
- To the Secretary of the U.S. Department of Health and Human Services, if necessary, to make sure your privacy is protected, and
- As required by law.

Your written consent is not required for these disclosures. Examples of disclosures that may be required by law include: (a) disclosures to government agencies as required by New York laws governing health maintenance organizations; (b) reporting to public health officials information relating to child abuse, domestic violence, births, deaths and various diseases; (c) responses to court orders or subpoenas issued by grand juries or administrative tribunals; and (d) disclosures required to comply with workers' compensation laws.

B. MetroPlus MAY use and disclose your PHI for the purposes described below.

Under New York law, your consent is required for certain disclosures, except to the extent that such disclosures are made to the Department of Health for quality assurance or oversight, or are otherwise required by law. Generally, the required consent is contained in enrollment application and renewal forms. When making disclosures for these purposes, MetroPlus also must follow federal, state and local laws that provide special privacy protections for health information relating to HIV, mental health and chemical dependency treatment.

1. Treatment: We may use your PHI and disclose it to health care providers as needed for you to get the health care you need. For example, a MetroPlus nurse care manager may help to arrange for special services or medical equipment that your doctor orders. In that case, the care manager may need to discuss your condition and specific needs with providers in order to make sure that you will get the right services or equipment when you need them. We also give our pharmacy and dental benefit managers a limited amount of PHI that they need to provide benefits to members.
2. Payment: MetroPlus uses and discloses PHI to pay for services covered by your health plan. For example, the health care providers who treat you bill us for their services and include PHI on their bills. MetroPlus uses this information to determine whether the services are covered by the Plan and how much MetroPlus should pay. We also may review medical records from your doctor or hospital

to decide whether services are medically necessary or to verify an emergency medical condition. In addition, MetroPlus may disclose your PHI to providers or their billing agents in the Plan's explanation of payment and in resolving payment disputes.

MetroPlus also may use and disclose your PHI as necessary to get paid for what we do. For example, New York State pays MetroPlus to manage health plan benefits for enrollees in Medicaid Managed Care, Family Health Plus, and Child Health Plus programs. MetroPlus discloses a limited amount of PHI in billing the State and may disclose PHI as necessary to resolve payment disagreements. Also, in order to receive payment from the State, MetroPlus must fulfill its responsibilities under our contracts with the State and City of New York. These responsibilities include reporting PHI as required by the State and City for their oversight and management of these programs. As another example, MetroPlus may use or disclose your PHI to obtain payment under a contract for reinsurance.

3. Health Care Operations: MetroPlus may use and disclose your PHI as necessary to make sure that you receive quality health care and health plan services. These activities may be performed by our employees or by business partners under contract to MetroPlus. A few examples are given below.

In order to provide customer services, we may use your PHI and may disclose it to contracted providers or business associates. For example, to investigate and resolve a complaint or problem that is brought to our attention, our staff may need to discuss the situation, including some of your PHI, with people inside and outside of MetroPlus. As another example, MetroPlus gives a limited amount of member contact and coverage information to the company that operates our after hours health care hotline, so that its representatives can connect you by phone to health care providers.

MetroPlus may use and disclose PHI about you (for example, by calling you or sending you a letter) to remind you of an appointment for treatment or that it's time for you to schedule an appointment for a regular check-up or immunization, or to provide information about treatment alternatives ("choices") or other health-related benefits and services that may be of interest to you.

Quality management also may involve use and disclosure of your PHI. This includes evaluating the performance of our employees, contracted providers and business partners, as well as monitoring and improving the quality of the Plan's programs, data and business processes. As an example, your medical record may be reviewed by our quality management staff or contracted nurse reviewers to evaluate the quality of care provided to you and all Plan members.

Other examples of MetroPlus activities that are part of health plan operations and may involve use and disclosure of your PHI include: premium rate filings and other activities involved in contracting to provide health coverage; financial audits; business planning and development; licensure, certification and accreditation reviews; internal compliance reviews; obtaining legal services and handling legal matters, and; fraud prevention and detection.

4. Government agency health oversight activities authorized by law. For example, we will give information to help the government conduct an investigation or inspection of a health care provider.
5. Public health agency activities authorized by law. For example, we provide information to assist the NYC Department of Health in maintaining its childhood immunization registry.
6. Disclosure to prevent a serious and imminent threat to your health and safety or to the health and safety of another person or the public, to someone who can help prevent the threat.
7. Law enforcement purposes, such as when required by a court ordered warrant or to report criminal conduct at the health plan.

8. Specialized government functions authorized by law. If you are a member or veteran of the armed forces, we may disclose PHI about you as required by military authorities. We also may disclose PHI to authorized federal officials for national security activities. In addition, we may disclose inmates' PHI to correctional institutions in limited circumstances.

III. Your authorization is required for other uses and disclosures

MetroPlus is required by law to get your written permission (an "authorization") to use or disclose your PHI for any purpose that is not included in one of the categories of uses and disclosures described in this notice. You may take back ("revoke") your authorization at any time by writing a letter to the MetroPlus Privacy Officer. Your letter will be effective as of the date it is received at MetroPlus but we cannot take back any disclosures already made.

IV. Your other health information privacy rights

- A. To see and get a copy of your PHI. In most cases, you have the right to look at or get a copy of health information about you that we may use to make decisions about you. Requests must be sent in writing to the MetroPlus Privacy Officer. If we don't have your PHI but we know who does, we will tell you who to ask for it. We will respond to you within 30 days after receiving your written request. In certain situations, we may deny your request. If we do, we will tell you in writing our reasons for the denial and explain your right to have the denial reviewed.

As allowed by law, we will charge you \$0.75 (75 cents) for each page of copies you request. Instead of providing the PHI you requested, we may give you a summary or explanation of the PHI as long as you agree to that and to the cost in advance.

- B. To have your PHI corrected or updated ("amended") if you believe there is a mistake in it, or that a piece of important information is missing, and we agree. You must send a request and your reasons for it in writing to the MetroPlus Privacy Officer. We will respond within 60 days of receiving your request. If we are unable to act within 60 days, we may extend that time by no more than an additional 30 days. If we need to extend the time, we will tell you about the delay and the date by which we will complete action on your request. If we approve your request, we will make the change to your PHI and tell you that we have done it. If we know or you tell us that someone else received the PHI we agree to amend, we will also tell them about the correction.

We may deny your request if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if:

- the information was not created by us, unless the person or entity that created the information is no longer available to make the correction;
- the information is not in records that you have a right to see or copy;
- we are not permitted by law to disclose the PHI; or
- the PHI is correct and complete.

Our written denial will state the reasons for the denial and explain your right to file a written statement of disagreement. If you don't file one, you have the right to ask that your request letter and our denial be attached to all future disclosures of the PHI.

- C. To get a listing (an "accounting") of disclosures we have made of PHI about you. The list will not include instances where your PHI was given directly to you or your personal representative or given to others with your authorization. The list also won't include disclosures made for treatment, payment or health care operations, or for national security purposes, to corrections or law enforcement personnel, or before April 14, 2003.

To get an accounting of disclosures, send a written request to the MetroPlus Privacy Officer. Your request must state a time period that may not be longer than six years and may not include dates before April 14, 2003. We will act on your request within 60 days if possible. If we need more time, we may take up to 30 more days. The first list you request in a 12-month period will be free. We are entitled to charge you for the cost of providing any more lists within 12 months of providing a free one. We will tell you the cost and you may choose to withdraw or modify your request before any costs are incurred.

- D. To ask MetroPlus to restrict or limit how we use or disclose PHI about you for treatment, payment and health care operations. We will consider your request, but by law we do not have to agree to it. If we do agree, we will comply with your request unless the information is needed by a provider to give you emergency treatment or a disclosure is required by law.

To ask for a restriction, write to the MetroPlus Privacy Officer. Your request must tell us: (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply - for example, to your spouse or parent.

- E. To ask for confidential communications. You have the right to ask us to communicate PHI to you in a certain way or at a certain location. For example, you can ask us to contact you by phone only at your work number, or only by mail sent to a particular address. We will accommodate all reasonable requests that we are able to meet. To ask for confidential communications, call our Member Services Department at 1-800-303-9626 (TDD 1-800-881-2812).
- F. To get a paper copy of this notice. You may get a paper copy of this notice at any time by calling our Member Services Department at 1-800-303-9626 (TDD 1-800-881-2812).

V. Changes to privacy practices and this notice

We reserve the right to change our privacy practices and this notice at any time in accordance with law. These changes will apply to all information about you that we maintain. If we make a significant change, we will send you a new notice by mail before the change goes into effect.

VI. Complaints

If you think MetroPlus has violated your privacy rights, you may file a complaint with our Privacy Officer at the address or phone number below, or you may call Member Services at 1-800-303-9626 (TDD 1-800-881-2812). You also may send a written complaint to the U.S. Department of Health and Human Services. We will not take any action against you for filing a complaint.

VII. Privacy Officer contact information

If you have questions about our privacy practices, or if you want to file a complaint or exercise rights described in section IV, items A, B, C and D above, please contact:

MetroPlus Privacy Officer
160 Water Street, 3rd Floor
New York, NY 10038
Phone: (212) 908-8600 Fax: (212) 908-8620
E-mail: MetroPlusPrivacyOfficer@nychhc.org

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